Tri-County: Saginaw, Bay, Midland Counties

Michigan Prisoner ReEntry Initiative

MPRI

Creating Safer Neighborhoods & Better Citizens

A Guide to Evidence-Based Prisoner Reentry Practices

This report was produced with the support of the Tri-County Michigan Prisoner ReEntry Initiative

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Compiled by Barbara Glassheim

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TABLE OF CONTENTS

FORWARD I

INTRODUCTION AND OVERVIEW 1

EVIDENCE-BASED PRACTICE CONCEPTS 4

- WEIGHING THE EVIDENCE 5
- EIGHT PRINCIPLES OF EVIDENCE-BASED CORRECTIONAL PRACTICE 7
- MEASUREMENT 10
  - SCREENING AND ASSESSMENT 10
    - COMPAS 11
  - PROGRAM EVALUATION 12
    - CORRECTIONAL PROGRAM ASSESSMENT INVENTORY – 2000 (CPAI-2000) 13

CULTURAL CONSIDERATIONS 15

- RACE 15
- GENDER 15
  - GENDER-RESPONSIVE APPROACHES 18
- PRISONIZATION AND JAILHOUSE CULTURE 18
  - SENSITIZING PROVIDERS TO THE EFFECTS OF CORRECTIONAL INCARCERATION ON TREATMENT AND RISK MANAGEMENT (SPECTRM) 20

COLLABORATION AND SERVICE DELIVERY 22

- JUSTICE MAPPING 23
- EFFECTIVE TRANSITION PLANNING: MITIGATING GATE FEVER AND EARLY RISK 25
  - TRANSITION FROM PRISON TO COMMUNITY MODEL (TPC) 27
  - TRANSITION ACCOUNTABILITY PLANS (TAPS) 30
  - INREACH 31
    - VIDEOCONFERENCING 31
    - RESOURCE GUIDES AND REENTRY HANDBOOKS 32
- CORRECTIONS CASE MANAGEMENT 32
- WRAPAROUND SERVICES 33
- EVIDENCE-BASED SUPERVISION STRATEGIES 33
  - PROSOCIAL MODELING 35
  - NEIGHBORHOOD-BASED SUPERVISION 35
  - GRADUATED RESPONSES: SANCTIONS AND INCENTIVES 36
- SPECIALTY SUPERVISION 38
  - MENTAL HEALTH 38
  - SEX OFFENDING 39
- STAGES OF CHANGE 42
- MOTIVATIONAL INTERVIEWING (MI) 43
- SUPPORTIVE INQUIRY 46
- CONFIDENTIALITY 49

RESIDENTIAL STABILITY 51

- SUPPORTIVE HOUSING 53
- REENTRY HOUSING 55
  - COMMUNITY-BASED CORRECTIONAL TRANSITIONAL RESIDENTIAL FACILITIES 57
- SUBSIDIZED HOUSING 58

HOUSING CHOICE VOUCHER PROGRAM (HCVP) 59
FAMILY UNIFICATION PROGRAM (FUP) 59
SUPPORTIVE HOUSING PROGRAM (SHP) 59
HOME INVESTMENT PARTNERSHIPS PROGRAM 60
LOW-INCOME HOUSING TAX CREDIT (LIHTC) 60
PROJECTS FOR ASSISTANCE IN TRANSITION FROM HOMELESSNESS (PATH) 60
SHELTER PLUS CARE (S+C) 61
SECTION 8 MOD REHAB PROGRAMS 61
HOUSING OPPORTUNITIES FOR PERSONS WITH AIDS (HOPWA) 61
SUPPORTIVE HOUSING FOR PERSONS WITH DISABILITIES (SECTION 811) 61
INDIVIDUAL DEVELOPMENT ACCOUNTS (IDAS) 62
PRIVATE MARKET HOUSING 62

EMPLOYMENT READINESS 66

EMPLOYER INCENTIVES 68
CORRECTIONS-BASED EDUCATION AND VOCATIONAL TRAINING 70
PRISON INDUSTRIES 71
WORK-RELEASE PROGRAMS 71
TRANSITIONAL JOBS MODEL (TJ) 72
ONE-STOP CENTERS 72
STRIVE (SUPPORT AND TRAINING RESULT IN VALUABLE EMPLOYEES) 73
WOMEN ARISE – PROVE PROJECT 74

SOCIAL SUPPORT 75

COMMUNITY INVOLVEMENT 75
RESTORATIVE JUSTICE 76
SYCAMORE TREE PROJECT® (STP) 78
BRIDGES TO LIFE (BTL) 78
CIRCLES OF SUPPORT AND ACCOUNTABILITY (COSA) 78
REENTRY COURTS 79
POLICE REENTRY PARTNERSHIPS 80
COMMUNITY-ORIENTED POLICING (COP) 82
SCANNING, ANALYSIS, RESPONSE, AND ASSESSMENT (SARA) 82
COLLABORATION WITH JAILS 84
APIC MODEL 84
MENTORING AND PEER SUPPORT 85
REINTEGRATION OF EX-OFFENDERS PROJECT 87
COLLABORATING WITH FAITH-BASED ORGANIZATIONS (FBOS) 87
PRISON FELLOWSHIP MINISTRIES (PFM) 88
KAIROS HORIZON COMMUNITIES IN PRISON 89
WORKING WITH FAMILIES 89
DOMESTIC VIOLENCE (DV) 91
BATTERERS' INTERVENTION PROGRAMS (BIPS) 92
DOMESTIC VIOLENCE COURTS 93
CHILDREN 93
AMACHI MENTORING PROGRAM 95
PARENTING PROGRAMS 95
GIRL SCOUTS BEYOND BARS (GSBB) 96
LONG DISTANCE DADS (LDD) 96
STRENGTHENING MULTI-ETHNIC FAMILIES AND COMMUNITIES 97

PROJECT SEEK (SERVICES TO ENABLE AND EMPOWER KIDS) 97
FAMILY MAPPING 98
GENOGRAMS 99
ECOMAPS 100
FAMILY CASE MANAGEMENT (FCM) 101
BODEGA MODEL 102
WORKING WITH CHILD WELFARE 103
ACCESS TO ENTITLEMENTS AND BENEFITS 105
SOCIAL SECURITY DISABILITY INSURANCE (SSDI) 105
TICKET TO WORK PROGRAM 106
SUPPLEMENTAL SECURITY INCOME (SSI) 106
PLANS FOR ACHIEVING SELF–SUPPORT (PASS) 107
TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF) 107
CHILD CARE AND DEVELOPMENT FUND (CCDF) 108
NUTRITION ASSISTANCE 108
MEDICAID 109
MEDICARE 109
VETERANS BENEFITS 110

HEALTH/BEHAVIORAL HEALTH 112

MENTAL HEALTH CARE 113
DIVERSION – ALTERNATIVES TO INCARCERATION PROGRAMS (ATI) 116
CRISIS INTERVENTION TEAM (CIT) 116
MENTAL HEALTH COURTS 117
MENTAL HEALTH CASE MANAGEMENT 118
FORENSIC INTENSIVE CASE MANAGEMENT (FICM) 118
ASSERTIVE COMMUNITY TREATMENT (ACT) 118
FORENSIC ASSERTIVE COMMUNITY TREATMENT (FACT) 119
PEER-OPERATED PROGRAMS AND SERVICES 120
PSYCHIATRIC ADVANCE DIRECTIVES (PADS) 121
ILLNESS MANAGEMENT AND RECOVERY (IMR) 122
SUPPORTED EMPLOYMENT (SE) 123
SUPPORTED EDUCATION (SED) 124
FAMILY PSYCHOEDUCATION (FPE) 124
CRITICAL TIME INTERVENTION (CTI) 125
DIALECTICAL BEHAVIOR THERAPY (DBT) 126
SOLUTION-FOCUSED BRIEF THERAPY (SFBT) 127
PHARMACOTHERAPY 129
TRAUMA-FOCUSED INTERVENTIONS 131
SEEKING SAFETY 131
TRAUMA RECOVERY AND EMPOWERMENT (TREM) 132
TRAUMATIC INCIDENT REDUCTION THERAPY (TIR) 133
PROLONGED EXPOSURE THERAPY (PE) 133
EYE MOVEMENT DESENSITIZATION AND REPROCESSING (EMDR) 134
GROUNDING 134
HELPING WOMEN RECOVER AND BEYOND TRAUMA 135
COGNITIVE-BEHAVIORAL THERAPY (CBT) 135
MORAL RECONATION THERAPY (MRT) 137
REASONING AND REHABILITATION (R&R) 138
RELAPSE PREVENTION THERAPY (RPT) 139

THINKING FOR A CHANGE (T4C) 140
STRATEGIES FOR SELF-IMPROVEMENT AND CHANGE (SSC) 141
AGGRESSION REPLACEMENT TRAINING (ART) 143
SKILLS TRAINING 144
ANGER MANAGEMENT TRAINING 145
SUBSTANCE USE DISORDERS TREATMENT 145
TREATMENT ACCOUNTABILITY FOR SAFER COMMUNITIES (TASC) 146
DRUG TESTING 147
DRUG TREATMENT COURTS (DTCS) 148
COMMUNITY REINFORCEMENT TRAINING (CRT) 150
COMMUNITY REINFORCEMENT APPROACH (CRA) 151
COMMUNITY REINFORCEMENT AND FAMILY TRAINING (CRAFT) 151
BRIEF INTERVENTION 152
MOTIVATIONAL ENHANCEMENT THERAPY (MET) 153
CONTINGENCY MANAGEMENT (CM) 154
GROUP THERAPY 155
SELF HELP AND MUTUAL SUPPORT 160
TWELVE STEP FACILITATION THERAPY (TSF) 160
THERAPEUTIC COMMUNITIES (TCS) 161
MODIFIED THERAPEUTIC COMMUNITIES (MTCS) 162
THERAPEUTIC COMMUNITIES FOR WOMEN 162
MEDICATION-ASSISTED TREATMENT (MAT) 163
CO-OCURRING DISORDERS (CODS) 164
INTEGRATED TREATMENT FOR CO-OCCURRING DISORDERS 166
INTERVENTIONS FOR SEX OFFENDING 166
COGNITIVE BEHAVIORAL THERAPY FOR SEX OFFEND ING 169

SUMMARY AND CONCLUSIONS 171

APPENDIX A: SELECTED REFERENCES 175

APPENDIX B: SELECTED RESOURCES 208

APPENDIX C: GLOSSARY 220

APPENDIX D: QUICK REFERENCE GUIDE 241

FORWARD

This guide is based on a review of the voluminous and robust base of literature on effective correctional practices as well as research from relevant social sciences. It is intended to inform local policy and practice and promote the maximization of resources. While aimed at corrections, it is hoped that all partners in reentry will find useful information.

A note about terminology is in order. The individuals who are the subject of this guide are referred to in various ways by agencies and service systems. In the public mental health system they are known as "consumers", while in the substance use disorder treatment field, they are called "clients", and in the medical arena they are labeled "patients". In the professional corrections literature terms such as "offender/ex-offender", "inmate", "prisoner/ex-prisoner", "criminal", "felon/ex-felon", "parolee", and "releasee" predominate. In Michigan there appears to be a movement toward the term "returning citizen". Although only one reference to this term was found in the literature (a faith-based document), it is the term used predominantly in this guide except when discussing other systems as noted. Above all, however, this guide adheres to person-first language in recognition of the humanity of all individuals.

Due to length and detail of this document, it may be less useful to read it as a sequential whole (as one would a book or an article), but, instead, review sections of interest. The electronic format allows the reader to use the table of contents to find topics of interest and move immediately to those topics through active hyperlinks. Other hyperlinks, denoted in blue underlined text, will take the reader to various Web sites listed.

It should be noted that this document is a snapshot in time. The evidence-based practice literature continues to evolve, and, as new information becomes available, subsequent iterations may be produced to account for significant developments.

Finally, while individual sources are cited in the reference section, no attempt was made to produce a document in accordance with established standards for publication in order to improve its readability.

This writer gratefully acknowledges the support and sponsorship of the Tri-County MPRI and the Saginaw County Community Mental Health Authority as the local administrative service agency, and applauds their endeavor to ensure the provision of effective services and supports to returning citizens.

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INTRODUCTION AND OVERVIEW

Parole in the United States originated in the Elmira Reformatory in New York State in 1867 as an option for the early release of individuals for good behavior and a means to reduce institutional overcrowding. In the early twentieth century, it came to be viewed as a tool for intermediate sentencing in furtherance of the goal of rehabilitation. However, during the 1970s concerns regarding the integrity of indeterminate sentencing arose due to increasing crime rates, a lack of empirical knowledge regarding effective correctional interventions, insufficient allocation of resources for rehabilitative interventions, and the so-called war on drugs. In addition, concerns were raised about inconsistent decision-making by paroling authorities that resulted in apparent unfairness and inequity in release decisions deemed arbitrary, capricious, racially biased, and resulted in unjustifiably disparate sentences. Also, studies in the 1970s (conducted by Martinson and Brody) found a paucity of convincing evidence that rehabilitation reduces recidivism.

During the 1980s incarceration came to be conceptualized as punishment (i.e., just deserts), and by the late 1980s and 1990s as a means of incapacitation and deterrence with far less concern for equity and proportionality in sentencing. Mandatory minimum sentences, three-strikes, truth-in-sentencing, and mandatory sex offender registration laws were enacted. Rehabilitation was discarded, often coupled with the reduction or elimination of discretionary parole release. This get tough on crime stance resulted in an explosive growth in prison populations[1], rates of incarceration, and costs of construction and operation of prisons. Ironically, as sentencing models focused more and more on punishment and incapacitation, research was providing evidence of effective interventions for reducing recidivism along with the ineffectiveness of incarceration.

Along with the shift from rehabilitation to punishment, the mission of parole to support reintegration, shifted to reflect the get tough on crime stance resulting in fewer releases prior to the expiration of sentences, holding individuals who were released for greater portions of their maximum sentences, and increasing rates of parole revocation and re-incarceration.

By the 1990s the United States incarcerated more persons per capita than any other country with over two million adults behind bars, amounting to an incarceration rate of about one in one hundred. At the onset of the twenty first century the criminal justice system faced a rising prison population[2] serving longer terms along with significantly diminished resources for prison-based programming, increased parole and probation caseloads, and scarce resources for returning citizens. Corrections costs (nearly ninety percent of which are allocated to prisons) soared creating serious budgetary pressures and accounting for significant amounts of statesôgeneral fund discretionary dollars. Growing numbers of returning citizens and serious fiscal crises facing many states gave rise to a burgeoning interest in reentry.

During the 1980s and 1990s, parole release and supervision focused primarily on enforcement and surveillance, using monitoring to stress compliance with conditions of release. Increasing rates of incarceration and release[3] have resulted in increasing numbers of persons under community supervision posing significant challenges to parole/probation agencies as resources

[1] After nearly four decades of uninterrupted growth, admissions to state prisons began to decline in 2007.
[2] Interestingly, studies have shown that states with increases in prison populations have not experienced concurrent reductions in violent crime. Also, during the 1990s, as the number of releases from prison increased, the crime rate decreased.
[3] It is estimated that 93% to 95% of individuals who are incarcerated are eventually released.

have not kept pace with these increases. By the turn of the century, parole revocation practices came under increasing scrutiny and efforts designed to reduce the rate of parole revocations, especially for technical violations, and promote more effective reintegration of returning citizens have become a major focus. Studies show that individuals released to parole through the discretion of a releasing authority are more likely to successfully complete their parole term without re-incarceration than individuals released through a mandatory system.

The majority of returning citizens have not experienced successful community reentry. According to data from the U.S. Department of Justice (DOJ), two-thirds (67.5%) of individuals released from prison are rearrested within three years more than half of whom are re-incarcerated. Studies have shown that returning citizens are at highest risk for recidivism during the first six months after release when almost one-third (29.9%) are rearrested. Despite public perception that people on parole are more likely to commit crimes, the vast majority do not return to prison for a new offense. Seventy percent are re-incarcerated[4] due to technical parole violations (e.g., missing appointments and not maintaining employment) rather than for the commission of new crimes.

Returning citizens are faced with significant challenges to successful reentry including reuniting with family and significant others, finding jobs and housing, and remaining substance-free while avoiding high-risk situations that can trigger relapse and recidivism. More individuals are released from longer terms of incarceration and are more are likely to have health or substance abuse problems which exacerbate these challenges. In addition, limited availability of jobs, housing, and social services in a community can adversely impact successful reintegration. Fifty-five percent of adults involved in the criminal justice system have minor children and parents who are incarcerated can owe an average of more than $20,000.00 in child support debt at the time of release.

There is now a substantive and growing research base of effective correctional practices that promote successful reentry. Strategies that can significantly reduce recidivism have been identified, including prison and community-based cognitive-behavioral therapy (CBT), substance abuse treatment, relationship enhancement skills (e.g., motivational interviewing), vocational and educational programming, and community supervision that includes a case management focus along with rewards and sanctions and linkages with appropriate treatment and service and support providers.

In sum, the large numbers of returning citizens, a significant proportion of whom are reincarcerated, concerns regarding community safety, state fiscal crises and increasing correctional costs, as well as research on evidence-based correctional interventions are now driving contemporary correctional practice. These have led to a shift in focus in correctional institutions from custody and control to preparing individuals for their release starting from admission and continuing throughout community supervision and beyond. Paroleôs traditional emphasis on surveillance and enforcement of conditions (i.e., identifying violations and quickly revoking parole for noncompliance) is being replaced by a focus on transition and successful reintegration.

This guide is divided into sections each of which begins with a discussion of salient issues followed by recommendations to address those issues. Woven throughout is a focus on the eight principles of effective correctional programs which are discussed in the first section on evidence-based practices. Also included in this section is a discussion of measurement as it relates to screening and assessment of returning citizens as well evaluation of programs and service providers. Measurement is essential to using evidence-based practices. The next

[4] In Michigan, prior to MPRI, fifty percent of persons on parole were re-incarcerated within three years; since MPRI, that number has been reduced to one third.

session includes discussion regarding culture and focuses on gender, race, and the culture of incarceration. While collaboration is discussed throughout the document as it is a hallmark of effective reentry practices, a section is devoted to this topic. It covers models of effective service delivery, justice mapping, transition planning, techniques to enhance relationships in working with returning citizens, and specialty supervision. The next section covers housing options for returning citizens and various residential models, funding and citing issues. The following section contains information regarding education and employment, two factors that have been shown to be critical to successful community reintegration. Social support is covered next with discussions regarding working with families, the community, police, jails, faith-based organizations, mentoring and peer support, and access to entitlements and benefits. The next section covers physical health care issues as well as behavioral health including evidence-based interventions for psychiatric disorders, substance use disorders, and co-occurring disorders. Included are interventions to address trauma and criminogenic needs and risks. A summary and conclusion section is followed by appendices that include selected references, resources, a glossary, and quick reference guide.

EVIDENCE-BASED PRACTICE CONCEPTS

The conventional wisdom of the 1970s and 1980s that correctional treatment is ineffective led to a rejection of rehabilitation programs in favor of punishment, incapacitation, and deterrence as the major goals of corrections. However, since the 1990s, a considerable body of quality research has been published on effective correctional interventions that lead to reductions in risk and recidivism and improved outcomes for individuals under supervision, particularly when targeted to those who are at higher risk and focus on their specific criminogenic needs.

The term evidence-based practice (EBP) originated within the healthcare field where it is considered to be both a standard and a philosophical framework for making clinical decisions. It is defined as the integration of the best research evidence with the clinical expertise of the provider and the values of the patient. The field of behavioral healthcare defines evidence-based practice in terms of specific intervention models and principles, but also includes a broader conceptual framework for integrating research evidence with assessment of the consumerôs needs, values, and preferences in order to individualize treatment. This entails involving consumers in collaborative decision-making relationships with practitioners in which potential interventions, outcomes, side effects, behaviors (e.g., the degree of adherence to clinical recommendations, quality of interpersonal supports for treatment, and intrinsic motivation), culturally-specific meanings attached to symptoms and behaviors, and the cultural context of encounters with practitioners are critically appraised.

Within the field of corrections, evidence-based practice refers to specific intervention models (e.g., cognitive-behavioral therapy) or principles (e.g., the responsivity principle) that are used to guide interventions that research has proven lead to desirable outcomes (e.g., reducing risk and recidivism and increasing public safety). Evidence-based correctional interventions incorporate proven practices from corrections, social sciences, business, and other disciplines. Within correctional treatment, the client is both the individual receiving treatment as well as the larger community affected by the individualôs behaviors.

Evidence-based practices are derived from the highest level of empirical evidence and incorporate current research and the best available data to guide policy and practice decisions to improve outcomes for returning citizens, victims, communities, and other key stakeholders. Evidence-based reentry practices are those that have demonstrable, positive outcomes in reducing recidivism, increasing victim satisfaction, or reducing expenditures.

Studies have demonstrated that there is a significant correlation between program implementation (i.e., fidelity) and reductions in recidivism. In other words, using evidence-based programs are insufficient; programs must be implemented with a high degree of fidelity. Research has demonstrated that if evidence-based practices are not well implemented, they are less likely to be effective Correctional programs that adhere to the principles and practices of evidence-based correctional intervention have been shown to be more effective in reducing recidivism and enhancing community integration.

Providers need to have the requisite credentials to deliver the practice; undergo specialized training, and sometimes obtain certification in the practice. In addition, research indicates that the quality of the therapeutic relationship accounts for thirty percent of the beneficial changes experienced by clients. Empirically supported therapeutic relationships include the qualities of empathy, warmth, enthusiasm, genuineness, and collaboration. The instillation of hope and confidence and a belief in the personôs ability to make positive changes are critical.

Evidence-based practice fosters the use of standardized treatment manuals, ongoing training, and expert supervision for quality assurance. Manualized treatment curricula define the treatment philosophy and provide goals and objectives for each session that can be measured to determine progress throughout the continuum of treatment services. In addition, manuals offer skill development exercises for participants that can be rehearsed during sessions and or as homework assignments. Finally, empirically validated, manualized curricula have a greater potential for being implemented with fidelity in contrast to idiosyncratic treatment conducted by practitioners with a broad range of personal and professional experiences that result in non-standardized services and variable outcomes.

Factors that have been found to impact the integrity and effectiveness of correctional program implementation and service delivery, and hence should be incorporated into performance measures and quality indicators include:

- A sound underlying theoretical model of change (e.g., cognitive-behavioral and social learning)
- Manuals that guide service delivery
- Staff skills including communication and relationship skills
- Ongoing staff training
- Ongoing supervision of staff to provide coaching and feedback and opportunities to enhance skills and performance
- Fidelity monitoring

WEIGHING THE EVIDENCE

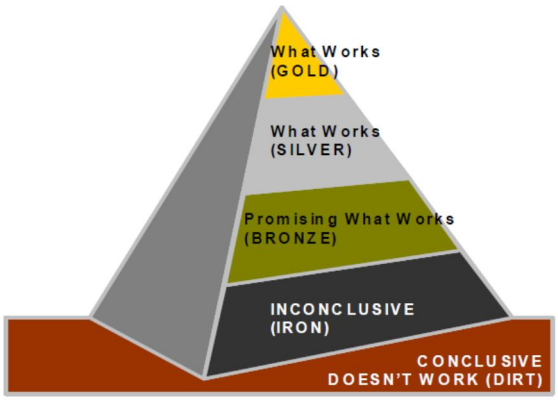
The identification of effective correctional interventions entails more than weighing the number of studies that support a specific intervention against those that fail to support the intervention because of variations in the ways studies are designed, conducted, and ultimately reported, all of which impact the relative emphasis placed on the findings. A number of factors need to be considered when determining the level of empirical evidence including:

- **Sample Size:** Large sample sizes result in a greater degree of confidence that research findings are more reliable, meaningful, and representative of the population, while small sample sizes limit the ability to generalize the findings because participants are less likely to be representative of the larger population and idiosyncratic characteristics of a small group can skew the findings. In addition, inclusion of the relevant population in the research sample is an important factor.
- **Matched Comparison Groups:** The determination of whether a specific intervention has a significant impact on outcomes requires comparisons between individuals who receive that intervention to others who received no intervention or a different intervention. Comparison groups thus provide evidence that outcomes are derived from a specific intervention. However, it should be noted that a comparison group does not necessarily indicate that observed differences in outcomes between intervention and control groups are entirely attributable to the intervention. Intervening variables (e.g., different ages, risk levels, or additional interventions that were provided) can influence outcomes. Therefore, control groups should be matched to the experimental groups based on demographic characteristics, recidivism risk, crime type, and other significant variables to help ensure groups are as similar to one another as possible. Any confounding variables should be documented and analyzed.
- **Random Assignment:** Randomly assigning research subjects to intervention (experimental) and comparison (control) groups minimizes the potential for selection bias. However, random assignment is not always feasible within social science research

because of ethical issues (e.g., the potential for denying intervention to individuals in need of treatment). Alternatives include quasi-experimental designs in which comparison groups not randomly selected from the same pool of subjects are compared to groups of program participants or designs that evaluate before and after intervention comparisons of participants.

- **Cross-Site Replication:** Generalization of results by independent studies increases confidence that observed intervention effects are authentic and not simply due to the research design, samples used, location, biases resulting from developers who are testing their own models or are reliant on external funding for ongoing support, or other intervening variables. In addition, studies should be published in peer-reviewed professional scientific journals.

Meta-analysis offers an objective approach to weighing the research base because it allows for evaluation of all known empirical studies of an intervention to determine an overall effect size and can control for intervening variables (e.g., quality of research design, older versus newer studies, and researcher affiliation with the program being studied).



Evidence-based practice requires the capacity to evaluate and judge levels of scientific evidence. Research evidence is ranked from the strongest (randomized, controlled trials or RCTs) to the weakest (anecdotal case reports). The highest quality research support (the gold level) consists of interventions and practices that have been evaluated using an experimental/control design in multi-site replications that demonstrate significant sustained reductions in recidivism. While the criteria for the next levels of support (silver and bronze) progressively decrease in terms of research rigor, all three levels require a preponderance of evidence that supports effectiveness. The iron level consists of interventions and programs that have inconclusive support for their efficacy or dubious evaluation methodology. The lowest level (dirt) consists of programs that have been evaluated (utilizing methods and criteria associated with gold and silver levels) with negative findings and thus determined to be ineffective.

Gold	• Experimental/control research design with controls for attrition • Significant sustained reductions in recidivism obtained • Multiple site replications • Preponderance of all evidence supports effectiveness
Silver	• Quasi-experimental control research with appropriate statistical controls for comparison group • Significant sustained reductions in recidivism obtained • Multiple site replications • Preponderance of all evidence supports effectiveness
Bronze	• Matched comparison group without complete statistical controls • Significant sustained reductions in recidivism obtained • Multiple site replications • Preponderance of all evidence supports effectiveness
Iron	• Conflicting findings and/or inadequate research designs
Dirt	• Silver and Gold research showing negative outcomes • Conclusively doesn't work

from Guevara, et, al. (2009)

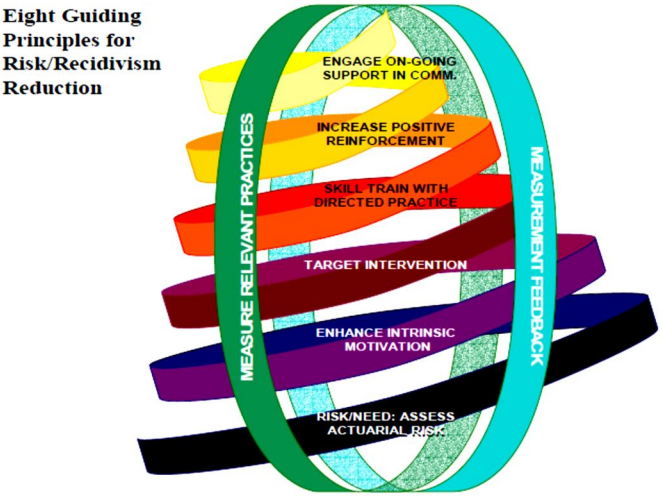
The applicability of RTCs to testing psychosocial interventions has been called into question because much of strength of treatment hinges on the provider-client relationship which is experienced subjectively and highly individualized. In addition, concerns have been raised regarding the ability to replicate the same conditions as those used in clinical trials. Questions have also arisen regarding the applicability of evidence-based practices to minority social and cultural groups.

Correctional research continues to evolve. New research creates the potential for new evidence that supports or refutes current practices. Adopting an evidence-based approach requires ongoing, critical review of the research literature to ascertain which practices are most effective given the best available evidence, continuous quality assurance and evaluation to ensure that practices are replicated with fidelity and outcomes are assessed, evaluation of the effectiveness of new practices, and the incorporation of new evidence as it becomes available. In addition to adopting practices that have been proven to be effective, it is also necessary to discard those that have been shown to be ineffective.

Finally, it should be noted that evidence-based practices do not exist for every condition, and not every individual responds to those that are available. Promising and emerging practices may be of use in such situations. Promising practices are those which show potential for positive results and or have significant evidence or expert consensus for their use. Emerging practices are innovative practices that deal with specific needs, but are not supported by the strongest scientific evidence.

EIGHT PRINCIPLES OF EVIDENCE-BASED CORRECTIONAL PRACTICE

Corrections research indicates there are eight principles that, together, increase the likelihood reducing risk for recidivism and, although not all of them are supported by the same weight of evidence, each has a sound empirical or theoretical basis. The National Institute of Corrections and the Crime and Justice Institute model (depicted here) calls for the integration of these principles in policies, procedures and everyday work of corrections agencies.



❶ **Assess Actuarial Risk/Needs:** Empirically validated instruments should be used to accurately assess risk and criminogenic needs (rather than relying solely on the subjective judgments and instincts of practitioners which have been shown to be significantly less accurate and reliable). Accurate assessment of risk and needs is critical to the development of effective intervention and supervision strategies, especially for individuals who have been shown to be at higher risk for recidivism and those with specific challenges such as psychiatric and substance use disorders. Research indicates that intervention strategies driven by reliable and valid assessments lead to positive reentry outcomes (i.e., reductions in recidivism and increased public safety) and foster the effective and judicious use of correctional resources. Information gathered informally through routine interactions and observations and from collateral sources (e.g., families, treatment staff, background records, pre-sentence investigation reports) supplements information from formal assessment instruments.

❷ **Enhance Intrinsic Motivation:** Motivational Interviewing and other motivation-enhancing techniques should be used to encourage positive behavioral change.

❸ **Target Interventions:**

- **Risk Principle:** Programming should be matched to the level of risk. Supervision and treatment resources should be prioritized and targeted to individuals who are at higher risk for recidivating. These individuals should receive more intensive programming for longer periods of time; those who are at low risk should receive low intensity services because intensive programming can increase their risk.
- **Need Principle:** Interventions should be targeted to dynamic (i.e. changeable) criminogenic needs that are associated with recidivism, the most significant of which are: (1) antisocial attitudes; (2) poor self-control; (3) antisocial associates/ peer affiliations (e.g., gangs); (5) problematic/dysfunctional family/marital relationships and circumstances; (6) educational/vocational/employment difficulties; (7) lack of prosocial leisure/recreational interests and activities; and (8) substance abuse. Addressing non-criminogenic needs (e.g., anxiety, stress distress and low self-esteem) does not lead to reductions in risk and recidivism.
- **Responsivity Principle:** Programming and interventions should be responsive to individual factors that influence responsiveness to intervention including temperament, learning style, cognitive development, culture, gender, and motivational stage of change for each problem being addressed, as well as characteristics that can interfere with ability and motivation. This entails matching to services and providers as well as tailoring interactions to the personôs priorities and interests, while being responsive to and targeting criminogenic needs.
- **Treatment Principle:** Treatment should be integrated into sentence and sanction requirements using a collaborative case management approach to planning and supervision. Individuals who are at lower risk should be diverted from the justice system whenever possible because exposure to peers at higher risk can be harmful and can interfere with involvement in prosocial community activities.
  - **Dosage:** Programs should be of sufficient duration and intensity; sustained behavior change cannot be achieved in a short period of time. Returning citizens who at higher risk have been found require significantly more initial structure. It is recommended that forty to seventy percent of their free time during the first three to nine months of post-release supervision be comprised of a clearly delineated routine and appropriate services, (e.g., outpatient treatment, employment assistance, education, etc.). Moreover, individuals with special needs (e.g., those with severe mental illnesses and co-occurring substance use disorders.) commonly require more extensive and specific services of a longer duration provided in a coordinated approach; evidence indicates that incomplete or uncoordinated approaches can have adverse effects. Research shows that individuals who are at higher risk who receive higher dosages of interventions over longer periods of time are less likely to recidivate.
  - **Density:** Programs that target multiple criminogenic needs lead to greater reductions in both institutional misconduct and post release recidivism. Research shows that correctional programs that address four to six criminogenic needs have significantly better outcomes than those that

target one to three criminogenic needs. Also, focusing on non-criminogenic needs reduces density and undermines the effectiveness of programs; rates of recidivism have been found to increase in programs that address a preponderance of non-criminogenic needs.

❹ **Skill Train with Directed Practice:** Cognitive-behavioral treatment methods in which skills are modeled and taught, rehearsed through in vivo and role-playing practice with feedback, and the provision of positive reinforcement of pro-social attitudes and behaviors have been demonstrated to be most effective.

❺ **Increase Positive Reinforcement:** Positive reinforcers should outweigh negative reinforcers by a ratio of four to one to optimize motivation, skill acquisition, and the achievement of sustained behavior change. Also, positive reinforcers/rewards, unlike negative reinforcers, can be effectively applied on a random (rather than consistent) basis. Reinforcements can be informal (a word of praise and encouragement) or formal (a letter of commendation sent to a judge, reduction of drug-testing frequency, reduction in community service requirements, or early release from supervision). Positive reinforcers can serve as extrinsic motivators for initiating behavior change.

❻ **Engage Ongoing Support in Natural Communities:** The community can function as a protective factor[5] against recidivism and provide support for successful reentry. Family members, neighbors, faith-based and cultural institutions, and community-based social service agencies can provide support to reduce criminal behaviors. Research indicates that positive natural supports can improve outcomes through everyday connections with others who function as positive role models and reinforce positive patterns of thinking and behavior. Routine home visits by supervision agents offer the opportunity to recruit such positive role models as well as identify individuals who may exert a negative influence. The observations of family members and other supporters (e.g., pastors, employers, community members, and mentors) can augment supervision efforts as well as provide positive influences.

❼ **Measure Relevant Processes/Practices:** What gets measured gets done. Individual as well as program and system performance measures should be used for evaluation. Ongoing assessment should be conducted to ascertain changes in individualsôcognitive and skills development, and ongoing regular assessment of staff performance should be provided to improve program fidelity. Effective reentry programs are data-driven and use quantitative data on recidivism, rates of crime, and other information, to measure success and ascertain opportunities to improve practices.

❽ **Provide Measurement Feedback:** The provision of individualized feedback regarding progress builds accountability and is associated with improved outcomes (e.g., enhanced motivation for change, lower treatment attrition, and improved treatment engagement and goal attainment) as well as staff performance.

[5] Strengths and protective factors that have been shown to reduce risk and criminogenic needs include pro-social family members/friends, employment, educational skills, adequate finances, safe housing, family bonds, social and emotional support, prosocial parents, friends, crime-free neighborhoods, and economic opportunities.

MEASUREMENT

Adopting an evidence-based approach to correctional practice includes the use of validated instruments to determine individualsôrisks, needs, and progress. In addition, it entails the use of valid process and outcome measures of the performance of staff members and programs in order to enhance the effectiveness of service delivery.

SCREENING AND ASSESSMENT

Screening is designed to identify indicators of the presence of issues (e.g., mental health, substance use, and physical health problems) that indicate a need for assessment and intervention and may include a brief interview, self-report instruments, and a review of archival records. Due to prevalence of medical issues, substance use disorders, mental health problems (particularly posttraumatic stress disorder and suicidality), and co-occurring psychiatric and substance use disorders among individuals involved in the justice system universal screening for these is recommended. In addition, it is recommended that women of child-bearing age be screened for pregnancy so that appropriate prenatal care can be provided and arrangements made for childbirth and infant care.

A number of screening instruments have been developed for identifying psychiatric and substance use disorders in the justice system including the Global Appraisal of Individual Needs (GAIN) and Psychiatric Research Interview for Substance and Mental Disorders (PRISM), for co-occurring psychiatric and substance use disorder, the Mental Health Screening Form-III (MHSF-III), and the Simple Screening Instrument (SSI), the Texas Christian University Drug Screen-II (TCUDS-II), the Alcohol Dependence Scale, and the Addiction Severity Index (ASI). The Addiction Severity Index (ASI), Texas Christian University Drug Screen (TCU, and Level of Service Inventory-Revisited) are available in the public domain.

Assessment should be initiated at the onset of involvement in the criminal justice system and be conducted periodically thereafter to support decision-making with regard to custody classification, release conditions, supervision levels, and treatment and support needs. Research has demonstrated that reliable, validated, and normed instruments effectively measure predictive criminogenic risk factors, enhance matching to appropriate levels of supervision and treatment, as well as help triage available resources to individuals at highest risk.

Fourth generation risk assessments consider static risk factors (e.g., number and severity of prior convictions, prior behavior during confinement, and a history of childhood abuse and neglect) that do not change in response to treatment or services as well as dynamic risk factors that can be effectively addressed with appropriate intervention. Such Instruments have supplanted reliance on human judgment which can result in biased interpretations of risk potential.

The literature recommends that the results of risk-assessment instruments be supplemented with collateral information from victims, law enforcement, treatment and service providers. significant others, community members and others as well as data from drug tests, polygraphs (especially for individuals who have committed sex offences), and electronic devices (e.g., position monitoring systems including electronic surveillance, voice and facial recognition, Global Positioning Satellite [GPS] systems, fingerprinting or biometric scanning, automated kiosks, and automobile ignition interlocks).

A number of validated instruments have been developed for assessing risk and criminogenic needs including the Correctional Offender Management Profiling for Alternative Sanctions (COMPAS), Historical, Clinical, and Risk Management Factors (HCR-20), Level of Service Inventory-Revised (LSI-R), Level of Service/Case Management Inventory (LSI/CMI), Psychopathy Checklist Revised (PCL-R), Statistical Information on Recidivism (SIR), Violence Risk Appraisal Guide (VRAG), and Wisconsin Risk and Needs. The Correctional Assessment and Intervention System, COMPAS, Offender Intake Assessment (OIA) of Correctional Services of Canada, and LSI/Case Management Inventory are fourth generation instruments that are software-based and incorporate integrated databases to link personal factors to environmental factors, criminal justice processing decisions, treatments, and outcomes to integrate data domains.

COMPAS

Michigan[6] uses the Correctional Offender Management Profiling for Alternative Sanctions (COMPAS) which contains four separate risk scales (i.e., violence, general recidivism, failure to appear, and noncompliance) and twenty two needs scales (which include criminal attitudes, criminal personality, criminal associates, financial problems, vocational/educational problems, criminal opportunity, and residential instability). It includes an automated decision-support software package that integrates risk and needs assessment with several other domains, including sentencing decisions, treatment and case management, and recidivism outcomes.

The criminal involvement scale includes items pertaining to the number of prior arrests (a major risk factor for predicting ongoing criminal behavior) and convictions, frequency of incarceration, and criminal justice involvement. The history of violence scale includes official history items reflecting prior arrests and convictions for violent felonies, use of weapons, infractions for fighting, and others. The history of noncompliance scale includes official items reflecting failures to appear, failures of drug tests, failures to comply with sentencing conditions, revocations for technical reasons, and others. The criminal associates scale assesses associations with others who are involved in drugs, criminal activity, and gangs. The substance abuse scale includes items that reflect the influence of alcohol or drugs on the personôs current offense, perceived benefit of substance abuse treatment, and prior substance abuse treatment. The financial problems and poverty scale including worry about financial survival, problems paying bills, and not having enough money to meet the personôs needs.

The occupational and educational resources (human capital) scale includes items reflecting levels of educational and vocational occupational success (e.g., job skills, current unemployment, low wages, and employment history). The family crime scale includes items assessing the criminality and drug use of parents and siblings (e.g., if a parent was ever jailed, had drug problems and whether the personôs mother was ever arrested). The high crime neighborhood scale assesses levels of crime, gang activity, and drug activity in the personôs neighborhood. The boredom and lack of constructive leisure activities (aimlessness) scale includes items that indicate proneness to boredom and lack of engaging in leisure activities (e.g., whether the person is often bored, has nothing to do, is restless with current activities, and experiences scattered attention). The residential instability scale assesses the number of recent moves, homelessness, and absence of a verifiable address. The social isolation versus social support scale depicts social isolation at one extreme and social supports at the other and includes items indicating self-reported loneliness, absence of friends, feeling left out of things, and the lack of a close or best friend.

[6] Michigan also uses the Michigan Pretrial Risk Assessment, a research-based instrument used to identify the level of community risk of a defendant as well as their likelihood for appearing in court. It is based on Pretrial and Evidence-Based Practices (LEBP) standards.

The criminal attitude scale assesses antisocial attitudes using items that may be used to justify, excuse, or minimize damage caused by the personôs crime (e.g., the law does not help average people, minor offenses such as drug use do not hurt anyone, and items stolen from rich people will not be missed). The antisocial personality scale assesses impulsivity, absence of guilt, selfish narcissism, dominance, risk taking, and anger or hostility (e.g., a short temper, often acting without thinking, and being viewed as cold and callous).

PROGRAM EVALUATION

Program evaluation offers opportunities to highlight and demonstrate positive outcomes and compete for limited funding as well as reveal ineffective practices so that alternatives can be sought in order to achieve goals. Examples of program measures include absconder rates, technical violations, use of incarceration as punishment for relapse, rates of graduation from treatment programs, use of substances, associations with antisocial peers, re-incarceration rates, rearrest and conviction rates, involvement in criminal activities, technical violations, housing stability, social functioning, access to health care, rates of substance use-related diseases, general health improvements, rates of technical probation and parole violations, absconder rates, number of drug use screens and proportion of positive to negative results, amount of time to first new arrest, completion of employment, or school, or vocational training.

Parole has historically been assessed in terms of the percentage of individuals who successfully complete their term of supervision. Success can be defined as lack re-incarceration, lack of rearrest while under community supervision, lack of commission of any technical violations, or more broadly in terms of achievement of stable employment, adequate housing, and healthy interpersonal relationships. There is currently no agreed upon universal standard for success (or failure),

Process measures help programs determine whether a practice is being implemented or operated in accordance with its design while outcome measures help organizations determine whether desired results are being achieved to determine the impact of an agency or program. Process evaluations are often conducted to assess penetration rates and program fidelity. Penetration rate analyses are conducted to determine the degree to which a target population is reached (i.e., the number of individuals engaged in the program divided by the number of those eligible in the target population). Evaluation of program fidelity includes all aspects of program planning, development, and implementation and entails examination of staff qualifications and training, program location and hours of operation, caseloads, supervisory structure, and program content.

Outcome evaluations are conducted to assess the results of a program and ascertain the degree to which it has achieved it goals. Key outcome variables (e.g., living and employment status, criminal justice involvement, and retention in treatment) are determined and measured, Outcome measures are linked to behavioral change displayed by individuals under supervision and assess the effectiveness of various interventions and program components so that agencies can learn from successes and fine tune practices. Examples of outcome measures include the following:

Public Safety Measures

- Rate of rearrest, reconviction, and re-incarceration within three months, six months, one year, and three years
- Types of crimes for which people are rearrested
- Number of months individuals remain crime-free or violation-free in the community

Public Health Measures

- Degree to which returning citizens use necessary health care services after release

	• Number of contacts with primary care physicians • Number of emergency room visits • Number of psychiatric hospitalizations • Level of medication adherence • Degree of testing for chronic and infectious diseases • Degree to which inmates apply for treatment upon release • Number of treatment sessions completed • Level of treatment enrollment • Number of returning citizens who continue in program(s) at 30-day intervals • Number of days an individual remains drug free • Number of positive drug tests/number of individuals who test positive • Number of returning citizens who are homeless • Number of returning citizens enrolled in public benefit programs
Restorative Justice Measures	• Amount of restitution collected • Hours of community service completed • Amount of financial obligations collected
Educational and Employment Measures	• Number of returning citizens who participated in and completed vocational training • Number of returning citizens employed • Number of days employed • Wages/benefits earned and taxes paid • Number of days returning citizens retain their jobs • Degree of full-time employment (for those that need it) • Degree of job stability over time (reduction in number of job changes) • Educational attainment (from adult basic education through postsecondary education)
Other Measures	• Compliance with child support obligations • Housing stability

CORRECTIONAL PROGRAM ASSESSMENT INVENTORY – 2000 (CPAI-2000)

The Correctional Program Assessment Inventory is a validated survey instrument for correctional treatment programs that assesses the degree of fidelity to the most evidence-based strategies for reducing recidivism. It reviews core program characteristics (e.g., client assessment, characteristics of the program and staff, and strategies for program evaluation). In addition to using the CPAI to measure program integrity, agencies are encouraged to evaluate outcomes using different indicators (e.g. new arrests, new convictions, types of new criminal activity [felonies, misdemeanors, or technical violations], and treatment completion).

The CPAI consists of seventy five items covering eight components critical for effective programs (e.g., program implementation, client pre-service assessment, program characteristics, staff characteristics, and evaluation) and two areas integral to effective programs (emphasis on evaluation and ethical considerations) based on factors found in the literature on effective correctional programs.

CPAI Components

Program Implementation	Surveys the conditions under which the program was introduced.
Pre-service assessment	Surveys applications of the principle of risk, need and responsivity.
Program characteristics	Assesses targeting of criminogenic factors and the use of cognitive-behavioral techniques.
Therapeutic integrity	Surveys service delivery, emphasizing intensity and matching conditions.
Relapse prevention	Surveys extent to which programs focus on post-release programs.
Staff characteristics	Surveys staff and training issues.
Evaluation	Examines the extent to which the system emphasizes/encourages research and evaluation activities.
Other	Assesses emphasis on ethical concerns and security of program funding.

CULTURAL CONSIDERATIONS

Cultural factors include race, ethnicity, age, gender, national origin, disability, sexual orientation, religion, language, socioeconomic status, religion, gender identity, and geographic location. Additional factors relevant to corrections include the psychosocial consequences of incarceration including jailhouse culture and prisonization.

RACE

People from minority groups are overrepresented in the criminal justice system. African-Americans and Latinos/Hispanics are arrested and convicted at significantly higher rates than Caucasians. While incarceration affects people from all walks of life, data from the U.S. Department of Justice indicate it disproportionately affects people who are economically disadvantaged, male, African-American, and Latino/Hispanic. For example, African American males are incarcerated at a rate that is seven times higher than that of Caucasian males and three times higher than that of Hispanic males and make up forty six percent of the prison population. African American males have a twenty nine percent lifetime chance of serving at least one year in prison, a rate that is six times higher than that for Caucasian males.

It is estimated that twenty percent of African American men aged twenty four to thirty five, and twenty two percent of thirty five to forty four year-old African American men, have been incarcerated (compared to nine and ten percent for Hispanic/Latino men and three and four percent for Caucasian men). Moreover, data indicates that fifty percent of African American men who have dropped out of high school have prison records by the time they reach their early thirties compared to ten percent of Caucasian males. Women of color under criminal justice supervision are, like their male counterparts, disproportionately represented particularly in correctional institutions rather than probation or parole where two thirds of the population is Caucasian.

GENDER

Increasing numbers of women have become involved in the justice system during the past two decades, the majority of whom are under community supervision (rather than incarcerated). And, while supervision, programs, and services in the criminal justice system have historically been predicated on the experiences of men (primarily due to their preponderance), there has been growing recognition of and attention to the issues and challenges unique to women, including responsibilities as primary caretakers of young children, economic challenges, specific healthcare needs, and cultural factors, all of which have a significant impact on successful reentry.

Women in the criminal justice system have been found to experience stigma and marginalization as a result of biases based on gender, race, poverty, incarceration, and sexual orientation. They tend to be economically disadvantaged, undereducated, lack marketable employment skills, and have sporadic employment histories. They are less likely than their male counterparts to have committed crimes of violence and more likely to have been convicted of crimes involving drugs or property which are motivated by economic circumstances (i.e., poverty) and/or substance use disorders.

Womenôs first encounters with the justice system often occur as juveniles who run away from home to escape violence and sexual[7] or physical abuse. A significant number are from impoverished urban environments, were raised by single mothers or lived in foster care or group homes at some point during childhood. They often grow up in families with substance use problems and family members with criminal justice system involvement.

While men and women face many of the same challenges during incarceration and reentry, women are impacted by their unique pathways into the criminal justice system and have unique responses to incarceration, community supervision, and treatment. Research has demonstrated that the most common pathways to crime for women are based on survival (of abuse and poverty) and substance abuse. Many become involved in the drug trade to combat poverty, or in prostitution (often subsequent to a history of sexual abuse) which in turn leads to substance abuse and vulnerability to further physical and sexual abuse.

Womenôs reentry needs are impacted by gender-specific factors including personal safety issues related to returning to live with an intimate partner who previously engaged in domestic violence and the need to secure adequate housing to meet child welfare requirements for regaining custody of children in foster care. Because reunification with children may be a primary concern, women are more likely to need childcare, and may have to consider whether potential job locations or work schedules will permit access to affordable childcare opportunities.

In addition, while all returning citizens face employment issues, women typically have more limited education, training, work experience, and earnings than their male counterparts. Yet, they need to be able to support themselves and their children and access adequate, affordable childcare. Women are also more likely than men to experience homelessness, have problems with intimate partners, maintain stronger ties to their children and have childcare responsibilities subsequent to release.

Fewer women than their male counterparts use a gun or other weapon during the commission of a crime and exhibit less violent behaviors while in custody. The most common types of crime for which they are convicted are forgery, fraud, and embezzlement (i.e., property crimes). More women than their male counterparts are incarcerated for drug offenses. Women are more likely men to commit crimes to obtain money to purchase drugs. Interestingly, while it is assumed that women with substance addictions are more likely to engage in prostitution to support the addiction, they are actually more likely to engage in property crimes. Many of the violent crimes committed by women are against a spouse, ex-spouse, or partner who has assaulted/abused them physically and/or sexually.

It is estimated that seventy percent of women involved in the criminal justice system have young children and most are single custodial parents who are often reliant upon public assistance for economic support. These women are significantly more likely than their male counterparts[8] to have been primary caretakers of children prior to incarceration and are more like to plan on returning to that role upon release. Incarceration can cause significant family disruption and fragmentation resulting in children being moved several times during their mothersô incarceration. Moreover, mothers are at risk of losing their children while they are incarcerated.

[7] While sexual abuse is considered to be widely underreported, available data indicate that one out of six women and one out of thirty three men have experienced attempted or completed rape during childhood or adulthood, and one in four girls and one in seven boys have been sexually abused by age eighteen.

[8] Data indicates that 90% of children of men who are incarcerated continue to reside with their mothers while only 28% of those of women who are incarcerated live with their fathers; more than half (52.9%) live with grandparents, 25.7% live with other relatives, 9.6% live in non-relative foster homes, and 10.4% live with friends or others.

Women also experience more frequent and serious health problems than men and have significant reproductive health issues including high risk pregnancies, sexually transmitted diseases, HIV (which has increased declined in men), and chronic diseases (e.g., hepatitis). It estimated that rates of HIV infection among women who are incarcerated are fifty percent higher than among their male counterparts. These women are also at risk for other infectious diseases, including tuberculosis (TB), sexually transmitted diseases (STDs), and hepatitis B and C. Women are also at greater risk for certain cancers (i.e., breast, lung, and cervical). They often enter correctional institutions in poor health due to poverty, poor nutrition, limited access to preventive care, inadequate care for health conditions, limited education regarding health issues, and substance abuse.

It is estimated that four to nine percent of women who are incarcerated are pregnant. The majority of these pregnancies are considered high-risk because of inadequate or a lack of medical and prenatal care, poor nutrition, and substance abuse. In addition, inadequate education regarding childbirth, parenting, and preparation for separation from the infant following delivery may pose further risks. Women who give birth while incarcerated are rarely allowed to spend time with their children after birth which seriously undermines mother-infant bonding.

Women who are involved in the criminal justice system are significantly more likely than men to have mental health problems (e.g., Posttraumatic Stress Disorder [PTSD], depression, anxiety, co-occurring substance use disorders, and personality disorders). Studies have shown that almost eighty percent of women involved in the criminal justice system have histories of trauma resulting from physical and sexual abuse. Rates of abuse are estimated to be twice as high as that of men during childhood and eight times higher during adulthood. Physical and sexual abuse has been shown to be associated with substance abuse.

Exposure to trauma and the presence of a substance addiction increase risk for other psychiatric disorders, especially PTSD. Women with PTSD may be viewed as unfit or inadequate parents due to some of the behavioral sequelae of the disorder (e.g., volatility and depression) placing them at risk for removal of their children or loss of custody. Standard policies and procedures in correctional settings (e.g., searches and especially strip searches, restraints, and isolation/seclusion) can be experienced as frightening and threatening and function as triggers for re-traumatization.

In contrast to men, whose primary developmental tasks are defined by the achievement of autonomy and independence, women's experiences are more defined through relationships. Women's involvement in criminal activities often occurs via relationships with family members, significant others, or friends. They are often first introduced to drugs by partners who may then continue to be their suppliers. Attempts to stop using substances and supply intimate partners with drugs through involvement in the drug trade or prostitution can elicit violent responses.

Healthy relationships have been demonstrated to be critical to women's reentry success and recovery from trauma. Studies have shown that those who maintain family connections while incarcerated (e.g., through letters and personal visits) experience reductions in recidivism. Recommendations for correctional facilities to strengthen family relationships include child-friendly visiting spaces and policies (e.g., allowing physical contact, providing snacks, removing limits on the number of children that can visit, and, flexible visiting hours), pairing parenting classes with therapeutic visiting programs, family reunification counseling programs, and liaising with the child welfare system to prevent termination of parental rights.

GENDER-RESPONSIVE APPROACHES

The Women's Prison Association has developed a matrix of basic life areas that provides a framework for addressing factors throughout the different stages of involvement in the correctional system which includes considerations of subsistence/livelihood, residence, family/relationships, health/sobriety, and criminal justice compliance.

Community supervision agencies are increasingly focusing on more gender-responsive practices. Some have instituted gender-specific caseloads to serve women, while others provide training for all agents on strategies and practices that are most effective with women (e.g., the importance of quality interpersonal relationships and issues related to victimization, parenting, and negative relationships with men). Studies indicate that these efforts result in increasing numbers of women successfully completing supervision.

Promising gender-responsive programs combine supervision with services and supports that are designed to address the specialized needs of women in highly structured and safe environments where accountability is stressed, a continuum of care is available, program expectations and rules are clearly articulated, an ethnically diverse staff that includes peers with previous criminal justice system involvement is provided, and community resources are provided in a coordinated fashion, and aftercare are available. Effective approaches are multidimensional and deal with specific women's issues, including substance use disorders, domestic violence, sexual abuse, pregnancy and parenting, relationships, and gender bias. In sum, treatment that has been found to be most effective focuses on relationships, is gender-specific, and addresses trauma.

Safe and supportive environments have found to be critical elements of gender-responsive correctional environments including freedom from physical, sexual, and verbal abuse, address needs for privacy, programming is based on women's life circumstances (pathways), and treatment approaches focused on their specific needs rather than on male-based models. In addition, the presence of staff members who function as strong female role models and the opportunity to form supportive networks with female peers (which often continue after release) are important components.

The elements of gender-responsive approaches include housing, physical and psychological safety, education, job training and opportunities, community-based substance use disorder treatment, economic support, positive female peer role models, and a community response to violence against women. Research supports the provision of access to safe and affordable housing, physical and psychological safety, education, job training and employment opportunities, substance use disorder treatment, positive female role models, and reliable daycare, all of which enhance the achievement of successful reentry.

The most promising community-based programs for women use an empowerment model of coping and decision-making skill building to develop competencies to achieve independence. Effective therapeutic approaches address issues specific to women including substance abuse, domestic violence, sexual abuse, pregnancy and parenting, relationships, and gender bias. Models of supervision that have found be effective for women focus on relationships, incorporate case management, employ a team approach, and include individual and/or group counseling.

PRISONIZATION AND JAILHOUSE CULTURE

The psychological consequences of incarceration can function as significant impediments to successful re-integration into prosocial networks, families, and employment settings, as well as resumption of parental roles. The range of effects includes institutionalization (or prisonization)

and the adoption of survival strategies (the inmate code) as well as the consequences of solitary confinement. There is evidence that returning citizens continue to be adversely affected on a long-term basis by traumas experienced during incarceration (e.g., pain, deprivation, and atypical norms of prison life).

Institutionalization, also known as prisonization, is characterized by a number of psychological adaptations including a dependence on institutional structure and contingencies characterized by:

- Diminished self-initiative and independence.
- Hypervigilance, interpersonal distrust, suspicion and alertness for signs of threat or personal risk characterized by the projection of a tough veneer to keep others at a distance.
- Excessive emotional control, alienation, and psychological distancing characterized by what is known as a prison mask in order to appear invulnerable to exploitation manifested by flat affect and social distancing.
- Social withdrawal and isolation.
- Incorporation of informal rules, norms, and values of prison culture known as inmate code

Many returning citizens suffer from the negative effects of adaptation to prison life characterized by distrust and hypervigilance which are manifest in social withdrawal, aloofness, seeking social invisibility. Upon release, individuals may need help with establishing daily structure, exercising initiative, autonomous decision-making (subsequent to exposure to institutional structures and routines) and overcoming the diminished sense of self-worth instilled by the exploitative prisoner culture.

The elements of jailhouse culture include a unique language and dress code, social values, and a hierarchy among peers (with certain types of crime frowned upon while others are glorified, and power earned through fear and intimidation), and coping mechanisms which generally conflict with the norms of mainstream society.

The inmate code includes rules and values (e.g., not snitching, doing oneôs own time, and not appearing weak) and manifested in behaviors such as not sharing any information with staff, minding oneôs own business to an extreme, and the demonstration of intimidating strength as well as the so-called prison face, a vicious stare worn to avoid fights by appearing willing to fight. Another coping mechanism is rule-defying behavior (i.e., adopting the rule not to follow rules) in response to rigid and seemingly inconsistent or illogical rules governing their lives which leads to the belief that one must do what has to be done in order get oneôs needs met. While such behavior may be adaptive as survival skills in a hostile setting, they interfere with community adjustment and conflict with the expectations of therapeutic environments.

This can result in barriers to meaningful interpersonal contact in the community including seeking appropriate help for problems and a unwillingness to trust others due to fear of exploitation. It can become manifest in overreactions to minimal provocations. The norms of inmate culture include: the maintenance of interpersonal respect and personal space; a diminished sense of self-worth and personal value in response to the prohibition of rights to privacy and loss of control over day-to-day aspects of existence (e.g., bedtimes, meals, etc.), living in small, sometimes extremely cramped and deteriorating spaces with little or no control over cellmates; and posttraumatic stress reactions to incarceration, which may be compounded by previous experiences of childhood trauma as well as the harsh, punitive, and uncaring environment of prison and the potential for being victimized by physical or sexual assaults may cause re-traumatization.

Individuals placed in solitary confinement have been found to experience a range of adverse effects including chronic depression; parasuicidality (self-mutilation and suicidal ideation, impulses, and behaviors); anxiety and panic attacks; emotional dysregulation; psychosis; impaired sense of identity; hypersensitivity to stimuli; cognitive dysfunction (e.g., confusion, memory loss, and ruminations); irritability, anger, aggression, and/or rage; violent behavior (e.g., stabbings, attacks on staff, or property destruction); lethargy, and a sense of helplessness and hopelessness;.

Cultural competence includes understanding prison survival strategies and coping behaviors acquired during incarceration. Community-based treatment providers who lack awareness of these behavioral patterns can misinterpret them as indicative of resistance, lack of motivation for treatment, evidence of character pathology, or symptoms of a mental illness. Providers may respond with unwarranted safety concerns and fail to cultivate and establish empathic relationships with returning citizens. Cultural sensitivity to jail culture has been found to be of equal importance to that of racial and ethnic differences and characteristics.

A number of strategies to enhance cultural competency and reduce barriers to trust and cooperation have been suggested. These include matching clients with providers who share the same language and culture; providing services in minority communities; offering flexible hours and walk-in services; including families in treatment where appropriate; allowing clergy and traditional healers to participate in the treatment process; and employing successful program graduates (who have an intimate knowledge of the challenges participants face) as staff who can serve as mentors. For example, staff members who share a history of both incarceration and a substance use disorder or mental illness with program participants may be better able to engage them in treatment. The inclusion of returning citizens in programs where they can serve as cultural ambassadors who can assist their peers with re-integration and function as role models has been found to have a positive influence on the perceptions of correctional staff as well as service recipients.

SENSITIZING PROVIDERS TO THE EFFECTS OF CORRECTIONAL INCARCERATION ON TREATMENT AND RISK MANAGEMENT (SPECTRM)

The culture of corrections (i.e., the environment created by the criminal justice system) is often in conflict with the culture of mental health treatment. The corrections culture is based on control and security, while treatment is based on concerns for safety and change. SPECTRM is an emerging approach to engagement of persons with mental illnesses with criminal justice system involvement that is based on awareness of the normative behaviors and beliefs of the culture of incarceration that can be delivered in correctional settings, shelters, hospitals and outpatient settings. The program targets behaviors that are adapted for confinement, trains staff in culturally competent responses to these correctional adaptations, and teaches participants a new behavioral repertoire that is designed to facilitate successful reentry.

SPECTRM provides a half-day training workshop for providers and a group intervention called RAP (Re-entry After Prison/Jail) for returning citizens. During the workshop behaviors considered to be adaptive in correctional settings, and how they are misinterpreted in community-based treatment settings, are reviewed along with culturally competent approaches to addressing them.

RAP uses a psychoeducational and social skills training curriculum consisting of cognitive-behavioral techniques. It focuses on helping participants develop an understanding of the effects of incarceration on their interactions with peers and treatment providers. Participants learn about emotional triggers and associated behavioral patterns that are maladaptive in community living and more effective coping mechanisms for solving interpersonal and practical

challenges in the community. Such behaviors include: intimidation (e.g., aggressive or threatening posturing), stonewalling (i.e., not sharing with staff), and snitching (i.e., concern about being too forthcoming with information with staff), feeling that a hospital is a prisonlike environment, and concern that taking medication makes one vulnerable to attack. Outcome studies indicate that the program leads to reductions in violent behaviors and a greater sense of trust in staff and peers.

COLLABORATION AND SERVICE DELIVERY

While reentry is commonly viewed as the domain of the criminal justice system, it has become increasingly apparent that responding to the challenges faced by many returning citizens requires a coordinated effort. No single agency, organization, or service provider can adequately address the multiple issues returning citizens face including coping with the stigma of incarceration, finding housing, obtaining employment, reconnecting with family, and dealing with substance abuse, mental and physical health problems.

Collaboration[9] offers the opportunity to provide a comprehensive, integrated, coordinated, and seamless system of services and supports from pretrial through sentencing and parole for returning citizens. In addition, access to a network of services, supports, and prosocial community connections has been shown to significantly enhance successful reentry. Coordination can also help reduce service fragmentation, minimize conflicting expectations of various agencies, identify service gaps and duplication, and create opportunities to leverage multiple funding streams. Criminal justice agencies and community-based organizations (e.g., mental health, workforce development, substance abuse treatment, and housing) have different traditions, missions, and values, use distinct terminology and evaluation criteria.

Shared populations served by the criminal justice system and public and community agencies that address education, employment, psychiatric and substance use disorders, and physical health issues offer opportunities to pool resources for the provision of coordinated reentry plans for returning citizens. Collaboration between public systems can help ensure coordination and minimize competing demands. Such collaboration can be facilitated through the assignment of staff liaisons to communicate information across agencies, cross-agency advisory groups, cross-training of staff members, and multiagency teams that develop a joint service and support plans for returning citizens.

Returning citizens and their families may be involved in multiple public systems that can have differing and sometimes conflicting requirements. Navigating multiple systems and agencies that often provide fragmented services and have conflicting requirements can impede supervision and successful reintegration. For example, TANF (Temporary Assistance to Needy Families) work requirements may preclude participation in mental health or substance abuse treatment required under the terms of parole or probation. Welfare requirements regarding employment, child support enforcement, and verification can conflict with court-ordered probation or parole conditions or other demands of the criminal justice or child welfare systems forcing parents to choose between maintaining benefits, treatment for substance use disorders, and retaining or regaining custody of their children.

Collaborative partners include:

- Law enforcement
- Prosecutors
- Victims advocates/assistance programs
- Pre-trial services
- Housing
- Defense counsel
- Judiciary
- Court administration
- Probation/Parole
- Public health
- Community-based volunteer organizations
- Institutional corrections
- State and local public policymakers
- Crime victims
- Civic organizations
- Neighborhood groups
- Mental health/Substance abuse treatment
- Treatment professionals

[9] Michigan has been cited in the literature for the establishment of successful collaborative partnerships through the MPRI.

- Faith-based organizations
- Organizations that serve culturally diverse clients
- Appellate-level case managers
- Education/vocational training
- News media
- Veterans Affairs
- Public health
- Employment services
- Community volunteers
- Returning citizens

The literature recommends a team approach to planning and coordination of services and supervision comprised of correctional staff, human service agencies, community-based services, housing providers, local law enforcement, the court system, advocates for victims, family members, and peers or mentors in order to reduce fragmentation and minimize potential conflicts among the various systems as well as leverage funding to support reentry and create linkages to resources. Formal partnerships established via MOUs (Memorandums of Understanding) can be used to delineate each organizationôs role and facilitate sharing information among agencies.

Another recommendation is establishing satellite offices and co-locating programs or stationing intake workers in community centers, public housing offices, public health clinics, hospitals, or parole offices using a ñno wrong doorò approach to access the full range needed services and supports through any portal of entry thereby eliminating any confusion regarding where to go to obtain assistance and minimizing travel and time off from work and family responsibilities. Some corrections agencies have partnered with community organizations to facilitate continuity of care and aftercare during the transition and release process through the establishment of **one-stop shops** which offer opportunities for returning citizens to meet with community supervision agents, obtain employment assistance, receive direct services or referrals for mental health, substance abuse treatment, and healthcare, and access public assistance.

Collaboration across agencies can be effectively facilitated by boundary spanners who function as liaisons and facilitate cross agency and system communication and coordination on a day-to-day basis through understanding of the different organizational and system cultures, policies, and procedures.

JUSTICE MAPPING

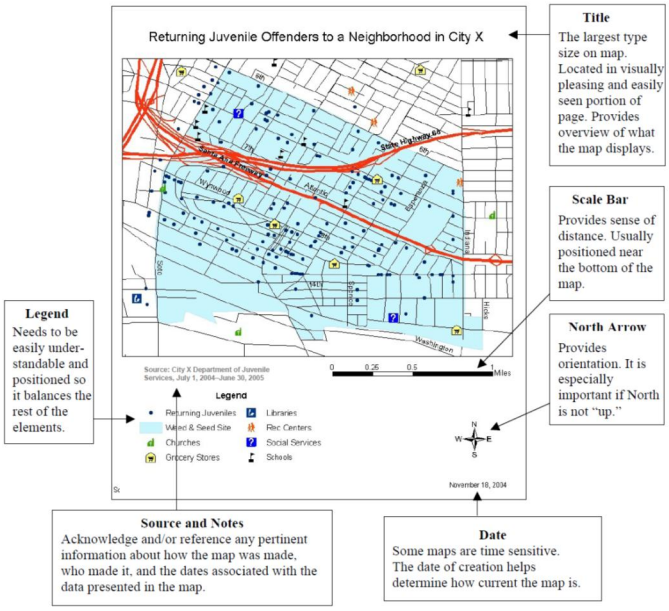
Reentry mapping can provide useful, data-driven information on reentry and its effect on local communities that can be disseminated to community stakeholder, returning citizens and their families, service providers, community organizations, and others to increase awareness about reentry issues, and engage community members in reentry initiatives.

Mapping tools can be used to inform reentry collaboration initiatives. Geographical Information Systems (GIS) analysis or computer mapping can be used to depict local resources (e.g., health, housing, employment, and social networks). Maps can display populations shared by the criminal justice and other public systems and illustrate opportunities for pooling resources to address identified gaps and unmet needs as well as utilize existing resources more effectively and efficiently. Mapping crime can also be used to identify areas to target crime desistance efforts. And, mapping can be used to assess the effectiveness of intervention efforts by, for example, mapping changes in employment rates over time.

Mapping and analysis can help identify areas that experience significant numbers of returning citizens so that resources and intervention efforts can be targeted to areas most in need. It also offers the ability to depict characteristics of communities including demographic information such as housing tenure, percentage of female-headed households, vacant housing, educational levels, marital status, fertility, infant mortality, place of birth, language, and ancestry which can measure available social capital and the extent to which communities are equipped to address the challenges of retuning citizens.

No definitive model or set of processes for creating a reentry mapping partnership has been developed and each strategy should be responsive to local conditions. Moreover, no predetermined sequence of processes exists. However, it is recommended that obtaining, analyzing, and mapping data and efforts to develop partnerships and engage the community should proceed contemporaneously.

Departments of corrections are the most common sources of data: (1) Release data during a specified period of time (e.g., the most recent fiscal or calendar year) which offers information on spatial patterns of reentry thus giving a snapshot of the characteristics and locations of the population of interest. However, this dataset only depicts those most recently released and becomes outdated relatively quickly, requiring subsequent data requests. (2) Cross-sectional data on current correctional populations which includes all individuals under supervision at a given point in time irrespective of when they were released. Therefore, an accurate depiction of current spatial reentry patterns requires the inclusion of a field that gives information regarding when the person was released. (3) Longitudinal data on correctional populations which consists of a series of datasets on correction populations over time which allows for tracking the reentry population over time.



from La Vigne, et al. (2006)

Release addresses must be verified and then geocoded (i.e., assigned geographic coordinates [longitudes and latitudes] to street addresses before a map can be created. Variables of interest include demographic data (e.g., age, race, and gender), criminal history, educational level, employment, substance abuse history, financial background, family and marital issues, in-prison program participation, data from risk management or classification tools conducted with inmates (including attitudes and orientation), program needs, work skills, and risk for drug and alcohol problems.

Six elements have been determined to be essential for maps: title, date. legend, north arrow, scale bar, and source and notes. More information on mapping tools can be obtained from http://www.urban.org/reentry_mapping/.

Thematic Maps: Thematic, or choropleth, maps depict information across an entire jurisdiction and are used when the data being mapped is already aggregated above the address level (e.g., information by census tract, police beat, and voting district). Thematic maps mask the specific locations of cases or individuals which can ensure confidentiality for victims of crime. Thematic maps enable layering of information so that relationships between two data sources can be compared (e.g., a point map of addresses of returning citizens overlaid on top of a thematic map depicting rates of unemployment across a community).

Such maps, which employ aggregate data, can be used to depict rates versus volumes which can help determine whether there are adequate services in the areas closest to where most returning citizens reside. Disadvantages to thematic maps stem from the modifiable areal unit

problem (MAUP) in which the aggregation of address data to a larger unit can mask concentrations within the unit. Another potential issue is that GIS software typically uses arbitrary value breaks which can alter the interpretation of a map.

Density Maps: Density, or hot spot, maps are derived from point maps and employ GIS software that transforms address-level data into small pixels, and interpolates that data across the geographic landscape being mapped. Such maps can thus depict multiple incidents at the same address. They also provide a cleaner display and allow for layering additional information. However, the smoothed surface generated by the GIS software gives the impression that there are points in places where there are actually no data. Moreover, the default values employed by the GIS software may not always be an appropriate choice, and modifications to these choices can change the resulting surface significantly, masking or revealing concentrations depending on the parameters chosen.

Point Maps: Point, or pin, maps are the most basic type of map wherein each point on the map represents a single entity. Such maps offer very detailed information regarding the geographic location of the subject being mapped but can reveal the identity of a specific person and if mapping a large amount of data will result in too many points overcrowding the map so that patterns cannot be discerned. In addition, point maps mask the locations of repeat addresses; because multiple points at the same location are simply layered directly on top of one another, one point on the map could represent hundreds of cases. Point maps are the least effective for reentry mapping.

EFFECTIVE TRANSITION PLANNING: MITIGATING GATE FEVER AND EARLY RISK

Individuals face a number of losses upon release from prison including a place to live, consistent health care services, a support system, shared culture, friends, structure, regular meals, and a place to sleep. Gate fever, experienced shortly after release, is characterized by suspicion, mistrust, anxiety, irritability, substance use, and self-destructive behavior. Precipitants include unpredictable release dates, little to no cash, inconvenient release times, lack of identification and other documents, and lack of transportation. The majority of returning citizens have been found to experience gate fever during the first days and months subsequent to release from incarceration.

The first days, weeks, and months following release have been shown to be a period of significant vulnerability and risk for returning citizens. The peak rates for the commission of new crimes and violations of the terms of parole have been found to occur during this time; the first six months account for forty percent of all recidivism, with thirty percent of all re-arrests occurring during the first months.

This early period of time offers opportunities to reduce risks and promote successful reentry. Therefore it is recommended that supervision resources and strategies be concentrated during the first few days and weeks after release in order to provide resources at the time they are most needed. Involvement by parole in prerelease planning can facilitate this by helping returning citizens understand the conditions of release and the expectations of the parole agency after release.

It is recommended that the risks at the moment of release be minimized by predictable release dates, sufficient gate money, appropriate clothing, identification documents, medical summaries, referrals for health care, and transportation. Services should be predictable and consistent with an emphasis on safety at the moment of release and during the first two months thereafter. the first hours, days, and weeks following release should focus on meeting critical needs first, then urgent needs, followed by important needs which include:

- **Transportation:** Transportation from the correctional facility to the person's release destination should be provided and a reliable transportation plan for the days immediately following release is in place for follow up on referrals and to meet initial parole requirements.
- **Clothing and food:** Clean, seasonally-appropriate clothing and basic toiletries (toothbrush, toothpaste, deodorant, and soap) as well as a list of accessible food providers and resources should be provided.
- **Financial resources:** An amount of gate money sufficient to attend to immediate needs during the first twenty four hours after release should be provided. Some correctional facilities offer debit cards instead of checks for money earned during incarceration which can be used at ATMs for cash or for point-of-sale machine purchases.
- **Identification and important documents:** Appropriate identity documents (e.g., state-issued photo identification cards, social security cards, birth or marriage certificates, and educational credentials) are often required to secure housing, open a bank account, cash checks, prove employment eligibility, and apply for public benefits to obtain health care. Many agencies require multiple forms of identification to access resources or receive benefits. Corrections agencies can coordinate with the Department of Motor Vehicles (DMV) to issue state ID cards at the moment of release or can issue another form of identification or documentation that can be exchanged for a state ID card upon release.
- **Housing:** Safe, affordable housing should be secured prior to release to reduce the potential for homelessness or residing in unsafe environments. Some housing programs meet with returning citizens at the time of release and escort them to the program to provide support and establish relationships with them. Some also provide a staff member to shadow the person for the first few days following release while others pair new residents with other program participants for the first month who accompany them to medical and social service appointments and orient them to the neighborhood.
- **Employment and education:** Returning citizens should be referred for employment services to facilitate access to finding and maintaining a job and be provided with documentation of their skills, challenges (e.g., literacy problems), and credentials to help overcome barriers to employment.
- **Health care:** Returning citizens should be provided appointments for mental health, substance abuse treatment and medical care. It is recommended that forty five days of medication be provided to help ensure adherence to treatment regimens and prevent relapse.
- **Support systems:** It is recommended that returning citizens be given release handbooks with listings of community resources, and those lacking natural support systems be linked with community or faith-based organizations to provide support, including mentors, during the immediate period following release.

Cognitive-behavioral interventions and stress reduction are recommended to address gate fever. Yoga, meditation, and visualization have been found helpful in reducing anxiety during the first days after release. In addition, peers who have successfully coped with reentry can be provide support and offer information on effective coping strategies.

TRANSITION FROM PRISON TO COMMUNITY MODEL (TPC)

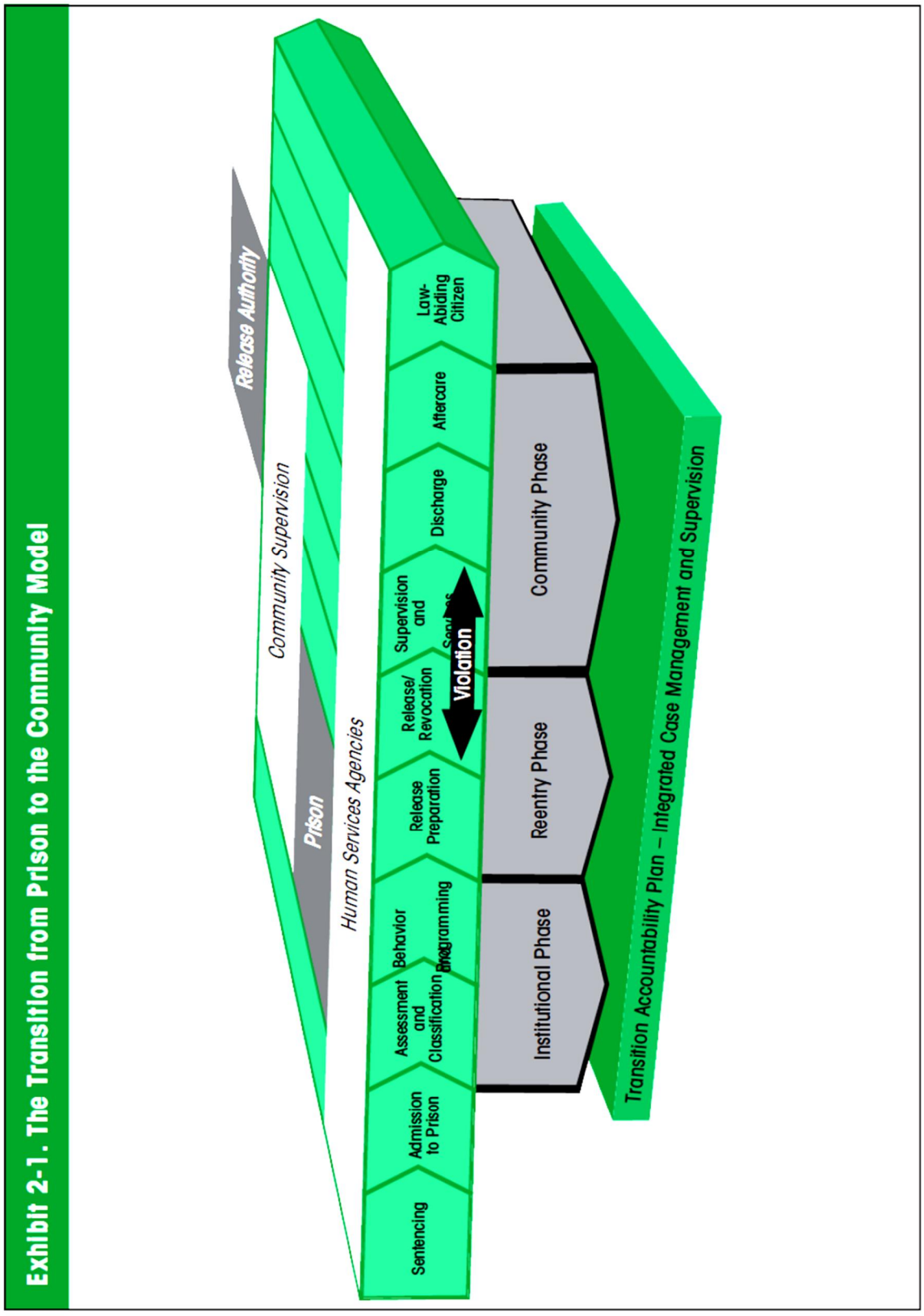
The National Institute of Correctionsô TPC model, developed by Abt Associates, has been implemented in a number of jurisdictions across the country, including Michigan. The model uses a problem-solving approach to reentry that starts from admission to prison and continues through discharge from post-prison supervision and beyond that is planned and implemented by a collaborative policy team that includes representatives from law enforcement, institutional and community supervision agencies, paroling authorities, public human services agencies, community service providers, and other stakeholders.

The Transition Process consists of seven elements: (1) Assessment and classification; (2) Transition Accountability Plans (TAPs); (3) release decision-making (discretionary and mandatory releases); (4) community supervision and services; (5) responding to violations of conditions of release/supervision with established graduated responses as well as the provision of incentives and rewards to motivate compliance and recognize achievements; (6) termination of supervision and discharge of jurisdiction; and (7) post-supervision community support and aftercare to autonomy and self-sufficiency.

The model includes:

- The formation of interdisciplinary, collaborative leadership teams (often convened by corrections agencies) to guide reentry efforts.
- Involvement of non-correctional stakeholders that can provide reentry services and supports.
- A multidisciplinary planning process that specifies goals and an understanding of the reentering population, rates of recidivism, and reviews existing policies, procedures, and resources for reentry.
- The use of assessment instruments that are normed and validated on the existing population and measure both static and dynamic factors at various stages of movement through the criminal justice system.
- Effective research-based interventions targeted to individuals on the basis of risk and criminogenic needs identified by assessments.
- An expansion of the traditional roles of correctional staff beyond custody, security, accountability, and monitoring to include an integrated approach to supervision and management that engages people under supervision in a process of change.
- Integration of the stages of the criminal justice system into a collaborative process among prisons, releasing authorities, and community supervision staff beginning upon admission to incarceration (or earlier), and continuing through assessment, programming during incarceration, preparation for release, release, and supervision in the community.
- Ensuring that all returning citizens have basic survival resources (e.g., identification, housing, medications, and linkages to community services and natural (informal) networks of support) before, during, and subsequent to release.
- Development of the capacity to measure progress toward specific outcomes, ongoing continuous tracking of progress, and using the information obtained for further improvement.

TPC includes a collaborative case management model that involves prison staff, the returning citizen, releasing authority, community supervision agents, public and private human service providers, victims, and neighborhood and community organizations to provide continuity in the implementation of case plans from incarceration through discharge and ensure smooth transfer of responsibility for the plan as the individual progresses from prison to parole to successful discharge from supervision.



TPC REENTRY HANDBOOK: TPC Model

Michigan began participating in the TPC initiative in 2003 and established the Michigan Prisoner ReEntry Initiative (MPRI) which incorporates the three-phase reentry approach of the Serious and Violent Offender ReEntry Initiative (SVORI) with the seven decision points of the Transition of the TPC, and includes the policies and recommendations the Council of State Governmentsô Reentry Policy Council. Since its inception, Michigan has witnessed significant improvements including reductions in prison populations and re-incarceration for new crimes committed by returning citizens, as well as expenditures for prisons.

The stated vision of MPRI is that every individual released from prison will have the tools needed to succeed in the community. Its stated mission is to reduce crime by implementing a seamless plan of services and supervision developed with each returning citizen and delivered through state and local collaboration from the time of their entry to prison through transition, reintegration, and aftercare in the community. The stated goals of MPRI are (1) to promote public safety by reducing the threat of harm to persons and their property by returning citizens in the communities to which they return, and (2) increase success rates of returning citizens who transition from prison by fostering effective risk management and treatment programming, accountability, and community and victim participation. MPRI includes three phases:

Phase One − Getting Ready: The **institutional phase** describes the details of events and responsibilities which occur during incarceration from admission until the point of the parole decision and involves assessment and classification (i.e., measuring the offenderôs risks, needs, and strengths), and prisoner programming (i.e., assignments to reduce risk, address need, and build on strengths).

Phase Two − Going Home: The **transition to the community or reentry phase** begins approximately six months before the returning citizenôs target release date during which highly specific reentry plans are organized that address housing, employment, and services to address addiction and mental illness and involves prisoner release preparation (i.e., developing a strong, public-safety-conscious parole plan) and release decision making (i.e., improving parole release guidelines).

Phase Three − Staying Home: The **community and discharge phase** begins when the person is released from prison and continues until discharge from community parole supervision. In this phase, the returning citizen, their network of community supports and mentors, and human services providers work to assure continued success through supervision and services (i.e., providing flexible and firm supervision and services), revocation decision making (i.e., using graduated sanctions to respond to behavior), and discharge and aftercare (i.e., determining community responsibility to take over the case).

The Michigan Department of Corrections (MDOC) provides the management staff for the MPRI under its Policy and Strategic Planning, Field Operations, and Correctional Facilities Administrations. The MPRI is organized under the Governorôs Office and is overseen by a State Policy Team (SPT) comprised of top-level leaders in five state departments: the Department of Corrections (prisoner custody, education, training; parole decision process; and parolee supervision); the Department of Community Health (physical and mental health; alcohol and drug addiction services); the Department of Labor and Economic Growth (housing, adult education, vocational training, employment preparation, and employment services); the Department of Human Service (family and child welfare); and the Department of Education (education for returning citizens and their children).

MPRI sites have a local governance structure made up of a Steering Team, Administrative Agency, Board of Directors, Advisory Council, MPRI Prison Facility Coordination Team, MPRI Field Operations Coordination Team, and a Community Coordinator. Comprehensive plans are developed by local community leaders serving on Steering Teams that are submitted to the

Administrative Agency's Governing Body for approval. Plans describe local assets to increase the potential for success for returning citizens, barriers that impede maximum use of these assets, gaps in services, proposed solutions to address the barriers and gaps, and must address sixteen service areas (e.g., housing, employment, substance abuse services, mental health, transportation, victim services, and the involvement of local law enforcement and faith-based institutions).

More information on MPRI can be accessed at http://www.michigan.gov/corrections/0,1607,7-119-9741_33218---,00.html.

TRANSITION ACCOUNTABILITY PLANS (TAPS)

Fragmentation within the criminal justice system can impede efforts to promote successful reentry. Responsibilities span from incarceration, preparation for release, and reentry. A single modifiable transition and reentry plan developed shortly after intake into prison that delineates strategies to enhance successful reentry can be used to guide in-prison programming, conditions of release, and management after release. TAPS, developed upon admission by prison staff, the parole board, field supervisors, the returning citizen, and staff of community agencies, incorporate formal and informal networks of support and are refined as circumstances change over time to guide preparations for release, release decisions, and responses to compliance and violations of conditions.

Effective reentry plans are developed in collaboration with returning citizens as well as community and correctional system agencies and address needs including mental health care, medical care, medications, appointments, housing, employment, substance abuse, health care/benefits, income/benefits, food/clothing, transportation, identification, life skills, family/children, emergency numbers for assistance, referrals to other services, court dates, and medical summaries of treatments, diagnostic test results, and medication regimens

TAPs are designed to follow returning citizens from entry into a correctional institution through discharge from post-release supervision TAPs are updated and revised as returning citizens move through the entire correctional process to reflect progress, challenges, and changes in risk and need and goals. TAPS provide all stakeholders in the reentry process (e.g., institutional staff, paroling authorities, and community supervision staff) access to comprehensive, accurate, and up-to-date information. Case management services are used to arrange, advocate, coordinate, and monitor the delivery of services and supports.

TAPs:

- Identify the assessed risk level and criminogenic needs; information can be used to establish conditions of supervision and triage returning citizens with surveillance for those at highest risk (i.e., not amenable to treatment) and administrative oversight for those at lowest risk, while targeting interventions to the rest
- Develop strategies to address obstacles and triggers
- Outline the returning citizen's responsibilities
- Include goals with measurable, attainable, relevant strategies with timelines that are directly related to the highest rated domains of criminogenic need
- Identify strengths and build strategies on such strengths.
- Assess readiness for change in order for case management teams to determine the most effective ways enhance motivation for change

INREACH

The adoption of a framework in which institutional and community-based corrections and service providers collaborate to facilitate successful reentry during the transition phase has been found to effectively link returning citizens to post-release resources and supports. Inreach services have been found to be specifically beneficial to returning citizens with specific challenges and risks including those convicted of sex offenses, those convicted of arson, persons with disabilities and medical and mental illnesses.

Inreach typically entails ongoing meetings with returning citizens beginning at least three months prior to their release to establish relationships and facilitate continuity of treatment. The literature recommends that transitional community corrections agents who can facilitate contact between individuals and their field agents be assigned in instances when this is not possible for the community corrections agent to meet with the individual.

VIDEOCONFERENCING

Technology[10] can harnessed as a resource for returning citizens as well as corrections staff and community service providers. While videoconferencing has been most commonly associated with health care, it is also being used in some jurisdictions for parole hearings (particularly to engage victims in the process), provide distance education programs in correctional facilities, and to link individuals nearing release with service providers and potential employers. Distance learning provides cost-effective opportunities for people who are incarcerated to earn advanced degrees because participants electronically pooled with other students.

Videoconferencing can be used to facilitate interaction, communication, and connections to the community thus alleviating geographic barriers associated with distances between correctional institutions and communities in which returning citizens will reside. Videoconferencing during incarceration allows individuals to participate in their post-release planning with agency representatives in their home communities and connects them with family members and mentors in the community to establish supportive relationships.

This technology is also used to facilitate communication across partner agencies and facilities reducing travel time and costs. For example, community agencies can provide services, including mentoring, vocational classes, and counseling without incurring travel costs and dealing with institutional safety protocols or the need to arrange secure transportation for offsite participation prior to release.

Telemedicine provided via videoconferencing can also be used to deliver health care through community-based specialists who can consult with individuals who are incarcerated and their institutional health care providers and see patients through a television or computer monitor. Telehealth and telemedicine can expand access to quality medical care and treatment in a cost-effective manner. In addition to the potential for bringing specific expertise to remotely located correctional institutions it can also provide a safe and efficient way to consult local specialists.

Although telemedicine is expensive to install, it can eliminate the expense and resources needed to provide secure, supervised transportation to offsite medical facilities for specialized care or providing full-time physicians in institutions. In addition, it can offer opportunities for early intervention prior to exacerbation of symptoms that can precipitate longer and more costly treatments and care in hospitals.

[10] The Internet can provide returning citizens with access to resources (e.g., housing, employment, and other resources) prior to release. Internet firewalls that prevent access to non-resource related sites and monitoring can ensure appropriate use of the technology.

Telemedicine can also provide linkages to community-based services and enhance continuity of care by allowing community health care providers to establish relationships with returning citizens prior to release. Telehealth techniques, including email and other web-based technologies, also can ensure timely and effective access to medical records, treatment plans, and other pertinent information.

While no standards have been established for the use of videoconferencing, the literature cautions against replacing face-to-face interaction entirely with videoconferencing and other technologies and recommends face-to-face contact prior to using remote access technologies to build trust and establish ongoing relationships.

RESOURCE GUIDES AND REENTRY HANDBOOKS

Simple, easy-to-read materials can be used to provide information to returning citizens regarding how to access services in the community (e.g., substance abuse treatment, health care, employment training/placement services, legal assistance, and family services), particularly those of an immediate nature within the first period of time subsequent to release (e.g., obtaining identification documents and resources for housing, food, clothing).

Pre-release handbooks and resource guides standardize the presentation of reentry information and resources and allow returning citizens access to information independent from the correctional system. Such guides also serve as a resource for people who receive minimal to no release planning and those who are released without community supervision. Resource guides can help reduce anxiety, promote adherence to treatment, and aid in the retention of important information.

Resource guides supplement other prerelease planning activities and are also a resource for correctional staff who provide assistance with discharge planning, particularly institutional staff, giving them access to information regarding government services, community organizations, local housing authority rules, employers, and transportation options in specific communities and limit the amount of time needed to research information for each returning citizen.

No standards are currently available for the development of reentry resource guides, but it is recommended that pocket-sized handbooks with basic information and contacts, which provide an organized, succinct reference resource, be used. In addition, guides need to be updated periodically to ensure services provided, contact information, and hours of operation remain up-to-date and accurate, including whether agencies are willing and able serve people with justice system involvement.

CORRECTIONS CASE MANAGEMENT

Case managers match returning citizens to available resources and services based on their identified needs, determine whether they receive services outlined in their case plans, and whether those services have been of benefit. Correctional case managers ensure that progress is not undermined by conflicting expectations and lack of inter-organizational coordination. Correctional case managers, like their mental health counterparts, broker and monitor services across agency boundaries. In other words, they function as boundary spanners and liaisons to facilitate communication and coordinate policies or services, and serve as the primary contact person for communication between agencies. Common functions include:

- Cultivating, developing, and maintaining working relationships with criminal justice and service provider agencies and staff
- Identifying returning citizens people who meet program criteria
- Making recommendations to the court regarding appropriateness for the program

- Developing and initial service plan
- Holding meetings to discuss service plans
- Coordinating with the mental health and other service systems to link people with services
- Maintaining established program policies, procedures, ethics, and confidentiality
- Monitoring and following up on consumer service resolutions
- Preparing and submitting compliance reports

WRAPAROUND SERVICES

Comprehensive individualized services and support networks wrap around clients rather than presenting them with set, inflexible treatment programs. Wraparound service delivery has been found to be effective for returning citizens who have multiple and complex needs that are most effectively provided in a coordinated manner that facilitates access to services and supports including mental health and substance abuse treatment; programs for survivors of family and sexual violence; family supports; emergency shelter, food, and financial assistance; educational, vocational, and employment; health care; child welfare system programs; transportation; child care; programs for children; self-help groups; womenôs programs; consumer advocacy; leisure options; faith-based programming; and community service clubs.

Women have been found to benefit from comprehensive array of wraparound services using a coordinated case management approach that addresses multiple treatment needs in a gender-responsive manner that includes child care, housing, transportation, job training, employment services, family reunification services, medical care, mental health and substance abuse treatment, peer support, safety from abusive partners, and access to staff beyond traditional business hours.

Wraparound services are designed to enhance or supplement treatment services to meet the needs of clients in multiple domains. Inherent in the provision of wraparound services is some form of case management. Studies have shown that wraparound services contribute to beneficial treatment outcomes.

Wraparound services can include:

- Childcare
- Transportation
- Reading assistance for individuals with literacy challenges
- Primary healthcare, including screening and referral for HIV/AIDS, tuberculosis, and other infectious diseases
- Financial assistance
- Supportive living arrangements, such as recovery houses
- Legal aid
- Mental health services
- Education
- Vocational/educational services
- Liaison services with the Immigration and Naturalization Service
- Services for victims of domestic violence

EVIDENCE-BASED SUPERVISION STRATEGIES

The two dichotomous parole practice paradigms that were predominant (punishment vs. welfare, monitoring vs. mentoring, and law enforcer vs. social worker) have been supplanted by supervision as an instrument for facilitating prosocial behavior by engaging returning citizens in the change process through interactions that provide them opportunities to learn about their behaviors and patterns, acquire new skills to address problematic issues, and develop self-maintenance tools to ensure long-term success. In other words, agentsô roles have been broadened from surveillance and monitoring to engaging returning citizens in the change process and facilitating their involvement in treatment programs and prosocial activities using

external (e.g., drug testing, curfews, family, etc.) and internal (i.e., intrinsic motivation) controls to prevent to help prevent recidivism.

Effective supervision includes the provision of clear expectations regarding acceptable and unacceptable behaviors, consequences for unacceptable behaviors, and incentives for acceptable behaviors. Consequences for violations should be rapid, measured sanctions of increasing severity. Incentives should be used in response to positive behaviors in a manner that mirrors sanctions for negative behavior and, like sanctions, should be swift, certain, and progressive as a person makes progress towards goals or other benchmarks set at the outset of treatment. In addition, regular feedback, including written progress reports which can incorporate graphic depictions of gains should be provided so individuals can track their accomplishments.

While monitoring has generally been used to confine returning citizens to specific places (e.g., home), it also can be used to help them avoid triggers that can lead to relapse to criminal behavior (e.g., drug testing, polygraph testing, and electronic position monitoring). Advances in supervision technology including Global Positioning System (GPS) monitors, rapid-result drug tests and ATM-like reporting kiosks provide new technologies for monitoring the whereabouts and activities of returning citizens in the community thereby enhancing opportunities to protect public safety and hold them accountable with sanctions other than re- incarceration.

Successful outcomes have been found to be highly dependent on the rapport developed between supervision agents and returning citizens. Agents have been found to be most effective when they maintain balance between their enforcement and support/intervention roles; clarify their role with the returning citizens; model pro-social behaviors: display empathy without reducing accountability; and focus on problem-solving and addressing criminogenic needs. The most effective relationships are characterized by mutual respect, openness, attentiveness, structure and support, warmth and empathy, genuineness, and flexibility is in clear contrast to the more traditional correctional supervisory relationship which tends to be built upon power, authority, and control. Research has demonstrated that individuals under justice system supervision who are treated in a respectful, direct, firm and fair manner have lower rates of recidivism.

Five elements of effective correctional supervision and counseling have been identified:

1. Relationships characterized by openness.
2. Authority that is characterized by being firm but fair; distinguishing between rules and requests; monitoring; reinforcing compliance; refraining from interpersonal domination or abuse.
3. Prosocial modeling and reinforcement that includes demonstrating and reinforcing clear alternatives to pro-criminal styles of thinking, feeling, and behaving.
4. Concrete problem solving using skill-building, removal of barriers to achieving increasing levels of reward levels for prosocial behavior at home and in community settings.
5. Advocacy for the most effective services and supports for returning citizens.

Effective relationships are established with attention to eye contact which is used to convey respect as well as assess body language during the different phases of supervision; social graces that convey mutual respect (e.g., shaking hands and being prompt for appointments); candid review of information where the agent provides information regarding results from assessments, informational controls, and performance without ascribing blame,; and empathy using active listening skills to acknowledge the returning citizenôs perspective while identifying the ground rules.

Agents should be honest and up front about conditions, incentives, and sanctions as well as their dual role as representatives of and advocates for both the returning citizen and the supervising court/board. Agents ensure returning citizens are aware of what sanctions are likely to occur as a result of a violation. And, when delivered, sanctions need to be clear, immediate, and proportional to the violation. A progressive sanctions model leads to awareness of the incentives and penalties so that a returning citizen is never caught by surprise when subjected to a sanction.

An effective strategy is to avoid defending the court/board, police report, or test results focusing on the observable conditions of supervision without debating the validity of a charge; admission of guilt is not a prerequisite of a change-focused conversation. Focusing questions on future behavior is helpful in avoiding the issue of innocence or guilt, which can be particularly useful when an offender denies the offending behavior. Talking about the pros and cons of a behavior given the conditions of supervision creates an alternative to debating innocence or guilt.

PROSOCIAL MODELING

Prosocial modeling focuses on the relationship between the agent and the returning citizen, rather than the features of an intervention or program. Moreover, as noted previously, a balance between supervisory and relational approaches has been shown to lead to optimal outcomes. Prosocial behavior includes conveying respect by being prompt for meetings and other appointments in recognition of other peopleÕs time constraints, using proper greetings for meetings and departures, and using verbal and nonverbal cues which establish the cultural norms for expected behaviors.

The central principles of this approach include:

- **Role clarification:** Frequent and open discussions about roles, purposes, expectations, the use of authority, negotiable and non-negotiable aspects of intervention and confidentiality.
- **Prosocial modeling and reinforcement:** Identification, reward, and modeling of behaviors to be promoted, as well as identification, discouragement, and confrontation of behaviors to be changed. Agents should model and reinforce pro-social and acceptable behavior throughout the supervision period, including appropriate salutations, promptness and respect.
- **Problem solving:** Appraising, ranking, and exploring problems along with goal setting and behavioral contracting and the development of strategies.
- **Relationship:** Being open, honest, empathetic, challenging but not minimizing rationalizations, non-blaming, optimistic, articulating the individualÕs feelings and problems, and using appropriate self-disclosure and humor.

NEIGHBORHOOD-BASED SUPERVISION

Traditionally, supervision of returning citizens has been conducted in office buildings removed from the places where returning citizens reside, work and engage in daily activities. Office-based supervision limits an agentÕs ability to understand the context in which the individuals they supervise live, effectively manage risk, or enhance public safety. Community-centered supervision allows for monitoring the whereabouts and behaviors of returning citizens in concert with other community members. In such models agents function as catalysts for building relationships with members of the community.

For example, the **"Broken Windows"** model, a proactive, problem-solving approach to community policing which engages citizens both as partners in the control of crime and the

primary customer of the services police provide to promote public safety, has been applied to parole and probation as a strategy to engage the community in the process of community supervision. This approach views the office as the base and the neighborhood as the place of supervision. It draws on informal sources of social control to monitor and respond proactively to public safety risks wherein supervision agents function as catalysts for building relationships within the community to mobilize this social capital.

Some community-based supervision programs focus on the social ecology of crime by concentrating their efforts on returning citizens who are at high risk, high risk areas in the community, and times of the day that are high risk.

Parole offices can be established in community centers, municipal offices, public housing projects, police precincts, mental health centers, and local storefronts. Co-locating community corrections offices with service providers (such as Workforce Investment Boards or benefits offices) can encourage compliance with conditions of release, engagement with services, and minimize travel for agents and returning citizens. In addition, neighborhood-based supervision services are provided beyond the traditional 8:00 a.m. to 5:00 p.m., Monday through Friday, workday and delivered nights, weekends, and holidays and include unannounced home visits.

An example of a collaborative, neighborhood-based supervision model is provided by **Wings of Faith (WOF)**. The Michigan Department of Corrections reentry program has partnered with Wings of Faith for case management services for returning citizens upon entry into a pre-release facility. Case managers conduct needs assessments and begin to address any barriers to successful reentry. Subsequent to release they work with the returning citizenôs parole agent and refer them for services Wings of Faith and parole agents are co-located in a one-stop center (The Samaritan Center) that also houses numerous local nonprofit service providers which facilitates more immediate access to services. Information on WOF can be obtained from http://www.wingsofprayerministries.com/.

GRADUATED RESPONSES: SANCTIONS AND INCENTIVES

Occasional violations of some condition of community supervision are common (e.g., relapse to substance use; conditions of employment due to labor market issues; and maintaining a stable residence, paying court fees, fines and restitution, and providing support to dependents resulting from economic challenges). The majority (three out of five) of violations are technical and include conduct that would otherwise not be considered criminal such as consumption of alcohol, failure to attend mandated programs, defaulting on court fee payment plans, failure to report as instructed, or a change of address without prior permission). Research indicates that noncompliance with technical conditions of release is not indicative of the likelihood of criminal behavior and that re-incarceration does not prevent future criminal behavior. Moreover, relapse or transitory regression to anti-social behavior is not always associated with a propensity to commit new crimes.

The literature recommends a strategic, problem-solving approach to violations consisting of a combination of penalties, rewards, and services with incarceration reserved only for individuals deemed high-risk and who present an imminent danger. This approach focuses on public safety while holding individuals accountable. It also includes the provision of community-based interventions that address the reasons for violations.

The literature also recommends a response to every detected violation proportional to the risk to the community, the severity of the violation, and current situational risk, previous violations, the nature of the particular violation, and the full range of potential responses, including a variety of community-based treatment and programming options using the least restrictive response necessary. Such responses should be standardized, predictable, and timely. Moreover, the

potential consequences of different behaviors should be made clear returning citizens and supervision staff. Finally, because violations vary in degree of severity and risk, a continuum of responses is needed to promote behavior change

Studies have shown that decisions to revoke community supervision can be inconsistent due to different supervision philosophies, supervision styles, and interpretations of agency policy which can also generate disparities in response to violations. A continuum of graduated responses to supervision that combines sanctions and incentives, with a particular focus on incentives has been found to be effective in reducing re-incarceration. In addition, a predetermined range of graduated sanctions reduces discretionary and inconsistent responses and increases accountability and responsibility.

Graduated sanctions should be applied in accordance with the following principles.

- Certainty: The perceived certainty of negative consequences functions as a deterrent.
- Celerity: Responses to violations should be immediate.
- Consistency: Comparable responses to comparable situations promote fairness.
- Parsimony: The least intrusive or restrictive sanction should be used.
- Proportionality: The level of sanction should be commensurate with severity of the behavior.
- Progressiveness: Continued violations should result in increasingly stringent responses.
- Neutrality: Responses should be impartial, have a sound rationale, and be congruent with rules and ethics.

Alternatives to incarceration include fines, restitution, supervision in community corrections programs, mandatory drug treatment, community service, or shortened sentences in county penitentiaries. Community-based alternatives to incarceration include electronic monitoring, work release, day-reporting centers, and halfway houses. Such alternatives are significantly less costly than incarceration and contribute to improve public safety by ensuring that individuals maintain community tenure and ties to families and support systems, employment, and services. Public health benefits including reductions in the transmission of infectious diseases, substance use, use of emergency rooms, and hospitalizations as well as improved management of mental illnesses and other chronic conditions, less family disruption, improved public safety, and costs savings.

Alternatives to Incarceration	
• Counseling or reprimand	• Increased drug/alcohol testing
• Increased reporting requirements	• Substance abuse treatment
• Loss of travel or other privileges	• Extension of supervision period
• Curfew time	• Regular (or more frequent) check-ins at day reporting centers
• 12-Step program attendance	
• Electronic monitoring/GPS	• Community service
• Home detention time	• More intensive treatment participation
• Increased level of supervision	• Remand to halfway house or other residential program
• Short jail stays	

It should also be note that supervision strategies that only increase the level of supervision (e.g., intensive community supervision, increased drug testing, and home confinement) have not been found to reduce recidivism. In fact, increased surveillance actually increases the likelihood of detecting technical violations because it provides more frequent opportunities for interaction and observation. Moreover, there is no evidence that increasing supervision alone leads to fewer crimes. On the other hand, supervision strategies that incorporate rehabilitation or treatment in

combination with surveillance techniques are more effective in changing behavior and reducing crime.

Incentives include reduced reporting requirements, allowing reports through phone calls or other methods that do not involve office visits, early termination of supervision, and extensions of time to accomplish specific activities. Examples of incentives or reinforcements include:

- Reductions in the level of supervision/reporting requirements
- Removal of an electronic tracking or monitoring device
- Reduction or elimination of drug testing
- Gift certificates or other financial incentives
- Reductions in the level of supervision/reporting requirements
- Verbal praise
- Recognition by service clubs or faith organizations
- Reduction in fines owed or mandatory community service work hours
- Letters of commendation
- Sobriety anniversary celebrations
- Graduation ceremonies
- Opportunities for leadership
- Early termination of supervision
- Waived fines
- Certificates of achievement

SPECIALTY SUPERVISION

In addition to specialized supervision that is gender-responsive, models have been developed to address the needs of returning citizens with mental illnesses and those who have been convicted of sexual offenses.

MENTAL HEALTH

Data indicates that more individuals with mental illnesses are under community supervision than elsewhere in the corrections system. In addition, the majority (three out of four) have a co-occurring substance use disorder and are twice as likely to fail on supervision, especially during the first months after release due to decompensation and inappropriate public behavior. Moreover, functional impairments can create difficulties in complying with standard conditions of release (e.g., maintaining employment and paying fines).

Close supervision and time to attend to the needs of returning citizens with mental illnesses has been shown to foster compliance with conditions of release and reduce recidivism. It is recommended that supervision agents receive training to address the needs of returning citizens with mental illnesses in order to employ graduated responses to parole/probation violations in a manner that recognizes that a violation may be a function of an illness but also holds the person accountable (e.g., providing more intensive treatment and services in response to decompensation).

People with mental illnesses under supervision require an array of services and supports, including medication; counseling; behavioral therapy; substance use disorder treatment; supportive housing; public benefits; crisis intervention services; peer supports; vocational training; and family counseling. Traditional community corrections agencies have limited resources to effectively respond to people with mental illnesses as a result of large caseload sizes and the time-consuming needs of this population.

Dedicated or specialized caseloads are a promising practice for meeting the needs and improving outcomes of persons with mental illness on probation, parole, or in other community corrections programs. Specialty supervision integrates community corrections supervision strategies with mental health services and support. One approach entails the designation of groups of staff in community corrections and mental health to work with individuals on shared caseloads. Such caseloads are smaller in order to provide more intensive services from both

systems. Studies have shown that specialty supervision leads to significant reductions in violations of probation/parole.

Features of specialized supervision include:

- Smaller caseloads with an of average forty five people per agent (compared to more than one hundred for traditional caseloads) composed exclusively of people with mental illnesses so more time can be spent with each individual to address their risks and impairments.
- Specialized agents who receive significant ongoing training regarding mental health issues (averaging twenty to forty hours per year).
- Specialized probation agents collaborate with treatment providers and coordinate services and supports often working in a team with treatment providers and participating in case staffings and advocate to secure treatment and supports (e.g., Supplemental Security Income and housing).
- Specialty agents employ problem-solving strategies to deal with lack of compliance with conditions of probation/parole rather than threats of incarceration and other sanctions.
- A menu of graduated sanctions (with increasing severity in accordance with the frequency or severity of violations) that are individualized to encourage prosocial choices, adherence to treatment recommendations, and maximize compliance.
- A menu of incentives for sustained adherence to the conditions of community supervision (e.g., less frequent contacts with supervision agents and treatment providers, certificates of compliance, non-cash rewards, and reductions in the duration of parole/probation).

Research indicates that people with mental illnesses under specialized supervision are more likely to receive mental health treatment and other needed services than they are under traditional community corrections supervision. They are also less likely to have their sentences revoked. Strategies that have been shown to be effective in reducing recidivism and increasing the use of services include:

- Firm but fair relationships that are characterized by caring, fairness, trust, and an authoritative (not authoritarian) style.
- Problem-solving strategies and positive pressures to encourage compliance with the terms of community supervision, which entails the identification of obstacles to compliance, resolving these problems, and agreeing on compliance plans while avoiding threats of incarceration or other negative pressures.
- Boundary-spanning in which agents coordinate and work in teams with treatment and service providers.

SEX OFFENDING

Specialized supervision for individuals convicted of sex offenses incorporates training and knowledge regarding such individuals as well as victims; specialized caseloads or units; specific conditions of supervision and restrictions designed to enhance accountability and safety as well as protect victims; technology (e.g., electronic monitoring, global positioning systems [GPS] and polygraph testing); and careful monitoring of risk factors unique to this population.

Supervision strategies include establishing collateral contacts with family and friends who are aware of the personôs behaviors, controlling the personôs environment by limiting their access to victims, situations, and triggers, and engaging them in the process of change. Monitoring systems, (e.g., position tracking and urine screens) and polygraph tests are often used to detect sex offending behaviors.

More intensive monitoring during community supervision is recommended in order to evaluate the personôs level of commitment to and compliance with all special conditions imposed to ensure they are actively engaged in and consistently attending an approved community-based treatment program as well as verify the suitability of their residence and place of employment. In addition, conducting frequent, unannounced field visits at home, place of employment, and during leisure time to monitor activities. Individuals should also be helped to develop support systems comprised of friends, family members, and employers who are aware of their criminal history, are supportive of the community supervision plan, and can recognize their risk factors.

Specialized supervision approaches for individuals convicted of sex offenses include the following components:

- A focus on preventing future victimization and protecting victims and the community
- Close collaboration and frequent information sharing among supervision agents, treatment providers, victim advocates, law enforcement officers, and others (e.g., polygraph examiners)
- Specialized, ongoing training for agents who work with individuals who engage in sex offending
- The involvement of supervision agents in each individualôs daily life and habits
- Small supervision caseloads to permit intensive community-based casework
- Special conditions of supervision that are designed to address the specific and unique risks and criminogenic needs of each individual with consistent monitoring of the personôs compliance. Specialized conditions include:
  - Disclosure and communication (signed waivers so that information can be shared among treatment, probation/parole, district attorneyôs office, and the court; and disclosure to others (e.g., schools and employer) as deemed appropriate)
  - Treatment (participation in and payment for evaluation and approved sex offender-specific treatment covered by a signed contract)
  - No contact with victims or their families and restitution (payment for victimsô counseling)
  - No contact with children
  - No unapproved driving after dark or when children are going to and from school (except for employment), hitchhiking, or traveling to another jurisdiction without written authorization
  - Residing only in the supervising jurisdiction, no unapproved visits with family, and maintenance of established curfew hours)
  - No sexual contact or un-chaperoned contact with anyone under the age of eighteen and appropriate attire when public view is possible, cannot spend time in locations where individuals under the age of eighteen are likely to be and no non-therapeutic contact with convicted sex offenders; and no view, purchase, or possession of adult-oriented materials.
  - No paid or volunteer work where contact with individuals under the age of eighteen is likely
  - Cannot hold a position that allows supervision of women or children
  - No purchase, possession, or consumption of alcohol/drugs and testing as requested
  - Polygraph, plethysmograph, and other and other physiological tests as directed by the supervising agent
  - No computer/Internet use without permission of their supervising agent as well as examinations and searches of their computers to verify that it is not utilized in violation of supervision and/or treatment conditions

- Other technology restrictions including no possession of a camera, camcorder, or videocassette recorder/player without the approval of their supervising agent

Some jurisdictions employ surveillance officers who work closely with probation and parole agents to assist with monitoring compliance with supervision conditions by monitoring whereabouts and activities in the community; verifying addresses; assuring that residences are in compliance with and regulations. Lifetime supervision has been implemented in some jurisdictions for individuals convicted of sex offenses to provide ongoing community supervision throughout the course of their lives because sex offending can be a life-long, chronic pattern of abusive behavior and while individuals can often control sex offending behavior, they do not always voluntarily choose to do so. In addition, extended probation/parole terms allow supervising agents to attend to offender risks and needs; and probation/parole terms can be reduced in response to progress but cannot be increased in response the need for more supervision and surveillance. However, outcome data regarding the effectiveness of this approach is lacking.

A promising method is a team-based approach to case management, investigation, community notification and sexual assault response. In some jurisdictions, supervision agents co-facilitate treatment groups with therapists. Teams include law enforcement, judges, prosecution and defense attorneys, institutional and community corrections staff, treatment providers, victim advocates, polygraph examiners, community and faith-based organizations, victims advocates, employers, child protective service agencies, mentors, family, and friends.

The most promising approaches include thorough pre-sentence investigation reports (PSI); complete assessments using empirically validated risk tools; case management teams; highly trained and specialized supervision agents; sex offender-specific conditions of supervision; mandated sex offender-specific treatment; the use of the polygraph; and individualized case plans.

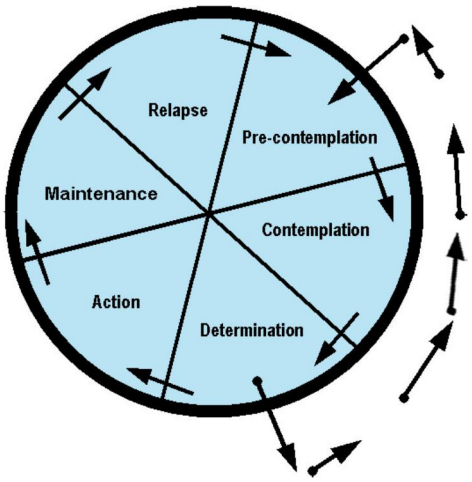
In addition to specialized supervision, sex offender registration and notification laws have been enacted in an effort to deter the commission of future crimes as well as provide law enforcement with an additional investigative tool and increase public protection by alerting the public to the presence of individuals convicted sex crimes in their communities. It is recommended that community notification include public education to reduce unintended consequences (e.g., vigilantism and homelessness), provide information and resources to the community regarding sexual victimization; and encourage the community to promote successful reintegration as a way to increase public safety.

Promising approaches to sex offender registration include written policies and procedures detailing the registration process, gathering comprehensive information on registered sex offenders and providing ready access to this information to law enforcement officers, and developing systems to transfer registration information within and across state lines effectively and efficiently.

One strategy being used in community notification entails assigning supervision agents to conduct community notification and encouraging community members to contact them should any suspicious behavior or concerns arise. Some jurisdictions are also using community notification as an opportunity to involve victim advocates in the process of community education regarding sex offending.

STAGES OF CHANGE

Change takes time and most people are not successful during their first attempt at change; periodic failure is part of the process of change. Moreover, people do not progress in a linear fashion through the stages of change; they tend cycle in and out of the stages and move back and forth between stages and can be in different stages for different problems (e.g., recognizing a mental health problem but not a co-occurring substance use disorder). Even individuals who are highly motivated experience slips at some point, returning to a previous stage before renewing their efforts. But, analyzing and learning from mistakes when lapses occur can foster future success.



from Taxman, et al. (2004)

Precontemplation: In this stage individuals either deny that a problem exists or do not recognize the problem and therefore are not considering changing their behavior, or are unwilling to change. For example, some people may admit guilt but deny they have a current problem or are unwilling the change their problem, while others deny they have committed the crime for which they were convicted. At this stage, the focus is on readiness to change through educational awareness and engaging the person in self-assessment and motivating them to move to the contemplative stage of change. A retuning citizenôs interest can be used to begin the change process by matching them to services and supports that will help them with that interest.

Contemplation: In this stage individuals recognize that a problem exists are thinking about how to solve it by seeking information and considering options. Ambivalence is manifest in vacillation regarding the seriousness of the problem and understanding the potential benefits of dealing with it while feeling conflicted about giving up benefits associated with it. The goal at this stage is to tip the balance in the direction of change using questioning techniques that help the person weigh the risks of the status quo and the potential benefits of change.

A **Benefits & Consequences (B&C) Analysis** in which individuals list the pros and cons (i.e., positive and negative aspects) of a behavior and assess whether the negative consequences outweigh the positive benefits can be useful at this stage to help them begin to view the possibility of change by seeing that the negative consequences outweigh the positive benefits of their behavior. Strategies focus on overcoming ambivalence and supporting self-efficacy and include an emphasis on positives, communication of the belief that change is possible, education, information regarding available supports and services (e.g., treatment programs), and developing a specific plan for change.

Determination: The person recognizes the problem behavior and begins to make a commitment to change. At this stage, the individual planning to make a change in the near future, but still faces obstacles (e.g., lack of full commitment to change, other obligations that require immediate attention, or a lack of awareness of how to take the first step). An effective tactic at this stage is to jointly develop a menu of options for the person to help them think even more about changing and solidify their decision to

change. Focusing on the development of cognitive skills that can help them make decisions that support changing their behavior can be effective.

Action: The individual is actively making changes in their life. They define a strategy for change with detailed steps that support the change that involve support systems, personal relationships, living situations, and other necessities. Tactics that are effective for this stage include positive reinforcement for progress. In addition, emphasis is placed on the development of social and cognitive skills (e.g., problem-solving) and the development of a relapse prevention plan that includes all of the personôs triggers (i.e., people, places, and things) that can lead to the reemergence of problematic thoughts and behaviors.

Maintenance: The person has met key milestones in changing factors associated with criminal behavior (e.g., substance use, interpersonal relationships, and living situations) and is in the process of maintaining and solidifying the changes they have made. The focus of this stage is stabilizing new behaviors and preventing relapse while continuing to provide support and reinforcement for progress and elimination of as many triggers as possible. A trigger analysis is used to help the person recognize patterns (i.e. people, places, and things) and develop alternative responses and supports in the community that can help to when trouble arises.

Relapse: The person experiences a slip as a one-time event, a series of mishaps, or, in the case of substance use, a period of prolonged use. Each slip should be addressed with attention to its causes, and an action plan to address the people, places or situations that triggered the slip should be developed.

Intervention needs to start where the person is in the change process. For example, if the person is in the pre-contemplative stage, motivational interviewing techniques are used to explore ambivalence about change and create discrepancy between the peopleôs stated goals and their current behaviors. Or, if the person has decided change is needed, focus is placed on teaching skills necessary to make the change, reinforcing pro-social thinking, modeling coping strategies, and directing the practice of those strategies. Thus interviewing strategies can be employed to move individual to the next stage of change. In addition, it is important to match services to where the person is in the process of change.

A number of communication tools and strategies have been shown to be highly effective with individuals involved in the justice system. They are strengths-based and entail structured interviews in controlled settings and the employment of motivational interviewing techniques including rolling with resistance and avoiding arguments. Numerous studies have demonstrated that a confrontational (i.e., harsh, coercive) counseling style increases resistance and reduces motivation for change and often results in movement to earlier stages in the change process as the person becomes more entrenched in defending the status quo.

MOTIVATIONAL INTERVIEWING (MI)

Motivational Interviewing is a directive, person-centered interactional style of counseling that is designed to foster change by helping individuals explore and resolve ambivalence about behavior change. MI can help increase an individualôs motivation to comply with supervision requirements, participate in treatment, and address their criminogenic needs. While MI is effective throughout the change process, it is particularly effective for individuals who are resistant to change, reluctant to change, or in an early stage of thinking about change.

MI has been shown to be effective for individuals with schizophrenia, depression, antisocial personality disorder, and limited cognitive functioning. It has been demonstrated to enhance

motivation for paying fees, finding a job, and preparing to engage as well as engaging in substance use disorder treatment. The use of MI with persons with co-occurring psychiatric and substance use disorders or individuals with more limited cognitive functioning may require modifications including simplifying questions, refining reflective listening skills, heightening affirmations, and integrating psychiatric issues into discussions).

Research has demonstrated that MI is very effective in supervising individuals involved in the criminal justice system. It has been shown to reduce an individualôs level of defensiveness as well as any confusion or uncertainty surrounding details of supervision plans. Techniques such as reflections make certain that all parties involved understand exactly what their roles and responsibilities entail.

Motivational Interviewing focuses on four basic listening and speaking techniques/strategies (known as **OARS**) that help guide the conversation toward change:

Open-ended questions

Affirm (positive talk and behavior)

Reflect (what is being heard or seen)

Summarize (what has been said and what has been agreed upon)

Principles of Motivational Interviewing:

- **Express empathy:** A nonjudgmental and accepting relationship using reflective listening without communicating criticism or blame fosters engagement and openness to change. Understanding of the personôs position is conveyed irrespective of agreement with their point of view.

- **Develop discrepancy.** The gap between a personôs goals or values and their current behavior creates discrepancy and is the basis for amplifying their own reasons for change. Assistance with self-assessment is provided by asking questions and making statements to help the person identify their own reasons for change, rather than telling people why they should change their behaviors, the outcome of which is the ability recognize the incongruence between personal goals and values and their actual behaviors and leads the person to determine that there is a need for change. Developing discrepancy is an effective strategy when a person is ambivalent about change. Showing people the difference between their present behaviors and their goals prompts them to realize that they must change to succeed.

  The goal of supervision is to assist the person to develop self-assessment skills so they learn to identify antecedents that cause problematic (criminal) behaviors and avoid these behaviors that may lead to trouble (consequences).

- **Roll with resistance:** Counterproductive confrontations are avoided when resistance, reluctance or ambivalence are expressed in recognition of the normality of mixed feelings when thinking about change. Thus, resistance is understood as part of the change process and also functions a signal that a new strategy may be warranted.

- **Avoid arguments:** Arguments increase defensiveness and resistance to considering new ideas. Conversations about behavior change often provoke arguments. Arguments can be avoided through a variety of techniques including reflections.

  Reflections (restatements of what an individual has said) can help reduce defensiveness and confusion or ambiguity, and let the person know that they are being listened to and understood as well as ensure that roles in and responsibilities in supervision plans are clearly understood.

- **Simple reflections** include**:**
  - **Parroting** consists of repeating what someone has said.
  - **Paraphrasing** repeats the meaning of what has been said without using the same words. **Reflecting feeling** is accomplished by showing the persons the emotion that they are displaying at that time.
  - **Reflecting content** focuses on why the person feels the way they do.
  - **Getting the gist** entails repeating the information in a more concise manner.
  - **Getting the meaning** entails finding the underlying significance of what the person has said.
- **Double-sided reflections** point out discrepancies in individualsô statements or situations in order to call attention to discrepancies, evoke ambivalence, and induce the desire for change.
- **Amplified reflections** magnify individualsôstatements to ascertain whether they can withstand closer scrutiny. An amplified reflection can show the gaps in a statement by pointing out the opposite extreme.
- **Summarizations** consist of a number of reflections strung together and can be used throughout interviews to ensure that major points are understood. Summarizing key points helps build rapport and reduce apprehension by demonstrating that the person is being listened to and understood. Summarizations are used periodically throughout an interview to recap major points.

- **Support self-efficacy (situational-based self-confidence):** Pointing out instances where the person has been successful enhances their confidence. Maintaining optimism, reminding the person of their personal strengths and past successes, and affirming all of their efforts toward change serves to convey confidence that the person is capable of successful change and overcoming difficulties. Eliciting and reinforcing a personôs belief in their ability to successfully achieve a goal has been found to be essential an essential component of change. Techniques such as affirmations can be used for affirming successes.

  Affirmations include:

  - Positive statements that are used to reinforce individualsô self-efficacy and reinforce pro-social behavior as well as build rapport, provide feedback, and increase the likelihood of positive behaviors
  - Calling attention to something admirable or interesting about the person
  - ñBlamingò people for their successes rather than dwelling on failures by focusing on successes

  To promote change, the optimal ratio is four affirmations for every critical comment. It is recommended that as many affirmations as possible be used and to affirm any desired behavior.

- **Open-ended questions** require the person to talk about and answer in a more detailed way rather than a yes/no response. Research has shown that asking multiple closed questions in a row effectively ends communication while open questions can lead to less resistance and fewer arguments.

- **Elicit self-motivational speech (DARN-C):**

Desire: The person expresses a wish to attain or succeed (e.g. ñI really want to get a job.ò)

Ability: The person talks about confidence (e.g., ñI could quit smoking pot. Iôve done it before, and itôs possible.ò)

Reasons: The person expresses a tangible incentive, motive, or rationale for change (e.g., how change would make things better or how continued behavior would make things worse such asòñSmoking crack makes my asthma worse.ò)

Need: Initially need may overlap with logical reasons and then becomes an urgency (e.g., from ñI have to.òto ñI must.ò)

Commitment: The person expresses a readiness or agreement to change (e.g., ñFive job applications? Yes, I will do that.ò)

The **Motivational Interviewing Treatment Integrity (MITI) Code** is a highly structured feedback system that uses a video or audio recording of an MI interview of at least twenty minutes in duration. A rater tracks the methods used in the interview, including those that adhere to MI principles and those that do not. The frequency of these interviewer behaviors are used to compute a skill balance. Raters also judge the recording based on global ratings (e.g., genuineness and empathy). The interviewer is given written feedback on all components of the interview, a skill balance rating, and an explanation of the rating form. The rater also provides coaching to the interviewer. This type of evaluation has been shown to be effective in improving the skills of MI practitioners. Peer reviewers need to participate in special training. More information on the MIT Code can be found at http://casaa.unm.edu/code/miti.html.

SUPPORTIVE INQUIRY

Supportive inquiry is a technique for engagement that frames questions in a non-assumptive, non-judgmental manner in order to explore capabilities, resources, and goals and facilitate a reflective process to empower individuals to take control over their lives. For example, in supportive inquiry, the person is asked ñWhat is the furthest education you have completed?ò rather than ñDid you finish high school?òto convey potential rather than deficits or limitations.

Supportive inquiry complements motivational interviewing by providing a means of asking and listening that helps individuals identify strengths and social supports that can be utilized to increase successful compliance with supervision and facilitate positive behavioral change. It is designed to evoke insight, gather information, enhance self-efficacy, and create and enhance connections. Examples of supportive inquiry questions include ñWhat is working best in your life right now?ò, ñWhat is important to you now?ò, ñWhat are your goals?ò, ñWhat are you good at?ò, and ñWhat do you like to do?ò ñHow is your life different today than it was six months ago?ò, ñWhat would be different six months from now if our work together was successful?ò, ñWhat are you doing to keep your head above water in this difficult time?ò, ñWhat would you do differently tomorrow than you are doing today?ò, ñWhat do you like about yourself and your family?ò, ñWhat do others like about you?ò, ñHow have you supported a friend or family member in the past?ò

Applying a strength-based perspective to supportive inquiry entails:

- Starting with positive or neutral questions (e.g., ñWhat are you good at?ò, ñWho helped you recently?ò, ñWhat did they do for you?ò, ñWhat is most important to you right now?ò, ñWho do you feel closest to?ò) and scattering challenging questions throughout the interview.
- Reviewing conditions with returning citizens to ensure they are understood.
- Asking returning citizens to define the problem.

- Asking returning citizens to tell their story first, rather than relying exclusively on the case record.
- Using open-ended questions that begin with ñhowò or ñwhatò, which expresses interest and allows the person to reflect, consider options, and assess their current situation.
- Avoiding questions that begin with ñis,ò ñare,ò ñdo,ò or ñdidò because such closed-ended questions generally require a ñyesòor ñnoòresponse and thus can hinder exploration.
- Avoiding questions that begin with ñwhyò because these may be experienced as accusatory or judgmental and not having answers to such questions can engender feelings of inadequacy.
- Checking assumptions and recognizing cultural biases and views through awareness of oneôs own values, biases, judgments, and personal histories that are brought to bear to any situation, being attuned to oneôs feelings and reactions when meeting with others (e.g., feeling frustrated with a participant or over identifying with their emotional needs).
- Refraining from using jargon and pejorative terms such as ñdenial,ò ñresistant,ò junkie,ò ñcriminal,òetc. which are laden with judgments and fail to evoke participantsôstrengths.
- Asking returning citizens for their ideas about solutions prior to making suggestions.
- Normalizing ambivalence; despite discomfort with a current situation, familiarity is comfortable and change can evoke mixed feelings including fear. It is important to assure people their feelings of fear are common and understandable.
- Being cognizant of timing and pacing of meetings to allot enough time for responding to questions that have potentially lengthy answers or highly emotional content.

Two primary types of questions are typically asked to help returning citizens identify and galvanize their strengths and resources:

① **Relational questions** offer a way to help returning citizens identify natural supports (e.g., family members and other social support networks) that may be helpful as well as provide a better understanding of how individuals/families view their relationships with others. Relational questions include ñWho do you help?ò ñWho among your friends are in recovery?ò ñWho takes care of your children when you are out?ò ñWho asks you for help?ò and ñIf things change in your life, who will be the first to notice?ò

Individuals may identify a negative peer influence or person who could jeopardize their success (e.g., a gang member or a family member actively engaging substance abuse or criminal behavior). Supervision agents confront negative networks of support, assist returning citizens in developing awareness of their harmful impact, and facilitate a process for breaking those ties and building prosocial systems of support.

② **Solution-focused questions** are a means of relating that help people construct or imagine their lives with the change they are seeking and typically include future-oriented questions. There are several types of **future-oriented questions**:

⊙ **Miracle Questions** are used to orient people to their desired outcomes by helping them construct a different future and consist questions regarding the present or future without the problem. Miracle questions allow people to set aside a problem and begin to consider what will happen when the problem is not there. When imagining a positive future, people begin to view difficulties as transitory rather than enduring.

Miracle questions include: ñImagine that you go to sleep tonight and a miracle occurs and your problems are gone. When you awake tomorrow, what will you notice first that things are different? ñImagine that we are now six months or more in the future, what will be different in your life.ò Follow-up questions are used to

shape the description into specific behavioral goals such as ñWhat is the first sign this is happening? and ñWhat will you be doing instead of the problem behavior?ò

Miracle questions are contraindicated for individuals with active psychosis. They are also not recommended for initial use upon meeting and beginning working with people; such questions are most effective subsequent to the development of rapport.

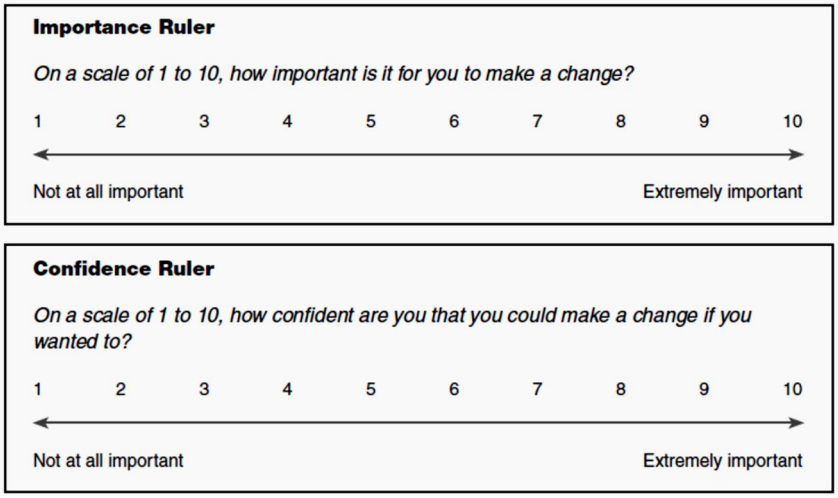
- **Scaling Questions** are those in which the person is asked to indicate on a scale from 1 to 10 where they are now (i.e., 10 = the problem solved and 1 = the problem is at its worst). Members of the personôs support system can also be asked the same scaling questions to ascertain how their responses compare. Scaling questions are an effective method of ascertaining how people perceive the severity of a problem, their progress in working on problems, and previous problem-solving efforts.

  Scaling questions elicit subjective appraisals of progress already made and further work to be accomplished and thus establish a baseline for measuring future progress. When asked over the course of supervision, a specific scaling question can also help people see how their feelings change over time.

  Scaling questions capture ambivalence more effectively than yes/no questions. Such questions can be used effectively for initiating conversations about change and assume at least a minimal willingness to change.

  Importance and confidence rulers can be used to elicit discussion about readiness to change.

Importance and Confidence Rulers



from Walters, et al. (2007)

- **Survival Questions** provide information on resilience in the face of adversity and identify internal and external resources ones that have been utilized. Such questions focus on and amplify survival qualities while promoting respect for these abilities.

- **Exception Questions** help people identify times when they were effectively managing their lives or things were going well (e.g., maintaining sobriety or held a job) and identify what might have been different in their lives that can be built upon again (e.g., going to AA meetings regularly or had a friend who took them

to work every day when they lost their license). Exception questions are used when a problem occurs people begin to violate a condition of their supervision, Examples include ñWere there times recently when the problem did not occur?ò ñWhen was the most recent time when you were able to [perform the desired behavior]?ò ñHow did that happen?ò ñWhat was different?ò ñWho was involved?ò

Resistance or denial is often a signal to modify strategies. Techniques that can be employed to deal with resistance include reframing, use of self, and active listening:

Reframing consists of re-casting objections by attributing a positive motive to them and showing how the desired behavior addresses that motive. For example, if a returning citizen indicates they do not want to involve their family because of pain caused in the past, their desire to protect the family (which is laudable) is acknowledged. The practitioner then ascertains whether the protectiveness means the family does not wish to involved or whether the family is concerned about the personôs ability to change and shows the returning citizen how involvement helps the family see that circumstances are currently different.

Use of self entails limited momentary self-disclosure such as ñIôm confused. On the one hand you say you are deeply committed to turning your life around and to recovery, but on the other hand, you donôt attend AA and missed three days at your program last week.ò

Active listening is way to demonstrate that the individualôs concerns have been heard and understood by giving signals and feedback. Periodic feedback allows for the corrections of any misunderstandings and clarification of their ideas by hearing how they are perceived and experienced by others. Guidelines for active listening include:

- ✓ Maintaining frequent and comfortable eye contact, but avoiding staring.
- ✓ Using appropriate non-verbal communication (body language, facial expressions, and gestures) and paraverbal (tone and volume of voice).
- ✓ Limiting the use of head nodding and ñuh-huhòresponses.
- ✓ Limiting interruptions and allowing periods of silence.
- ✓ Paraphrasing what is heard.
- ✓ Focusing on emotions heard rather than details, as well as using probing or directing questions (e.g., ñDid you feel angry when that happened?òor ñYou looked sad when you talked about thatò).
- ✓ Separating people from their behavior; acceptance does not equate with approval.

CONFIDENTIALITY

Preserving the confidentiality of personal information facilitates the establishment of trust between returning citizens and providers, including supervision agents. It can also protect individuals in instances of domestic violence or embarrassing personal information (e.g., marital conflicts, substance abuse, medical issues, etc.) which could have an adverse impact on employment, housing, and educational opportunities. Supervision agentsô case notes and records can be subpoenaed, but the private notes of therapists cannot be disclosed without consent.

Federal confidentiality laws, such as the Health Insurance Portability and Accountability Act (HIPAA) of 1996 (http://www.hhs.gov/ocr/hipaa/bkgrnd.html) affect how agencies must handle sensitive medical information. The HIPAA Privacy Rule sets boundaries on the use and release of medical records and individually identifiable health data. Under HIPAA, patients must be informed about how their personal information may be used and individuals are allowed to control certain disclosures of their personal information.

Federal regulations regarding the confidentiality of alcohol and drug abuse patient records, 42 C.F.R. § 2.1, et seq. (http://www.access.gpo.gov/nara/cfr/waisidx_03/42cfr2_03.html), also place strict constraints on the disclosure of patient information. These regulations protect individuals in substance abuse treatment by restricting the disclosure of information that reveals a person is currently in treatment, has applied for treatment, or has had a history of treatment. Exceptions to this rule include instances where the information is being disclosed within a program or a qualified service organization that directly deals with the treatment program.

Confidentiality issues can be effectively addressed by advising returning citizens of the legal implications of signing a waiver or release of information and then requesting them to sign a form that clearly specifies what information is being disclosed, to whom, and for what purpose.

A memorandum of understanding (MOU) among agencies partnering in collaborative reentry efforts can be used to facilitate interagency communication and adherence to laws pertaining to confidentiality. Some collaboration partnerships use a single standardized consent/authorization form that meets federal and state laws to facilitate the process. Business associate agreements and qualified service organizations can be used to facilitate information sharing.

RESIDENTIAL STABILITY

Housing is often the most immediate and critical challenge faced by returning citizens upon release. While many can reside with their families, others must cope with limited options stemming from the scarcity of affordable housing, prejudices, and regulations that restrict tenancy in subsidized housing. Many returning citizens lack needed financial resources or personal references to secure housing in the private market. Federal laws may bar individuals convicted of felonies from public housing and federally assisted housing programs, and living with family or friends is not always an option. Moreover, maintaining a stable residence after release can be challenging due to employment instability, family circumstances, health problems, and changes in entitlement or benefits. Returning citizens who are unable to secure housing may end up in shelters or become homeless.

Studies have demonstrated that the first month subsequent release from prison is a critical period of vulnerability and risk for homelessness and/or recidivism. Lack of stable housing during this time can undermine successful reentry. It is therefore recommended that assessment and planning for housing be initiated at least six months (and up to one year) prior to release.

Outcomes research on the impact of access to appropriate housing at reentry demonstrate that housing plays a critical role in providing a foundation for engagement and participation in a range of services that promote successful reentry. Research indicates individuals under parole supervision who lack stable housing face a higher risk for parole violations, rearrest and re-incarceration while, on the other hand, studies have shown that stable housing is strongly linked to reductions in recidivism and reintegration. Thus, housing is viewed as a service that leads to other services and supports, rather than simply a place to live.

Inadequate housing has a far-reaching impact. People who lack stable housing experience difficulties finding and maintaining employment. Individuals who are homeless are at greater risk for violent victimization, have higher rates of health problems, mental illnesses, and substance use disorders, and are less likely to access services. Lack of stable housing combined with an inability to meet other basic needs (e.g., finding and maintaining employment, access to substance abuse treatment and health care services) can increase the risks for relapse and recidivism.

Use of shelters, both before incarceration and subsequent to release, has been found to be associated with an increased risk of return to prison and studies show a significant overlap between the homeless population and the population of people who have had contact with the criminal justice system. Studies show that living in homeless shelters after release increases the risk for re-incarceration and absconding from supervision.

Many returning citizens are vulnerable to homelessness. Studies show an association between homelessness and time spent in a correctional facility. It is estimated that fifty four percent of persons who are homeless have experienced incarceration. Approximately ten percent of individuals entering prisons have experienced periods of homelessness, and people with histories of mental illness and substance use disorders are at increased risk; twenty percent of persons with a mental illness have experienced homelessness during the months before and subsequent to incarceration. Moreover, homelessness can exacerbate medical, psychiatric, or substance abuse issues.

Returning citizens convicted of sex offenses face distinctive challenges due to actual or perceived risks they pose to public safety. Their return to a community can attract media and

public attention, and property managers or family members often experience community pressure to refuse to house them. In addition, these individuals are subject to sex offender registration laws that give the public information regarding their whereabouts as well as pose restrictions on where they can reside. However, while there is a paucity of research regarding the impact of community notification, such regulations have the effect of limiting housing options without creating alternatives.

The establishment of so-called sex offender free zones prohibits residing within a prescribed distance of schools, parks, daycare centers, or other areas where children may be present. For example, Michigan statute prohibits individuals with a criminal sexual conduct conviction from living within one thousand of a school, park, or other area where children congregate. Negative public sentiment has fueled efforts to bar individuals with convictions for sex offenses from some neighborhoods in which community members have mobilized to both them from moving in or force to move from existing residences. In others, fears of congregate residences have resulted in the enactment of local ordinances that prevent more than one such individual from living in a single dwelling, including halfway houses, group homes, and community shelters. Some public housing entities and homeless shelters have established exclusionary rules to bar individuals with sex offender convictions.

Ironically, such efforts can compromise public safety, rather than enhance it, by exacerbating risk factors (e.g., housing and employment instability, loss of community supports, and increased hostility and resentment). In fact, shared residency options and their proximity to schools and parks do not appear to be associated with new sex crimes. Moreover, those who are unable to find housing may be more likely to report false addresses on sex offender registries which impedes efforts to provide effective supervision and monitoring.

Women who are parents face unique challenges in securing safe and affordable housing subsequent to reentry due to the need to include their children. Women may need to consider the need to avoid recurring domestic violence. And, they are more economically disadvantaged than their male counterparts.

Safe, decent, and affordable housing is critical to the well-being of parents and children. Parents returning to the community after incarceration will be unable to regain custody of their children if they cannot find appropriate housing. It is recommended that transition planning for parents with children in foster care include coordination with the local child welfare agency to determine the availability of family reunification programs with supportive services, such as the Family Unification Program (discussed below).

Returning citizens often lack the financial means to enter the private housing market which represents ninety seven percent of the total housing stock. Most individuals leave prison without enough money for a security deposit on an apartment. Moreover, in most communities the fair market rent for a two-bedroom apartment is above the earnings from a full-time minimum wage job. In addition, landlords typically require employment and housing references and disclosure of financial and criminal history information, placing returning citizens at a disadvantage. Honest responses can provide landlords with reasons to reject applications for tenancy, while failures to disclose such information can lead to disqualification due to omission of information.

Studies indicate that the majority of returning citizens live with a family member, close friend, or significant other upon release. However, these are not options for some due to family conflicts, limited family financial resources to support the person, reluctance of family members to welcome a person who has been violent back into their lives, lack of family, or legal restrictions as conditions of parole that prohibit returning citizens from living with a family member or close friend who has a criminal history. In addition, family members who live in public housing may be subject to exclusion policies and eviction for housing someone who is not on the lease.

Also, while families can be a source of support and encouragement, they can also contribute to the risk of recidivism or relapse. Some families lack the means to support another family member and strains family resources can lead to further criminal activity. Family members may have been the source or cause of unsafe behaviors that precipitated criminal activity.

The paucity of residences designed specifically for returning citizens have been addressed by the development of housing that is operated entirely by returning citizens, post-release housing built as a community service project by returning citizens, post-release housing linked with micro-enterprise or social-entrepreneurial ventures, and low threshold/low demand housing for those who are challenging to serve.

The involvement of returning citizens in rehabilitating abandoned housing offers opportunities for skills training, employment, participation in community revitalization efforts, and the creation of viable affordable housing stock. Employment of returning citizens helps them develop construction and maintenance skills while converting abandoned property into needed housing for them and teaches them basic skills that will help them find gainful employment. Moreover, the construction industry has been found to be willing to hire returning citizens.

The NIMBY phenomenon can create barriers to the development of group homes or supportive housing for returning citizens. Fears expressed include increased levels of crime, noise, and traffic, lower property values. Surveys show that community opposition is greatest when facilities are developed for people with substance use disorders. However, research does not support many of these common fears and studies also show that small facilities can be successful in overcoming community opposition. In fact, studies have demonstrated that the general impact of Section 8 occupancy and supportive housing actually appears to have a positive impact on property values and, if negative impacts do occur, they are most likely the result of facilities in areas already experiencing crime.

It is recommended that neighborhood residents be involved early on to neutral fears and avoid NIMBY-ism (not in my backyard) and provide information regarding support services, safety measures to help assuage their concerns. Research indicates that the most effective way to overcome NIMBY-ism is an educative and collaborative process that begins prior to site selection and includes contributions to the community by a facility's sponsors.

SUPPORTIVE HOUSING

Supportive housing provides affordable rental housing linked to onsite or readily accessible supportive services for people at risk of becoming homeless. It typically includes access to substance abuse treatment, mental health services, education and job training, parenting skills development, and may include programs for children. Some asset-based programs, such as social-entrepreneur ventures linked to housing for returning citizens, provide opportunities build a sense of community among residents to reduce their social isolation and empower them to provide support for one another as they become self-reliant. Asset-based models emphasize contributions residents can make to their own support and that of the wider residence.

Supportive housing is transitional (with a set length of stay) or phased permanent housing that includes a variety of support services to help residents achieve self-sufficiency. Residents do not typically have occupancy agreements or leases.

Phased-permanent housing is a short-term model in which residents have month-to-month occupancy agreements (rather than leases) and therefore have some rights of tenancy. This type of housing aims to help residents move on to more permanent forms of housing and also offers reentry housing tenants the option moving out when they no longer require assistance.

The availability of phased-permanent housing units can be beneficial for individuals who experience challenges in maintaining residential stability following the end of their tenancy.

Supportive housing programs offer a range of services including family counseling, case management, medical services, substance abuse counseling, socialization skills groups, anger management, vocational training, and assistance with obtaining vital documents (e.g., Social Security cards and birth certificates). These programs are often targeted to returning citizens to prevent homelessness.

There is a variety of supportive housing programs funded by private and charitable foundations, grants, or subsidies from state and federal governments that are typically operated by nonprofit and faith-based organizations and targeted to individuals and families who are homeless as well as people with chronic health challenges (e.g., mental illness or HIV/AIDS) and individuals leaving incarceration. However, only a few of the latter receive funding from correctional agencies despite the promise they hold to improve successful reintegration through the provision of subsidized housing in conjunction with a range of supports and services and linkages to treatment, jobs, education, and assistance with family reunification.

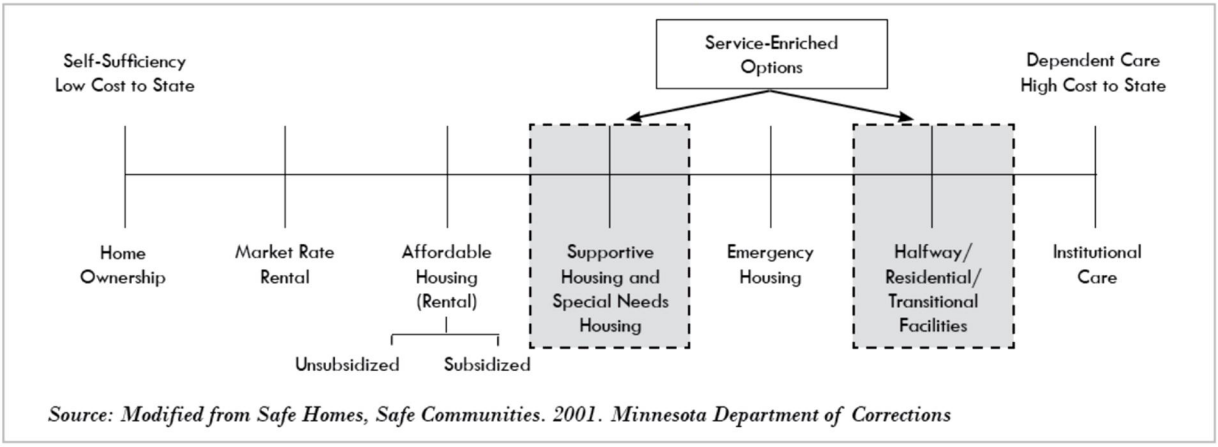
Supportive housing has been shown to help individuals with complex challenges including homelessness, very low incomes, substance use disorders, mental illnesses, and HIV/AIDS. It has been shown to have a positive impact on health, employment, treatment for mental health disorders, the amelioration of substance abuse, and is associated with significant reductions percent in emergency room visits and hospital inpatient days and increases in sobriety. Supportive housing has been found to be effective in meeting the long-term housing needs of people with mental health, substance abuse, and chronic health challenges, many of whom have histories of criminal justice system involvement. Residents have been shown to experience both health improvements and reductions of involvement in the criminal justice system.

A definitive model for implementing supportive housing has yet to be developed. Housing designed for the exclusive use of returning citizens may be stigmatizing and make it more challenging for residents to reintegrate into the community. Moreover, community opposition can make this type of housing difficult to site. Models that incorporate returning citizens on work release who restore low-income housing and groups such as Habitat for Humanity have the potential to increase available affordable housing stock while preparing program participants for gainful employment.

A model for incorporating harm reduction in post-release housing has been developed for individuals who are challenging to serve. Harm reduction/low threshold housing, known as the **housing first** model, includes a lack of requirements (e.g., sober/clean-time or participation in treatment) for admission, expulsion based solely on adherence to the terms of a lease, offering, but not requiring, participation in treatment; responding to relapses with intervention; and teaching harm reduction techniques (e.g., needle exchange, sterilizing drug paraphernalia, and safe sex practices, etc.).

The housing first approach offers the direct placement from the street (or an institution) to housing with support services available, but not required. Although some evaluation studies have found that housing with low-demand service provision may work well for persons with mental illness and co-occurring substance use disorders, low demand services might not be an option when individuals are under high levels of correctional supervision. Correctional supervision-related coercion (e.g., mandatory drug testing) has been shown to work well in many circumstances for individuals with substance use disorders who are involved in the criminal justice system. Little is known regarding how coercion works for those who have a mental illness.

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

REENTRY HOUSING

Reentry housing is based on the supportive housing model. Like supportive housing, it blends a multiple sources of funding that usually involves partnerships and linkages among providers with different areas of expertise and offers residents a comprehensive array of services and supports in addition to affordable housing. However, it differs from supportive housing because it not only provides case management and counseling services tailored to meet the needs of returning citizens, it is part of a continuum of services beginning in the correctional institution. Such services and supports can include transportation from the correctional facility, entitlements and benefits advocacy, family reunification services, legal advocacy, and assistance with criminal justice supervision requirements. Some re-entry housing programs include additional services targeted to returning citizens with mental illnesses, substance use disorders, and HIV/AIDS.

Service-enhanced transitional housing and supportive housing are two basic housing models for returning citizens. Service-enhanced housing includes transitional (i.e., fixed length of stay) or phased-permanent housing (in which residents have month-to-month occupancy agreements rather than leases) combined with a variety of support services to assist clients in achieving self-sufficiency. Supportive or service-enhanced housing programs offer a range of services including family counseling, case management, medical services, substance abuse counseling, socialization skills groups, anger management intervention, vocational training, and assistance with obtaining vital documents (e.g., Social Security cards and birth certificates). Some jurisdictions have targeted these programs to returning citizens due to homelessness or risk for homelessness. Combining housing services with additional support services has shown be of benefit to returning citizens who have limited resources.

Reentry housing includes single-site, congregate models in which all units are located in a single location, and scattered-site models in which rental subsidies are used to rent units in the private rental market. Some single-site models are linked with scattered-site projects to provide a continuum of housing options for returning citizens to encourage those who no longer require supportive services to live independently.

Some reentry housing includes the co-location of emergency housing with permanent or phased-permanent housing to provide immediate access to safe and stable shelter subsequent to release as well as a longer-term housing option with links to supportive services for returning

citizens who require them. Such housing continuums can address both immediate and longer-term housing needs.

There are a number of housing programs for returning citizens funded by private foundations, charities, and grants or subsidies from states and the federal government. These residential facilities, the majority of which focus on treatment, are operated by nonprofit or faith-based organizations. Residents often pay a fee based on a sliding scale of ability to pay which increases as the person progresses through program phases. A variety of funding sources and partnerships are usually needed to sustain these programs. Like corrections-run halfway houses, these programs must overcome NIMBY-ism, but may be viewed by area residents as having the interests of the community at heart.

The limited research[11] on the relative effectiveness of various post-release housing models indicates that residents of halfway houses engage in less severe and less frequent criminal activities. However, while community-based residential programs have been shown to be effective in reducing recidivism for individuals at moderate to high risk, participation leads to increases in risk for those who are at low risk. Additionally, the establishment of these facilities often provokes community opposition known as NIMBY (Not in My Backyard). Finally, the availability of funding for these programs can pose a barrier to their construction.

A number of services and supports are recommended for new residents starting with inreach services that connect returning citizens to housing resources prior to release, followed by transportation from the prison to the residence, shadowing by other residents or peers or mentors during the first days after release, orientation to the neighborhood (e.g., grocery stores, bus stops, etc.), orientation technology (e.g., payment systems in public transportation, shopping cards in grocery stores, computers in libraries, the Internet, etc.). In addition, it is recommended that more structure be provided at the outset with a lessening of schedules, rules, and limits as time passes.

Support services include case management and referrals needed services; relaxation and self-calming activities; support for adherence to mental health and medical care and medication regimens; employment assistance; substance abuse treatment and relapse prevention as well as on-site self-help groups (AA, NA, rational recovery, and relapse prevention groups); social gatherings: group meals, holiday parties, etc.; social reintegration activities (e.g., trips to grocery stores, post offices, recreational spots, places of cultural interest, etc.); life skills classes or counseling; financial planning and management; emergency and after-hours response.

No definitive model has been shown to be universally effective. Some housing providers advise creating highly structured residential environments with expectations for acceptable behavior, some advocate for a low threshold for entry and maintaining tenancy, and others support a moderate approach which emphasizes structure at the outset of tenancy with reductions in expectations over time. Funds for the construction or rehabilitation of reentry housing are typically provided by multiple public and private sources due to the high costs associated with construction and redevelopment.

There is some research that supports small residences with shared living space for up to ten or fifteen residents offer the intimacy of a family-like environment in which relationships and camaraderie can be fostered. These natural relationships can be stronger sources of support than those with professionally trained staff. An on-site, live-in building manager who receives free room and board in exchange for providing after hours staffing has been found to be economical post-release housing and effective in ensuring onsite availability to respond to

[11] Most of the studies are methodologically weak due to the lack of comparison groups. Most focus on isolating variables associated with successful program completion.

immediate needs and emergencies. Large residences with fifty to one hundred residents, on the other hand offer economies of scale and provide wide range of social services on-site. The provision of multiple services in one centralized location has been found to be especially effective for returning citizens and eliminates difficulties arising from the need to move between multiple sites to obtain services.

It has been postulated that mixed-use housing, rather than large, concentrated residences, can mitigate NIMBY-ism because it is more appealing to neighbors and helps returning citizens feel integrated into the community. On the other hand, housing dedicated to returning citizens may engender feelings of being more accepted as a result of camaraderie with others who have similar experiences.

COMMUNITY-BASED CORRECTIONAL TRANSITIONAL RESIDENTIAL FACILITIES

The corrections system provides housing assistance through halfway houses (also known as pre-release or reentry centers) while individuals are still incarcerated or as they transition into community-based supervision. Halfway houses provide an intermediate step between the highly structured environment of prison and total independence. Lengths of stay usually range from thirty to one hundred twenty days and most facilities provide supportive services. Some jurisdictions in the country have established halfway back facilities as an alternative to re-incarceration for returning citizens who violate the conditions of parole.

Halfway houses offer structured environments for returning citizens while supervising and monitoring of their progress. Many of these neighborhood-based facilities have staff that function as case managers to broker and coordinate the delivery of services and supports to residents. Most also have a work or school requirement and permit residents to work in the community and offer substance and mental health counseling; job placement assistance; life skills instruction; and other services. Residents are typically required to abide by a curfew and are assigned facility maintenance tasks. They remain under the jurisdiction of the criminal justice system and if they do not comply with program rules can be re-incarcerated to complete their sentences.

Halfway house placements can facilitate a successful community reintegration because they allow residents time in their communities to seek appropriate housing and employment without the need to resort to criminal behavior for survival or become homeless. Studies indicate that transitional housing leads to significant reductions in recidivism.

The Michigan Department of Corrections developed specialized housing units so that individuals nearing release can be located with other returning citizens in housing with access to programs and, optimally, in close proximity to the communities in which they will reside after release. These community residential programs (CRPs) are designed to facilitate successful transition. Individuals residing in CRPs serve approximately six months in a county corrections center or on electric monitoring and must have a job or attend classes during the program.

Tri-Cap (http://tricap.net/) is a Saginaw-based structured residential program that serves individuals who are involved in the criminal justice system. Tri-Cap provides supportive services to help individuals achieve successful completion of parole/probation, including, substance abuse counseling, twenty-four hour supervision, educational remediation, vocational training, recreation, a job club and employment assistance, as well as interventions designed to alter criminogenic ideation and behavior.

SUBSIDIZED HOUSING

Federally subsidized and administered housing is designed for individuals and families with very low incomes. The U.S. Department of Housing and Urban Development (HUD) (http://portal.hud.gov) offers three federally subsidized housing programs: (1) the Housing Choice Voucher Program (formerly called Section 8); (2) the Federal Public Housing Program, and (3) a variety of projects and programs that consist of privately owned federally subsidized stock. These three programs serve about one-third of all eligible renter households with incomes up to eighty percent of the area median income. However, returning citizens face barriers in accessing federally subsidized and administered housing due to the scarcity of housing stock (which affects all individuals who need affordable housing), and formal and informal regulations and prejudices that restrict tenancy. Public housing authorities routinely perform criminal background checks on all applicants for subsidized housing and admission can be denied to whole families for the criminal behavior of one member, or even of a guest.

Obtaining public housing may not be a viable option for individuals with a felony drug conviction. In 1996, the federal government implemented the One Strike Initiative, authorizing local public housing authorities (PHAs) to obtain the criminal conviction records of all adult applicants or tenants from law-enforcement agencies. Federal housing policies permit (and in some cases require) PHAs, Section 8 providers, and other federally assisted housing programs to deny housing to individuals who have a felony drug conviction or are suspected of drug involvement. Michigan, however, is more lenient in its public housing application process when considering criminal records.

According to the Federal Housing Opportunity Program Extension Act of 1996 (Public Law 104-120, 1996), individuals are ineligible for public housing and Section 8 assistance if they have been evicted within the previous three years from housing assisted under the United States Housing Act. In addition, tenants who use drugs illegally and whose illegal use or pattern of illegal use of drugs may interfere with other tenantsô health, safety, or peaceful enjoyment of the premises are ineligible. However, exceptions are permitted when a person who has been evicted successfully completes a rehabilitation program, or the circumstances leading to the eviction no longer exist. In addition, federal statutes authorize PHAs to reject from housing or terminate the lease of households where any household memberôs drug use, alcohol abuse, or criminal behavior threatens other residents.

Federal law allows Public Housing Authorities (PHAs) and federally assisted housing providers to screen or refuse to house or accept Section 8 vouchers from people who have been convicted of certain crimes (e.g., drug-related crimes and sex offenses) and individuals evicted from public housing during the past three years. However, housing providers have discretion to shorten the three-year ban for people evicted based on drug-related criminal activity if those individuals successfully complete a rehabilitation program approved by the local housing provider or if the circumstances leading to the eviction no longer exist. The housing provider may permit such individuals to be admitted or to remain if they demonstrate that they are not currently abusing alcohol or illegally using drugs and that they have been rehabilitated in any one of three ways: (1) participation in a supervised alcohol or drug rehabilitation program; (2) completion of a supervised alcohol or drug rehabilitation program; or (3) successful rehabilitation in some other manner.

An exception is made for individuals who fall under the physical or mental impairment provision of the Fair Housing Act under which refusal to rent to individuals participating in substance abuse treatment programs constitutes illegal discrimination. PHAs can grant exceptions to individuals who are participating in treatment or social service programs, or who can demonstrate their completion of treatment or rehabilitation. Certificates of Rehabilitation

awarded after successful completion of treatment programs can be used to increase access to employment and public housing or Section 8 vouchers.

The primary source of funding for homeless assistance consists of the McKinney-Vento Act programs administered by HUD. The availability of McKinney-Vento Act funds has resulted in the creation of thousands of homeless and supportive-housing programs. However, levels of McKinney-Vento funding have not increased to meet ever-rising demand. Nonetheless, McKinney-Vento funds have been used to help returning citizens access affordable housing. In 2000 HUD changed its definition of homeless to include individuals who are incarcerated for over thirty days, experience homelessness prior to incarceration, have no identified residence following release, lack support networks outside of prison, or were evicted from a prior residence.

HOUSING CHOICE VOUCHER PROGRAM (HCVP)

Housing Choice Vouchers are locally administered by public housing agencies (PHAs), which receive federal funds from HUD. Families issued housing vouchers are responsible for finding a suitable housing unit of their choice where the owner agrees to rent under the program. The voucher covers the difference between the Fair Market Rent (determined by HUD) and what the family pays in rent, usually between thirty to forty percent of a family's adjusted income. Housing Choice Vouchers waiting lists are closed in most localities, and individuals may wait several years for a voucher. PHAs may also distribute specialized housing choice vouchers through targeted initiatives such as the Family Unification Program (FUP) or Welfare-to-Work Voucher programs. Information on the program can be obtained from http://portal.hud.gov/hudportal/HUD?src=/hudprograms/hcvp.

FAMILY UNIFICATION PROGRAM (FUP)

The Family Unification Program provides vouchers to enable families to purchase or lease property for the unification of parents whose children are in foster care due to a lack safe and affordable housing. In addition, FUP provides funds for support services to address issues that can impact families undergoing reunification, including outreach, child care, job training and placement, case management, health care, transportation, education, life skills classes, counseling, housing search assistance, substance abuse treatment, parenting courses, mental health care, and budgeting advice. Information regarding FUP can be obtained from http://portal.hud.gov/hudportal/HUD?src=/programdescription/familyunification.

SUPPORTIVE HOUSING PROGRAM (SHP)

The Supportive Housing Program is a grant program that funds permanent housing construction and subsidizes operating costs for a building. Funds are directed to a project sponsor rather than tenants and can also be used to pay for services for tenants (but are most often used to pay for maintenance and operating costs). HUD's Supportive Housing Program (http://portal.hud.gov/hudportal/HUD?src=/program_offices/comm_planning/homeless/programs/shp) can be used to fund four types of supportive housing:

1. **Transitional Housing** to facilitate access of individuals and families who are homeless to permanent housing. Residents live in transitional housing for up to twenty four months and receive support services designed to enable them to live more independently. Such housing may be facility-based or individual units in scattered sites. Supportive services can be provided by the organization managing the housing or coordinated by that organization and provided externally by other public or private agencies.

2. **Permanent housing for persons with disabilities** with supportive services for people with disabilities who are homeless to enable them to live as independently as possible in a permanent setting in one location or scattered-site housing units.
3. **Safe Havens** which are targeted to single adults with serious mental illnesses who have been living on the streets and have been unwilling or unable to participate in supportive services. Safe Havens provide basic needs (e.g., bathing facilities, food, clothing, and shelter) and serve as an entryway to transitioning to the acceptance of services and movement toward more permanent housing. No limits are place on length of stay and clients are not required to receive services.
4. **Innovative Supportive Housing** funding enables applicants to design programs outside the scope of the other components. Applicants must demonstrate the distinctiveness of their approach and that it is a reasonable model that can be replicated in other communities.

HOME INVESTMENT PARTNERSHIPS PROGRAM

The HOME program provides formula (block) grants to states and localities to build, buy, and/or rehabilitate affordable housing for rent or homeownership, or provide direct rental assistance to individuals with low incomes. The HOME program emphasizes the creation of linkages and partnerships between for-profit and nonprofit organizations. States and localities must submit a five-year comprehensive housing affordability strategy that includes partnerships and a fifteen percent set-aside to housing community development organizations in order to receive HOME funding,

LOW-INCOME HOUSING TAX CREDIT (LIHTC)

LIHTC is a tax credit designed to encourage the development of low-income rental housing. State agencies review applications submitted by developers and providers of low-income housing and allocate housing tax credits according to criteria that reflect their own housing policy goals within federal guidelines. Projects may be developed for nonprofit organizations or for-profit organizations. States must set aside ten percent of the LIHTC funds for use by nonprofit organizations. Property owners determine populations targeted for residence in new properties.

PROJECTS FOR ASSISTANCE IN TRANSITION FROM HOMELESSNESS (PATH)

PATH provides funding for community-based outreach, mental health and substance abuse services, case management, and limited housing services for individuals experiencing serious mental illnesses, including those with co-occurring substance use disorders, experiencing homelessness or at risk for becoming homeless. Services eligible for funding under PATH include:

- Outreach services
- Screening and diagnostic treatment services
- Habilitation and rehabilitation services
- Community mental health services
- Alcohol and drug treatment services
- Relevant housing services
- Staff training
- Case management services
- Supportive and supervisory services in residential settings
- Referrals for primary health services, job training, educational services

SHELTER PLUS CARE (S+C)

Shelter Plus Care is a rental assistance program in which funds are allocated directly to a tenant, sponsor of the program, or a single or scattered-site unit. In scattered-site units tenants sign leases and the S+C allocation goes to the organization that manages the building; or the lease can be in the tenant's name with the allocation going directly to that tenant.

The purpose of this program is to provide rental assistance for hard-to-serve homeless people with disabilities in connection with supportive services funded from sources other than this program. The four components of S+C are: (1) tenant-based rental assistance, (2) sponsor-based rental assistance, (3) single room occupancy for homeless individuals, and (4) project-based rental assistance. Grants are awarded for up to 5 years.

Sponsors of supportive or service-enhanced housing for individuals who are homeless apply for McKinney programs through their local Continuum of Care (CoC) planning process which determine funding priorities for use of McKinney funds each year. Some local Continuum of Care plans include persons leaving correctional institutions as one their priority populations. More information can be obtained from http://portal.hud.gov/hudportal/HUD?src=/program_offices/comm_planning/homeless/programs/splusc.

SECTION 8 MOD REHAB PROGRAMS

The Section 8 Mod Rehab program provides rental assistance similar to Shelter Plus Care or Housing Vouchers, but targets projects that entail moderate rehabilitation of existing buildings. The Section 8 Moderate Rehabilitation for Single Room Occupancy (SRO) Dwellings program is designed to bring more standard single room occupancy (SRO) units into the local housing supply and use those units to assist individuals who are homeless. Public housing authorities and private nonprofit organizations are eligible to apply for funds which may be used only for rental assistance and administering the rental assistance. Grants are awarded for up to a ten-year term.

HOUSING OPPORTUNITIES FOR PERSONS WITH AIDS (HOPWA)

The HOPWA funding program targets individuals with HIV/AIDS and has been used to develop supportive housing for returning citizens with HIV/AIDS. Funds may be used for a wide range of housing, social services, program planning, and development costs including, but not limited to, the acquisition, rehabilitation, or new construction of housing units; costs for facility operations; rental assistance; and short-term payments to prevent homelessness. HOPWA funds also may be used for health care and mental health services, substance abuse treatment, nutritional services, case management, assistance with daily living, and other supportive services. Information on this program can be obtained from http://portal.hud.gov/hudportal/HUD?src=/program_offices/comm_planning/aidshousing/programs.

SUPPORTIVE HOUSING FOR PERSONS WITH DISABILITIES (SECTION 811)

HUD provides funding to nonprofit organizations to finance the acquisition, rehabilitation or construction, as well as an operating subsidy, for rental housing and supportive services for adults with very low incomes who have psychiatric, developmental, and physical disabilities. The rent subsidies for projects are designed to help make them affordable. Information on this program can be obtained from http://portal.hud.gov/hudportal/HUD?src=/program_offices/housing/mfh/progdesc/disab811.

INDIVIDUAL DEVELOPMENT ACCOUNTS (IDAS)

IDAs are dedicated savings accounts (similar in structure to Individual Retirement Accounts [IRAs]) that can only be used for the purchase of a first home, education or job training expenses, or for a small business start-up. IDAs are designed to help individuals with low incomes save money to purchase a home. Private and public sources are used to match funds for participants. Accounts are managed by community organizations and held at local financial institutions. This program can be used to help returning citizens build savings accounts for purchasing homes or for rental assistance. Information on IDAs can be obtained from http://cfed.org/programs/idas/.

PRIVATE MARKET HOUSING

The private housing market is the largest, making up ninety seven percent of available housing units. Returning citizens are faced with significant barriers to the private rental market including affordability, lack personal documentation, stigma of a criminal history, and community objection due to public safety issues. Of these, affordability is the most significant barrier as most individuals leave prison insufficient funds for a security deposit on an apartment and lack a source of income. However, returning citizens may be able to secure housing by renting a single room in a boarding house or sharing a rental property.

There are two primary sources of financial assistance available for people seeking private housing subsequent to release from incarceration: public assistance and stipends. Returning citizens, who are likely to have low incomes and thus qualify for public assistance, can use that as a source to pay for housing. Stipends can be used to help defray housing costs by funding the first few monthsôof rental payments subsequent to release.

Options have been developed for the provision of financial assistance to families who are economically disadvantaged and to increase the availability of options by expanding the pool of individuals or families who are unrelated but willing to provide housing to returning citizens if the costs are offset. One option is a kinship housing subsidy that is given to a family to help pay for subsidized housing. Another is a foster care model in which families are paid to provide housing for returning citizens following release.

Private sector or nonprofit affordable owned and managed housing may be more accessible than public housing or HCVs for returning citizens who cannot afford pay market rates. Such affordable housing can be subsidized in a manner similar to HCVs where in tenants pay thirty percent of their monthly incomes toward rent, but without the use of federal funding and, hence, not bound by federal regulations that can restrict access for people with certain criminal convictions. In general, private sector/nonprofit affordable housing eligibility is income-based; applicants must submit verification of income status, a credit check, and rental history. In addition, many private and nonprofit affordable housing projects provide access to onsite supportive services (e.g., money management, housing maintenance, employment, and recreation) similar to that provided by supportive housing. In some communities, community development corporations (CDCs) and nonprofit housing providers have used this model and created housing specifically targeted to returning citizens.

HOUSING OPTIONS FOR RETURNING CITIZENS

TYPE OF HOUSING	FEATURES	BENEFITS	POTENTIAL DISADVANTAGES
PRIVATE MARKET RENTAL HOUSING	• Individual secures apartment on the private rental market	• Most universally available • May be partly or wholly paid for by public assistance	• Rental property owners may screen for, and refuse to, rent to people with criminal backgrounds under federal and state statutes • Individual must have ability to pay security deposit immediately and rent subsequently • Public assistance may be denied to individuals with criminal records • Rental housing includes no supervision or service support to assist individual with maintaining housing
COHABITATION WITH FAMILY MEMBERS	• Individual connects to family or other natural support system that accepts the individual into their homes	• Likely to be immediately available • May coincide with efforts to rebuild family relationships • May provide emotional and/or financial support	• Not all returning citizens maintain family ties • Family members must be willing to accept the individual • Reunification may produce additional financial, emotional, or other stresses on individual or family members • Unstable or risk-intense environments may put vulnerable returning citizens or their family members at risk • Legal status of family housing situation may be jeopardized by accommodation of individual with criminal record
PUBLIC HOUSING AND HOUSING CHOICE VOUCHERS (HCVS) – TENANT-BASED ASSISTANCE OR SECTION 8	• Priority for housing is decided locally • Tenant pays 30% of adjusted income towards rent or, with HCV, up to 40% • Section 8 uses a voucher system to subsidize rents based on a Fair Market Rent (FMR) system. HUD pays the difference between 30%-40% of the family's income and the FMR for the unit	• More affordable than private rental market housing • May include units specially designated for people with physical or mental disabilities, or elderly persons • May be used anywhere the family chooses to live and can find housing within the FMR	• Under federal law, Public Housing Authorities may screen or refuse to house or accept vouchers from people who have been convicted of certain offenses, as may any federally assisted housing provider • Returning citizens may not be immediately considered "homeless" and therefore not prioritized for agencies that use homelessness as a priority need • Availability is limited—waiting lists may be long • The application process may be lengthy and intimidating

TYPE OF HOUSING	FEATURES	BENEFITS	POTENTIAL DISADVANTAGES
			• Income verification and a background check of all household members are required • May or may not make available additional service supports
NONPROFIT FOR PRIVATELY OWNED AND MANAGED AFFORDABLE HOUSING	• Financed using a variety of government subsidies (and limited private sources) Generally, tenant pays 30% of income towards rent • Mission-driven to serve people with low-incomes or who are disadvantaged • Often coordinated or run by community development corporations (CDCs) or neighborhood-based housing development organizations	• More affordable than private rental market housing • Not bound by statutory restrictions that govern public housing • May provide on-site support services	• Availability is limited—waiting lists may be long • Owners may exercise discretion to exclude people with criminal histories, though bound by Fair Housing laws
HALFWAY HOUSES, PROGRAMMATIC OR TRANSITIONAL HOUSING	• Provides housing for individuals close to or just after release, usually in a highly structured environment • May be focused on behavior change, including substance abuse • Housing may be conditional on compliance with community-based services or other conditions	• Offers transition between fully secure, structured, monitored environment of incarceration and the community • May have alternative funding streams, including Substance Abuse Prevention and Treatment (SAPT) block grants, which provide revolving loans to help people with substance abuse disorders to secure housing • May enable individuals to work during their residency while keeping their expenses (if any) very low	• May be available for limited duration only • Availability is limited—waiting lists may be long • May not be desirable because of rigid structure, including possible limitations on visitation and freedom to come and go at will • Does not address post-sentence, post-parole or longer-term housing needs
SUPPORTIVE HOUSING (SPECIAL NEEDS AND HOMELESS HOUSING)	• Specialized form of nonprofit owned and managed affordable housing (see above) • Tenant pays 30% of income	• May be the first available housing most returning citizens can access. • Offers affordable housing along with comprehensive social services,	• Availability and funding may be limited from one jurisdiction to another • McKinney-Vento funded housing is targeted to people who are homeless as defined by federal

TYPE OF HOUSING	FEATURES	BENEFITS	POTENTIAL DISADVANTAGES
	towards rent, often from public benefits (Supplemental Security Income, etc.) • Provides services to tenants using case-management model. • Focus is on housing stability, not behavior change or treatment • Funded and subsidized by a variety of federal, state and local sources; heavily reliant on federal McKinney-Vento programs	improving accessibility for recently released individuals • Tenancy is often longer-term and legally protected (not necessarily tied to compliance with services) • Can lower the risk of detention and incarceration among people with mental illnesses who were formerly homeless	statute, which excludes incarcerated persons who were not homeless (shelter- or street-dwelling) prior to incarceration • Many supportive housing programs are reliant on funding that may exclude people who have criminal records or are managed by PHAs and thus subject to restrictions against people with criminal records • Co-residency of returning citizens may have a stigmatizing effect
SPECIALIZED RE-ENTRY HOUSING	• Shares many of the same features as supportive housing, but provides specific services for individuals recently released • May provide emergency, transitional or longer-term housing • Often linked to transition planning activities	• Addresses specific housing and service needs of returning citizens • Nonprofit operators and staff are usually trained to interface with criminal justice personnel • May provide peer support and mentorship • May co-locate emergency with permanent or phased-permanent housing	• Very limited availability—not available in most jurisdictions • Difficult to create due to lack of dedicated funding streams and community opposition to target population

Adapted from the Report of the Re-Entry Council (2006)

EMPLOYMENT READINESS

Employment has been found to be critical to successful community reintegration. It provides a consistent source of funding for food, shelter, clothing, transportation, and other basic needs, increases feelings of self-efficacy and self-sufficiency, and offers a means of self-support that obviates the need to resort to criminal activities or rely on others for funds. Studies have demonstrated that employment is correlated with reductions in recidivism and that higher wages are correlated with greater reductions in criminal behaviors. Employment is thus a protective factor that mitigates criminal behavior.

Returning citizens are confronted with significant challenges in finding and maintaining gainful employment, particularly outside of the low-wage sector. These challenges include lower levels of education, vocational skills and work experiences, as well as stigma and lost time in the labor force. During incarceration opportunities to gain marketable work experiences, skills, and professional and social connections that lead to employment prospects upon release can be lost. Further, incarceration exposes people to a culture that strengthens ties to peers who engage in criminal or antisocial behaviors (e.g., gangs). Studies show an inverse correlation between length of incarceration and participation in the legal economy; the longer the period of incarceration, the less likely individuals are to participate in the legal economy. In addition, many returning citizens come back to communities that are economically disadvantaged and have limited employment prospects and social networks and contacts for legitimate employment.

While most (two-thirds) of individuals involved in the criminal justice system were employed prior to incarceration, their education levels, work experiences, and skills are generally lower than that of the general population. Further, the stigma associated with incarceration often makes it difficult for them to secure jobs, and those who find jobs tend to earn less than individuals with similar backgrounds who have not been incarcerated. Employment programs during incarceration and subsequent to release (i.e., vocational training, prison industries, transitional jobs, and job placement programs) have been found to be effective in helping returning citizens find and maintain gainful employment.

Arrest and incarceration impact employment rates and earnings of returning citizens due to a dearth of jobs in some areas to which they return to live after incarceration as well as laws and regulations that prohibit hiring them, and the stigma of having a criminal record (even for those who had access to employment programming during incarceration). Returning citizens who find legitimate employment upon release have lower levels of compensation than their peers, a wage disparity estimated to be twenty to thirty percent.

Surveys have found that employers are more reluctant to hire returning citizens than any other group of workers who are disadvantaged or stigmatized. Studies have shown that job applicants with criminal records are significantly less likely to be hired and those who are African American and male even less so. Access to criminal records on the Internet has made it easier for employers to conduct criminal background checks on potential employees.

Finding employment is more challenging for returning citizens convicted of sex offenses due to the need to minimize access to victims and exposure to other potential risk factors, the consequences of negative public sentiment, sex offender-specific legislation (e.g., community notification, and so-called sex offender free zones). It is also more challenging for women with criminal justice system involvement, the majority of whom are economically disadvantaged, have limited educations and job skills, as well as sporadic employment histories. Many are

single mothers who must find ways to support both themselves and their children and the capacity to be economically self-sufficient is essential to successful reentry.

According to the National H.I.R.E. (Helping Individuals with criminal recorders Re-enter through Employment) Network, the services, manufacturing, construction, commercial food, distribution, and some transportation sectors are more open to hiring people with criminal records. Manufacturing and construction industry employers have been found to be more willing to hire returning citizens than those in the retail trade or services sectors (i.e., jobs that require a wide variety of skills and direct contact with customers). However, jobs in the manufacturing and construction sectors are less available while those that bar returning citizens (e.g., childcare, elder care, customer contact, and service industry jobs) are becoming more available.

Individuals with criminal records face stigma from potential employers due to concerns regarding reliability, trustworthiness, and fear of crime against their businesses or other employees. In addition, employers can be legally liable[12] for certain crimes committed by employees if they are found to engage in negligent hiring practices and are required to conduct background checks in fields with legal prohibitions against hiring people with certain types of conviction records. These include jobs in childcare, education, security, nursing and home healthcare. An applicantôs failure to disclose or misrepresentation of information and an employerôs discovery of such can result in termination of employment. Finally, employers value experience and continuity of work history and returning citizens have been out of the labor market and thus have not supplemented their work experiences.

Employers have been found to be more willing to hire individuals who have been convicted of drug-related and property crimes than violent crimes, individuals not recently released, and those who have had some work experience since their release. Also, the use of third-party intermediaries (e.g., social service organizations, faith-based and community-based organizations, case managers, or parole/probation agents) that can work with new hires to help avert workplace problems has been shown to lead to increased willingness of employers to hire returning citizens. Incentives (e.g., the Federal Bonding Program, Work Opportunity Tax Credit, and Welfare-to-Work programs) can also be effective in encouraging businesses to hire returning citizens.

A number of state and federal employment laws protect returning citizens from discrimination based on their conviction records. Title VE of the Civil Rights Act of 1964 (which is enforced by the Equal Employment Opportunity Commission [EEOC]) governs employment activities. Title VII prohibits private employers and state and local governments from discrimination in employment decisions on the basis of race, color, gender, national origin or religion. According to the EEOC, the exclusion of individuals from employment on the basis of their arrest and conviction records may violate Title VII due to disproportionately excluding minorities because data shows that minorities are arrested and convicted at rates significantly in excess of their representation in the general population. An exception can be made if an employer can establish a business necessity by demonstrating consideration of three factors in making an exclusionary employment decision: the nature and gravity of the crime(s); the time that has passed since the conviction and/or completion of the sentence; and the nature of the job.

While employers are permitted to ask whether job applicants have ever been convicted of an offense and consider convictions in hiring decisions, according to the EEOC, employers

[12] In most cases employers are not held legally liable if they make reasonable efforts to conduct background checks and consider potential employeesô backgrounds to determine whether an applicant has a history of propensity to engage in harmful behavior (and thus could have foreseen crimes).

governed by Title VII of the Civil Rights Act cannot exclude individuals based upon arrests[13] that did not lead to convictions unless there is a business justification, In addition, employers cannot exclude individuals because of criminal convictions unless there is a business necessity.

State laws also prohibit pre-employment inquiries and consideration of arrest information. Michigan, for example prohibits employers and occupational licensing agencies from considering arrests that do not lead to convictions, and employers cannot inquire about arrests that did not lead to convictions, and occupational-licensing authorities may consider only certain criminal records.

It should be noted that many criminal record reports have been found to contain inaccuracies including missing and erroneously recorded disposition information which can lead to pejorative personal profiles. Therefore, it is recommended that employment service providers help returning citizens obtain and correct any inaccuracies in their official records of arrests and convictions.

In general, it is recommended that returning citizens limit their responses on employment applications to the specific information asked and portray their backgrounds honestly but not elaborate on or refute their convictions. Employers who learn of a dishonest portrayal on job applications or in job interviews (e.g., through a background check or reference from another source) can legally discharge the employee. Returning citizens should be encouraged to explain any mitigating circumstances connected to a particular crime and emphasize their efforts at rehabilitation by focusing on subsequent vocational training/education, employment experiences, and any community service performed.

EMPLOYER INCENTIVES

A number of programs, including the Federal Bonding Program, the Work Opportunity Tax Credit, and Welfare-to-Work programs, have been found to be effective in encouraging businesses to hire returning citizens. In addition, third party intermediaries can be an effective incentive.

The **Federal Bonding Program** allows employers to request fidelity bonds to cover individuals who are or may be denied coverage by commercial insurance carriers due to their criminal histories. Fidelity bonds issued though the Federal Bonding Program insure an employer against theft, forgery, larceny, or embezzlement by an employee at no cost to the employer. This program is currently managed by the McLaughlin Company (as an agent for Travelers Property Casualty) through state employment centers and employment and training agencies. Bonds range from $5,000.00 to $25,000.00 coverage for a six-month period with no deductible amount (i.e. the employer receives one hundred percent insurance coverage) and, when this coverage expires, continued bond coverage can be purchased from the Travelers by the employer if the worker demonstrated job honesty while covered under the Federal Bonding Program. Information regarding this program can be obtained from http://www.bonds4jobs.com/.

The **Work Opportunity Tax Credit (WOTC)** is a federal tax credit that encourages employers to hire individuals who are hard to employ by reducing employersôfederal income taxes by as much as $2400.00 for people who have been convicted of felonies. In addition to welfare tax credits that are available to employers who hire welfare recipients, Work Opportunity Tax Employers who are willing to train and provide work experience to returning citizens may be

[13] Arrests are not considered sufficiently reliable for precluding applicants from holding jobs since arrests have not been vetted through a judicial process; arrests are accusations rather than findings of guilt. According to the EEOC inquiries into arrests that did not end in convictions are considered discrimination unless there is a specifically articulated business justification/necessity.

eligible to receive WIA assistance including on-the-job training and Welfare-to-Work wage subsidies. Information about this tax credit can be obtained from http://www.doleta.gov/business/incentives/opptax/.

Third-party intermediaries are individuals or organizations that provide support and guidance for employees who have recently re-entered the workforce and can serve as liaisons between employees and employers, as well as address employment related concerns (e.g., employee tardiness). The availability of services from third-party intermediaries (e.g., social service, faith-based and community-based organizations, case managers, or parole/probation agents) to help avert problems with new hires has been demonstrated to increase the willingness of businesses to hire returning citizens. Third party intermediates can ensure employersô needs are met and returning citizens fulfill their conditions of release. Intermediaries may continue to work with returning citizens after their community supervision has ended.

Partnerships between corrections and employment services agencies can ensure that returning citizens receive training and acquire marketable skills. For example, local chapters of Habitat for Humanity have partnered with correctional programs in Michigan[14] and other states to create opportunities for returning citizens to learn building trade skills and help their communities through prefabricating Habitat homes. Funding for such on-the-job training programs can be secured under the federal Workforce Development Act, which allows localities to enter into contractual relationships with organizations providing services to special populations.

Studies indicate participation in prison industry, vocational instruction, education, apprenticeship training, and work programs leads to reductions in conduct problems while incarcerated and reductions in recidivism following release. Additionally, participants in work programs are more likely to be employed following release and have higher earnings.

Research indicates that employment is crucial to the prevention of criminal behavior and re-incarceration. In addition, studies show that returning citizens are at highest risk for the commission of new crimes during the first year subsequent to release. Therefore, it is recommended that programs engage participants within ninety days before or after release in order to provide immediate access to services and supports that lead to employment.

It is recommended that employment preparation begin early during incarceration starting with a comprehensive vocational assessment designed to obtain information regarding interests, work values and skills, as well as identify barriers to employment (e.g., housing, substance abuse, health problems, transportation, and educational deficits). Research indicates that traditional employment interventions in combination with supportive services that address health, substance abuse, life skills, and housing needs, are most effective:

- Case management
- Mental health and substance abuse treatment and other supports
- Life skills training (e.g., obtaining housing, balancing checkbooks, maintaining appropriate interpersonal relationships)
- Education or training activities that target soft skills and skills directly related to specific employer needs
- Prerelease supports and training, including assistance with securing necessary documents (e.g., Social Security card, driverôs license, birth certificate) which may be required to obtain employment
- Transitional work experience for a minimum of three to six months
- Job placement assistance

[14] The **Michigan Prison Build Program** ((http://www.michigan.gov/prisonbuild/0,1607,7-252-23507---,00.html) provides training in the building trades and helps provide homes for families with low incomes.

- Post-employment supports, including transportation services and job coaching
- Child care services

CORRECTIONS-BASED EDUCATION AND VOCATIONAL TRAINING

The first American prison, the Walnut Street Jail in Philadelphia, developed by the Quakers in 1791, was designed to ensure public safety and provide humane opportunities for rehabilitation. A school was added in 1798 to provide opportunities for learning and improving reading, writing, and math skills. Beginning in the 1820s there was an increase in prison-based education and training programs (along with debates regarding penal philosophy of rehabilitation versus punishment). Such programs proliferated in the 1930s but have since fluctuated in accordance with alternating emphases on rehabilitation and punishment. For example, there was a resurgence of programs during the 1960s and a shift away from rehabilitation in the 1970s. Prison reforms during the 1980s largely excluded correctional education and spending for correctional education programs declined significantly during the 1980s and 1990s.

Many individuals who are incarcerated have a limited education. According to the Bureau of Justice Statistics, only forty six percent of individuals who are incarcerated have a high school diploma or equivalent. In the past, unskilled manual labor jobs were more available, but jobs in the contemporary labor market increasingly require some postsecondary education. Moreover, returning citizens can find themselves competing with people leaving welfare for the unskilled jobs that are available.

Prison-based educational programming typically includes:

- **Adult basic education (ABE)** which includes instruction in basic-level math and reading comprehension.
- **High school/general education degree (GED)** programs.
- **Post-secondary classes** including associate degree classes and bachelor degree classes However, because Pell Grants[15] are no longer available to people who are incarcerated, participants must pay their own tuition for post-secondary classes resulting in small numbers of programs and enrollment.

Research indicates that the most effective educational programs are more extensive, of substantial duration (at least several months), focus on skills needed in the job market (actively engaging employers and focusing on meeting their needs), time participation to occur close to release dates, and provide follow-up subsequent to release (including treatment and supportive services) be provided.

Education has been found to increase employment opportunities for people with criminal records and reduce the risk of recidivism. There is significant evidence showing that participation in prison-based and community educational programs leads to reductions in rearrests and re-incarceration. Research shows that there is an inverse correlation between level of education and recidivism: the more education a person receives the less likely they are to recidivate.

Vocational training focuses on the development of skills specific to a particular trade or industry (e.g., auto detailing, carpentry, welding, electronic servicing, horticulture, graphic arts/printing, and masonry). Outside accrediting agencies provide instruction in some correctional facilities to ensure programming meets established industry standards. Many prison-based vocational programs offer certificates to graduates to enhance the value of vocational training. Certificates

[15] The loss of eligibility for federal Pell Grants in 1994 for people who are in prison resulted in a significant reduction in prison-based post-secondary education programs.

of rehabilitation, which create a presumption of rehabilitation, have been found to assist returning citizens in securing employment with public agencies and removing legal bars to obtaining licenses.

Employability training services programs provide assistance in obtaining and retaining employment, particularly instruction in work ethics and values (the so-called soft skills), that focus on the development of professional workplace habits. These include résumé writing, conducting a job search, job interviewing skills, problem-solving skills, working as part of a team, effective communication, arriving at work consistently and on time, appropriate attire, time management, and trustworthiness.

The Michigan Department of Corrections participates in **Amer-I-Can** which is a sixty-hour manualized course comprised of a fifteen chapters delivered in a group format with fifteen to thirty participants by a trained facilitator that addresses skill development in nine domains: (1) motivation, habits, and attitudes; (2) goal setting; (3) problem-solving and decision-making; (4) emotional control; (5) family relationships; (6) financial stability; (7) effective communication; (8) employment search and retention; and (9) drug and alcohol abuse. Tests are administered at the end of each chapter to assess participantsô comprehension and learning. In addition a sixteen question personal growth inventory questionnaire is completed by each participant who rates themselves on a one-to-ten scale before and after the course and is retained for future use. A Life Management Skills Survey is completed by the participants, their parents or guardians, facilitators, and counselors at the end of the course. More information on the program can be obtained from http://www.amer-i-can.org/.

PRISON INDUSTRIES

Prison industries programs typically involve work in a particular industry such as laundry, food services, and license plate manufacturing, as well as farming, textiles, and refurbishing computers for use in schools. Their focus, in contrast to vocational training, is on reducing idle time and operating costs of prisons (e.g., cleaning and maintenance, electrical and plumbing work, and food production and preparation) while providing useful job skills and training. Many produce goods and services that are sold to government and nonprofit agencies. Some programs partner with the private sector and create linkages with community organizations to increase post-release employment opportunities. Prison industries can also provide services to communities as a form of restorative justice.

The **Prison Industry Enhancement Certification Program (PIE)**, administered by the U.S. Department of Justice, Bureau of Justice Assistance, operates in numerous state, federal, and private correctional facilities. The program encourages states and local governments to establish partnerships with private-sector companies to provide jobs for people who are incarcerated as well as reduce idle time in prison, increase job skills, and improve reentry success. Wages are paid by private employers to the prison industries and are spent on room and board, support for dependents, victims, and taxes. The PIE program exempts state departments of corrections and private-sector partners from certain restrictions on the sale of goods produced by people who are incarcerated in interstate commerce (e.g., lifting the $10,000.00 sales limit on goods and services sold to the federal government by state departments of corrections).

WORK-RELEASE PROGRAMS

Work-release programs usually target returning citizens who are nearing the end of their sentences. Such programs offer opportunities for gaining community-based work experience during incarceration, developing marketable skills, providing restitution to the community,

preparing for the responsibilities of independent living, and creating collaborative linkages with employers to expand post-release employment opportunities. In addition, such programs offer opportunities for people in prison to reimburse the state for part of their confinement costs and build up savings for use after release. Finally, work release offers restricted, supervised involvement in the community prior to release thus providing a bridge between the structured and monitored environment of prison and life in the community.

Research has shown that participation in work release programs increases the potential to find and retain employment during in the three to six months following release while participation in job training and job readiness education or institutional job placements are less likely. Employers also benefit from work release programs because the corrections system absorbs most of the risk, provides transportation and workers who may subsequently fill full-time positions. While work-release programs can be of benefit at any time during a period of incarceration, it is recommended that individuals access them during the final six to twenty-four months of a prison term.

TRANSITIONAL JOBS MODEL (TJ)

Transitional jobs can provide a bridge to permanent employment for returning citizens who are unable to secure a job immediately upon release. They provide immediate employment which contributes to stability, income to meet basic needs, work experience, and improved access to traditional employment. The TJ model incorporates time-limited jobs at competitive wages that combine real work, specialized training and skill development, as well as supportive services in order for participants to rapidly and successfully participate in the labor market. It also helps participants to transition into permanent unsubsidized jobs either with the same employer or a different one. Research indicates that participation in transitional employment and intensive employment services during the first three months following release reduces the risk of parole revocations, felony convictions, and re-incarceration.

Transitional jobs are typically relatively low-skill, entry level positions for individuals without substantial experience in the labor force. Wages are usually paid on a frequent basis (i.e., daily) so employees have funds to support themselves immediately subsequent to release. In addition, close supervision, mentoring, coaching, and case management are provided. Wage subsidies are paid to employers for a set period of time (e.g., for three months as a probationary period) to offset training and retention costs.

The TJ model has been shown to be an effective employment model, particularly for individuals with employment challenges, including returning citizens. Participation in TJ programs has been linked with increases in rates of stable employment, job retention, and income, as well as reductions in felony convictions, parole revocations, and re-incarceration for new crimes. Transitional job programs have been found to be most effective when participants remain focused on securing employment, provide clear guidelines and practices for achieving success, and offer employers support and financial incentives to hire returning citizens.

ONE-STOP CENTERS

One-Stop career centers, established under the Workforce Investment Act (WIA), offer physical[16] or virtual resources for employers and job seekers and are designed to function as

[16] The WIA requires the establishment of at least one physical site by each local workforce investment area to service employers and job seekers. Local workforce boards can establish more than one physical One-Stop and create virtual One-Stops in partnership with community-based organizations, or in other facilities, such as prisons or churches.

single points of access to employment services and offer assessment, job counseling, and other assistance. In addition, many returning citizens may be eligible for community-based skills training programs. One-Stops can offer employment assistance prior to reentry because people who are incarcerated are eligible to access basic job-listings and search services. In addition, many individuals who are incarcerated meet the criteria for intensive services.

It is recommended that job placement and supportive services be integrated into one location, and information regarding services and supports be made accessible through a single clearinghouse allowing businesses and job seekers to connect in real or virtual communities, share information about the labor market and particular positions, and provide centralized access to education and training opportunities.

It is also recommended that facilities be located in those communities in which their services are most in demand. Returning citizens often come to back areas with significant levels of unemployment and limited access to supportive services. Many lack transportation and the need to travel to employment assessment and training programs can pose an insurmountable barrier for even those with high levels of motivation. Moreover, situating employment centers in communities of high need helps employment staff members acquire knowledge regarding local issues encountered by jobseekers and develop strategies to address them.

It should be noted that, due to programmatic limitations or reporting and evaluation disincentives, people who are incarcerated may not receive the types or levels of services available through One-Stop career centers since many tend to target current workers with experience who have the ability to conduct self-direct job searches; people who are incarcerated require additional assistance to access and fully benefit from One-Stops.

STRIVE (SUPPORT AND TRAINING RESULT IN VALUABLE EMPLOYEES)

Support and Training Result in Valuable Employees is a national, privately funded, nonprofit employment service that operates in Michigan (Battle Creek, Flint, and Benton Harbor) and other states. STRIVE uses a strength-based model that emphasizes self-assessment, critical thinking, effective interpersonal relationships, and team building to increase self-empowerment. The program focuses on encouraging a positive attitude and teaching communication skills needed for acquiring and maintaining a job. Participants receive an intensive three-week job readiness workshop that addresses soft skills including workplace behavior, appearance, and attitude. The initial session engages each participant in exploring the reason for their participation and expectations for accomplishment. It is designed to reduce hostility, increase confidence, and identify realistic goals. During group interaction sessions trainers assess participantsô motivation levels. Job application skills are also enhanced through nine hours of work on résumé writing, twenty one hours of interviewing practice, and six hours of telephone skills rehearsal. Graduates of the program receive ongoing monitoring for a minimum of two years.

STRIVE also offers a career development program called Access Support and Advancement Partnership (ASAP) for graduates who have successfully maintained employment for eight months. ASAP provides four to nine months of training to help participants with advancement in the labor market and obtain gainful employment in growth industries (e.g., telecommunications, financial services, and computer technology). The training, which is developed or endorsed by employers, consists of courses designed to help participants acquire specific skills as well as provides support services during training and after placement. Evening-hour training sessions are available to accommodate participantsôwork schedules.

Outcome data indicate that eighty percent of STRIVE graduates are consistently placed in jobs, the majority of whom (seventy five to eighty percent) retain employment for at least two years. Information about the program can be obtained from http://www.strivenational.org/.

WOMEN ARISE – PROVE PROJECT

Women ARISE provides services and supports to women involved in the criminal justice system in Wayne County, Michigan during pre-trial and while on probation, parole, or incarcerated in jail. Services include assistance with accessing child care; GED preparation, cognitive-behavior therapy, wraparound services (including transportation, food, and clothing); and womenôs health issues classes which address AIDS and other health issues.

The programôs Post-Release Opportunities for Vocational Education (PROVE)[17] provides educational and vocational opportunities for women returning to the community from prison as well as monthly peer meetings, counseling, parenting classes, tutoring, grade monitoring, educational advice, and financial assistance for books and tuition and defaulted loans. The program is now part of Matrix Human Services. Information can be obtained from http://www.matrixhumanservices.org/index.php?option=com_wrapper&Itemid=92.

[17] In 1977 a group of women incarcerated in Michigan filed a lawsuit in federal court claiming the state failed to provide education and training for them comparable to that received by their male counterparts. The suit was decided in their favor in 1999 and the U.S. District Court judge fined the Michigan Department of Corrections for noncompliance with his decision in 2000 and awarded punitive damages to the women. The funds were given to Women ARISE Post-Release Opportunities for Vocational Education resulting in the creation of Women ARISE.

SOCIAL SUPPORT

Social networks have been shown to effectively assist returning citizens with reintegration. Studies show that those with strong prosocial networks experience improvements in health, well-being, service utilization, adherence to treatment, and community tenure. Moreover, informal agents (e.g., family, friends, neighbors, and clergy) have been found to be more effective in engendering enduring positive behavioral changes than formal agents of control (e.g., parole/probation agents, police, and judges) alone. While parole/probation agents typically work in eight-hour shifts, community members are close to returning citizens on a twenty-four hour a day basis and have more intimate and immediate knowledge about them and local neighborhoods which can facilitate appropriate responses to both progress and lapses as well as inform plans in areas such as housing and employment.

Informal social bonds have been shown to be the strongest predictor of criminal recidivism. Research has shown that the most significant factor in successful reentry is family and community support as evidenced by outcomes of the Ready4Work initiative[18] which was a three-year national, faith-based employment-focused reintegration demonstration project that provided reentry services to returning citizens aged eighteen to thirty four. Ready4Work provided intensive case management (including referrals for housing, health care, drug treatment and other programs), employment services (i.e., job readiness training, placement services, full and part-time jobs, and on-the-job training), as well as mentoring to provide emotional and practical support (e.g., helping with finding a place to live, obtaining a driverôs license, and transportation options). Services and supports were delivered through partnerships among local faith, justice, business, and social service organizations for twelve months. Outcome studies showed increases in employment and reductions in recidivism.

COMMUNITY INVOLVEMENT

The community has been found to be an essential partner in reentry. Community members can augment supervision efforts and enhance social capital of returning citizens. Individuals who regularly interact with returning citizens are resources for observing and encouraging their progress by reinforcing prosocial behaviors.

Returning citizens who lack natural support systems can benefit from relationships with community advocates (or neighborhood guardians) who volunteer or are paid to provide daily guidance on living in the community and function as companions in a manner similar to sponsors in self-help groups.

Neighborhood guardians can be cultivated through the establishment by supervision agents of relationships with individuals in the neighborhoods and areas in which returning citizens reside (e.g., spouses, family members, parents, employers) and with protective relationships with persons who might become potential victims in places that may be vulnerable to the risk of victimization (e.g., security guards, teachers). Such guardians augment supervision and offer opportunities for community engagement.

[18] Ready4Work engaged local businesses, workforce development agencies, criminal justice staff, and faith-based and community organization partners in collaborative efforts to connect returning citizens to the workforce, enhance their prosocial networks, and provide other supports including transportation, child care, and substance abuse treatment.

RESTORATIVE JUSTICE

Restorative justice initiatives involve victims, returning citizens, and communities in activities to address the harm caused by crimes and include services for victims, enhancing community safety, holding individuals who committed crimes accountable for their behavior and repairing or correcting the damage caused by their actions. A restorative justice framework views crime as a violation against the community, which creates obligations to repair harm to victims of crime and the community at-large. Partnerships among public agencies that share responsibility for public safety (i.e., courts, prosecutors, law enforcement, and corrections agencies) and community residents and community organizations are cultivated. Such partnerships increase the leverage of parole and contribute to a shared ownership for managing risks posed by returning citizens under community supervision. Opportunities for dialogue and problem-solving among victims, returning citizens, their families and other supporters can facilitate successful reentry.

Examples of programs that incorporate restorative community justice principles include impact of crime classes, victim impact panels, Victim-Offender Mediation (VOM), Family Group Conferencing (FGC), Restorative Conferencing (RC), Circles of Support and Accountability (CoSA), and community reentry boards, sentencing circles, reparative boards, and others.

Community reentry boards provide a forum for returning citizens and representatives of the community to establish mutually acceptable expectations and conditions of release and enhance community support for successful reentry.

Reparative boards are composed of a small group of citizens trained to conduct public, face-to-face meetings with returning citizens who have been ordered by a court to participate in the process. These boards develop sanction agreements with returning citizens, monitors their compliance, and submit compliance reports to the court.

Accountability boards review behaviors of returning citizens in the neighborhood that may not be in keeping with community standards (e.g., harassment, failure to pay financial and legal obligations, or other community infractions).

Sentencing circles are conducted in partnership with the criminal justice system to develop consensus on a sentencing plan that can address the concerns and need for healing and include the victim, returning citizen, their supporters, court personnel, police, and interested community members.

Restorative community service has historically been used as a sanction to hold individuals accountable for their actions, and pay the community back in some way for the harm that is caused by crime. Some communities have used community service to support for victim assistance programs (e.g., fund raising).

Family Group Conferencing (FCG) consists of voluntary meetings in which a person who has committed a crime, their victim, and family, friends, and key supporters of each collectively determine the resolution of a criminal incident, address unresolved emotional issues, and decide on specific terms of restitution. The process uses a trained facilitator who contacts the victim and the person who committed the crime to explain the process and invite them and key members of their respective support systems to a conference to discuss how they and others have been harmed by the offense and how that harm might be repaired. Participation is entirely voluntary and the person who committed the crime must admit to the offense in order to participate.

A conference typically starts with the individual who committed the crime describing the incident, followed by a description of the impact of the incident on lives of the participants. The victim is asked to identify desired outcomes from the conference following a thorough discussion of the

impact of the offense on those present, and thus helps to determine reparative obligations. The session ends with participants signing an agreement outlining their expectations and commitments.

Impact of Crime on Victims Programs (IOC) programs address the rights of victims and focus on exploration of how participants view the rights of others and raise their awareness of the long-term impact of their actions. They help participants recognize how their victimization/abuse during childhood currently impacts them and provide opportunities to develop prosocial parenting relationship skills. Participants are offered opportunities to gain insight into their propensity to depersonalize the individuals they injure as well as consider the manner in which they are accountable for their crimes. In addition, victim rights are examined, how childhood experiences can influence behavior is discussed, and ways in which non-abusive relationships can be fostered are explored.

The most effective programs include classes that consist of interactions with actual victims and employ experiential activities including video recordings with study guides, television newscasts of programs), guest speakers, notebooks with articles, scenarios and exercises (e.g., assessing and writing about what participants think they owe to their victims), and role-playing. Visits by actual victims have been shown to have the greatest effect. Victim services advocates who have worked with several victims and can relate stories of people they have assisted are also included in lieu of actual victims. Everyday news stories are used to provide material involving ordinary people.

Victim Impact Statements (VIS) are used prior to sentencing or adjudication, institutional classification and programming, hearings relevant potential release from incarceration, parole or probation revocation hearings, and inform reentry plans.

Victim impact panels are forums in which victims of different types of crimes publicly discuss the impact of the crime on their lives. In victim-offender mediation programs victims and individuals who committed criminal acts meet face-to-face with a mediator to discuss what happened. These programs are designed to help individuals who have committed crimes appreciate the consequences of their actions and offer opportunities for victims to directly confront and question the person who committed the crime. The participants generate an agreement regarding what the person who committed the crime will do to ameliorate the harm caused by their crime.

Participation in restorative justice programs has been found to lead to increased satisfaction for people who have engaged in criminal behavior as well as victims of crime. Restorative justice programs have been shown to lead to successful restitution completion and reductions in recidivism. Beneficial outcomes for victims include increases in their ability to return to work, resume normal daily activities, trust of other people, feelings of self-confidence, as well as improvement in sleep and reductions in anxiety, fear, and anger toward the person who committed the crime. In particular, victim-centered programs that are initiated within correctional facilities and continue in the community have been found to be effective in influencing attitudes and behavior of returning citizens.

The inclusion of the perspectives of victims of crimes in reentry has been found to be beneficial. Some victims know the individuals who committed crimes well (e.g., victims of domestic violence and sexual assault by friends or acquaintances). They may reside in the same communities as returning citizens and be able to offer helpful information regarding coping with reentry challenges and risks.

Victim service providers and victim advocates can function as liaisons to victims, provide services and supports to address the needs of victims during the reentry process, and ensure

victimsô rights are protected. Victimsô advocates can also work with law enforcement and/or prosecutors and may be able to provide information relevant to assessments.

Victims are often afforded rights allowing them to participate in release including being informed about parole-related events and proceedings; being heard on matters relating to the individualôs parole and related incidents, attending parole proceedings, and an order for restitution as a condition of parole.

Returning citizens often go back to communities in which their victims also reside. To minimize the trauma associated with potential confrontations, some jurisdictions have established safe zone perimeters around victims (e.g., twenty miles from the victimôs residence) and enforcing these as conditions of supervision. Other communities create cocoons of support from friends and neighbors to help victims feel safe and prevent re-victimization.

SYCAMORE TREE PROJECT® (STP)

The Sycamore Tree Project[19] is an intensive five to eight week prison-based program in which small groups of crime victims meet with groups of unrelated individuals who are incarcerated and have been recruited by the Prison Fellowship Ministries (PFM) to discuss the effects of crime, harms it causes, and ways to make amends for criminal behavior.

Groups are led by facilitators using a discussion guide to conduct groups through a series of topics culminating in sharing letters and an agreement which expresses their feelings and how they wish to move forward. Individuals who are incarcerated explore ways of making restitution for the harm caused by their criminal behavior and victims are provided with the opportunities to consider ways they can regain control of their lives and begin to recover.

Studies have shown that participation in the program leads to significant improvements in victim empathy, significant changes in attitudes about offending behavior, and reductions in recidivism. Anecdotal evidence indicates that the STP also improves in-prison offender behavior (e.g., participation in substance use disorder treatment and rehabilitation programs). Information on STP can be obtained from http://www.pfi.org/cjr/stp/introduction.

BRIDGES TO LIFE (BTL)

Bridges To Life (BTL) is a nondenominational faith-based nonprofit corporation that focuses on crime reduction by decreasing the recidivism rate of returning citizens. The program includes prison-based face-to-face sessions held with persons who committed crimes and victims. It is based on the principals of restorative justice and includes families of victims, their friends, and the community at large. The program offers education to returning citizens regarding the impact that their actions have had on their families and the families of the victims. The program also ministers to victims of crime and returning citizens. Outcomes include healing to victims of crime, and reductions in recidivism among graduates of the program. Information on BTL can be obtained from http://www.bridgestolife.org/.

CIRCLES OF SUPPORT AND ACCOUNTABILITY (COSA)

COSA is restorative justice program that recruits and trains volunteers to develop community support networks for returning citizens who have been convicted of sexual offenses that

[19] The program was named after the story in Luke 19:1-10 about Jesus and Zacchaeus, a dishonest tax collector in which Zacchaeus came to see Jesus but was unable to get through the crowd and climbed a sycamore tree to get a better view. He was noticed by Jesus who engaged him conversation, following which he repented and agreed to pay his victims back. Jesus then helped the crowd understand the power of restorative justice in reconciliation.

originated in the Mennonite church in Canada. The program enlists lay volunteers to provide support to returning citizens convicted of sex offenses who are being released from prison. The volunteers visit or contact the person every week. Community-based professionals (e.g., psychologists, law enforcement, correctional agents, and social workers) work with the volunteers in coordinated interagency teams that meet weekly.

COSA targets individuals who are at high risk and being released from prison following the expiration of their full sentence and do not have existing natural supports or accountability structures in the communities to which they are returning. COSA matches them to needed supports and resources while holding them accountable for their behaviors. Volunteers receive professional training focused on restorative justice principles, the dynamics of sex offending (including signs of impending relapse to engage professional support), and are provided education and supervision regarding the creation and maintenance of appropriate boundaries. Subsequent to training they are matched with other volunteers and a participating sex offender (known as a Core Member) to create a Circle of Accountability and Support, which is comprised of five to seven volunteers with support from professional staff.

Core Members must make a commitment to change their offending behaviors and are recommended to the Circles program by their treatment providers after they have made significant progress in treatment. Core Members lack appropriate supports in the community who can assist them during their transition and reintegration following release from incarceration. These participants are carefully screened to reduce risk to the community and the Circle volunteers. Volunteers are fully informed of the Core Member's pattern of thinking errors and offending behaviors that can lead to recidivism. Circle Volunteers work to hold the Core Member accountable in an effort to prevent re-offense using specific guidelines.

COSA is considered a promising program. Participation has been shown to lead to significant reductions in recidivism as well as a sense of safety in community members.

REENTRY COURTS

Reentry courts encourage adherence to the conditions of supervised release by monitoring and addressing any violations. Such courts are empowered to sanction violations and reward compliance thereby making decisions that guide the supervision process more transparent and allowing for community involvement in decision-making and behavioral controls. The formal and public nature of court proceedings demonstrates the significance of compliance with conditions of parole/probation as well educate and engage community members in the process.

Reentry courts employ graduated sanctions and positive reinforcements as well access to services and supports to promote positive behavior. Judges function as reentry managers, rather than assuming their traditional role of imposing sentences (which terminates their contacts with returning citizens). While the reentry court model, which is based on the drug court and other problem-solving court models, is still evolving, a number of core components have been identified including:

- Assessment and planning (involving the returning citizen, judiciary, institutional correctional staff, parole agency and other key partners) which entails the identification of appropriate candidates for participation and conducting a needs assessment to ascertain services that would be of benefit and culminating in the development of a contract or treatment plan prior to release.
- Ongoing status assessment meetings (involving the returning citizen and their circle of supporters or representatives from their family and community, the judge, supervision agent, and community policing officer) which includes regular court appearances from

the time of release and continuing throughout community supervision. Returning citizens witness court appearances of other participants.

- Identification of needed resources and coordination of support services including (e.g., substance abuse treatment, faith-based organizations, housing services, and job training services) using a case management approach.
- Community accountability through involvement of a citizen advisory board, crime victimsô organizations, and neighborhood groups, as well as restitution requirements.
- The use of a predetermined range of graduated and prudent sanctions for violations of the conditions of release/supervision which are administered swiftly, predictably, and universally.
- The use of rewards (e.g., early release from parole, graduation ceremonies) for success in achieving established goals/milestones presented in a public arena.

Reentry courts allow the reentry process to commence at sentencing and continue throughout the release period. In addition, such courts are able to leverage judicial authority and maximize the use of sanctions and rewards beyond existing conditions of supervision which can function as a crime prevention tool.

POLICE REENTRY PARTNERSHIPS

Returning citizens are arrested at rates that are thirty to forty five times higher than that of the general population. Police involvement in reentry can help with crime prevention, improve police-community relations, and help reduce fears of victimization by returning citizens. Studies have shown that proactive crime-prevention partnerships can result in long-term reductions in crime.

Partnerships between corrections and law enforcement include regular contact to identify problems of mutual concern, the allocation of joint resources to identify and implement solutions to enhance public safety, and cross-system training. Reentry partnerships with police can include a number of activities:

- ➲ Police may participate in prerelease meetings with returning citizens. Law enforcement officers tend to be the last point of contact with individuals before they enter the corrections system and may have acquired information during previous contacts with individuals while in the community prior to incarceration that can be of help in reentry. Input into post-release supervision conditions can be provided by police through sharing information with corrections regarding returning citizensô criminal histories in the community, and making recommendations regarding neighborhoods or associates returning citizens need to avoid.
- ➲ Law enforcement can partner with community corrections to ensure that returning citizens comply with the conditions of release and supervision by conducting joint scheduled and unscheduled home and workplace visits, curfew checks, and joint ride-alongs on neighborhood patrols. Other efforts include team-based supervision through joint staffing of neighborhood police substations and joint fugitive apprehension units to locate and apprehend persons who have absconded from probation or parole supervision.
- ➲ Police can facilitate sessions that notify returning citizens of the expectations and support of their community. Notification sessions, also known as call-in meetings or lever-pulling meetings, mobilize service providers and community members to demonstrate solidarity against crime and violence in their neighborhoods during which

police inform returning citizens that they will be working with corrections to monitor their compliance with conditions and will not hesitate to arrest them or impose discipline on those who fail to follow requirements. Various levers (e.g., proactive targeted law enforcement, harsher penalties, enhanced community supervision, and revocation of probation and parole) are explained in meetings with returning citizens that will be used to ensure compliance with conditions of release. Subsequent to the communication of the law enforcement message returning citizens are provided with community resources to support their efforts to conform to the law. Service providers offer transitional services and community members are provided with an opportunity to identify individuals who are responsible for violence in their communities. The sessions impose an element of accountability. In some sessions, law enforcement and service providers interact with returning citizens in the same room while in others returning citizens meet with each separately.

- Police can gather and share investigative information on the behavior of returning citizens that indicates difficulties with reintegration. Enhanced supervision partnerships with law enforcement makes use of information regarding the criminal and substance abuse histories of returning citizens and continually monitoring their associations with gangs and their activities in the community. This information enables law enforcement to target interventions to individuals at the highest risk of reoffending and focus on individuals released from prison unconditionally (i.e., without correctional supervision or requirements).

  Information on individual returning citizens can also be exchanged include: classification records, which may provide information about the personôs behavior and social service needs; gang-related rivalries which may provoke violence after return to the community; suicide attempts while in prison which can inform effective prevention strategies for police responding to a suicide call; returning citizensô release dates and times, particularly for those released without supervision, to increase awareness of potential risks and opportunities for intervention; notification of the release of individuals convicted of sex offenses which can help police work with the community members to protect themselves; and mental health status which can enhance understanding of any subsequent criminal behavior resulting from a psychiatric disorder so that, when appropriate, police can divert individuals to treatment.

- Police have opportunities to connect returning citizens with community resources and broker new ones, as well as participate in the development of referral protocols for special populations (e.g., persons who are homeless or have psychiatric disorders). Police can partner with service, faith, and safety organizations to provide a wide range of services that can help connect returning prisoners to positive support in the community.

- Police can collaborate on crime deterrence through heightened surveillance, and communicating with community residents in an effort to overcome barriers caused by prior harms

- Police can serve as intermediaries between victims of crimes and returning citizens in restorative justice initiatives. Police can become involved in restorative justice programs in which returning citizens and meet with police and corrections staff to develop strategies for successful reentry by focusing on (1) holding returning citizens accountable for their past and future actions (e.g., acknowledging harm caused, making amends to the victim and the community, and developing a plan for leading a crime-free life); (2) protecting victims and the community at large from future victimization; and (3)

helping returning citizens develop competencies including work experiences, life skills, anger management.

Police are typically the first to respond when an individual has been victimized and are tasked with addressing victimsôneeds to feel safe, express their feelings regarding the event, and explaining relevant procedures to victims. Police may be involved in situations in which an order of protection is required prior to release and can encourage victims to participate in restorative justice initiatives with returning citizens.

- Police can provide leadership to problem-solving efforts in communities beset by crime. Law enforcement can offer GIS mapping assistance and crime data to identify crime hot spots, allocate patrol resources, and develop crime prevention strategies. Police officers can encourage the development of community-based problem-solving activities convening groups of stakeholders to identify resources, services, and mentors. Police can provide education to the community regarding prisoner reentry (e.g., supervision and support strategies) to reduce fear and enhance the publicôs confidence that issues are being addressed in a comprehensive way.

COMMUNITY-ORIENTED POLICING (COP)

Reentry initiatives mesh with community policing or problem-oriented policing models which entail the creation of partnerships with local businesses, residents, government agencies, and other community stakeholders to garner support and resources to proactively address crime problems. Community policing is characterized by policing services organized on a geographic basis (most typically around neighborhoods), maximizing contacts with residents in the neighborhoods (often through foot or bicycle patrols), ongoing meetings with community organizations and groups to identify problems that need to be solved, establish strategies for solving them, and provide feedback on the progress of initiatives.

Community policing models entail reallocating patrols from large police districts to smaller neighborhood-based assignments, many of which center around police substations which create opportunities to develop relationships with the community and support public safety efforts focused on the characteristics of places and targets that generate crime. Such place-based approaches are often used in the context of problem-oriented policing (POP) which are defined by crime type and by place and focus on increasing the perceived effort and risk associated with committing crime to deter criminal behavior. Police work with supervision agencies to identify the types of places and situations that are likely to increase a returning citizenôs criminal opportunities and how those opportunities might be reduced.

Partnerships formed through community policing with parole agents are designed to create opportunities to intervene proactively and mobilize resources in response to circumstances or behaviors that threaten stability or compliance with the conditions of supervision. Information sharing can also enforce accountability by ensuring that appropriate sanctions are consistently and rapidly applied in response to noncompliant behavior.

SCANNING, ANALYSIS, RESPONSE, AND ASSESSMENT (SARA)

SARA is a sequential problem-solving methodology used in community policing which can also be applied to reentry issues in specific localities, identifying the specific risk factors of returning citizens, as well as the challenges they face as they return to the community.

The SARA model can also be used to guide jurisdictions in collecting and analyzing data in designing effective re-entry strategies. It is comprised of the following sequential steps:

① **Scanning** the environment for information on recurring problems (i.e., types of behavior, places, people, events, times, or a combination thereof), and their consequences that are of concern to police and the community. Scanning aims to identify a basic problem, determine the nature of that problem, the scope of seriousness of the problem, and establish baseline measures. Stakeholders from the community are identified during this phase and, in partnership with the police, identify and prioritize concerns.

② **Analysis** of the events and conditions that contribute to the problem in order to understand its dynamics, limits of current responses, correlates, and cause and effect. When applied to reentry, analysis includes:

- The scale and geographic distribution of returning citizens in the community
- The proportion of new crime attributable to returning citizens
- The rate and pattern of offenses committed by returning citizens including variation in the type of crimes being committed and whether a specific area in the community or period after release is particularly criminogenic
- The risk factors associated with recidivism (e.g., unemployment, substance abuse)
- The services currently available to reduce risk factors and increase protective factors, including the identification of any gaps in services
- Leverage to enforce compliance and prosocial behavior
- Identification of key community stakeholders and partners to be involved in responding to the challenges of reentry

During the analysis phase, information regarding aspects of the crime triangle is sought regarding the victim, the person who committed the crime, and the location of the crime (i.e., who, what, where, how, and why/why not).

The crime (or problem analysis) triangle is a technique that is used to understand a problem which entails visualizing links between the victim, the person who committed the crime, and the location of the crime as well as aspects that could have an impact on them (e.g. capable guardians for victims, handlers for people who commit crimes, and managers for locations). This problem analysis technique helps police focus on factors they can impact (e.g., limiting access to criminal opportunities) rather than addressing the root causes of a problem.

③ **Response** involves developing and implementing strategies tailored to address an identified problem based on knowledge acquired during the analysis phase in order to eliminate the problem, substantially reduce the problem, reduce the harm caused by the problem, or improve the quality of community cohesion. Police can respond by:

- Partnering with probation and parole to enhance supervision
- Facilitating sessions that notify returning prisoners of the expectations and support of the community

- Gathering and sharing intelligence on behavior indicating problems with community reintegration (e.g., violating curfew restrictions or hanging out with gang members)
- Connecting returning citizens to services and community resources
- Communicating with the residents to overcome issues caused by prior harms
- Enhancing community collaboration efforts or reentry

④ **Assessment**, conducted in order to determine the extent to which the response strategies were successful in reducing the problem, and whether the response contributed to the decline. Both process and outcome measures are used (e.g., whether the response was implemented as planned, reductions in recidivism among returning citizens were achieved, and decreases in citizensô fears of crime were attained).

COLLABORATION WITH JAILS

Jails are often described as the entry point to the correctional system and its backstop, housing individuals for multiple reasons and for multiple agencies and jurisdictions. In addition to processing and holding individuals awaiting arraignment, trial, conviction, or sentencing to ensure court appearances and protect the public, they also hold people who have been sentenced to less than one year of incarceration, as well as individuals who have violated the conditions of their pretrial release and parole or probation supervision. They also house individuals for state or federal authorities because of prison overcrowding and can also receive returning citizens transferred from state prisons as a step-down in the reentry process to allow individuals to strengthen family and community ties prior to release.

Data indicates that about seventy three percent of jail inmates have been previously sentenced to either probation or incarceration and more than half had previous criminal justice system involvement at the time of their arrest; thirty four percent were on probation and thirteen percent were on parole, seven percent were out on bail or bond, and two percent were on some other form of pretrial release.

Recognition of overlapping jail and community corrections populations has spurred improved coordination and collaboration efforts to slow the revolving door of individuals who cycle in and out of jails and minimize the role of jails as gateways to the criminal justice system. This has resulted in a change from the traditional mission of jails from care, custody, and control to a focus on diversion and opportunities for intervention.

APIC MODEL

The APIC model is designed to address treatment needs of individuals who are admitted to correctional institutions for brief stays and have ongoing co-occurring psychiatric and substance abuse treatment needs. It is also applicable to individuals with medical treatment needs. The model divides transition planning and treatment into four steps:

1. **Assess** the individualôs psychosocial, medical, behavioral needs and strengths, motivation for treatment, capacity for change, and public safety risks using standardized instruments
2. **Plan** for the treatment and services required to address immediate and long-term needs including community resources (e.g., family support, housing, medication, integrated treatment for co-occurring disorders, case management and outreach, medical care, income supports and entitlements, food and clothing, transportation, and child care)

3. **Identify** required community and correctional programs responsible for post-release services, ensuring that the intensity of supervision and treatment match the severity of criminal behavior and history, level of disability, motivation for change, and availability of community resources
4. **Coordinate** the transition plan to ensure implementation and avoid gaps in care with community-based services through case management and inreach services from community-based providers

MENTORING AND PEER SUPPORT

Mentors can provide ongoing support and guidance to returning citizens to help them overcome the challenges of reentry by facilitating the creation of positive social capital, modeling and providing support for prosocial behaviors, values and attitudes in a range of settings. Mentors can also provide practical assistance (e.g., job interviewing tips and information on transportation options) as well as help mentees set goals, cope with stress, or budgeting their time and their funds.

Mentoring programs for returning citizens have included the provision of informal efforts to link them with volunteers from members of faith-based organizations involved in prison ministry, business people who provide career guidance, and other returning citizens (i.e. peers). These short term informal relationships are designed to offer guidance and support. Longer-term mentoring programs engage returning citizens in a formal capacity, and mentors in these programs are screened, trained, provided with ongoing supervision, and matched to returning citizens based their interests and skills.

While mentoring usually entails the development of one-on-one relationships, group mentoring has become more common. The features of one-to-one, or individual, mentoring programs usually entail the matching of one mentor with one mentee who meet on a consistent basis (e.g., once a week or once every other week) for six months to a year at times and places of their choosing for one to two hours. Contact is maintained between meetings by telephone. The mentee and mentor decide how they will spend their time (e.g., go out for a meal or attend a sports event). The mentor provides support, a sounding board, and stable, nonjudgmental guidance

Although no proven mentoring model has been established for returning citizens, one-to-one mentoring is generally considered to be the most effective due to its potential to provide strong support and foster deeper, more meaningful relationships. In addition, it has the potential to reduce transportation and time barriers since mentors and mentees decide when and where each meeting will take place (unlike group mentoring sessions that take place at set times in designated places). However, some returning citizens have been found to be resistant to one-to-one mentoring due to feeling such a relationship places them in a childlike role. This model can also be challenging to implement as it requires ongoing efforts to recruit, screen, train, and supervise mentors.

There is a paucity of research on group mentoring and specific features that make it most effective are unknown. A number of group mentoring models have been developed. In most models, several participants and mentors meet as a group at a set time and place on a weekly or biweekly basis. While the sizes of groups and mentor-to-participant ratios can vary, the same mentors meet consistently with the same group of participants over time. Group sessions are usually about two hours in duration. A structured approach incorporates a curriculum or major discussion topics and activities which are determined for the group prior to meetings, while in a

less structured approach, mentors and participants decide discussion topics at the outset of each session.

Group mentoring sessions focus on topics that are relevant to returning citizens and their reintegration efforts (e.g., goal-setting, stress management, budgeting and financial pressures, family reunification, strategies for situations that trigger antisocial behaviors, involvement with negative peer influences, and prosocial behaviors). Groups may view relevant theme-based videos, invite guest speakers to facilitate discussions, or go on outings together (e.g., sports games or movies). Mentors in group meetings can facilitate or contribute to discussions moderated by program staff.

Group mentoring requires fewer mentors, which can reduce the effort needed to recruit, screen, train, and supervise mentors. In addition, returning citizens may experience more peer support and feel more comfortable sharing thoughts and experiences with others who have similar experiences. On the other hand, although evidence is lacking, group mentoring may not result in relationships and support that are as strong as those experienced in one-to-one mentoring. In addition, while some participants may feel more comfortable in group formats because they participated in groups while incarcerated, groups may evoke feelings of still being in prison to others. Finally, some participants and mentors may not feel as committed to the mentoring process because they know that sessions will continue even in their absence.

Combinations of one-to-one and group mentoring have been developed. In one model group sessions are held along with some one-to-one sessions that are extensions of group meetings. In this model, some or all of the participants are matched with one-to-one mentors. Mentors and participants attend group meetings during which they engage in individual conversations and converse by telephone between group meetings, but may not spend time together in individual meetings outside of the group sessions. Another model focuses on group sessions while allowing one-to-one relationships to evolve naturally during the time before and after group mentoring sessions when mentees and mentors hold one-to-one discussions. A third model focuses on one-to-one mentoring with occasional group meetings of several sets of mentors and mentees for discussions.

It has been noted that some returning citizens are reluctant to participate in mentoring. One strategy suggested for addressing this is to eliminate potentially negative connotations the term ñmentorò has by using terms such as ñcoachò, which has a sports connotation, or ñlife coachò which connotes the development of specific skills and emphasizes the provision of guidance rather than on forming relationships. Other terms that can be used are ñcareer coachò or ñtransition coachò. Alternative terms for ñmenteeò that have been suggested include ñparticipantò, ñpartnerò, ñprotégéò, or ñassociateò. Alternatives for the term ñmentoringò that have been suggested are ñlife coachingò or ñtransition coachingò.

Research indicates that relationships endure for longer periods of time and are more likely to result in positive outcomes when menteesô case managers play an active role in supervising and supporting mentoring relationships. In addition, barriers to participation by mentees (e.g., time conflicts or constraints, and lack of transportation and/or childcare) need to addressed by scheduling mentoring meetings at convenient times and locations, and offering stipends to cover transportation. Finally, the scope of the mentor/mentee relationships needs to be clearly delineated so that boundaries between mentors and mentees are understood and assistance requested by a mentee that is beyond the scope of the relationship can be addressed appropriately.

The literature on mentoring for returning citizens recommends that mentoring programs use one-to-one matches and group sessions that are gender-specific, such as the Womenôs Prison Associationôs two mentoring programs, WomenCare and Escort to Care Peer Mentor, and the

Shadow/Mentorship Program provided by the Islamic Health and Human Services (http://www.hammoude.com/Ihhs.html) for men in Michigan who are of the Islamic faith. In addition, it is recommended that mentors and mentees be matched on race, ethnicity, and socioeconomic background. When this is not feasible, then matches should be made between individuals who have shared interests, hobbies and personality traits, and geographic propinquity to ensure compatibility.

Research has shown that support from peers, particularly for individuals with substance addictions, may be more effective in reducing recidivism than professional staff in treatment programs and corrections. Involving returning citizens in reentry programming creates opportunities for mutual peer support during reentry. Supportive peer relationships can help returning citizens feel more connected to other individuals with similar experiences.

Peer mentors are individuals who have previously been incarcerated, or are in recovery, and have successfully overcome the challenges of reentry and substance use disorders. Peers can provide one-to-one mentoring to returning citizens as well as facilitate support groups that provide opportunities to share concerns and advice regarding reentry challenges. In some jurisdictions, peers serve as returning citizen representatives on community accountability panels and participate in supervision and support activities for returning citizens.

REINTEGRATION OF EX-OFFENDERS PROJECT

The Reintegration of Ex-Offenders Project is a structured mentoring program that emphasizes accountability and responsibility. Mentors work with individuals while they are incarcerated in to help them develop a transition plan. After individuals are released, Conquest Offender Reintegration Ministries (CORM) volunteers meet with them to help them secure housing, clothing, and employment. Services provided include:

- Mentoring returning citizens
- Prerelease counseling
- Assistance with finding employment (pre-employment preparation, resume preparation
- seeking and gaining employment)
- Assistance with obtaining vital papers (applications, birth certificate, social security card, etc.)
- Family counseling: marriage counseling, parenting skills, family development, budgeting, and home management
- Mentoring children of parents who are incarcerated
- Assistance in finding a local house of worship
- Training for ministers, missionaries,

Information can be obtained from http://www.livingwordmission.com/PrisonMinistry.html.

COLLABORATING WITH FAITH-BASED ORGANIZATIONS (FBOS)

Facilitating
Assistance
In
Transition and
Healing

Members of faith-based organizations have been providing support to individuals during incarceration and subsequent to release since the origins of penitentiaries in Europe and the United States in the 1700s. Prison chaplains have long been available to provide spiritual guidance to individuals (who have a constitutional right to religious participation in prison). Many FBOs have moved beyond traditional correctional ministries to establishing mentoring relationships during incarceration many of which continue after release. A number of FBOs welcome returning citizens after release and offer a range of formal and informal

services and supports to help individuals and families cope with the effects of incarceration and reentry. These include emergency shelter, transitional and long-term housing, food, clothing, job training and employment services, mental health and substance abuse treatment, and mentoring of returning citizens and their children. They also provide direct services to victims of crime, repair property, legal assistance, moving assistance, victim assistance, and victim-offender mediation/dialogue programs. A number of programs and services offered by FBOs utilize restorative justice models and offer counseling and support subsequent to incidents of violent crime as well as supports and services for children who have been abused and neglected.

Communities of faith and worship provide environments for reinforcing prosocial behaviors through prayer, religious studies, planned social activities, volunteering, and the provision of companionship. FBOs offer opportunities to interact with role models who have successfully faced similar challenges, form relationships with prosocial peers, impart religious lessons that focus on promoting prosocial values and skills, and provide prosocial support networks and skills, all of which can affect behavioral and social change. Research indicates that religious beliefs reduce recidivism among adults who are incarcerated.

Churches, mosques, synagogues, and other faith-based institutions are often a significant source of volunteers to support returning citizens, particularly in underserved communities, where faith-based institutions are often the most comprehensive service providers as well as and the most trusted, respected, credible, and established institutions. Many provide volunteers who function as a single point of contact for returning citizens and facilitate their access to a network of resources.

The services and supports provided by FBOs for returning citizens and their families can be used to enhance social capital. Faith-based programs can help provide inspiration and motivation as well as exposure to peers who have successfully overcome similar challenges. In addition, faith-based programs can provide support during the transition from institutional structure to the lack of structure in the community. Reentry partnerships with FBOs offer opportunities for collaboration and leveraging of resources, particularly since FBOs are already serving the needs of returning citizens and their families or offer services and supports targeted to persons at high-risk who have not engaged in criminal activities.

Some studies have found that people who participate in faith-based programming while incarcerated receive fewer disciplinary infractions and are less likely to be arrested in the first year after release. In addition, some research suggests that individuals who are incarcerated and who identify themselves as religious have fewer health problems and experience personal and emotional well-being are able to cope with stress more effectively. However, it is not known whether the correlation is directly due to religious participation or other factors.

PRISON FELLOWSHIP MINISTRIES (PFM)

PFM is an example of faith-based programming for individuals who are incarcerated. PFM partners with local churches across the country to minister to individuals who are incarcerated, returning citizens, and their families. Services include visiting prisoners, in-prison bible-based rehabilitative programming, and providing services to the children of prisoners (mentoring), and teaching others to live and look at a life from a biblical perspective. The organization promotes the application of biblical standards (i.e., restorative Justice) of justice in the criminal justice system. Outcome studies reveal some potentially promising outcomes including reductions in rearrests and re-incarceration subsequent to release. Information on PFM can be obtained from http://www.pfm.org/.

Transition of Prisoners (TOP®) is a national faith-based aftercare program for Michigan Department of Corrections inmates who are within six months of release and are returning to the Detroit area. It was established by the Prison Fellowship Ministries with financial support from the W. K. Kellogg Foundation. Participants enter the program immediately after release from prison and stay in the program for six months to two years depending on when they complete their transition plan, The program helps individuals reintegrate back into the community through the involvement of institutions of faith, mentoring, group interactions, and referrals to social service agencies in the community coordinated through a central office in Detroit. Staff work with local leaders and faith institutions to bring together volunteer mentors to help participants and their families. A study of the program found significant reductions re-incarceration. Information on the program can be found at www.topinc.net/index.htm.

KAIROS HORIZON COMMUNITIES IN PRISON

Kairos Horizon uses trained volunteers from communities of faith to work with men who are incarcerated. Programming focuses on anger and stress management, family relations and fatherhood, financial management, addiction recovery, and education conducted three times a week in the evening for one year prior to release. It includes the following components:

- Godparents (or Outside Brothers or Sisters) is a six-month informal mentoring component in which volunteers from local churches, synagogues, and mosques visit with the participants.
- Journey is a four month group-study session that focuses on self-discovery and the scripture.
- Quest is a seven month program that emphasizes anger management, parenting skills, relationship skills, and life skills.
- Family Relations provides an opportunities for participants to work on building relationships with their families though weekly letter-writing and special events (e.g., a family day) to facilitate family reunification.
- Worship, Prayer, and Service is a component of the program for participants in the program who live in ñfamily podsò of about six to eight other men. It also includes weekly meetings to discuss ñcommunityò issues.

Kairos Horizon also offers programs that include monthly workshops on prayer and meditation, substance abuse programming, computer classes on Windows programming, GED classes, and discussion groups on listening, cooperating, and problem solving, as well as a journaling series on fatherhood issues. Studies of the program have found improved family relations and the inculcation of a positive subculture within a prison population, along with improvements in work performance. More information can be obtained from http://www.kairosprisonministry.org/.

WORKING WITH FAMILIES

Families have been described as the reentry program of first and last resort. Returning citizens with strong family support have been shown to experience reductions in substance abuse, rearrests, improvements in physical and mental health, and increased levels of employment. Although families have not historically been included in correctional rehabilitation, studies have shown that family members can exert a positive influence as well as help with the identification of individual strengths, areas of interest, and other motivators for returning citizens.

The traditional definition of family typically includes members of a social unit related by blood or marriage. A broader definition includes individuals outside the biological family such as, friends, partners, social and religious groups and other significant individuals (e.g., staff from community

agencies). Therefore it is incumbent upon providers to allow individuals to identify the network of people who are significant. In other words, family is defined by each individual and can include blood relatives, friends, and other significant individuals.

Families have more knowledge regarding themselves than anyone else and have expertise regarding their own histories and strengths, and challenges. Families frequently exert more influence on returning citizens than anyone external to the family including supervision agents and can be integrated into the three phases of the reentry process (discharge planning, community supervision, and post-supervision) and provide ongoing support subsequent to the completion of supervision and termination of relationships with service providers.

Formal involvement of family members in reentry has been shown to increase the likelihood that returning citizens will follow through with restorative justice activities and expressions of remorse for harmful behavior. They can function as a resource for help, encouragement, and support during the supervision process and function as informal agents of control. Moreover, family members spend more time with an individual than community supervision agents and are more familiar with the person. They are thus able to anticipate as well as observe and respond more quickly to both positive and harmful behaviors. Finally, they are able to provide assistance with issues such as housing and employment because of their relationship with the individual and knowledge of the community.

Incarceration is a significant source of stress and causes disruptions in relationships between intimate partners; many marriages end during incarceration. Few prisons allow conjugal visits or extended contacts and gender-specific correctional institutions preclude typical patterns of dating, friendship, and courtship.

It should be noted that it is important to be aware of who returning citizens identify as supporters because family members can exert a negative influence (due to involvement in criminal activities) that can impede successful reentry. In addition, family members may have experienced emotional or physical harm or material loss due to the behavior of a returning citizen. Also, families may have established new relationships resulting in changes in family composition or relocated during the returning citizen's absence. Assistance may be needed to help families repair relationships, establish rules and boundaries that promote healthy interpersonal interactions, and cope with changes in roles and responsibilities.

However, in some instances parental incarceration can result in the temporary improvement of a family's circumstances due to relief from an abusive parent or a parent with an addictive disorder who appropriated family money or property to support their addition. Moreover, reunification is not always in the best interest of a children or parent when harm has been caused prior to incarceration.

Parental incarceration impacts family structure, financial responsibilities, emotional support systems, and living arrangements and can dramatically disrupt spousal relationships, parent-child relationships, and family networks. Re-establishing these relationships, reunifying with family, and resuming roles and responsibilities can pose significant challenges. Research has clearly demonstrated that strengthening family networks and maintaining supportive family contacts can improve outcomes for both family members and returning citizens. Maintaining family ties through written correspondence, telephone calls and personal visits has shown to reduce recidivism rates. However, the challenges of maintaining contact including visiting regulations, transportation costs to distant correctional facilities, other financial barriers, and emotional stress pose significant impediments.

Correctional institutions can facilitate successful family reunification by helping them plan for anticipated challenges. Prerelease centers that include family counseling sessions with inmates

and their families, and/or group educational sessions for families alone have been developed for this. However, where it is not feasible to directly include families a number of alternatives have been developed including partnering with community-based agencies to provide counseling or information sessions, increasing visitation opportunities (e.g., weekend stays for children and conjugal visits with partners) that include meetings with prerelease counselors, or using video conferencing technology.

A number of programs and services have been developed to help families cope with incarceration and improve their functioning. These include various forms of marital and family therapy, parenting skills classes, victim services, mentoring programs for children whose parents are incarcerated, and interventions designed to make families aware of returning citizensô risk factors and effective coping strategies to support prosocial lifestyles. Family-focused interventions[20] have been found to be especially beneficial in working with individuals who are from more sociocentric cultures, women, and members of non-dominant social and cultural groups which are known to place a high value on lifelong family member interdependence.

DOMESTIC VIOLENCE (DV)

Most of the research on prisoner reentry has focused on the impact of unemployment, substance abuse, strained family relationships, and inadequate housing on recidivism. Yet, despite the fact that many individuals who are incarcerated report histories of domestic partner violence, there is a paucity of research on the relationship between reentry and intimate partner violence or domestic violence and recidivism.

Failure to address domestic violence during reentry can place victims in continued danger and increase the risk for recidivism and re-incarceration. Intimate partner and sexual violence can result in physical injury; mental health issues (e.g., depression, anxiety, low self-esteem, substance abuse, and suicide attempts), and physical health problems (e.g., gastrointestinal disorders, gynecological disorders, sexually transmitted diseases, and pregnancy complications) which can lead to hospitalizations, disabilities, or deaths.

Data indicate that women experience more chronic and injurious assaults from intimate partner violence than men and that intimate partner violence affects more African-American women than their Caucasian counterparts and they are twice as likely to be murdered by an intimate partner.

Studies show that the first incident of intimate partner violence is more likely to be severe or life threatening if the male displays violent behavior outside the home, uses drugs, and is unemployed and not seeking employment, all of which can be characteristic of returning citizens. Several studies indicate that men experience significant levels of conflict with their intimate female partners both during and following incarceration.

Studies have shown a robust correlation between substance abuse and domestic violence. For example, one fourth to one half of men who commit acts of domestic violence have substance abuse problems (particularly alcohol and cocaine abuse disorders), and a significant number were raised by parents with substance abuse problems. Women who abuse substances have been found to be more likely to experience domestic violence.

[20] There are a number of types of family therapy (e.g., Functional Family Therapy, Multidimensional Family Therapy, Strategic and Structural Family Therapy, Cognitive and Behavioral Family Therapy, and Couples Therapy).

It is recommended that returning citizens receive assistance to prepare for reuniting with their intimate partners and families in order to manage new roles and responsibilities and deal with conflict effectively. Reentry programs are advised to incorporate a family life preparation component that focuses on domestic violence prevention, parenting skills, and anger management.

Cognitive and behavioral treatment programs for domestic violence have been found to be the most effective. These programs include learning new coping skills such as anger control and restructuring erroneous thinking (e.g., the victim induced the violence) and engagement in substance use disorder treatment when this is a factor. Programs also target maintenance of employment or attendance at job training when needed. In addition, ensuring the safety of victims has also been found to be critical.

BATTERERS' INTERVENTION PROGRAMS (BIPS)

BIPs, also known as spouse abuse abatement programs (SAAPs) are widely used, but there is little evidence to support their effectiveness. Studies have concluded that, while BIPs have a positive albeit modest effect upon violence prevention, they do not produce statistically significant changes in recidivism. Longer programs are plagued by high rates of attrition (ranging from twenty five to sixty five percent, and even higher for men of color). Therefore, no single treatment of choice for individuals who engage in physically abusive behavior can be recommended.

Most BIPs incorporate didactic or educational exercises in which participants are taught to identify various forms of abuse, take responsibility for abuse, refrain from abuse, learn alternatives to abuse (e.g., listening, supporting and validating oneôs partner, recognizing perspectives of others, and compromising) using cognitive restructuring. The Duluth Model (http://www.theduluthmodel.org/) is the most commonly used program model. It is designed to help men confront their attitudes about control and teaches them other strategies for dealing with their partners. This model also incorporates coordinated community responses to domestic violence, which studies have been shown lead to lower rates of recidivism.

An alternative to the Duluth model is the cognitive-behavioral intervention approach which focuses on skills training and anger management. The group practice model, another type of program, includes a combination of a psychoeducational curriculum, cognitive-behavioral techniques, and an assessment of individual needs.

A research-informed model to address domestic violence has also been developed. It includes an individualized case formulation approach based on research-informed targets for intervention that takes into consideration the heterogeneity of the population of men who engage in domestic violence. The model includes: (1) a functional behavioral assessment of the abusive behavior; (2) building working alliances with community supports and family members who are committed to non-violence; (3) building a collaborative working alliance with the batterer; and (4) using motivational interviewing to increase batterersôcommitment to change.

Intervention is targeted to: (1) cognitive factors (i.e., attitudes and beliefs that support violence and precede physical and emotional abuse; selective attention to situational cues; maladaptive interpretation of interpersonal and social interactions; faulty externalizing attributions for oneôs aggressive behaviors); (2) substance use and abuse; and (3) relationship-behavioral factors (i.e., relationships that are distressed, poor interactional skills, and power struggles).

Because of the degree of risk posed to their families and communities, it is recommended that objective, actuarial methods of violence prediction (rather than clinical judgment) be used to predict dangerousness. The Danger Assessment Instrument (DAI), typically administered to

female victims, is a short, fifteen-item instrument that covers risk factors empirically correlated with spousal homicide. The Spousal Assault Risk Assessment Guide (SARA), based on a clinical interview and case file review, is a twenty-item checklist that covers past criminal history and violence factors as well as variables specific to spousal violence. The SARA has been shown to reliably discriminate between individuals who engage in spousal abuse who are likely to recidivate and those who are not likely to recidivate upon the completion of a probationary term. The Partner Assault Prognostic Scale (PAPS), based on interviews with both batterer and victim, and does not have to be administered by a clinician or specially trained professional, is a seventeen-item scale that combines components of several existing screening tools, including the DAI. While it has been shown to predict physical assault, severe violence, and criminal recidivism, more conclusive research is needed to fully establish its validity.

DOMESTIC VIOLENCE COURTS

Many jurisdictions have developed specialized domestic violence courts, the majority of which. share the following elements: (1) effective management of domestic violence cases, coordinating all of the cases involving the relevant parties and integrating requisite information for the court; (2) specialized intake and court staffing for domestic violence cases; (3) improved victim access, expedited hearings, and assistance for victims, often with assistance from specialized domestic violence prosecution units; (4) court processes to ensure victims' safety, such as court metal detectors, separate waiting rooms, specialized orders, and victim referrals; (5) increased court monitoring and enforcement of batterer compliance with court orders often by specialized probation supervision units; (6) consideration of any children involved in the domestic violence; and (7) enhanced domestic violence training for judges.

Some research shows that specialized domestic violence courts are associated with reductions in abuse as well as increases in compliance resulting from the imposition of court-ordered conditions and increases in penalties for noncompliance.

CHILDREN

Studies indicate that more than ten million children under that age of eighteen have experienced the arrest, incarceration, or release of a parent or caretaker. It is estimated that more than seven million children have a parent who is incarcerated or under state or federal supervision, more than two million of whom are under the age of eighteen. There are more African American than Hispanic/Latino parents or Caucasian parents incarcerated. Almost one in fourteen African American children has a parent who is incarcerated.

One in five children witnesses the arrest and removal of a parent, more than half of whom are under seven years of age. The trauma of arrest and separation can result in anxiety, guilt, shame, and fear that can be manifested in behavior problems, poor academic achievement, truancy or dropping out of school, gang involvement, early pregnancy, substance abuse, and delinquency. There is currently a lack of agreement regarding the provision of information to children about their parentsô arrest. On the one hand, it is argued that children should be shielded from this information to minimize trauma, while on the other hand, it is argued that lack of information exacerbates fear and anxiety.

Numerous studies have documented the disruptions in lives of children caused by parental incarceration including separation from parents, siblings, dislocations to different caregivers, and economic consequences (including insufficient food, shelter, and/or clothing) due a reduction in income. Children whose parents are incarcerated have been found to suffer a number of social, emotional, and behavioral problems resulting from this traumatic loss including withdrawal, anxiety, aggression, and depression, as well as poor academic

performance, substance use, and delinquency. Adverse outcomes for young children aged two to six include insecure attachments which are linked to difficulties with peer relationships, school problems, and diminished cognitive abilities. The near term impact can include feelings of shame, social stigma, loss of financial support, attenuated parental bonds, alternations in family structure, delinquent behaviors, and increased risk of abuse or neglect. The long-term effects can include doubting parental authority (i.e., rejecting rules and limits set by adults in parental roles), pejorative views of police and the legal system, and difficulties coping with stressors or trauma, disruption of development, as well as intergenerational criminal behaviors.

In addition to the social and emotional problems experience by children whose parents are incarcerated, they are more likely to become incarcerated themselves. Statistics indicate that as many as seventy percent of these children may eventually be incarcerated. More than half of juveniles and one-third of adults who are incarcerated have immediate family members who have also been incarcerated.

Most children resided with their mother prior to her incarceration; only a small percentage lived with their father as the sole caregiver. Children whose fathers are incarcerated are more likely to remain with their mothers, while those of mothers who are incarcerated are more likely to reside with a grandparent or another relative. Ten percent of children who resided with their mothers are placed into foster care while only two percent of those who lived with their fathers prior to incarceration are placed into foster care.

Research demonstrates that maintaining family contact during incarceration has a positive impact on returning citizens and their families including reductions in the stress of separation, and increases in the likelihood of successful reunification following release as well as successful community reintegration and reductions in recidivism. Yet, parents who are incarcerated typically have limited contact with their children whether through letters, phone calls, or personal visits. And, the number of parents who maintain contact with their children decreases with the lengths of their sentences. More than half of the children of women prisoners never visit their mothers during incarceration primarily because of the remote location of prisons, lack of transportation, and the inability of caregivers to arrange for visits. Yet, visits with their children have been found to a key factor in motivating positive behavioral change and successful community reintegration. In fact, fathers who are incarcerated are more likely to see their children.

Maintaining relationships with family members during a term of incarceration through visits, phone calls, and letters is challenging. Geographic distances between prison facilities and family residences and the time-consuming nature of visits can result in infrequent or a lack of visits. Visits to prisons can be unpleasant experiences for family members due to security procedures (which can create discomfort and embarrassment), visiting hours that are often predicated on prison schedules rather than that of family members, and lack of visiting arrangements that are conducive to parent-child interactions. Telephone calls can be financially prohibitive for families who cannot afford the long-distance calling costs.

Few prison facilities permit mothers to keep their infants with them during incarceration. Mothers of newborns are usually only permitted a few days of contact prior to having to relinquish their infants resulting in a lack of opportunity for attachment and bonding which are critical developmental tasks for both.

It is recommended that children have regular contact with their parents during incarceration, with the exception of situations in which the parent has been convicted of child sex abuse. It is also recommended that parents have regular contact with other close family members, including those who have assumed responsibility for child-rearing while they are incarcerated. Such contacts can include written or video recorded correspondence, email, telephone calls, and

personal visits. In addition, a number of practices have been instituted to address the needs of families including:

- Conjugal visits, furloughs, and family and marital counseling.
- Co-detention in which children are raised in prison thus allowing mothers and their children to remain together for a period of time. (Prison nurseries date back to early in the twentieth century and permit mothers to develop emotional attachments with their children). However, concerns regarding the appropriateness of the environment for children and the degree of freedom they are allowed have been raised.
- Alternatives to incarceration, or community-based sentencing, including house arrest; halfway houses; or day programs at correctional institutions in which mothers return home at night. Studies indicated that community-based programs lead to reductions in recidivism and increase family preservation.
- Family visitation programs and services in correctional institutions that provide play areas for parents and their children, activities for parents and children, extended visits, the provision of transportation, and more flexible scheduling. One example of a visitation program is Girl Scouts Beyond Bars (GSBB).

AMACHI MENTORING PROGRAM

Amachi[21] is a national mentoring program that targets youth whose parents are incarcerated or under criminal justice system supervision and is designed to reduce risky behaviors and promote achievement. The program offers mentoring services to children whose parents or caretakers are currently or formerly incarcerated, and is collaboration between Public/Private Ventures, Big Brothers Big Sisters of America (BBBSA), and the Center for Research on Religion and Urban Civil Society (CRRUCS) at the University of Pennsylvania.

The Amachi program incorporates support and involvement of faith-based congregations from the participantsô own or nearby neighborhoods which provide volunteer mentors. It uses the one-to-one community-based mentoring model of Big Brothers Big Sisters that entails mentoring matches and regular, frequent contacts of a minimum of one hour, between an adult mentor and a child for one year or longer.

Secular and faith-based community institutions recruit volunteers from congregations to provide one-to-one mentoring services to children who are at risk. Volunteers are matched with children and meet at least one hour a week for one year at an agreed upon date, time, and location and engage in a variety of activities together (e.g., meals, homework, playing sports, cultural and social events, and church services and activities). Professional case management and support are provided to ensure effective mentorï mentee relationships are maintained.

Evaluations of Amachi reveal that participants indicate feeling more confident about doing their school work, skip fewer days of school, earn higher grades, and are less likely to start using drugs or alcohol. Information on the Amachi/Big Brothers Big Sisters Saginaw Bay Area program can be found at www.sagbaybbbs.org/.

PARENTING PROGRAMS

Research indicates significant benefits result from improving parenting skills. A number of programs have been developed to facilitate and strengthen family connections during

[21] Amachi is a West African word that means ñWho knows but what God has brought us through this child?ò

incarceration. Such programs have been found to lead to reductions in health problems, substance use, and recidivism. Parenting education programs have been developed for both mothers and to fathers

It is recommended that parenting classes include information on child development and parent-child interactions, the impact of parental physical or sexual abuse on children, and parenting skills specific to children's developmental stages. Didactic instruction combined with group practice and individualized follow-up tailored to the specific needs of each family along with supervised practice with the child; and involvement of the whole family are recommended. Many programs offer anger management or other domestic violence classes to returning citizens who have histories of family violence. Finally, it is recommended that parenting programs address child-support responsibilities.

GIRL SCOUTS BEYOND BARS (GSBB)

Girl Scouts Beyond Bars is a national mother-daughter visiting and mentoring program that provides supports to young girls whose mothers are incarcerated and focuses on strengthening the bond between mother and daughter. GSBB hosts mother/daughter troop meetings twice per month at correctional facilities where mothers are offered opportunities to lead troop meetings to develop and practice leadership, parenting, and conflict resolution skills. The Girl Scouts participate in a support group with others whose mothers are incarcerated and spend time with their mothers. Troop leaders provide guidance and function as positive role models. Facilities that host GSBB have found reductions in behavioral problems and rule infractions by mothers who participate in the program. Information on the program can be obtained from http://www.girlscouts.org/program/program_opportunities/community/gsbb.asp.

LONG DISTANCE DADS (LDD)

Long Distance Dads is a national parenting program developed by the National Fatherhood Initiative (NFI) that provides character-based education, support, and peer leadership to fathers in correctional institutions to help them become more involved, supportive parents. The program uses a curriculum that focuses on universal aspects of fatherhood as well as the unique challenges faced by fathers who are incarcerated. It aims to help participants acquire positive family values, knowledge of parenting and family-relationship skills, strategies for connecting with their families; strategies for fulfilling their responsibilities as fathers while incarcerated and after release; the effects their behavior and incarceration have on their families; developing a viable family reunification plan; using positive skills for dealing with issues of loss, shame, and guilt; and clearly communicating the negative effects of incarceration to their children.

The curriculum consists of twelve modules, each of which is delivered in two to three hour blocks by trained peer leaders who facilitate the program during the twelve weekly sessions in a small group format with ten to fifteen participants. The modules include: a fatherhood self-assessment, character of a man, my child's life, and developing healthy relationships with a focus on basic fathering skills including self-control, self-discipline, consistency, and nurturing. The program focuses on self-discipline, nurturing, and consistency and also addresses anger management, communication, and relationships. Participants are also encouraged to become more involved in the lives of their children through various activities (e.g., letter-writing and holiday events).

LDD collaborates with faith-based organizations, human service agencies, and child support enforcement agencies. Long Distance Dads is currently used in federal, state, and county correctional facilities across the country. NFI provides training to corrections staff and

community agencies to deliver the curriculum. Information can be obtained from National Fatherhood Initiative (NFI) at http://www.fatherhood.org/.

STRENGTHENING MULTI-ETHNIC FAMILIES AND COMMUNITIES

Strengthening Multi-Ethnic Families and Communities[22] is a promising program for violence prevention and intervention targeted to culturally and ethnically diverse parents of children aged three to eighteen. It is designed to decrease substance use, teen suicides, juvenile delinquency, gang involvement, child abuse, and domestic violence as well as increase parental sense of competence, positive family/parent/child interactions, positive parent/child relationships, child self-esteem and self-discipline, child social competency skills and parental involvement in community activities.

The program consists of twelve three-hour sessions taught in consecutive weeks and is comprised of a curriculum of five components titled Cultural/Spiritual Focus, Rites of Passage, Positive Discipline, Enhancing Relationships, and Community Involvement. Facilitator manuals are available in English and Spanish and materials for parents are available in English, Spanish, Vietnamese, Korean, Chinese, Russian, and Somali. Parent training classes are held in a variety of accessible locations (e.g., churches, schools, and community agencies). Sessions are conducted by one or two instructors who receive training to deliver this discussion-oriented program.

Outcome studies indicate that participation leads to enhanced family bonding and significant improvements in parental sense of competence, family/parent/child interactions, and children's behavior. In addition, parents display increased involvement in their communities and children's schools as well as enhanced capacity to deal effectively with child rearing challenges, pride in cultural heritage, community bonding, and reductions harmful behaviors toward their children.

An intensive Five-Day Facilitator Training Workshop is available for groups of fifteen to twenty people at a per-person cost of $535.00 for a National Trainer and $625.00 for a Master Trainer, plus travel expenses for one trainer. Training includes a Workshop Manual and a Session by Session Activities Manual as well as overhead materials and parent worksheets. Parent Manuals are purchased for each parent (or family) for $17.00 from the program developer. It is also recommended that childcare, refreshments and a graduation ceremony be provided. A Child Activities Supplement to augment the parent program with corresponding session activities for children aged three to eighteen is also available. More information on the program can be obtained from http://www.parentingacrosscultures.com/training/training.html.

PROJECT SEEK (SERVICES TO ENABLE AND EMPOWER KIDS)

Project SEEK[23] is a nationally recognized model program that is designed to prevent delinquent behavior, stop intergenerational crime, and stabilize families affected by incarceration. It is targeted to children under age sixteen whose parents are incarcerated for a term of seven years or less that operates in Genesee County, Michigan. Children must be eleven years or younger at intake to be eligible for participation.

The program aims to promote social competency, cognitive development, academic success, emotional and physical well-being, and family stability, and improvement of the care-giving environment by promoting the psychological and physical well-being of caregivers, increasing

[22] A number of evidence-based family strengthening programs are available. This one was selected for inclusion because it is cited in the corrections literature.

[23] A number of evidence-based prevention programs that target children are available. Project SEEK is highlighted here because it is cited in the corrections literature and is Michigan-based.

their ability to meet basic needs, improving parenting practices, maintaining the parent-child relationship when appropriate while the parent is incarcerated, and assisting with family issues of reintegration at the time of the parentôs release.

Services include home visits, support groups for children and their caregivers, and referrals to other community services (e.g., financial assistance, housing, health care, mental health, and legal services). The program facilitates communication between children and their parents during incarceration where appropriate. A child development curriculum, Building Strong Families, is used during home visits.

Preliminary evaluation results indicate improvements in academic performance and cognitive skills, reductions in delinquent behavior and substance use, and a greater sense of an internal locus of control, and reductions in recidivism for their parents.

Training in conflict resolution and the Building Strong Families curriculum are provided at a cost of $400.00 per day plus travel and consultation is available at $50.00 per hour. The annual cost for replicating Project SEEK is approximately $275,000.00 to serve one hundred fifty children from one hundred families. Information regarding this program is available from http://www.fcnetwork.org/reading/mott.html.

FAMILY MAPPING

Family mapping tools are designed to help understand the characteristics of families and their resources. Maps are essentially snapshots of families at fixed points in time that foster understanding of families within the context of their environments by creating a visual representation of significant information. Family mapping can be used during assessment to trace multigenerational patterns of strengths, resilience, accomplishments, and challenges, as well as identify existing and potential community resources. Mapping tools can also be used to gauge how returning citizensô life circumstances are changing throughout course of supervision.

Mapping tools are most effective and informative when constructed in a collaborative partnership with returning citizens and/or their families which has been found to increase their accuracy as well as recognition of strengths, awareness of connections and patterns (and opportunities to alter these patterns). It is recommended that information be obtained from several family members to increase the reliability of that information as well as provide an opportunity to compare perspectives and observe interactions. In addition, it is recommended that maps be updated about every three months, or when there is a change in a familyôs configuration or resources.

Mapping tools have been found to be beneficial because they create opportunities for families to tell their stories, provide useful information at a glance, and reveal how families are functioning at home and in the community. The process of family mapping has also been found to foster engagement, provide practice with open communication, cultivate resources, help family members connect with one another and with the case manager/supervising agent, as well as identify internal strengths and external supports previously unrecognized. Finally, family mapping encourages families to tell their stories on their own terms rather than merely answer questions on a formal assessment or fill out a questionnaire.

Ecomaps and strengths-based genograms are two family mapping and intervention tools for contextualizing families, explicating positive and challenging elements (e.g., criminal justice involvement, employment, chronic illness, mental illness, and substance use disorders), and available resources.

GENOGRAMS

A genogram is a family tree that depicts elements of a family and the nature of its relationships. Genograms have traditionally been used to highlight family problems and deficits (e.g., generational patterns of substance abuse, involvement in the justice or social service systems, and mental illnesses), but are now used to support strength-based models of service delivery to present an intergenerational perspective on returning citizensô families.

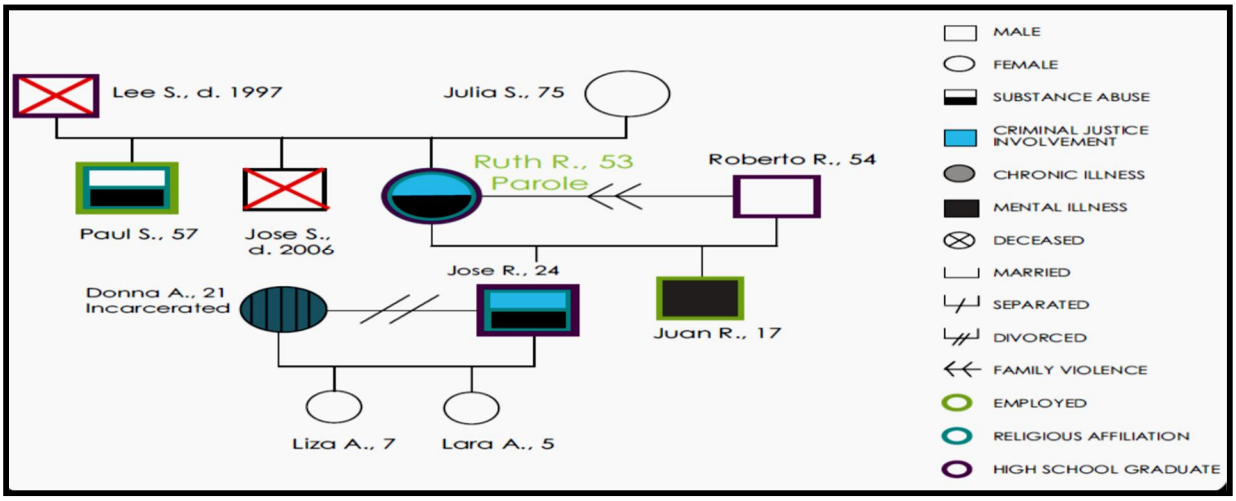
Genograms depict family roles and patterns of interaction over three or more generations and reflect patterns of involvement in the justice system, histories of substance use, employment, and education. They also chart ethnic and religious backgrounds, major family events, occupations, losses, alliances, and separations, as well as strong relationships, positive role models, and support systems. The process of creating a genogram can help family members and case managers visualize and identify available supports within their family system that can be harnessed.

The process of constructing a genogram that has been found most effective begins by allowing family members to describe their family in a spontaneous fashion. Discussion begins with open-ended questions and prompts (e.g., ñTell me about your familyò) and follows up on information given rather than relying on a standard list of questions. Connections that can be depicted on a genogram include who lives together, who is on speaking terms with one another, healthy alliances, and long-term relationships.

Information depicted in a genogram typically includes:

- Gender
- Date of birth
- Living or deceased
- Cause of death
- Chronic illnesses (HIV/AIDS, mental illnesses, hypertension, diabetes)
- Substance use
- Cause of death
- Tobacco use
- Occupation (including retirement and disability)
- Location of birth
- Primary language
- Status as adopted or foster child
- Religion (observant or not)
- Education
- Marital status
- Criminal justice involvement, history, and status

As noted above, it is important for returning citizens and their families to take an active role in creating the map to increase its accuracy. Engaging them in a collaborative process can reduce any feelings of shame associated with revealing any stigmatizing life events and situations to a stranger. In addition, the process also can help individuals under supervision and their families recognize strengths and observe connections and patterns in their families for the first time or in new ways which may result in opportunities for them to consider ways they can effectively alter dysfunctional, destructive, or unhealthy patterns.



from Mullins, Toner (2008)

A male is indicated by a square and a female by a circle. Dates of important events are included. Romantic partnerships are indicated by a line connecting the partners. A separation is signified with one slash through the horizontal line connecting partners while two slashes through the horizontal line signify divorce. Offspring are entered in accordance with their ages, starting with the oldest on the left. An adopted child is identified with a small ña.ò Family members who are deceased are indicated with a small ñxòin the corner of the circle or square. Family members who comprise the household are included within a circle around them. Siblings and cousins are depicted horizontally and the generations through time are depicted vertically. Each genogram should include a key to understand the information presented.

ECOMAPS

An ecomap is a visual representation of a family in its environment and identifies available formal and informal external resources (e.g., health clinics, mental health treatment programs, schools, and places of worship) as well as significant positive or conflicted connections between a family and its environment. It depicts the flow of resources and energy into a family system as well as the flow from the family to external systems, displays conflict between services that highlight the need for coordination, and sources of support that may be utilized in new ways. Ecomaps have been found to be effective for gaining a better understanding of the array of agencies and systems with which an individual under supervision may be interacting including those that exert control and how many are not of their choosing.

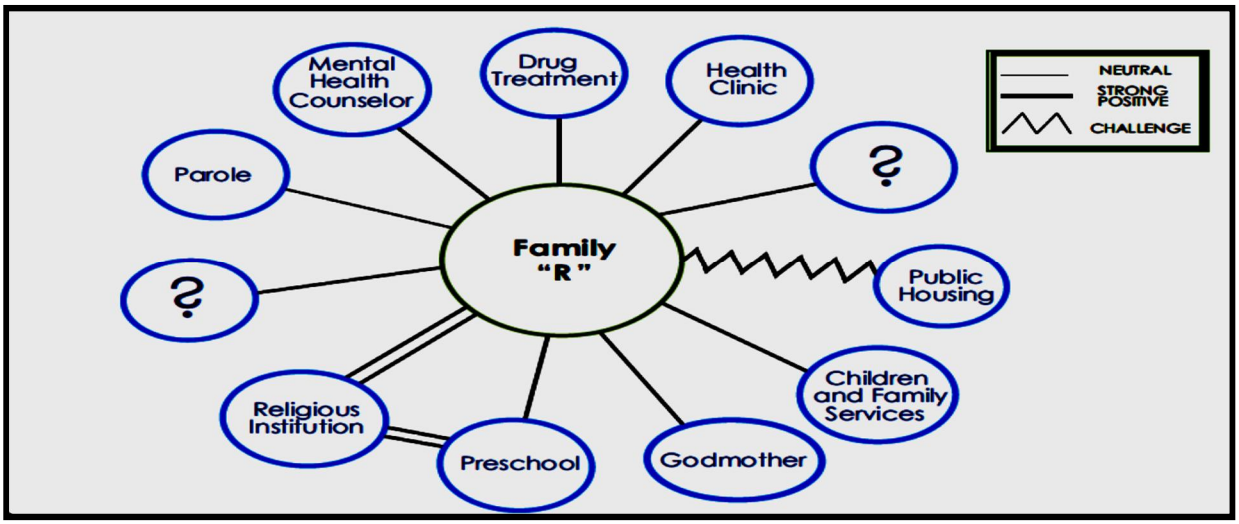
Ecomaps are constructed during the early stage of case management/supervision in order to identify existing resources, prevent duplication of services and supports, identify potential conflicts, and serve as quick reference guides for collateral contacts during supervision by recording the names and phone numbers of the persons at the various agencies next to their respective circles on the ecomap (e.g., social services, substance abuse treatment facility).

The mapping process starts with the identification of people and institutions with whom a retuning citizen interacts, followed by drawing lines from the center circle (the family) to each of the outside circles, and indicating the type of relationship the individual or family member has with each entity. A straight line represents a neutral relationship, a double line represents a strong positive relationship, and a jagged or zigzag line represents a challenged relationship. The type of relationships various entities have with each other can also be indicated. Connections on an ecomap include:

- Faith-based institution
- Welfare

- Childcare
- Schools/teachers
- Workplace (employer, supervisor, co-workers)
- Girlfriend/boyfriend/spouse/partner
- Co-parent of a child
- Vocational training
- Mentor/sponsor
- Substance abuse treatment program
- Mental health treatment program
- Medical care provider
- Informal organizations and groups (e.g., social clubs, sports teams, etc.)
- Medicaid
- Supplemental Security Income (SSI)
- Probation/parole
- Landlord/public housing authority
- Gang/peer group
- Neighbors
- Court
- Government entities (federal, state, local)
- Self-help groups (e.g., 12-step programs, Rational Recovery)
- Child protective services/parenting class

Connections can be identified using motivational interviewing and supportive inquiry. An Ecomap can be introduced by depicting it as a representation of a walk through a week of their life and using open-ended questions and prompts if needed (e.g., Where do you go? With whom do you interact? Who helps you ī family, neighbors, social service agencies, schools?).



from Mullins and Toner (2008)

Ecomaps often lead to observations of involvement with a number of compulsory/mandated systems and agencies (e.g., parole/probation, substance abuse treatment, community service, housing authorities, and mental health services). One goal of supervision is to engender changes in ecomaps so that more of the systems and agencies with whom returning citizens interact are of their own choosing (e.g., daycare, faith-based institutions, friends, employers) over time. Periodic reviews and updates to ecomaps allow returning citizens and case managers to view progress toward reducing the number of mandated systems and agencies involved, as well as identify additional support networks for achieving supervision goals.

FAMILY CASE MANAGEMENT (FCM)

FCM is a strengths-based model that is designed to engage families and other natural supports in the community supervision process in which case managers model effective relationship skills and focus on developing social capital. It consists of three phases:

Phase One: Engagement and Assessment includes the development of an initial comprehensive assessment within thirty days of the initial contact. It covers several areas of family life (mental health, substance use, physical health, education, and employment) and a

summary of strengths and challenges, including recommendations for the family action plan. An initial home visit, genogram, and ecomap are completed within thirty days of the initial contact.

Phase Two: Family Action Plans are developed with the active involvement of returning citizens and their families from information gathered during the assessment phase. Plans outline the goals and objectives for case management based on the prioritization of goals set by returning citizens and their families. Plans may include goals for one or more individual members, as well as family goals. It is recommended that families be encouraged to establish a goal of providing support to one another. In addition, goals and objectives should be reasonable and attainable, specific and measurable, include time frames, clearly define responsibility for actions, and be framed in a positive, strengths-based manner. It is further recommended that at least one easily and quickly attainable objective and goal should be articulated in order to increase self-confidence and set a precedent for appreciating the rewards of achievement.

Family action plans should be **S.M.A.R.T.:**

Simple/Straightforward/Specific: Each achievement for a goal should be divided into smaller goals and goals should also be strength-based.

Measurable: Stated results should be expressed in measurable (i.e., numeric) terms specifying quantity and timeframes

Attainable: Plans should be within reach under normal or anticipated circumstances

Realistic: Goals should be achievable (and take into account a familyôs limitations)

Time-framed: Objectives should include target dates for completion

Phase Three: Transitioning from Family Case Management to Sustainability entails successful completion of FCM exemplified by reduced reliance on governmental and case management support staff, demonstration of effective problem-solving skills, goal attainment, an established support network, and internal resources (e.g., a sense of competence and self-esteem).

BODEGA MODEL

The Bodega Model® is a nationally recognized, strengths-based, family case management program for individuals with substance use disorders who were previously incarcerated or are currently involved in the criminal justice system (on parole or probation). Family case management and other services are provided to supplement probation, parole, or pre-trial supervision. The program is designed to increase the effectiveness of substance use disorder treatment, decrease the use of incarceration to punish relapses, and reduce the harm caused by addiction within families.

A range of support services are offered in addition to family case management including referral and prevention services, walk-in services, twenty four-hour crisis intervention for emergencies related to substance use (e.g., arrest, relapse, or potential eviction from housing), advocacy, support groups, and cultural activities. Case managers link participants with social service agencies to help them obtain housing, medical care, and substance use disorder treatment. Staff may also accompany family members at court appearances and function as advocates with lawyers and judges.

Families beginning the program attend weekly individual and group counseling sessions, often bringing together family members who are estranged from one another to discuss unresolved issues. Parole agents are included in family counseling sessions as warranted. Crisis services are provided via a twenty-hour hot-line and include support and mediation, stabilization of the

situation, and advocacy for services (e.g., substance use disorder treatment, or temporary housing).

Case managers help each family develop an action plan that utilizes a number of community-based services, help families negotiate the numerous social service agencies with which they may be dealing, and advocate with parole agents to promote the use of alternatives to incarceration when individuals with substance use disorders violate the terms of their parole due to relapse. Families and case managers create ecomaps to depict each family's sources of formal support, reveal conflicts between services, and highlight areas where service coordination is beneficial. Case managers also help families create genograms which allows them to identify potential sources of additional family support, substance use, criminal justice supervision, and other current and past issues, as well as identify positive patterns, (e.g., steady employment across generations, educational attainment, skill development, and effective parenting skills).

Evaluations of the Bodega model have shown that participation leads to significant reductions in substance use, arrests, and convictions for new offenses. In addition, family members have been found to obtain needed medical, social, housing, and mental health services at significantly higher rates and report having a significantly stronger sense of being supported emotionally and materially in their social relationships. Interestingly, reductions in substance use appear to be a direct result of pressure and support from family members and case managers rather than from increased substance use disorder treatment. Information on Bodega can be obtained from www.familyjusticeinc.org.

WORKING WITH CHILD WELFARE

Parents who are incarcerated risk losing custody of their children. The Adoption and Safe Families Act (AFSA) of 1997, enacted to make it easier to move children from foster care to permanent adoptive homes and thus prevent children from being moved from one home to another, and expedite the process of achieving a stable living environment, accelerates the termination of parental rights and bars individuals with certain convictions from being foster or adoptive parents.

ASFA mandates the termination of parental rights when a child has been in foster care for fifteen of the last twenty two months, a short period of time for parents while incarcerated as well as subsequent to release when they must satisfy the conditions of release and child welfare mandates for reunification (e.g., finding a suitable place to live, find work and participate in family counseling, parenting education, and mental health or substance abuse treatment, etc.). Exceptions can be made if a relative is caring for the child, or there is a compelling reason for not moving to terminate parental rights, or reasonable efforts to return the child home were required but necessary reunification services were not provided.

Parents who are incarcerated are at risk for loss of their parental rights[24] if they adhere to child welfare regulations that require regular contact between a parent and a child placed in foster care. Parental rights can be terminated on the basis of the duration of incarceration. For example, mothers who are incarcerated serve an average of eighteen months. Maintaining regular contact with children can be very difficult or impossible due to the limited number of correctional facilities for women and children; caretakers and children may have to travel long

[24] In 2010, the Michigan Supreme Court, in *re Mason,* determined that custodial parents who are incarcerated have to be available by phone to take part in all matters pertaining to their custody, and that foster care workers must attempt to engage parents who are incarcerated in developing a case service plan regardless of the length of the parent's incarceration.

distances without the wherewithal or time to do so. And even when the duration of incarceration permits sufficient time to, lack of prison-based programs can preclude compliance with the provisions of family service or reunification plans.

Few correctional institutions facilitate sharing relevant child welfare information with parents who are incarcerated or participation in relevant proceedings. The impact the loss of a mother-child relationship through a termination of parental rights lack of contact during incarceration can have profound negative consequences.

It is estimated that fifty percent of parents who are incarcerated have open child-support cases, half of whom have an existing support order, while the rest are awaiting the establishment of paternity or a support order. Parents who enter prison with a child-support order remain responsible for payments irrespective of whether they can meet those obligations. However, most people who are incarcerated have little or no ability to meet their child support obligations and have been found to owe more than $20,000.00 on average when they are released which can impede family reunification. Parents may need assistance with the initiation of a review to modify support orders to reflect their current circumstances, or to correct orders that have been based on errors (e.g., incorrect income). In addition, it is important to ensure realistic child support payments upon release are established.

The child welfare and criminal justice systems have been found to have many families in common. Cross-system collaboration, coordination, and service delivery can enhance opportunities to promote successful family reunification by providing families of incarcerated parents with needed supports; facilitating visits and other contacts with children, and helping families plan for reentry. Finally, child welfare can make foster care placements with relatives to lessen the trauma of placement because such caregivers are usually familiar parental figures who can help provide ongoing relationships with parents, siblings, other relatives, and friends.

Public child welfare agencies provide a number of services, including prevention services, to keep children and families from entering the child welfare system; early intervention family prevention services address the needs of families that are at risk or in crisis; child protective services in which cases of suspected abuse and neglect are investigated and treatment services provided; foster care for the placement of children in out-of-home care; permanency planning in which a permanent home (reunification with biological family, adoptive families, or relatives or guardianship) for children; post-permanency services to support a permanent placement (e.g., reunification services, post-adoption, kinship-care, or guardianship); independent living services to prepare older youths and those aging out of the foster care system for self-sufficiency Individuals who have custody of children whose parents are incarcerated often rely on Temporary Assistance to Needy Families (TANF), Medicaid, the Supplemental Nutrition Assistance Program (SNAP), child welfare, cash assistance, and other supports.

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ACCESS TO ENTITLEMENTS AND BENEFITS

Returning citizens often rely on their families to help with immediate needs following release, but families may not in a position to provide support due to limited resources. Incarceration can adversely affect the financial situations of families due to the loss of a wage earner; most parents were employed prior to incarceration. Moreover, such financial loss disproportionately burdens those families already living in poverty.

The incarceration of a parent or caregiver can precipitate financial problems for their family leading to housing instability and increasing amounts of debt. Returning citizens may need public benefits to reunite their families, pay rent, and buy food, clothing, and other necessities following reentry. They are unable to seek employment without an income because finding a job requires funds for transportation, telephone calls, access to ads on the Internet or in newspapers, suitable clothing, and child care during the search and application process. Some returning citizens have disabilities that prevent them from working while others can work but need assistance until they are able to secure employment which often requires more time than for individuals who do not have criminal records.

Public assistance can create a financial bridge to become self-supporting as well as fund services such as substance abuse treatment, health care, and job training as well as food and housing during transition. For example, returning citizens with mental illnesses who have been incarcerated need access to public benefits in order to access services and supports in the community, avoid homelessness, abject poverty, and decompensation due to lack of treatment. Having Medicaid upon release has been found to be linked to increased use of services and supports as well as reductions in arrests.

Due to need for immediate access to benefits, the range of benefits for which returning citizens may be eligible, and the application processes involved, it is recommended that information regarding benefits and the submission of applications where permissible be initiated prior to discharge. Representatives of benefits administration agencies or benefits counselors can help determine eligibility and facilitate the application process. Returning citizens with learning disabilities or other cognitive challenges may require assistance in completing forms.

SOCIAL SECURITY DISABILITY INSURANCE (SSDI)

The Social Security Administration (SSA) administers two programs that provide monthly cash benefits to individuals who are disabled and meet certain criteria: Retirement, Survivors, and Disability Insurance (RSDI, or Title II) and Supplemental Security Income (SSI or Title XVI). Disability insurance under RSDI is commonly referred to as Social Security Disability Insurance (SSDI). In order to receive disability benefits under SSDI or SSI, an applicant must meet certain non-medical criteria and be found to have a physical or mental impairment that has lasted, or is expected to last, for at least a year, or will result in death, and be so severe that the individual is unable to engage in any substantial gainful activity. The rules for qualifying as a person with a disability under SSDI are the same as for SSI; individuals must have significant health impairment and be unable to engage in substantial gainful activity.

SSDI is financed with Social Security taxes paid into the Social Security Trust Fund by workers, employers, and individuals who are self-employed. Individuals may be eligible for SSDI based on their own contributions or the contributions of a family member. People who are eligible based on their own work records must have accumulated a sufficient number of credits for taxable work income (usually twenty credits in the last ten years ending with the year in which the disability occurred; workers aged thirty or younger may qualify with fewer credits). An

individual may begin receiving SSDI payments in accordance with the amount contributed to the Social Security Trust Fund in the sixth month after SSA determines that the disability began.

Individuals who acquired a disabling impairment as a result of the commission of a felony for which they were convicted after October 19, 1980 are barred for life from receiving SSDI benefits based on that impairment, although they may have other impairments that qualify them for SSDI. (See SSR 83-21 at http://www.ssa.gov/OP_Home/rulings/oasi/27/SSR83-21-oasi-27.html for more information.) In addition, Federal law prohibits payment of SSDI to individuals with disabilities that are solely due to a substance use disorder. Individuals who have been approved for SSDI benefits generally become eligible for Medicare after a two-year waiting period.

SSDI benefits are suspended, not terminated, following conviction of a criminal offense and thirty days of incarceration, any thirty-day period during which an individual is confined in a jail or prison in connection with a verdict of not guilty by reason of insanity or guilty but insane, or a finding of incompetence to stand trial. Reinstatement and new applications can be considered by SSA prior to release. Information on SSDI is available at http://www.ssa.gov/pgm/disability.htm.

TICKET TO WORK PROGRAM

The Ticket to Work program was enacted by Congress in 1999 and is a SSA work incentive program implemented by each state that provides a voucher for individuals to obtain vocational services from any willing provider who participates in the program. It also includes the Medicaid buy-in which allows SSDI recipients who work to buy into the Medicaid program. Detailed information on this program can be found on the SSA Web site at http://www.socialsecurity.gov/work/aboutticket.html.

SUPPLEMENTAL SECURITY INCOME (SSI)

The Supplemental Security Income program provides cash payments to adults and children who are unable to work due to a disability or are at least sixty five years of age. SSI, unlike SSDI, is a means-tested entitlement that is financed through general tax revenues and is available to individuals who are aged, blind, or disabled with limited assets and incomes, and are U.S. citizens or qualified aliens.

To qualify for SSI on the basis of a disability, an individual must have a diagnosed disorder and be unable to engage in substantial gainful activity because of that disability as well as have a low income and assets to meet the financial eligibility requirements. Monthly cash payments start the first full month after the date a claim is filed, or the date the individual becomes eligible for SSI.

Individuals who have been found to deliberately dispose of resources in order to receive SSI may be ineligible for benefits for up to thirty six months. Individuals fleeing to avoid prosecution, custody or confinement for a felony, or are fugitives as a result of violating a condition of probation or parole, are ineligible for SSI. As with SSDI, individuals whose primary or sole diagnosis is a substance use disorder are ineligible for SSI. SSI applicants must agree to apply for all other cash benefits to which they may be entitled (e.g., SSDI, pensions, veterans benefits, etc.) before receiving SSI since it is considered a benefit of last resort.

Benefits are payable until a person has been incarcerated for a full calendar month, after which benefits will be suspended and no further cash payments will be made. When suspension of the benefit lasts less than twelve consecutive months, payments can resume soon after the individual is released. SSA must be informed of the release and the individual must submit a

form with evidence showing that they again meet the financial and other non-disability requirements. (SSA presumes that individuals remain disabled under federal rules).

Individuals can apply for reinstatement of SSI while incarcerated, and suspended SSI benefits can be reinstated for many individuals prior to their expected release date, although payments will not start until they are released. Individuals whose benefits have been terminated must file a new application for SSI; it can take several months for SSA to make a decision regarding eligibility. Information on SSI is available from http://www.ssa.gov/ssi/.

PLANS FOR ACHIEVING SELF–SUPPORT (PASS)

The PASS program enables recipients of SSI who are employed to set aside a portion of their monthly income and/or assets to achieve a work goal (e.g., attend college or a training program) and to purchase equipment to set up a business. Recipients must work with a SSA representative to set up a PASS and receive approval from SAA for the plan. All PASS funds must be used for the agreed upon vocational goal and funds saved are deducted from earned income before the countable income is calculated. SSA reviews PASS plans regularly, usually on at least an annual basis. Information on PASS can be found on the Web at http://www.ssa.gov/disabilityresearch/wi/pass.htm.

TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF)

The Temporary Assistance to Needy Families program provides cash assistance and services including child care, transportation, employment and training, and child welfare services to families with low incomes. Each state sets specific eligibility requirements for TANF and it is generally time-limited. In Michigan it is known the Family Independence Program (FIP)[25]. TANF cash assistance ceases upon incarceration, but including case management, vocational rehabilitation, job preparation, job training and job search, mental health (but not medical) services, and literacy-skills training can be furnished to non-custodial parents who are in jail or prison.

Children who live apart from either of their parents are eligible for child support services irrespective of income. Children who receive TANF cash assistance, Medicaid, federally funded foster care, and food stamps are required to participate in the child support program while others can apply for services. Services for custodial parents seeking support for their children can receive assistance to establish paternity and obtain, adjust, or enforce child support obligations owed by non-custodial parents.

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 includes a lifetime ban on eligibility for food stamps and benefits under the TANF program for anyone who receives a felony drug conviction if both the conviction and the underlying conduct occurred after August 22, 1996. However, children in the family retain TANF eligibility. The 1996 welfare law also prohibits states from providing TANF assistance, food stamps, SSI, and public housing to anyone who is in violation of their probation or parole. The duration of ineligibility for SSI and food stamps is for the month and any period of time that an individual has either absconded from or is out of compliance with the conditions of release.

States can opt out of the welfare ban completely or narrow it, but only through legislation. Otherwise, the ban is permanent and continues regardless of a person's successful job history, participation in drug treatment, abstinence from drug use, or avoidance of recidivism. Seventeen states are enforcing the ban and denying TANF assistance and food stamps to all individuals

[25] For detailed information on FIP see http://www.michigan.gov/documents/dhs/DHS-News-Pubs-TANFStateDRAFT-Jan2010_291487_7.pdf.

with felony drug convictions. Michigan opted out the federal ban and places no restrictions on TANF eligibility for individuals with felony drug convictions.

While Michigan has opted out of bars to public assistance and food stamps for individuals with drug felony convictions, the state adheres to provisions of federal law that bars assistance for ten years from the date of conviction to individuals who have been convicted of the fraudulent duplicate receipt of assistance, fugitive felons, and individuals in violation of the terms of probation or parole. Persons convicted of a felony for the use, possession, or distribution of controlled substances after August 22, 1996, can receive assistance as long as they are not in violation of the terms of probation or parole, but their benefits are paid in the form of third party or vendor payments. TANF cash assistance can be restored to returning citizens as soon as they can demonstrate they meet the state's eligibility requirements, including resumption of the caregiver role. Applications can be prepared while individuals are incarcerated, but benefits are not payable until release.

Individuals leaving prison may be eligible for short-term, non-recurrent TANF benefits to meet immediate personal and family needs following release, including those who are ineligible for regular TANF benefits. These benefits are limited to four months and designed to deal with a specific crisis situation or episode of need, rather than recurrent or ongoing needs, and do not count as assistance.

Although returning citizens are not eligible for SSI or TANF while incarcerated, screening for post-release eligibility and facilitation of the application process prior to release can eliminate the often lengthy waiting periods for benefits to begin after release and facilitate transition by permitting to access treatment or services that are often conditions of release and enabling returning citizens to begin supporting themselves and their dependents without resorting to criminal activities if in the absence of employment.

CHILD CARE AND DEVELOPMENT FUND (CCDF)

The CCDF provides childcare to families in which the adults who are employed, attending school, or in training programs. It enables parents with low incomes and those receiving Temporary Assistance for Needy Families (TANF) to work or to participate in educational or training programs, and for family preservation in instances of parental health care treatment participation. Funds may also be used to serve children in protective services. In addition, a portion of CCDF funds must be used to enhance child care quality and availability. Subsidized child care services are available to eligible families through certificates (vouchers) or grants and contracts with providers. Information on the CCDF can be obtained from http://www.michigan.gov/dhs/0,1607,7-124-5453_5529---,00.html.

NUTRITION ASSISTANCE

The **Supplemental Nutrition Program (SNAP)**, formerly known as food stamps, provides aid to meet the cost of food. Benefits are provided on an electronic card that is used like an ATM card and accepted at most grocery stores and are available to individuals with low-incomes who meet the work requirements of TANF and the qualifying income and resource requirements. Most individuals without a disability must register for work to receive SNAP, with the exception of those who receive federal disability benefits (SSI/SSDI), or those who are caretakers of children under the age of six.

SNAP benefits are not available to individuals during incarceration, but can be effective upon release, and applications can be combined with applications under the SSI pre-release procedure. (See http://www.ssa.gov/ssi/spotlights/spot-prerelease.htm for more information).

Information on Michigan's Food Assistance Program (FAP) can found at http://www.michigan.gov/dhs/0,1607,7-124-5453_5527-21832--,00.html.

The **Supplemental Nutrition Program for Women, Infants, and Children (WIC)** program provides supplemental food assistance for women who are pregnant, breast feeding, and postpartum, as well as infants and children up to age five who are at nutritional risk and have incomes below one hundred to one hundred eighty five percent of the federal poverty level. Information on WIC can be obtained from http://www.michigan.gov/mdch/0,1607,7-132-2942_4910---,00.html.

MEDICAID

Medicaid is a means-tested entitlement program that provides medical insurance to individuals with low-incomes that is funded jointly by the federal government and the states. The federal government matches state Medicaid funding based on a formula that compares each state's per capita income to the national average. States must agree to provide coverage for a set of core services to individuals in certain eligibility categories in order to receive federal funds, but have the option to expand the range of services covered and the eligibility groups within categories.

Eligibility criteria include meeting financial criteria pertaining to income and resources; membership in a group that is categorically eligible for benefits (i.e., children, pregnant women, adults in families with dependent children, individuals with disabilities, or elderly); U.S. citizenship or qualifying immigrant status; and residency in the state where the application is filed. Most people with disabilities qualify for Medicaid on the basis of qualifying for SSI.

Under federal law, states do not receive federal matching funds for services provided to individuals who are incarcerated, but the rules do not require termination of Medicaid eligibility upon incarceration. Federal law permits suspension of Medicaid benefits during incarceration which enables people in prison to reactivate their coverage and begin receiving care immediately upon release.

When a person's Medicaid eligibility is tied to their SSI eligibility, reinstatement of Medicaid benefits following release will occur once SSI eligibility is restored. Restoration of Medicaid benefits for individuals whose SSI benefits have been terminated will occur following reapplication for restoration of SSI. Up to three months of retroactive payments for Medicaid-covered services that individuals receive while waiting for SSI approval following release will be provided by the federal government once SSI is reinstated. When an individual's Medicaid eligibility is not tied to SSI, Medicaid eligibility is supposed to be reevaluated before eligibility is denied. Federal rules require that states conduct a re-consideration prior to terminating a person's Medicaid eligibility and stipulate that suspended Medicaid benefits must be fully reinstated upon release from incarceration. Individuals can apply for Medicaid prior to release. Information on Medicaid can be found at http://www.michigan.gov/mdch/0,1607,7-132-2943_4860---,00.html.

MEDICARE

Medicare is a federal program that covers health and some mental health services including inpatient hospitalization, outpatient physician services, and psychotherapy provided by other qualified mental health professionals. Medicare Part A covers hospital care, Part B covers outpatient services, and Part D covers prescription drugs.

Medicare does not pay for any services while a covered individual is incarcerated but, individuals do not lose Medicare eligibility while incarcerated and benefits can be reinstated upon release. Inpatient coverage (Part A) is reinstated immediately upon release. Outpatient

services coverage (Part B) requires payment of monthly premium during months of incarceration. Returning citizens can pay the back-premiums upon release if the outstanding premium is for no longer than ninety days. Returning citizens who have not paid their Part B premium can reapply during the General Enrollment Period (January through March). Individuals who elect to reapply may face a surcharge on their premiums related to the break in coverage, which is ten percent per year for every year not enrolled in Part B. Outpatient prescription drug coverage (Part D) is terminated upon incarceration; individuals must reapply to a drug plan upon release to again receive that benefit.

Part B premiums are normally deducted from SSDI (or Social Security) checks. Once that benefit is suspended due to incarceration, the person is directly billed for the premium (notices are sent to the last address on record). If the premium is not paid, Part B coverage terminates after three months. Once an individualôs SSDI is reinstated the benefit will be reduced in order to pay the back premiums. In addition, the individual will have to pay higher premiums in the future if re-enrolled in Part B. Individuals can request to withdraw from Part B while in prison and reapply upon release to avoid premium payments for Part B coverage during incarceration, but this can lead to an extended wait before coverage begins. If an individual remains eligible for Medicaid, the state can pay the Part B premium through the optional Medicare buy-in program (http://www.michigan.gov/mdch/0,1607,7-132-2943_4860-240802--,00.html). Information on Medicare can be found at http://www.medicare.gov/default.aspx?AspxAutoDetectCookieSupport=1.

VETERANS BENEFITS

The Department of Veterans Affairs (VA) offers an array of benefits to veterans including cash assistance and health care (http://www.vba.va.gov/VBA/). There are two VA cash assistance benefit programs for veterans with disabilities: Veterans Pension Benefits, for veterans under the age of sixty five with a permanent and total non-service-related disability, and Veterans Compensation for those whose disability is at least ten percent related to their service.

Pension benefits are available to veterans with non-service-related injuries who are permanently and totally disabled who have had ninety days or more of active military service, at least one day of which was during a period of war, and their disability is not the result of willful misconduct. Monthly pension amounts are determined after consideration of other sources of income because a qualified veteranôs total income (i.e., pension plus other income) cannot exceed a level set by Congress. Pension benefits are suspended after conviction for a misdemeanor or felony and sixty days of incarceration. Dependents may receive a portion of the benefits while the person is incarcerated. If overpayments occur due to failure to notify the VA regarding incarceration, payments cease until the overpayment is recovered.

Veterans who receive service-connected disability pensions continue to receive full benefits until convicted of a felony and incarcerated for sixty days. Once the sixty first day of incarceration occurs compensation is reduced but not terminated. Those who receive benefits due to a non-service-related disability continue to receive benefits until convicted of either a felony or a misdemeanor and are incarcerated for sixty days; benefits will be suspended beginning on the sixty first day of incarceration. Veterans who were receiving VA disability benefits prior to incarceration are eligible to receive benefits again on the day of release. However, the VA must be notified and approve the benefit. Veterans must contact the VA regional office and the VA may then require a medical examination to determine if a disability has improved.

Veterans who are disabled by injury or disease incurred or aggravated during active military service are eligible for monthly cash assistance through disability compensation benefits. Compensation may also be paid for a spouse, child, or dependent parent when the disability

rating is thirty percent or more. Veterans receiving compensation prior to incarceration continue to receive payments while awaiting trial or are convicted of a misdemeanor. If convicted of a felony and incarcerated for more than sixty days, compensation is reduced. Veterans who are incarcerated can apply to have eligible dependents receive any amounts not paid to the veteran. Overpayments of compensation due to not notifying the VA regarding a personôs incarceration results in the loss of payments until overpayment amounts are recovered by the VA.

The VA offers a variety of hospital and outpatient health care benefits to enrolled veterans in eight priority categories who meet specific service, disability, or income requirements including enrolled veterans with non-service-connected disabilities or non-compensable service-connected disabilities (e.g., those receiving compensation for inactive tuberculosis) who agree to pay co-payments for services. In addition, the VA provides health care to veterans who are not enrolled with the VA but have a service-connected disability of fifty percent or more; want care for a disability that the military determined was incurred or aggravated in the line of duty, but which the VA has not yet rated, during the twelve-month period following discharge; or want care for a service-connected disability only. Veterans who qualify for VA health benefits may also qualify for Medicare or Medicaid, depending on their circumstances. Veterans who are incarcerated cannot receive VA health benefits while incarcerated but retain eligibility for benefits.

Eligibility for most health care benefits is based solely on active military service in the Army, Navy, Air Force, Marines or Coast Guard (or Merchant Marines during World War II), and discharged under other than dishonorable conditions. VA health benefits are not available to individuals who are incarcerated, but are available to individuals on probation, parole, or work release, in a halfway house, or state hospital.

Individuals who are incarcerated may apply for veteransô benefits. Veteransô benefits do not, unlike other federal benefits, need to be suspended while the person is incarcerated, although the level of benefits will likely be reduced. In addition, Veterans Administration (VA) outreach staff can assess returning citizens prior to release. The VA has a standard administrative form (Form X) structured to elicit information regarding military service, history of supportive services, and other information, including eligibility for both VA and non-VA benefits. These assessments can supplement those conducted by corrections staff and be used to facilitate access to benefits.

Veterans who are incarcerated can: (1) apply for benefits, (2) request information that will help expedite benefits claims, (3) request benefits payments for dependents, (4) apply for physical examinations to determine eligibility for compensation or pension benefits, (5) apply for compensation benefits so that benefits can begin during incarceration, and (6) apply for pensions so that these benefits may begin immediately upon release. They can also request that the VA research their military records to determine periods of service or discharge status for determining pension eligibility. These actions can expedite new claims, which can take several months to process.

The VA requires written proof that the individual is no longer incarcerated to restore benefits upon release and has established the Healthcare for Re-entry Veterans (HCRV) program (http://www.va.gov/HOMELESS/Reentry.asp) to facilitate the benefit reinstatement process. This program is designed to assist reentering veterans with health concerns and focuses on outreach and pre-release assessment services, referrals and linkages to medical, psychiatric and social services, as well as short-term case management assistance.

HEALTH/BEHAVIORAL HEALTH

Individuals who are incarcerated have been found to have significant rates of chronic diseases (e.g., asthma, diabetes, chronic renal failure, chronic lung disease, coronary artery disease, and hypertension); infectious diseases including HIV/AIDS, hepatitis B and C, and tuberculosis (TB); physical disabilities; traumatic brain injury (TBI); cancers; sexually transmitted diseases (STDs); mental illnesses (including schizophrenia, psychosis, major depression, bipolar disorder, and post-traumatic stress disorder); substance use disorders; and developmental disabilities. Moreover, many of these conditions went untreated prior to incarceration.

Rates of HIV infection in prisons are ten to fourteen times higher than in the general population and deaths from AIDS are three times more likely in prison. Gender and racial disparities have been noted in rates of infection. Women who are incarcerated are twice as likely as their male counterparts to have AIDS (rather than the reverse found in the general population). African Americans and Hispanics/Latinos also experience higher rates of HIV/AIDS.

Individuals with traumatic brain injuries (TBIs) have been found to be more likely to experience disciplinary problems during incarceration. They may also have seizures and co-occurring mental health (e.g., anxiety and suicidality) as well as substance use disorders. Among women, TBIs are associated with physical abuse and domestic violence.

Physical health problems experienced by individuals in correctional institutions are often related to substance use. For example, HIV and hepatitis can be transmitted through injection drug use and risky sexual behaviors (e.g., bartering sex for drugs). Despite the effects of drug interactions, integrated treatments for HIV, substance abuse, and mental illness are rarely provided.

Many individuals who are incarcerated have multiple diagnoses and research shows that treatment, or the lack thereof, for one disorder affects treatment for a co-occurring disorder. For example, treatment of substance use disorders improves the likelihood of benefitting from adequate HIV treatment, particularly if integrated systems of care are used. On the other hand, failure to address a substance use disorder can have a negative impact on physical health treatment and impede access to care and adherence to with treatment regimens. Moreover, the presence of multiple disorders increases the degree of disability which, in turn, can make it difficult for individuals to succeed in vocational, social, and educational pursuits.

It is recommended that correctional health care programs include instruction on general wellness issues including nutrition, compliance with medication regimens, and protection from sexually transmitted diseases. Participants may be more receptive to programs taught by peers.

Health and mental health disorders can create challenges to successful reintegration and compliance with terms and conditions of community supervision. For example, a person who is ill may be unable to meet regularly with a supervision agent or hold down a job. Returning citizens with dual and triple diagnoses (e.g., physical illness, substance abuse, mental illness, and HIV/AIDS) face especially significant reentry challenges due to multiple, complex service and support needs.

Treatment regimens initiated during incarceration need to be continued after release; stopping treatment prior to completion can pose serious risks to the individual and to public health. For example, premature cessation of treatment for latent TB increases the risk of developing active TB, transmitting the disease, and developing drug-resistant strains. Lack of adherence to anti-retroviral treatment for HIV may lead to the development of drug-resistant viral strains and

increases in infectivity; treatment initiated during incarceration must continue after release to maintain effectiveness. Individuals with mental illnesses released without appropriate medication and community-based treatment and supportive services can decompensate which can increase the risk for engaging in antisocial or criminal activity. On the other hand, continuation of prison-based mental health treatment after release has been found to have a beneficial impact on reentry.

Studies have shown that returning citizens are most likely to adhere to treatment regimens subsequent to release if they receive medication upon release, have follow-up appointments scheduled, receive copies of their prison medical summaries, are provided with assistance completing in applications for medical benefits, and are linked with other needed services and supports such as housing, and cash benefits.

The inability to fill a prescription and pay for it present barriers to proper adherence to treatment regimens. It is recommended that returning citizens receive a supply of their medications upon release sufficient to cover the time to their first appointment in the community. The American Public Health Association's standard calls for a two-week supply of medication at discharge; a prescription is not considered an adequate substitute for medication. Individuals with HIV/AIDS can access AIDS Drug Assistance Programs (ADAPs) which provide HIV-related prescription drugs if they have low incomes and limited or no prescription drug coverage.

In addition, it is recommended that returning citizens be provided with a summary of their health records that can be used to provide information to community-based providers and that correctional health care providers obtain signed HIPAA-compliant release forms and send copies summary health records to community-based providers.

Medical care, mental health care, and substance abuse treatment are provided by distinct service systems and programs which can lead to inefficiencies and risks for vulnerable populations, including returning citizens, who need to find and arrange for care and supports from multiple providers and service systems. Partnerships between corrections and service systems can lead to improvements in the quality of care and reductions in the costly duplication of resources. Inreach by community providers prior to release can foster continuity of care and reduce the burden of illness and prevent further disease transmission.

MENTAL HEALTH CARE

Individuals with mental illnesses are overrepresented in the criminal justice system including the courts, correctional facilities, parole and probation, and have more contacts with law enforcement. This is particularly true for those with co-occurring psychiatric and substance use disorders, many of whom cycle in and out of the mental health, substance abuse treatment, and criminal justice systems. It has been pointed out that correctional facilities, particularly jails, have become primary mental health care providers; more people receive mental health treatment in prisons or jails than in hospitals or treatment centers.

The incidence of serious mental illnesses (e.g., schizophrenia, major depression, bipolar disorder and post-traumatic stress disorder) in prisons is two to four times higher than that found in the general population. It is estimated that eight to sixteen percent of individuals who are incarcerated have a serious mental illness. Females who are incarcerated are more likely than their male counterparts to have a psychiatric diagnosis, and people with mental illnesses who are incarcerated are disproportionately people of color.

It has been suggested that the overrepresentation of individuals with mental illnesses in the criminal justice system stems from deinstitutionalization and the resulting occurrence known as transinstitutionalization (i.e., movement from state hospitals to jails and prisons). However,

research does not support this. While the shift from institutionally-based care since the enactment of the Community Health Centers Act of 1964 and the underfunding of community-based mental health services are contributors, there is little evidence that individuals who were formerly housed in institutions have been shifted to jails and prisons. Lack of affordable housing, discrimination based on stereotypes that associate mental illness with violence, concentrated efforts to reduce public nuisance crimes and stringent prosecution of drug offenses are considered significant contributory factors.

Symptoms of mental illness can contribute to involvement in the criminal justice system and the stressful setting of a correctional facility can exacerbate mental illnesses and disrupt treatment. People with mental illnesses are at significantly higher risk for being arrested than persons without a mental disorder are for similar offenses. A disproportionately large number of calls to law enforcement involve people with mental illness in most communities. Such individuals may exhibit public behavior symptomatic of an untreated mental illness or substance use disorder (e.g., public disturbance, public intoxication, or other nuisance offenses). In addition, almost one third of people who experience homelessness have serious mental illnesses, and homelessness makes them highly visible to law enforcement officers. Traditional law enforcement strategies can cause confusion and feelings of being threatened to people with mental illnesses who may respond with behaviors that can result in injuries to themselves or officers. Law enforcement officers often are ill-prepared to deal with people who are having a mental health crisis which often results in arrest rather than mental health treatment.

Individuals with mental illnesses require more time and are more costly for correctional systems because of their treatment needs and longer average stays. These individuals serve longer sentences (on average four to five months longer for the same crimes as their counterparts who do not have mental illness), and half of individuals with mental illnesses serve their maximum sentence and leave prison without community supervision. The rules and routines of prison environment may especially difficult to adjust to and result in the accrual of demerits that delay time to release. Prison is traumatic for individuals with mental illness, and the stress of incarceration can exacerbate symptoms. Individuals with mental illness are more likely to commit rule infractions. Many end up in isolation units which exacerbate symptoms due to sensory deprivation, inactivity, and lack of social stimulation. They are at higher risk for suicide.

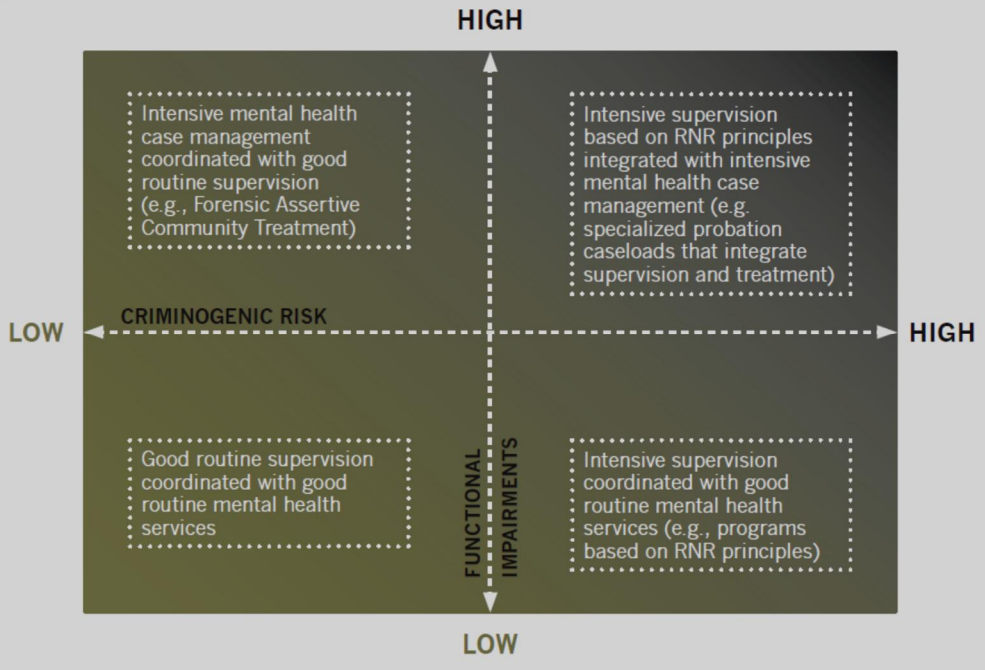
Returning citizens with mental illnesses face significant barriers to successful reentry, particularly those with a severe illness, who may have difficulty coping with basic reentry responsibilities such as finding housing and employment or meeting their basic needs. Subsequent to release, many experience significant challenges in adhering to conditions of supervision due to symptoms that interfere with the ability to meet court-ordered mandates or the conditions of probation or parole. Studies show that sixty four percent of people with mental illnesses are rearrested within eighteen months of release from prison. Often such arrests are for nonviolent property offenses and low-level crimes (e.g., trespassing or disorderly conduct) or violations of the conditions of release.

It should be noted that evidence indicates that, contrary to popular stereotype[26], individuals with mental illnesses do not, as a rule, display a greater propensity for violence. The majority of arrest of individuals with mental illnesses are for misdemeanors associated with crimes of survival (i.e., panhandling or public urination). The vast majority of individuals with mental illnesses who engage in serious violent acts have co-occurring substance use disorders or lack access to effective services. In fact, people with mental illnesses are no more violent than

[26] Public perception regarding the link between mental illness and violence is often skewed by sensationalized media reporting, misuse of terms such as psychotic and psychopathic, and exploitation of stereotypes by the entertainment industry.

members of the general population and are actuality more likely to be victims of crime. On the other hand, however, the presence of a mental illness does not confer immunity from criminogenic thinking. Moreover, individuals with mental illnesses can develop behaviors that are adaptive to prison culture and are in conflict with societal norms.

Individuals with mental illnesses under corrections supervision pose different degrees of criminogenic risk and have a wide range of functional impairments, both of which need to be considered in supervision and treatment. A matrix has been developed that depicts levels of coordination and integration in accordance with the level of criminogenic risk and functional impairment. Individuals with high levels of functional impairment and low criminogenic risk (left upper quadrant) or low functional impairment and high criminogenic risk (lower right quadrant) require coordination, whereas those with levels of high criminogenic risk and functional impairments (upper right quadrant) require integrated interventions.



from Prins, S., Draper, L. (2009)

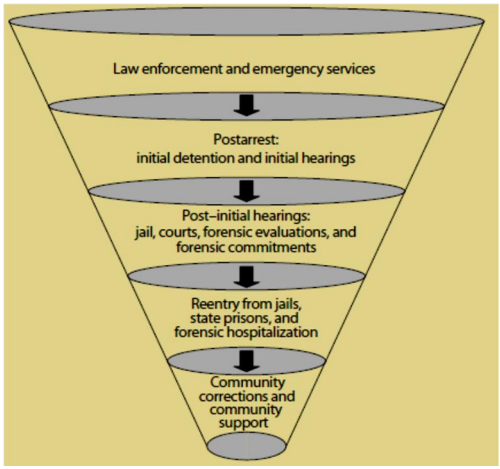
There is robust evidence showing the following eight risk factors are the strongest predictors of recidivism irrespective of the presence of a mental illness. Moreover, there is some evidence that mental illnesses may increase the risk. Thus, it is recommended that interventions designed to alter criminogenic ideation and behavior be made available to persons with mental illnesses who are involved in the criminal justice system.

1. History of criminal behavior (prior interactions with the criminal justice system)
2. Anti-social personality pattern (for example, antagonism, impulsivity, and risk-taking)
3. Pro-criminal attitudes (for example, negative expressions about the law, conventional institutions, values, rules, procedures, etc.)
4. Anti-social associates
5. Poor use of leisure/recreational time
6. Substance use
7. Problematic circumstances at home (for example, low caring or supervision, high neglect or abuse, homelessness)
8. Problematic circumstances at school or work (for example, limited education, unstable employment history)

DIVERSION – ALTERNATIVES TO INCARCERATION PROGRAMS (ATI)

Diversion entails redirecting individuals with mental illnesses from the traditional criminal justice processing into treatment. The predominant approaches to preventing unnecessary arrest and incarceration of persons with serious mental illness are specialized policing responses (SPRs), mental health courts which divert individuals to treatment as well as alternatives to incarceration (ATI) programs, and community correctional services that combine sanctions with therapeutic services. A number of mental health and justice system collaborative models have been developed including training of police officers to intervene in mental health crisis situations; training of corrections officers to identify and intervene with mental health problems in correctional facilities, and diversion programs to redirect individuals from the criminal justice to the mental health system. Research indicates that jail diversion results in positive outcomes for people with mental illnesses including reductions in jail and hospital stays and does not increase public safety risk.

There are several points at which a person suffering from a mental illness or co-occurring substance use disorder can come into contact with the criminal justice system. The National Gains Center for People with Co-occurring Disorders in the Justice System has developed the **Sequential Intercept Model** to depict the five points at which the criminal justice and mental health systems intersect and in which opportunities for diversion are present: (1) law enforcement and emergency services; (2) initial detention and initial hearings; (3) jail, courts, forensic evaluations, and forensic commitments; (4) reentry from jails, state prisons, and forensic hospitals; and (5) community corrections and community support services.



Some programs are prebooking (engaging individuals at the point of arrest), while others are postbooking (engaging individuals on release from court or jail). Postbooking diversion programs screen individuals with mental illness in jails and direct them into psychiatric treatment as an alternative to prosecution or continued incarceration within the criminal system. In prebooking programs police refer individuals directly into treatment as an immediate alternative to arrest. Pretrial interventions are designed to avoid court-ordered supervision for people with mental illnesses and eliminate the association of conviction and sentencing as mechanisms for initiating treatment and services. These often include mandated treatment which can result in reduced or dismissed charges. Pretrial Services is often the first to identify the needs and risks of defendants entering the justice system, the first to match defendants with needed services and supervision, and the first to monitor their compliance with court-ordered conditions. Pretrial Services also has contact with those on probation or parole if they are rearrested on new charges which offers another opportunity for intervention for people during reentry. More information on pretrial services can be obtained from the Pretrial Services Resource Center at www.pretrial.org.

CRISIS INTERVENTION TEAM (CIT)

Mobile crisis units are often deployed to crisis situations. However, these teams may need assistance with persons who pose an acute danger to themselves or others. Mental health co-responder teams, which consist of police officers and mental health practitioners who respond to mental health crises jointly, are better able to respond to such situations. Law enforcement first secures the scene so that mental health services can safely intervene. On-site intervention

may result in transport to a mental health facility and involuntary hospitalization or outpatient treatment, as well as voluntary referrals for treatment.

CIT is a prebooking diversion, crisis response model in which specially trained uniformed officers function as primary or secondary responders to mental health crisis situations. CIT officers are available each shift and provide assistance to consumers and their families and facilitate emergency mental health assessments. In this model law enforcement agencies partner with mental health and community groups to train police responders to recognize the symptoms of mental illnesses and use crisis de-escalation techniques including defusing skills and calming behaviors. Officers prioritize treatment over incarceration when appropriate.

Some law enforcement agencies hire licensed (i.e., civilian) mental health staff as secondary responders who are located in the police department are under the chiefõs supervision, or outside the department where staffing is shared with the local mental health system. These staff ride along with officers in special teams or respond when called by an officer after a scene has been secured. These clinical staff members develop relationships with community-based organizations and locate available services and supports within the community.

Essential components of CIT include twenty four hour access to mental health resources with a single point of entry, a no refusal policy at police drop-off points, a streamlined intake service for police and access to services for individuals who are in crisis but who do not meet the criteria for emergency services. CIT programs also ensure forty hours of training are provided for specialized officers and close collaboration between law enforcement and mental health is maintained.

Some communities use **specialized crisis response cites** such as crisis triage centers or crisis stabilization units which adhere to a no-refusal policy for law enforcement officers. This offers law enforcement staff a single point to access to mental health services and rapid disposition of crisis situations as well as dropping off persons in crisis and returning to regular patrol duties. In addition, such sites provide a critical component of police-based prebooking jail diversion programs in which mental health services are sought rather than arrest and detention. Such programs offer cross-training of police officers and mental health providers in order to enhance collaboration.

MENTAL HEALTH COURTS

Mental health courts are a specific form of diversion using specialized court dockets that hear only cases involving defendants with mental illnesses. Mental health courts provide alternatives to criminal justice system processing for individuals with mental illness, mental retardation, or co-occurring psychiatric and substance use disorders charged with misdemeanors and/or nonviolent offenses. They entail coordination between the mental health system and judicial system for service delivery and include specialized training of criminal justice personnel to identify and address the unique needs of individuals with mental illnesses. Participants typically must agree to voluntary mental health treatment, with the potential for dismissal of charges or reduced sentencing based on successful completion of treatment. While the over one hundred fifty mental health courts currently in existence operate individually, according to the Bureau of Justice Assistance, they share a number of common elements including:

- A specialized court docket which employs a problem-solving approach to court processing in lieu of more traditional court procedures for certain defendants with mental illnesses.
- Judicially supervised, community-based treatment plans for each defendant participating in the court, which a team of court staff and mental health professionals design and implement.

- Regular status hearings during which treatment plans and other conditions are reviewed, incentives are offered to reward adherence to court conditions, and sanctions (e.g., increased treatment) are imposed for lack of adherence to the conditions of participation.
- Criteria defining a participantôs completion (graduation) from the program.

MENTAL HEALTH CASE MANAGEMENT

Case management programs are designed to coordinate the services and supports provided to consumers. Case managers function as primary liaisons between providers of different service systems, including the mental health service and criminal justice systems. The specific services mental health case managers provide are driven by each consumerôs individualized treatment plan.

Core Functions of Case Management
❶ Assessment
❷ Planning
❸ Linking
❹ Monitoring
❺ Advocacy

Case managers can help consumers with basic daily living skills (e.g., shopping and time management) as well as managing the details of treatment (e.g., making and keeping appointments). In addition, case managers provide guidance, encouragement, and emotional support to build resilience and reinforce the pursuit of individual recovery goals by working to empower consumers to make their own decisions and take charge of their lives and helping them to develop and/or utilize skills needed to fulfill their own obligations and take responsibility for their own behavior.

FORENSIC INTENSIVE CASE MANAGEMENT (FICM)

Intensive Case Management (ICM) mirrors ACT with regard to assertive, in vivo, and time-unlimited services, but differs in that it uses case managers with individual case loads, lacks a self-contained team, and brokers access to psychiatric treatment rather than delivering it directly. In other words, the focus of ICM is on linking and coordinating services rather than treatment for the consumer. **Standard case management**, in comparison, is much less intensive due to larger caseloads, more office-based service delivery, and less frequent consumer contact.

Studies of the effectiveness of FICM show mixed and conflicting results leading to difficulties drawing any firm conclusions. Some studies show reductions in criminal justice involvement with diversion to FICM postbooking but no appreciable decrease in psychiatric symptoms, while others indicate reductions in psychiatric symptoms.

ASSERTIVE COMMUNITY TREATMENT (ACT)

Assertive Community Treatment is a service delivery model in which a transdisciplinary team that is comprised of ten to twelve practitioners including psychiatrists, nurses, mastersô and doctoral level professionals, consumers (i.e., peer support specialists), employment specialists, substance abuse specialists, and a program assistant, who serve approximately one hundred consumers. The ratio of staff to consumers is one to ten. ACT teams work together in a highly integrated fashion across professional boundaries to the maximum extent possible to support a consumerôs life in the community. They are available twenty-four hours a day, seven days a week. Services are provided in vivo rather than office-based settings, allowing for the delivery of supports in natural contexts where problems arise and skills are needed. The team provides care coordination on a continuous basis, including when the consumer is in the hospital.

TEN PRINCIPLES OF ASSERTIVE COMMUNITY TREATMENT

❶	Services are targeted to a specified group of individuals with severe mental illness
❷	Rather than brokering services, treatment, support, and rehabilitation services are provided directly by the assertive community treatment team
❸	Team members share responsibility for the individuals served by the team
❽	The staff-to-consumer ratio is small (approximately 1 to 10)
❾	The range of treatment and services is comprehensive and flexible
❾	Interventions are carried out at the locations where problems occur and support is needed rather than in hospital or clinic settings
❽	There is no arbitrary time limit on receiving services
❽	Treatment and support services are individualized
❾	Services are available on a 24-hour basis
❿	The team is assertive in engaging individuals in treatment and monitoring their progress

ACT is generally reserved for a specific subset of consumers who experience the most serious and intractable symptoms, have the greatest difficulties in activities of daily living, and have not responded well to services that are more traditional. Typically, such consumers have been extensive histories of inpatient hospitalization, co-occurring substance use disorders, involvement in the criminal justice system, as well as experiences of homelessness, and unemployment.

An extensive research base for ACT exists. Studies show that it is very effective in reducing hospitalization and improving housing stability. Its effects on quality of life, social functioning, and symptoms are similar to those of other interventions such as case management. Reduced levels of substance abuse are found when a substance specialist is part of the team. Higher rates of competitive employment are achieved when employment specialists are part of the team. Most studies have also shown that consumers and their families are more satisfied with ACT than other types of services. However, most studies have shown little effect on rates of arrest and incarceration. Information on ACT can be obtained from http://store.samhsa.gov/product/Assertive-Community-Treatment-ACT-Evidence-Based-Practices-EBP-KIT/SMA08-4345.

FORENSIC ASSERTIVE COMMUNITY TREATMENT (FACT)

FACT is an emerging approach to the prevention of arrest, incarceration, and recidivism of adults with serious mental illness who have significant histories of criminal justice system involvement. The model incorporates components of assertive community treatment and criminal justice and is designed to prevent arrests and incarceration and is an example of integrated mental health and criminal justice intervention as exemplified by the incorporation of probation/parole agents as team members.

FACT programs partner with criminal justice agencies and place a greater emphasis on substance abuse treatment than ACT programs and have a supervised residential treatment component for consumers who are at high-risk, especially those with co-occurring psychiatric and substance use disorder. FACT also differs from ACT in the prioritization of persons involved with the criminal justice system, the predominance of criminal justice agencies as referral sources, and the integration of mental health and criminal justice agency services.

Outcomes research has yielded mixed results with some studies showing that FACT program participants have fewer jail and hospital stays, while other studies show higher community supervision revocation rates, which may, in part, be attributable to enhanced oversight. Further research is needed to establish the structure, function, and effectiveness of this developing model of service delivery. A fidelity scale has been developed for the model and can be found on the Web at

http://www.mhmraharris.org/LocalPlan/documents/7-FACTOutcomeMeasureGuidelines.pdf.

PEER-OPERATED PROGRAMS AND SERVICES

Returning citizens with mental illnesses and co-occurring substance use disorders face the burden of managing and coping with a triple stigma (a psychiatric disorder, a substance use disorder, and criminal justice involvement) and reentry. The stigma associated with mental illnesses inhibits support for the full integration of people with mental illnesses into their communities and presents a significant barrier to effective mental health treatment. Biases, mistrust, stereotypes, fears, embarrassment, and avoidance can deter individuals from seeking treatment and accessing resources and opportunities leading to social isolation and inhibiting the pursuit of full participation in society. Without sufficient support, individuals with mental illnesses can fail to connect with treatment providers and engage in behaviors that places them at risk for further involvement with the criminal justice system.

Individuals who have been affected by mental illnesses (i.e. consumers and families), particularly those who have had contact with the criminal justice system, have a wealth of experience that can utilized both to meet their own needs as well as those of their peers and their communities. Support provided by a peer group with shared experiences has been shown to have a positive impact on consumers and empower them to overcome barriers created by stigma. Consumer-operated services are an important component of the continuum of services and supports, but are not intended to replace professional services.

Peers have been found to be effective in engaging people who are reluctant to accept them, particularly those with co-occurring disorders involved with the criminal justice system. Peer specialists also provide a significant source of support through interactions with other individuals who have had comparable experiences. However, no particular approach to the provision of peer supports has been demonstrated to be more successful than another.

Peer programs are administered and staffed by individuals in recovery from mental illnesses, substance use disorders, or co-occurring psychiatric and substance use disorders, who provide services for other people with the same types of problems. Peer specialists can provide outreach, advocacy, case management, social programs, psychiatric rehabilitation, vocational and employment services, and counseling.

Research shows that consumer-operated supports and services are effective in helping people with mental illnesses gain insight into their illnesses, build effective coping strategies, and support their pursuit of recovery. Example of peer-operated mental health services include:

- **Drop-In Centers:** These programs offer safe environments for people to socialize, communicate, and participate in activities that support recovery. Activities vary from place to place, and month to month, based on consumers' needs and interests. Drop-in centers may offer support sessions and social events, sponsor excursions to museums or sporting events, or offer consumer-led computer and Internet training.
- **Social Clubs:** These programs offer recreational and socialization opportunities for people in recovery from mental illness.
- **Self-Help and Mutual Support Programs:** These are programs initiated and operated by individuals seeking support from others struggling with recovery from mental illnesses and substance use disorders. Self-help can also include the provision of information through literature, the Internet, the media, or other sources in addition to mutual support through meetings and other contacts.
- **Advocacy Services:** Peers offer assistance in accessing resources, services, obtaining benefits, negotiating legal problems, or meeting other basic needs

- **Educational Programs:** Peer educators offer classes and facilitate discussion groups designed to help consumers understand their mental illnesses, ways to effectively cope and their manage symptoms, and care for themselves.
- **Activities of Daily Living Assistance:** Peer providers can offer assistance in helping consumers develop or enhance daily living skills needed for independence.
- **Employment/Vocational Programs:** Programs to prepare people for employment can be fully peer operated or include peer support specialists.
- **Housing Programs:** Some housing programs are completely peer operated while others include peer counselors who provide a variety of supports
- **Case Management:** Some case management programs are fully peer operated while others include peer counselors as case managers, including **forensic peer specialists** who are in recovery from a mental illness (and often from co-occurring substance use disorders) and have a history of incarceration or other involvement with the criminal justice system. Forensic peer specialists have been often found to be more effective in engaging their peers in services than other mental health service providers and helping them avoid relapse and recidivism. They are also important members of ACT and FACT teams.

PSYCHIATRIC ADVANCE DIRECTIVES (PADS)

Psychiatric advance-directives (PADs) are an emerging method of treatment planning that is self-directed. Advance directives are designed to establish an individual's preferences for intervention should the individual become unable to communicate those preferences as result of a crisis or incapacity. There are two forms of advance directives. The instructional directive informs providers what to do about treatment in the event that the individual becomes incapacitated. The proxy directive designates an individual the consumer wants to make treatment decisions in the event that he or she becomes unable to do so.

On January 3, 2005, the Michigan Mental Health Code was amended to allow individuals to create Psychiatric Advance Directives. Under the law, providers must comply with consumer advocate directives unless treatment is not consistent with generally accepted mental health best practices. The consumer is allowed to waive the right to revoke a consumer advocate designation for 30 days and allow the advocate to make mental health treatment decisions only if both a physician and a mental health practitioner have examined the consumer and certify, in writing, that the consumer is incapable of making decisions on their own behalf.

Online psychiatric advance directives are available from the Bazelon Center for Mental Health Law at http://www.bazelon.org.advir.html/. There are also a number of self-directed PAD programs that create a dialogue with the user who is then guided through a series of questions about key areas such as medication, emergency responses, specific interventions, and treatments. The answers to the queries drive the branching logic and enable a concise presentation of the material. AD MAKER is an example. The National Mental Health Association (http://www.nmha.org/), in conjunction with SAMHSA has developed an implementation resource kit for creating and implementing PADs that is available on line.

PADs have the potential to increase consumer empowerment and autonomy, improve crisis intervention planning, and reduce hospitalizations, court proceedings, and costs. Studies indicate that compliance with advance directives can only be assured when they are disseminated to providers. More information can be obtained from the National Resource Center on Advance Directives (NRC-PAD) which provides a link to Michigan's PAD form at http://www.nrc-pad.org/.

ILLNESS MANAGEMENT AND RECOVERY (IMR)

Illness Management and Recovery consists of psychoeducation which includes the provision of information to consumers about their illnesses, including symptoms, stress management strategies, side effects of medications, and warning signs of impending relapse. The program uses both individual and group formats, as well as combinations of both formats, depending upon need. The individual format is easier to tailor to the specific needs of the individual, allowing for more time on specific elements, whereas the group format has the advantage of providing more sources for feedback, role modeling, and social support. The program consists of a series of weekly sessions designed to help consumers develop and implement strategies for the management their illness and moving forward with their lives. It generally lasts for three to six months and can be provided in the community, the personôs home, or can be office-based.

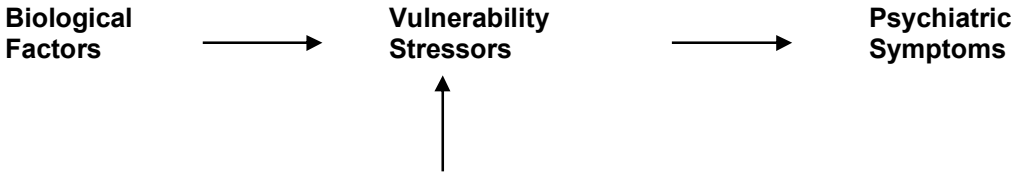
The goals of Illness Management and Recovery are to:

- Instill hope that change is possible
- Develop a collaborative relationship with a treatment team
- Help people establish personally meaningful goals to strive towards
- Teach information about mental illness and treatment options
- Develop skills for reducing relapses, dealing with stress, and coping with symptoms
- Provide information about where to obtain needed resources
- Help people develop or enhance their natural supports for managing their illness and pursuing goals

The following topics are covered in nine educational handouts:

1. Recovery Strategies
2. Practical Facts about Schizophrenia/Bipolar Disorder/ Depression
3. The Stress-Vulnerability Model and Strategies for Treatment
4. Building Social Support
5. Using Medication Effectively
6. Reducing Relapses
7. Coping with Stress
8. Coping with Problems and Symptoms
9. Getting Your Needs Met in the Mental Health System

The stress-vulnerability model is used to teach relapse prevention by disputing beliefs that relapses occur randomly and cannot be prevented. It suggests that vulnerability to relapses may be reduced by biological factors (such as by taking medications as prescribed and avoiding drugs and alcohol), environmental factors (such as enhanced social supports and reduced stress), as well as personal factors (such as meaningful structure and improved coping skills).



According to this model, a person has a biological vulnerability for a particular mental illness. The person with a biological vulnerability to the illness may develop that illness spontaneously or when experiencing stress. When the illness develops under the latter condition, it may recur intermittently. Vulnerability appears to increase with repeated recurrences for some individuals.

Illness Management and Recovery incorporates a number of cognitive-behavioral techniques designed to consumers learn to cope with symptoms and develop skills to deal with stress and relapses. Behavioral tailoring for using medications as prescribed encompasses teaching consumers strategies to incorporate medication use into their daily lives. This entails the use of cues as reminders to minimize forgetting to take medications. Examples include placing medication next to a toothbrush or deodorant, on the kitchen counter (to pair them with meal preparation), and wearing a watch with an alarm. Coping skills training is comprised of cognitive-behavioral interventions to cope with symptoms. For example, distraction techniques (e.g., listening music) are used to cope with auditory hallucinations. Relaxation training teaches muscles relaxation and breathing techniques paired with relaxing thoughts, which can be used when the person is in situations that evoke anxiety. Relapse prevention focuses on teaching individuals to identify early warning signs and situational triggers and then take actions to prevent or short-circuit exacerbations of symptoms or distress. Cognitive restructuring is also part of the program and used on a formal as well as informal basis. Information on cognitive restructuring can be found in the section on psychotherapeutic interventions. The practitioner uses a number of behavioral interventions to help people master skills including reinforcement, shaping, modeling, role-playing, and practice. Skills are practiced during sessions and homework assignments are given so that the person can practice techniques in vivo. Family members are encouraged to become involved and assist the consumer.

Information on this evidence-based practice can be found at http://store.samhsa.gov/product/Illness-Management-and-Recovery-Evidence-Based-Practices-EBP-KIT/SMA09-4463.

SUPPORTED EMPLOYMENT (SE)

Supported Employment is designed to help people with mental illnesses secure and maintain gainful employment in integrated work settings with follow-along supports. Employment services are provided by employment specialists who meet with treatment providers on an ongoing basis to integrate supported employment with mental health services.

The philosophy of supported employment is that everyone with a mental illness is capable of attaining competitive employment if the right ñfitò is found. It emphasizes jobs that pay competitive wages and are in integrated settings that include co-workers who do not have disabilities. Supported employment de-emphasizes prevocational assessment and training. The importance of rapid job searches and placements for anyone who expresses a desire to work are stressed. These programs have a zero exclusion policy; consumers are not excluded due to symptoms, substance abuse, prior work history or because they are ñnot readyòto work.

In this model, employment specialists work with the consumerôs treatment team. Employment specialists can accommodate caseloads of twenty to twenty-five people. They provide follow-along supports on an indefinite basis; individualized supports continue for as along a consumer wants assistance. Employment specialists need to work full time without the diversions of other roles (e.g., case manager). They also need to be fully integrated into the treatment team and participate in team meetings. Their performance is the most productive when they are members of a vocational unit where staff can provide backup for each other.

While concern has been expressed that competitive work may increase stress for consumers, studies indicate that supported employment does not lead to increased symptoms, distress, or other negative effects. Supported employment has been successful irrespective of age, gender, diagnosis, symptomatology, prior hospitalization, education, and racial or ethnic group. However, a very depressed labor market may affect job availability.

The research on supported employment shows that consumers who participate in supported employment programs are more successful in obtaining competitive employment, work more hours, and earn more wages from work than those in traditional vocational programs. While participation does not generalize to non-vocational outcomes, there is evidence that when consumers find competitive work, their self-esteem improves, as does their satisfaction with finances and symptoms.

Information on this evidence-based practice can be found at http://store.samhsa.gov/product/Supported-Employment-Evidence-Based-Practices-EBP-KIT/SMA08-4365.

SUPPORTED EDUCATION (SED)

Research indicates that almost fifty percent of individuals with a mental illness have had some college education and sixty two percent have a desire to start or finish an education program. Many individuals with a mental illness have had their education interrupted by the illness. It has been estimated that almost five percent of individuals who drop out of college have a mental illness. Completion of secondary education has become more important in attaining upward occupational mobility. Studies have shown that participation in supported education is the most prominent and consistent predictor of successful employment. Individuals who do not obtain degrees can find themselves relegated to lower paying jobs and underemployment.

Supported education provides an array of services and supports to adults with mental illness to assist them in returning to school in order to complete their academic career and ultimately attain degrees and secure gainful employment. It is an evidence-based program with significant research showing that the vast majority of participants successfully complete their educations. It is recognized by SAMHSA as an exemplary practice.

Core services include: pre-admission assessments, financial aid planning, school enrollment help, career planning, on-site campus support groups and mentorships, coordination with community mental health agencies and other community resources.

There are three basic models of supported education:

Mobile support: Services and supports are delivered by community-based providers and are not tied to a specific educational institution.

Classroom support: A pre-set curriculum that focuses on academic skill building, career goals, and support is used.

On-site support: Services are housed in existing campus programs and provided by the school's staff.

Studies suggest that supported education is successful in helping individuals integrate into the post-secondary educational milieu. Students who participate in supported education programs are able to complete ninety percent of classes they enroll in. They maintain a grade point average of 3.14. In addition, they report increased self-esteem, levels of satisfaction with their living situation, finances, family and social relationships, and daily activities when compared to individuals who are not attending school.

FAMILY PSYCHOEDUCATION (FPE)

Family Psychoeducation is an evidence-based practice that reduces relapse rates and facilitates recovery by partnering with families and providing education about the illness and teaching specific problem-solving strategies for dealing with difficulties arising from the illness. It is derived from theories of expressed emotion (EE), which are based on observations that

individuals with schizophrenia discharged home from hospitalizations to families with high expressed emotion are more likely to suffer a relapse. Expressed emotion has two components: criticism (CR) and emotional overinvolvement (EOI). Expressed emotion is characterized unsupportive, critical, negative interactions. It has been shown to be a significant and strong predictor of relapse with studies demonstrating that individuals living in household with high levels of EE are much more likely to relapse than those living in households with low-EE.

Family Psychoeducation is designed to replace individual meetings with consumers. It is an approach to working with families in a partnership to help them acquire coping skills for dealing with difficulties posed by mental illness in the family and supporting the recovery of a family member with a mental illness. The partnership is engendered by collaborating with families as consultants to help with the management of the illness. Family Psychoeducation is not family therapy; the focus of intervention is the illness (or illnesses for consumers with co-occurring disorders), not the family.

Family Psychoeducation can be provided in the home, community settings, mental health offices, hospitals, or other settings. In the context of Family Psychoeducation, family is defined as anyone the consumer designates as such. Family does not have to be a relative, and can be anyone committed to the support of the person including friends, relatives, landlords, neighbors, etc. The requirement is that at least one person in the consumerôs life participates as a ñsponsorò or ñsupporterò

Families meet every two weeks for the first months, then once a month for as long as they choose to meet. Programs last from nine months to five years. There are both single and multi-family formats. The multifamily format consists of six to eight families and consumers. Both entail referrals and encouragement to participate in family support groups such as Family-to-Family Education Program developed by the National Alliance for the Mentally Ill (NAMI) to reduce social isolation and stigma. Both formats aim to reduce expressed emotion, with multifamily models addressing stigma and social isolation as well.

Information on this evidence-based practice can be found at http://store.samhsa.gov/product/Family-Psychoeducation-Evidence-Based-Practices-EBP-KIT/SMA09-4423.

CRITICAL TIME INTERVENTION (CTI)

Critical Time Intervention is a nine-month, three-stage intervention that is designed to enhance engagement and connections with treatment and community supports by enhancing problem-solving skills, using motivational coaching, and providing advocacy. The goal of CTI is to provide transitional support while helping the person build a resilient network of community supports that continues after CTI ends. CTI an empirically supported practice that been shown to enhance continuity of care for people with mental illness transitioning from homeless shelters and psychiatric hospitals, and is considered a promising model for the provision of support for reentry from prison for people with mental illnesses.

The intervention consists of two components, the first of which focuses on strengthening the individual's long-term ties to services and natural supports (family and friends). The second component consists of the provision of emotional and practical support and advocacy during the transition from institutional to community living. This consists of attenuating ties to the institution and having therapeutic and basic needs met on site and reducing social isolation in the community.

The core elements of CTI include small caseloads, active community outreach, individualized case management plans, psychosocial skill building, and motivational coaching. It is based on assertive community treatment and community living training.

CTI is a homelessness prevention intervention recognized in the National Registry of Evidence-Based Programs and Policies of the Substance Abuse and Mental Health Services Administration (SAMHSA). More information can be obtained from http://www.criticaltime.org/.

DIALECTICAL BEHAVIOR THERAPY (DBT)

Dialectical Behavior Therapy is a cognitive-behavior therapy for the treatment of borderline personality disorder and self-harm behaviors. It is conducted by therapists working together in a team approach. DBT combines behavior therapy with Eastern mindfulness practices into four skills modules: (1) mindfulness, which involves attention to the present moment and targeting self-dysregulation and identity confusion by emphasizing self-awareness; (2) distress tolerance, which focuses on using strategies to tolerate distress, without making it worse by engaging in impulsive, self-destructive behavior, emphasizing distraction and self-soothing techniques, as well as strategies that help individuals accept traumatic events in their lives; (3) emotion regulation, which teaches participants how to identify and describe emotions, reduce vulnerability to negative emotions, and increase positive emotions; and (4) interpersonal effectiveness which teaches assertiveness and other interpersonal skills to help in dealing with conflict situations and to obtain what the person wants and needs in a manner that maintains self-respect the respect and regard of others.

The theoretical basis for DBT is that individuals with borderline personality disorder have a pervasive deficit in their capacity to regulate emotions. This deficit is thought to originate in and be maintained by negative social interactions that are invalidating to the individual. In DBT, the practitioner takes a nonjudgmental approach in relation to the individual which eliminates the typical tendency of others to blame the person for their own maladaptive behaviors.

Treatment begins with establishing a collaborative relationship between the consumer and practitioner who then jointly construct a list of prioritized targeted behaviors to change. This list guides the rest of sessions which are divided into four stages. Stage one focuses on mastery skill development and behavioral control. Stage two focuses on resolving posttraumatic stress. Stage three is comprised of addressing issues of self-regard and individual goals. Stage four is aimed at enhancing the personôs capacity to experience pleasure. The consumer monitors his or her own progress with a diary card that is reviewed with the therapist.

DBT uses a number of modalities and requires a treatment team that is trained in the approach. There are five treatment components. The first consists of a two and a half hour weekly skills training group using a DBT skills training manual. The second consists of individual psychotherapy on a weekly (or twice weekly in some instances) basis aimed at enhancing motivation for treatment and behavior change. The third component consists of consumer telephone calls to their therapists between sessions for coaching and skill generalization in vivo. The fourth component is comprised of weekly consultative meetings of individual therapists and group skills trainers aimed at improving their skills and maintaining their motivation. The fifth consists of the structure of the treatment environment provided by DBT program directors and case managersôprovision of assistance to consumers to help them structure their environments.

Research findings across studies indicate that DBT reduces target severe maladaptive behaviors and increases treatment retention. It has also been found to reduce hospitalization. Outcome data suggests that improvements are maintained for a year following termination of treatment. DBT has been adapted for correctional settings in a model known as Forensic DBT. Information on DBT can be obtained from http://behavioraltech.org/.

SOLUTION-FOCUSED BRIEF THERAPY (SFBT)

Solution-focused therapy is a form of brief therapy that builds upon individualsô strengths by helping them evoke and construct solutions to their problems. It has been refined over the years since its development and applied in a number of settings (e.g., hospitals, residential treatment settings, outpatient office settings), and for a variety of problems (e.g., substance abuse, panic attacks, phobias, eating disorders, family relationship problems). The therapy focuses the future rather than the past or present, and on hope and achievement, rather than problems and their causes. It entails developing a solution to a problem and discerning the resources to accomplish the solution. A central aspect of solution-focused therapy is the active exploration and acknowledgement of the personôs strengths and resources. It is not driven by diagnostic formulations or problem exploration.

The first session entails four therapeutic tasks as depicted below:

Task of therapist	*Examples of opening questions*
Find out what the person is hoping to achieve from the meeting or the work together	What are your best hopes of our work together? How will you know if this is useful?
Find out what the small, mundane and everyday details of the person's life would be like if these hopes were realized	If tonight while you were asleep a miracle happened and it resolved all the problems that bring you here what would you be noticing different tomorrow?
Find out what the person is already doing or has done in the past that might contribute to these hopes being realized	Tell me about the times the problem does not happen When are the times that bits of the miracle already occur?
Find out what might be different if the person made one very small step towards realizing these hopes	What would your partner/doctor/friend notice if you moved another 5% towards the life you would like to be leading?

from Iveson (2002)

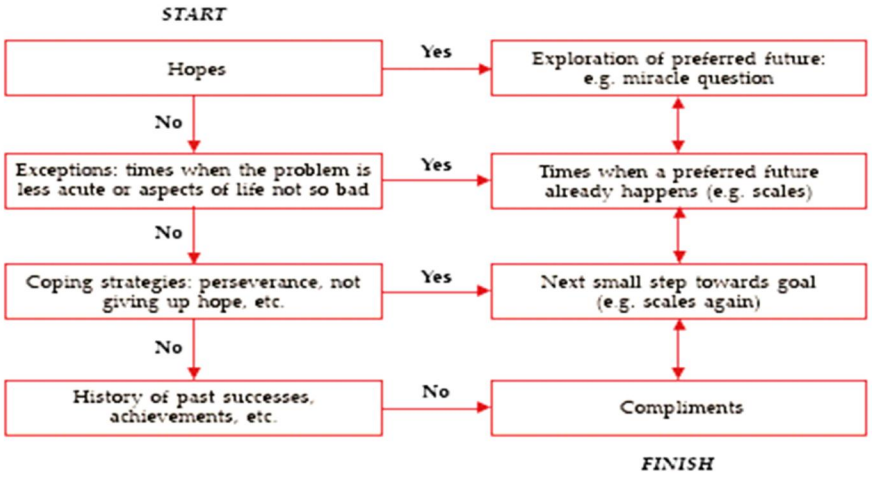
A zero to ten scale is used to assist the person to rate their achievements. It is used to distinguish different characteristics of the problem, as well as the solution. A ten indicates that all of the identified goals have been achieved. A zero signifies that none of the personôs goals have been achieved. Scaling is used to determine progress during each session in response to the therapistôs opening question: ñWhat is better?ò The therapist verbally commends the personôs reports of progress.

Points to mark		*What to explore*
10	The perfect solution	The miracle question as a means to encourage creative thinking
7	A good but realistic outcome	
3	Where the consumer is now	A realistic description of the consumer getting on with his/her life without the problem interfering too much. The more concrete and realistic the better, since it is the small, mundane aspects of living that go together to make an acceptable life
0	The worst scenario	Everything the consumer is doing that has helped him/her reach this point on the scale and/or everything he-she is doing to prevent matters getting worse
		Best not to delve into

from Iveson (2002)

The average duration of solution-focused therapy is five (to eight) forty-five minute sessions. If there is not demonstrable improvement after three sessions, it is unlikely that this therapy will prove effective for the person. The time between sessions is typically extended as the person makes progress so that a five-session course of treatment takes place over several months. It should also be noted that there are reports in the literature of effective single-session successes, but these typically involve individuals who are ñstuckò in a problem and can be assisted to see a clear way out through the explication of a desired future, or have already solved their problem, but do not realize it.

Most sessions start with the top left of the flow chart, then move down through the right column. Subsequent sessions are more likely to focus on the second and third boxes in each column, more to the left if progress is minimal and more to the right if progressing well.



from Iveson (2002)

PHARMACOTHERAPY

There is a robust evidence base that supports the effectiveness of medication for severe mental illnesses. However, the rapid development of new medications creates challenges for prescribers in keeping up to date with those developments and incorporating them into clinical practice. This has been addressed by the development of guidelines and algorithms based upon research and expert consensus. Despite the availability of these guidelines and algorithms, evidence indicates that medications are often used inconsistently. In particular, antipsychotic medication prescribing patterns have been shown to lack adherence to expert recommendations. Moreover, it has also been shown that medication is often poorly documented in the clinical record and often does not adequately address residual side effects and symptoms. The Michigan Implementation of Medication Algorithms (MIMA) consists of medication algorithms for major depression, bipolar disorder, and schizophrenia adapted from the Texas Implementation of Medication Algorithm (TIMA).

Psychotropic medications are used to treat the symptoms of mental disorders such as schizophrenia, depression, bipolar disorder, anxiety disorders, and attention deficit-hyperactivity disorder (ADHD), and are often used in combination with psychotherapeutic interventions. The table below lists current medications in use for various psychiatric disorders:

GENERIC NAME	TRADE NAME	FDA APPROVED AGE
Combination Antipsychotic and Antidepressant Medication		
fluoxetine & olanzapine	Symbyax (Prozac & Zyprexa)	18 and older
Antipsychotic Medications		
aripiprazole	Abilify	10 and older for bipolar disorder, manic or mixed episodes; 13 to 17 for schizophrenia and bipolar;
chlorpromazine	Thorazine	18 and older
clozapine	Clozaril	18 and older
fluphenazine (generic only)	fluphenazine	18 and older
haloperidol	Haldol	3 and older
iloperidone	Fanapt	18 and older
loxapine	Loxitane	18 and older
molindone	Moban	18 and older
olanzapine	Zyprexa	18 and older; ages 13-17 as second line treatment for manic or mixed episodes of bipolar disorder and schizophrenia
paliperidone	Invega	18 and older
perphenazine (generic only)	perphenazine	18 and older
pimozide (for Tourette's syndrome)	Orap	12 and older
quetiapine	Seroquel	13 and older for schizophrenia; 18 and older for bipolar disorder; 10-17 for treatment of manic and mixed episodes of bipolar disorder
risperidone	Risperdal	13 and older for schizophrenia; 10 and older for bipolar mania and mixed episodes; 5 to 16 for irritability associated with autism
thioridazine (generic only)	thioridazine	2 and older
thiothixene	Navane	18 and older
trifluoperazine	Stelazine	18 and older

GENERIC NAME	TRADE NAME	FDA APPROVED AGE
ziprasidone	Geodon	18 and older
Antidepressant Medications (also used for anxiety disorders)		
amitriptyline (tricyclic)	Elavil	18 and older
amoxapine	Asendin	18 and older
bupropion	Wellbutrin	18 and older
citalopram (SSRI)	Celexa	18 and older
clomipramine (tricyclic)	Anafranil	10 and older (for OCD only)
desipramine (tricyclic)	Norpramin	18 and older
desvenlafaxine (SNRI)	Pristiq	18 and older
doxepin (tricyclic)	Sinequan	12 and older
duloxetine (SNRI)	Cymbalta	18 and older
escitalopram (SSRI)	Lexapro	18 and older; 12 - 17 (for major depressive disorder)
fluoxetine (SSRI)	Prozac	8 and older
fluoxetine (SSRI)	Sarafem	18 and older for premenstrual dysphoric disorder (PMDD)
fluvoxamine (SSRI)	Luvox	8 and older (for OCD only)
imipramine (tricyclic)	Tofranil	6 and older (for bedwetting)
imipramine pamoate (tricyclic)	Tofranil-PM	18 and older
isocarboxazid (MAOI)	Marplan	18 and older
maprotiline (tricyclic)	Ludiomil	18 and older
mirtazapine	Remeron	18 and older
nortriptyline (tricyclic)	Aventyl, Pamelor	18 and older
paroxetine (SSRI)	Paxil	18 and older
paroxetine mesylate (SSRI)	Pexeva	18 and older
phenelzine (MAOI)	Nardil	18 and older
protriptyline (tricyclic)	Vivactil	18 and older
selegiline	Emsam	18 and older
sertraline (SSRI)	Zoloft	6 and older (for OCD only)
tranylcypromine (MAOI)	Parnate	18 and older
trazodone	Desyrel	18 and older
trimipramine (tricyclic)	Surmontil	18 and older
venlafaxine (SNRI)	Effexor	18 and older
Mood Stabilizing and Anticonvulsant Medications		
carbamazepine	Tegretol	any age (for seizures)
divalproex sodium (valproic acid)	Depakote	2 and older (for seizures)
gabapentin	Neurontin	18 and older
lamotrigine	Lamictal	18 and older
lithium carbonate	Eskalith, Lithobid	12 and older
lithium citrate (generic only)	lithium citrate	12 and older
oxcarbazepine	Trileptal	4 and older
topiramate	Topamax	18 and older
ANTI-ANXIETY MEDICATIONS (ALL OF THESE ANTI-ANXIETY MEDICATIONS ARE BENZODIAZEPINES, EXCEPT BUSPIRONE.)		
alprazolam	Xanax	18 and older
buspirone	BuSpar	18 and older
chlordiazepoxide	Librium	18 and older
clonazepam	Klonopin	18 and older
clorazepate	Tranxene	18 and older
diazepam	Valium	18 and older
lorazepam	Ativan	18 and older

GENERIC NAME	TRADE NAME	FDA APPROVED AGE
oxazepam (generic only)	oxazepam	18 and older
ADHD Medications (All of these ADHD medications are stimulants, except atomoxetine and guanfacine)		
amphetamine	Adderall	3 and older
amphetamine (extended release)	Adderall XR	6 and older
atomoxetine	Strattera	6 and older
dexmethylphenidate	Focalin	6 and older
dexmethylphenidate (extended release)	Focalin XR	6 and older
dextroamphetamine	Dexedrine, Dextrostat	3 and older
guanfacine	Intuniv	6 and older
lisdexamfetamine dimesylate	Vyvanse	6 and older
methamphetamine	Desoxyn	6 and older
methylphenidate	Ritalin	6 and older
methylphenidate (extended release)	Metadate CD, Metadate ER, Ritalin SR	6 and older
methylphenidate (long-acting)	Ritalin LA, Concerta	6 and older
methylphenidate patch	Daytrana	6 and older
methylphenidate (oral solution and chewable tablets)	Methylin	6 and older

from NIMH http://www.nimh.nih.gov/health/publications/mental-health-medications/complete-index.shtml

TRAUMA-FOCUSED INTERVENTIONS

Individuals with mental illnesses and co-occurring substance use disorders, and criminal justice system involvement, particularly women, have been found to experience significantly elevated rates of childhood physical and sexual abuse. Individuals with histories of trauma are more vulnerable to victimization and ongoing abuse and lack of treatment of trauma can interfere with recovery. The effects of trauma can complicate mental illnesses and substance use disorders and trigger relapse.

Trauma-focused interventions are promising practices for addressing the high rates of trauma found among people with mental illnesses, especially women and who are involved in the criminal justice system. The effects of trauma can complicate other mental illness or substance use disorders, and the symptoms of trauma frequently trigger relapse of mental illness or a return to drug or alcohol use. Studies have shown that trauma-specific interventions reduce associated symptoms.

SEEKING SAFETY

Seeking Safety is a present-focused manualized intervention with twenty-five topics that integrates treatment for PTSD (posttraumatic stress disorder) and substance use disorders that can be combined with trauma-processing techniques. It can be used for men or women, in individual or group formats, and within outpatient or residential treatment facilities. Sessions focus on skills designed for both substance use problems and PTSD (e.g., distraction techniques that can be used to subdue the triggers for both disorders) to help clients attain a sense of self-control and avert engagement in high risk behaviors, relationships, ideation and behaviors. Seeking Safety covers five areas:

❶ Safety, the priority of treatment.

❷ Integrated treatment of both disorders including helping participants understand the two disorders and why they frequently co-occur, teaching safe coping skills that apply to both disorders, exploring the relationship between the two disorders in the present (e.g., using a substance to cope with trauma flashbacks), and teaching that recovery from each disorder requires attention to both disorders.

❸ A focus on ideals; the title of each session is framed as a positive ideal that is the opposite of the negative characteristics of PTSD and substance abuse.

❹ Four program components: cognitive, behavioral, interpersonal, and case management. The interpersonal domain deals with issues regarding trust of others, confusion regarding expectations in relationships, avoidance of reenactments of abusive power, and dealing with the perpetuation of substance abuse in relationships. The case management component offers help obtaining referrals for problems such as housing, job counseling, HIV testing, domestic violence, and child care.

❺ Attention to clinician processes.

Seeking Safety is comprised of twenty-five topics. Seven interpersonal topics are: Asking for Help; Honesty; Setting Boundaries in Relationships; Healthy Relationships; Community Resources; Healing from Anger; and Getting Others to Support Your Recovery. The seven behavioral topics are: Detaching from Emotional Pain: Grounding; Taking Good Care of Yourself; Red and Green Flags; Commitment; Coping with Triggers; Respecting Your Time; and Self-Nurturing. The seven cognitive topics are: PTSD: Taking Back Your Power; Compassion; When Substances Control You; Recovery Thinking; Integrating the Split Self; Creating Meaning; and Discovery. In addition, four combination topics are: Introduction to Treatment / Case Management; Safety; The Life Choices Game (Review); and Termination.

Studies of the program show that it leads to significant reductions in substance use, trauma-related symptoms, suicide risk, suicidal thoughts, depression, and cognitions related to substance use, as well as improvements in social adjustment, family functioning, problem solving, and didactic knowledge related to the treatment. The Seeking Safety website, http://www.seekingsafety.org/, provides sample topics, articles, and other materials that can be directly downloaded in English and Spanish.

TRAUMA RECOVERY AND EMPOWERMENT (TREM)

TREM is a group intervention designed for women survivors of trauma that addresses issues of physical, sexual, and/or emotional abuse. It consists of thirty-three seventy-five-minute sessions conducted over a nine-month period led by female clinicians that usually includes between six to eight participants. It is provided in outpatient mental health settings, homeless shelters, welfare-to-work programs, and correctional facilities (prisons). The session topics are divided into the following sections:

Part I: Empowerment (eleven topics): introduces themes of gender identity, sexuality, interpersonal boundaries, and self-esteem without specifically addressing abuse issues.

Part II: Trauma Recovery (ten topics): focuses on sexual, physical, and emotional abuse and their relationship to psychiatric symptoms, substance abuse, and current relationships.

Part III: Advanced Trauma Recovery Issues (nine topics): examines additional trauma issues such as blame, responsibility, and the role of forgiveness in recovery.

Part IV: Closing Rituals (three topics): allows group members to assess their own progress and plan for continued healing either on their own or as part of a community of other survivors.

Part V: Modifications or Supplements for Special Populations: addresses issues related to specific populations (e.g., women who have a serious mental illness, women who are

incarcerated, women who are parents, women who engage in abusive behaviors, and male survivors).

Each session also includes an experiential exercise (physical activity, poetry, singing, drawing, and storytelling) to promote group cohesiveness and foster the inclusion of less verbal members.

Studies of TREM have demonstrated that this is a promising model that leads to improvements in overall functioning and psychiatric symptoms as well as reductions in the use of emergency services, HIV risk behavior, and substance use. Variations of the model have been developed for adolescent girls (G-TREM) and for men (M-TREM). Information regarding TREM can be obtained from http://www.communityconnectionsdc.org/trauma/trem.htm.

TRAUMATIC INCIDENT REDUCTION THERAPY (TIR)

Traumatic Incident Reduction Therapy is a highly structured, person-centered, promising practice designed to help individuals resolve painful incidents through a guided imagery process. It is a regressive desensitization procedure for reducing or eliminating the negative residual impact of traumatic experience that consists of: (1) identifying a traumatic incident; (2) identifying when it happened, how long it lasted and where the person was at the time; (3) the person is then asked to imagine going to the start of that incident (e.g., the moment just before the upsetting event began) then close their eyes and report what they are aware of and then imagine moving through the incident until it is over; and (4) opening their eyes and reporting what happened as they moved through it. Following this the person repeats the process of going back to the onset of the incident, moving through it mentally to the end and reporting what happened. This process of reviewing the incident is repeated multiple times (often 5 to 25).

With each subsequent reviewing the person typically notices or remembers different things, may release pint-up emotions, experiences changes in feelings and sensations, and the incident will become less disturbing. The person will typically gain a deeper insight into the experience and ultimately may revise the meaning associated with the event. A session continues until the participant is completely relieved of whatever stress the target trauma originally provoked and any cognitive distortions (e.g., observations, decisions, conclusions) embedded within the incident have been restructured.

TIR has been shown to be effective for post-traumatic stress disorder (PTSD) and remediation of specific unwanted stress responses (e.g., panic attacks), that occur without significant provocation. Information on TIR can be obtained from http://www.tir.org/.

PROLONGED EXPOSURE THERAPY (PE)

Prolonged Exposure Therapy is a cognitive-behavioral intervention for individuals suffering from PTSD with a significant research base to support its effectiveness in reducing symptoms of PTSD, anger, depression, and general anxiety. It is a SAMHSA model program (http://nrepp.samhsa.gov/ViewIntervention.aspx?id=89).

The standard treatment protocol consists of nine to twelve ninety-minute individual therapy sessions conducted in accordance with a manual that specifies the agenda and content for each session. It includes three components:

1. Psychoeducation about common reactions to trauma and the cause of chronic post trauma difficulties
2. Imaginal exposure: repeated recounting of the traumatic memory (emotional reliving)
3. In vivo exposure gradually approaching trauma reminders (e.g., situations, objects) that, despite being safe, are feared and avoided.

Research shows that PE reduces intrusive thoughts, nightmares and flashbacks, irritability, avoidance, emotional numbing, excessive avoidance, sleep disturbances, attention and concentration difficulties, sleep disturbances, and hypervigilance which are the hallmarks of PTSD.

A number of studies have also demonstrated that PE is very effective in reducing symptoms of PTSD in female victims of rape, aggravated assault, and childhood sexual abuse. It has been shown to be very beneficial for both men and women whose PTSD symptoms are related to combat exposure, traffic and industrial accidents, and violent crime. Finally, PE is effective for individuals with mental illness and co-occurring substance use disorders when it is combined with substance abuse intervention.

EYE MOVEMENT DESENSITIZATION AND REPROCESSING (EMDR)

Eye Movement Desensitization and Reprocessing (EMDR) is a cognitive-behavioral therapy that is used for the treatment of posttraumatic disorders. It combines CBT with exposure therapy. In EMDR an image of a traumatic event is evoked while visually tracking an external image (usually the therapistôs finger as it moves back and forth across the consumerôs visual field, or a moving light, or tones alternating from one ear to another.) The eye movements are used to engage attention to an external stimulus while focusing on distressing material. It is thought that after repeated exercises, the consumerôs thinking about the traumatic event is altered so that new, more adaptive associations are made.

EMDR uses a staged approach with eight phases that include compiling a complete history, preparing the consumer, identifying target and their components, actively processing past, present and future aspects, and on-going evaluation.

There is a significant divergence in the protocols used by practitioners of EMDR with sessions ranging from one ninety-minute session to models of eight to ten sessions. In addition, dismantling studies have failed to establish any enhanced effect from the use of eye movements in outcomes. The beneficial effects of EMDR have been deemed likely to be due to the exposure-based elements of CBT. EMDR has been shown to be effective in reducing the symptoms of PTSD, but it appears to be no more effective than exposure therapies.

GROUNDING

Grounding (also referred to as centering, looking outward, distraction, and healthy detachment) has been found to be of benefit to individuals with co-occurring disorders who have experienced trauma from sexual abuse. It is often used for posttraumatic stress disorder symptoms, substance abuse cravings, panic, intense anxiety, and rage. Grounding consists of techniques that soothe and distract individuals from strong emotions and assist them in anchoring in the present and, hence, in reality. The technique must be practiced on a frequent basis in order to be most effective.

Grounding Techniques:

- **Anchoring/grounding** entails sitting in a relaxed posture in a chair with eyes closed (or open if uncomfortable closing them), focusing on breathing. The person is asked to concentrate on feeling the chair supporting their weight and the floor underneath their feet. The person is helped to recognize how grounded they are in the present and that despite anxiety experienced from reliving moments from the past, they remain safe and grounded in the present.
- **Mirroring** entails practicing breathing techniques and synchronizing breathing with that of the therapist.

- **Timeout** entails allowing the person to leave the room for a few moments in order to stop a current activity or behavior pattern that is disruptive.

Mental grounding entails describing oneôs environment in detail (e.g., the color of the walls, types and kinds of furniture, temperature, etc.), playing category games with oneself (e.g., names of composers, cars, television shows, novels, etc.), age progressions starting at a younger age and working oneôs way to the present, describing an everyday activity in detail (e.g., cooking a meal), using imaginal exercises to obtain a mental picture of change (e.g., driving away from a painful situation); using humor to alter mood, counting or saying the alphabet slowly, and self-talk using safety statements. Physical grounding includes activities that alter sensation. These include physical movement, touching objects, exercise, eating, and focusing on breathing. Soothing grounding includes coping self-statements, planning a safe treat (e.g., a nice meal), recollections of a safe place, thinking of things one is looking forward to, etc.

HELPING WOMEN RECOVER AND BEYOND TRAUMA

Helping Women Recover: A Program for Treating Substance Abuse and Beyond Trauma: A Healing Journey for Women are manual-driven treatment programs that, when combined, provide trauma-informed interventions for women in correctional settings who have substance use disorders and co-occurring trauma histories (i.e., sexual or physical abuse). The two programs can be delivered conjointly as one intervention or separately as independent, stand-alone treatments. A community version has been developed for use in residential and outpatient substance abuse treatment settings, mental health clinics, and domestic violence shelters.

Sessions are conducted by female counseling staff (with optional assistance from peer mentors) to groups of eight to twelve participants for one and a half hours in duration once or twice a week. A strengths-based approach is used which focuses on personal safety, the development of effective coping skills, healthy relationships, and develop a stable positive interpersonal support network. Techniques include cognitive-behavioral skills training, mindfulness meditation, experiential therapies (e.g., guided imagery, visualization, art therapy, and movement), psychoeducation, and relational techniques to help participants understand the different forms of trauma, typical reactions to abuse, and the adverse impact of a history of victimization interacts with substance use.

The Helping Women Recover program consists of seventeen sessions organized around four domains: (1) Self, (2) Relationship/Support Systems, (3) Sexuality, and (4) Spirituality. The Beyond Trauma program consists of eleven sessions organized around three domains: (1) Violence, Abuse, and Trauma; (2) Impact of Trauma; and (3) Healing From Trauma

Outcome evaluations of these SAMHSA model programs indicate that participation leads to reductions in substance use, and re-incarceration as well as increases in enrollment in voluntary aftercare treatment subsequent to release. The programs have been found to be effective for adult women of varied ethnocultural backgrounds. More information can be obtained from http://www.centerforgenderandjustice.org/.

COGNITIVE-BEHAVIORAL THERAPY (CBT)

CBT has been demonstrated to be effective for treating depression, generalized anxiety and panic disorders, social phobias, and substance use disorders. In addition, a number of cognitive-behavioral programs have been developed to address criminogenic ideation and behavior (i.e., pro-criminal attitudes; pro-criminal associates; impulsivity; inadequate socialization; risky behaviors; inadequate problem-solving skills, poor self-control skills) as well as deficits in educational, vocational, and employment skills. CBT can be delivered in

institutional or community settings by mental health specialists or paraprofessionals, and administered as part of a multifaceted program or as a stand-alone intervention.

CBT has been found to be particularly effective for people struggling with both addiction and criminal conduct. When applied to individuals with substance use disorders and criminal justice system involvement, CBT targets four core processes that underlie addiction: (1) self-efficacy (i.e., the individualôs perceived ability to deal with events that lead to substance use problems such as problem-solving and social skills); (2) attributions (i.e., the rationalizations that persons with substance use disorders who engage in criminal behavior offer for the use of maladaptive behaviors); (3) outcome expectancies (i.e., the personôs limited and maladaptive perception of the benefit of substance use and criminal conduct; and (4) decision-making processes (i.e., the seemingly automatic choice of maladaptive thinking and behaviors which can be replaced with more conscious, intentional, and pro-social choices).

Correctional CBT program models are designed to help individuals to improve relationships, social interactions, reasoning skills, and problem-solving skills in order to alter negative behaviors. Some CBT programs target anger control and conflict resolution skills, while others focus on assuming personal responsibility for crimes committed (e.g., challenging the tendency to justify oneôs behavior by blaming the victim), and developing victim empathy (e.g., by correcting their minimization of the harm they caused). Variants of CBT with adaptations tailored to specific populations (e.g., individuals who engage in sexual offenses, battering, and those with substance use disorders) are also available.

CBT uses cognitive restructuring (CR) and social and interpersonal skills training. Reinforcement is used to strengthen thoughts that lead to positive behaviors and positive behavior as well as its consequences. Cognitive restructuring is used to alter maladaptive cognition through methods such as self-talk (including thought stopping, planting positive thoughts, countering, shifting the view, exaggerating the thought, etc.) and training in problem-solving skills, mood-management, critical reasoning, rational responding, scaling emotions, and de-catastrophisizing. The focus of interpersonal and social skills development includes communication skills, assertiveness training, relationship skills, conflict resolution training, and aggression management.

In addition to cognitive restructuring and interpersonal skills, correctional-based CBT includes a sociocentric component that focuses on the responsibility toward others in the community by building attitudes and skills for empathy and concern for the welfare and safety of others and emphasizes empathy building, victim awareness, and the development of prosocial attitudes (i.e., concern for the safety and welfare of others).

A substance body of scientific research has found that CBT is effective in reducing recidivism, particularly for individuals who are at high risk. It is also cost-effective. Studies have estimated economic returns of $2.54 to $11.48 for every program dollar invested in cognitive behavioral treatment (in comparison to the $.50 to $.75 return for every program dollar spent on punishment-oriented interventions).

CBT can be used with individuals, but is more commonly used as a group treatment modality in the justice system. Manualized CBT curricula used in the criminal justice system include Reasoning and Rehabilitation (R&R), Moral Reconation Therapy (MRT), Aggression Replacement Training (ART), Thinking for a Change (T4C), Relapse Prevention Therapy (RPT), and Strategies for Self-Improvement and Change (SSC). At present, however, there is insufficient evidence to conclude that any one of these programs most effective.

MORAL RECONATION THERAPY (MRT)

Moral Reconation Therapy[27], based on Lawrence Kohlbergûs stages of moral development, was originally developed for prison-based therapeutic communities and later expanded to include individuals in the criminal justice system who have been convicted of driving while intoxicated (DWI), domestic violence, and sex offenses. It has also been applied to parenting skills development, job attitude improvement and addressing general antisocial thinking. MRT is currently used in more than forty states, Canada, and Puerto Rico.

The program identifies nine personality stages of development:

1. **Disloyalty:** This stage is typified by self-centered behavior and a willingness to be dishonest, blame, and victimize others.
2. **Opposition:** This stage Includes the same behaviors as disloyalty but less with frequent occurrence.
3. **Uncertainty:** The person is unsure of how they stand with or feels about others and still makes decisions based on their own pain or pleasure.
4. **Injury:** At this stage destructive behavior still occurs but with recognition of the source of the problem; some responsibility for behavior is taken and some decisions may be based on consequences for others.
5. **Nonexistence:** People at this stage feel alienated from things but have a few satisfying relationships; these individuals vacillate between making decisions based on formal rules and decisions based on pleasure and pain.
6. **Danger:** People at this stage commit to goals and make decisions primarily on law and societal values; when regression occurs, anguish and loss of self-esteem are experienced.
7. **Emergency:** At this stage social considerations are made, but idealized ethical principles influence decision-making.
8. **Normal: I**ndividuals at this stage of development are relatively happy and contented having chosen the right goals for themselves and fulfilling them properly; decision-making based on pleasure and pain has been virtually eliminated.
9. **Grace:** The majority of decisions are based on ethical principles.

MRT is conducted in open-ended groups consisting of five to twenty participants that may meet once a month or up to five times a week. Homework assignments are completed outside of the group and then presented to group members during meetings. MRT does not require a high level reading skills or levels of cognitive functioning; homework includes making drawings or writing short answers. Groups address the following issues:

- Confronting personal beliefs
- Assessing relationships
- Facilitating identity development
- Enhancing self-esteem
- Decreasing hedonism
- Developing tolerance for the delay of gratification

The program consists of a series of group and workbook exercises designed to raise the moral reasoning level of participants through sixteen graded moral and cognitive stages:

Steps 1 & 2: Client must demonstrate honesty and trust.

[27] Conation was a term used in psychology until the 1930s when it was replaced by the term, ego. Conation was defined as the conscious process of decision-making and purposeful behavior. The term reconation implies a reevaluation of decisions and moral judgments to the making of correct, prosocial decisions regarding behaviors.

Step 3: Client must accept rules, procedures, treatment requirements, and other people.
Step 4: Client builds genuine self-awareness.
Step 5: Client creates a written summary to deal with relationships that have been damaged because of substance abuse or other antisocial behavior.
Step 6: Client begins to uncover the right things to do to address the causes of unhappiness.
Step 7: Client sets goals.
Step 8: Client refines goals into a plan of action.
Step 9: Client must continue to meet timetables he or she set up.
Step 10: Client conducts a moral assessment of all elements of his or her life.
Step 11: Client reassesses relationships and forms a plan to heal damage to them.
Step 12: Client sets new goals, for 1 year, 5 years, and 10 years, with a focus on how accomplishment of the goals will relate to happiness.
Steps 13–16 (optional): Involves clientôs confrontation of the self with a focus on an awareness of self. Goals continue to be defined and expanded to include the welfare of others.

While, outcome studies show that adult MRT during incarceration leads to significant reductions in rearrests and re-incarceration, some of the studies are methodologically weak. Nonetheless, MRT is listed on SAMHSAôs National Registry of Evidence-based Programs and Practices (NREPP, http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=34). Information on MRT, including training opportunities, is available from Correctional Counseling, Inc. (www.ccimrt.com) and www.moral-reconation-therapy.com.

REASONING AND REHABILITATION (R&R)

Reasoning and Rehabilitation delivered in institutional and community corrections settings and can be used concurrently with other correctional programs. It consists of thirty five sessions conducted for eight to twelve weeks with six to eight participants. R&R focuses on enhancing self-control, interpersonal problem-solving, social perspectives, and prosocial attitudes. Participants are taught to think before acting, consider consequences of actions, and conceptualize alternate patterns of behavior.

The program is organized around exercises (e.g., Critical Thinking, Social Perspective-Taking) that are designed to modify impulsive, egocentric, illogical and rigid thinking and teach participants to stop and think before acting, consider the consequences of their actions, conceptualize alternative ways of responding to interpersonal problems, and consider the impact of their behavior on other people, particularly individuals who have been victims of their actions.

Sessions include audiovisual presentations, games, puzzles, reasoning exercises, role playing, modeling, and group discussions. Topics include problem-solving techniques (e.g., information gathering, conceptualizing, alternative thinking, and assertive communication), creative thinking, social skills, managing emotions, negotiation, critical reasoning, and values. In addition, participants learn to respond to complaints, be open-minded, and respond to the feelings of others. Family members and significant others are encouraged familiarize themselves with the programôs principles in order to reinforce skill acquisition.

R&R2 is a shorter version of R&R that includes motivational interviewing, relapse prevention, prosocial modeling, and encouragement to acquire a long-term prosocial lifestyle (desistance). Participation requires an IQ of 70 or higher. The program includes sixteen group sessions of four to ten participants and homework assignments with in vivo practice of cognitive skills and

feedback from participants regarding their observations and experiences occurring between sessions.

Outcome studies indicate participation in R&R leads to reductions in recidivism but studies tend to be methodologically weak and findings are inconsistent. However, some studies have shown that R&R is effective for individuals with mental illness who have criminal justice system involvement. The Program is under copyright to T3 and Associates (www/t3.ca/).

RELAPSE PREVENTION THERAPY (RPT)

Relapse Prevention Therapy was originally developed as a maintenance program to prevent and manage relapse following addiction treatment and is designed to teach individuals how to anticipate and cope with relapse, RPT is used as a component in treating aggression, violence, criminal behavior, and sex offending, and as a case management tool for addressing any type of criminal conduct. It is designed to help individuals develop cognitive risk-management strategies and behavior skills for avoiding or deescalating the precursors to criminal behaviors (e.g., high-risk situations, places, associates, or maladaptive coping responses).

RPT uses techniques from cognitive-behavioral coping-skills training to teach clients self-management and self-control of their thoughts and behavior. Cognitive skills and cognitive restructuring are incorporated into a curriculum that builds behavioral strategies to cope with high-risk situations and stop the relapse cycle before lapses develop into a full relapse.

Relapse prevention is a cognitive-behavioral approach to self-management that focuses on teaching individuals alternate responses to high-risk situations. Relapse prevention is incorporated into variety of interventions. It focuses on teaching individuals how to identify high-risk situations, avoid habitual coping styles, and enhance feelings of self-efficacy in dealing with such situations. The key components of relapse prevention are:

- Recognition of an offense-chain or cognitive-behavioral chain: This entails teaching individuals to recognize their offense cycle or the initial cues that warn them that they may be in danger of engaging in a criminal behavior).
- Relapse rehearsal: This entails the identification of potential relapse situations and the development of skills to address such situations with low-risk responses through opportunities for rehearsal with corrective feedback.
- Advanced relapse rehearsal: Managing gradually more challenging hypothetical relapse situations.
- Identify high-risk situations: This consists of teaching individuals to identify situations that are conducive to criminal behavior and how to manage these situations when in one of them.
- Dealing with failure situations: This teaches individuals to cope with relapse or failure in a constructive manner without responding to setbacks with a loss of optimism or overwhelming discouragement.
- Self-efficacy: This entails the inculcation of feelings of self-confidence that the personôs efforts will be successful in avoiding future criminal behavior as a result of participating in treatment, a program, or an intervention.
- Coping skills: This is comprised of developing or enhancing coping skills.
- External support systems: This entails the provision of training to significant others (e.g., family, friends, work peers and other natural supports) in the intervention model so they can properly reinforce the individual for displaying prosocial behaviors learned in the program.
- Booster sessions/aftercare: Sessions that supplement an intervention/program material.

RPT uses five therapeutic strategies:

1. Coping-skills training: teaching ways to handle urges and cravings that occur in early stages of change.
2. Relapse Road Maps: identify tempting and dangerous situations and detours for avoiding these situations and successfully coping without a lapse or relapse.
3. Strategies to identify and cope with cognitive distortions (e.g., denial and rationalization), that can increase the possibility of relapse with little conscious awareness.
4. Lifestyle modification techniques: replacing substance use with constructive and health-promoting activities and habits.
5. Learning to anticipate possible relapses: replacing unrealistic expectations of perfection with encouragement to be prepared for mistakes or breakdowns; skills taught include how to learn from those mistakes and persevere.

Components of relapse prevention that are associated with more positive effects (i.e., reductions in future criminal behavior) include training significant others in the program model, identifying the offense-chain and high-risk situations, and role-playing these situations. On the other hand, teaching individuals how to cope with failure situations and the provision of booster sessions have not been found to be as effective. In general, increasing the number of relapse prevention components within a program or intervention has been shown to significantly enhance it benefits. Thus, a multimodal approach to correctional intervention which targets multiple areas of criminogenic need is optimally effective. Conversely, relapse prevention within programs that predominantly target non-criminogenic needs are associated with mild increases in recidivism. RPT is listed on SAMHSAôs National Registry of Evidence-based Programs and Practices (NREPP, http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=97).

THINKING FOR A CHANGE (TF4C)

T4C is a cognitive-behavioral program developed by the National Institute of Corrections (NIC) of the U.S. Department of Justice in 1997 that is used in state correctional systems, jails, community-based corrections programs, and probation and parole departments. The curriculum uses problem-solving, cognitive restructuring, and social skills development to increase awareness of self and others. It is comprised of twenty-two core lessons and ten additional lessons that can be provided on an indefinite basis. Role plays and in vivo practice sessions (i.e., homework) are used as teaching methods. TF4C is conducted in closed-ended groups of eight to twelve individuals and sessions are held twice per week for one to two hours. Booster sessions or an aftercare group are recommended to assist in relapse prevention.

T4C starts with instruction of an introspective process for examining ways of thinking, feelings, beliefs, and attitudes which is reinforced throughout the program. Social skills training is provided as an alternative to antisocial behaviors. Participants are taught to report situations that could lead to criminal behavior, and identify thoughts, feelings, attitudes, and beliefs that might lead to the commission of offenses. They document and use a thinking report[28] as a way of determining awareness of risky thinking that leads to difficulties. The social skills component of the program entails practice in role plays followed by group discussion and assessment of how well each participant adheres to the steps of the social skill being learned. Participants apply problem-solving steps to problems in their own lives. The program culminates by integrating the skills learned into steps for problem-solving to work through challenging situations without engaging in criminal behavior.

[28] Thinking reports can be used in tandem with sanctions to help returning citizens learn from mistakes because they target understanding underlying cognitive and emotional features of decision-making to foster consideration and practice of alternative, adaptive behaviors.

Outcome studies indicate reductions in new criminal offenses and improvements in social skills and interpersonal problem-solving skills. However, there is lack of research on outcomes for individuals with mental illness and criminal justice system involvement.

Lesson plans and manuals for the program can be found on the web at http://www.nicic.org in English and Spanish. The program is also available on CDï ROM in English and Spanish as well as distance learning recordings. Materials are available at no cost and include:

- A two-day curriculum titled *What Are They Thinking?* (available at www.nicic.org/Library/020100) which covers the Thinking Reports and Problem Solving processes that are used in T4C, the theoretical foundations and evidence for the use of CBT are highlighted as well as ways to use T4C in community supervision, demonstration and observation of the techniques involved. A PowerPoint presentation for use with the curriculum can be found at www.nicic.org/downloads/ppt/020100-ppt.ppt.
- A Manual for Delivery of Cognitive Self Change (available at www.nicic.org/Library/021558) which offers an in depth guide to using the program including an overview of Cognitive Self Change, the Thinking Report, Cognitive Check-ins; delivery of the program, case management, program standards, and administrative procedures; admission, discharge, and transfer procedures; group delivery, program management, and supervision; and helpful forms and program memoranda.
- Thinking for a Change: Facilitator Training: Lesson Plans is a thirty two-hour training program which covers the theoretical foundations of CBT and basic components of T4C, including cognitive self-change, social skills, problem solving, and implementation of the program. It is available for download at www.nicic.org/Library/017124.

STRATEGIES FOR SELF-IMPROVEMENT AND CHANGE (SSC)

Strategies for Self-Improvement and Change is a standardized, structured, skill-based, multimodal, intensive, long term (nine months to one year) program for adults with substance abuse problems who are involved in the criminal justice system. It targets extra-personal circumstances (i.e., events) and intrapersonal processes (i.e. cognitions, emotions, beliefs, attitudes) that lead to criminal conduct and substance abuse. The program can be used in community settings and correctional facilities, including jails, prisons, residential treatment programs, therapeutic communities, and outpatient treatment settings. Participants are engaged in an assessment process in partnership with providers in five areas:

- **Alcohol and other drug (AOD) use and abuse** which uses a number of tools, including self-report questionnaires and participation in a reflection group, to assess use and abuse. Inclusion guidelines for AOD services are provided with both minimum symptom criteria and descriptions of psychometric tests to identify the types of drugs used, perceived benefits of use, real consequences of use, and concerns of use.
- **Criminal conduct** is assessed to ascertain the extent of antisocial patterns, including criminal associations and criminal attitudes. Assessment of risk factors focuses on modifiable, crime-inducing needs. Patterns of criminal thinking and thinking errors are assessed using a tool called a thought report.
- **Cognitive and affective processing** to help participants gain understanding and control of their emotions and actions that influence their thought processes.

- **Life-situation problems** including social-interpersonal adjustment; psychological-emotional adjustment; work and finances; marriage, family, and relationships; and health, are assessed.
- **Motivation and readiness** for treatment are assessed during the clinical intake interview through questions regarding willingness to be involved in treatment; whether the person feels a need for help at the present time; whether the individual has thought about making changes in particular areas; whether the person has actually made deliberate changes; the degree of problem awareness; and whether others feel that the client should make changes or needs help.

Sessions are divided into three parts starting with an introduction and rationale which covers the sessionôs objectives and key words. The second part is the content and focus of the session which includes exercises and worksheets. The third part consists of a summary of the sessionôs activities and a process group. and includes a scale that participants use to rate their level of knowledge and skills learned in the session and suggested topics for the group

The curriculum consists of twelve modules that are structured around three phases of treatment. Each module is taught in sequence; basic topics are covered first and more difficult concepts are subsequently reviewed. The phases of the program are:

Phase I: Challenge to Change involves the participant in a reflective-contemplative process. A series of lesson experiences is used to build a working relationship with the client and help them develop motivation to change. Sessions include basic information on how people change, the roles of thought and behavior in change, and basic information about substance abuse and criminal conduct. This phase is designed to help participants develop self-awareness through self-disclosure and feedback. Clients are confronted with their own pasts and then challenged to bring those pasts into a present change focus in order to get them define the specific areas of change and commit to that change. This phase includes a review of the clientôs current alcohol/other drug use and criminal conduct, the results of which become a focus of the reflective-contemplative process. Participants identify targets of change and, through ongoing process group feedback and counselor/client collaboration, develop a comprehensive relapse and recidivism prevention plan.

Phase II: Commitment to Change involves clients in an active demonstration of implementing and practicing change. This phase focuses on strengthening basic skills for change and helping clients learn key CBT methods for changing thoughts and behaviors that contribute to substance abuse and criminal conduct. Topics include coping and social skills training with an emphasis on communication skills; managing and changing negative thoughts and thinking errors; recognizing and managing high-risk situations; managing cravings and urges that lead to substance use and criminal conduct; developing self-control through problem-solving and assertiveness training; managing thoughts and feelings related to anger, aggression, guilt, and depression; understanding and developing close relationships; and understanding and practicing empathy and prosocial values and moral development.

Phase III: Ownership of Change is the stabilization and maintenance phase and involves participantsô demonstration of ownership of change over time through treatment experiences designed to reinforce and strengthen their commitment to established changes. This phase includes a review of the concepts of relapse and recidivism prevention as well as sessions on critical reasoning, conflict resolution, and establishing and maintaining a healthy lifestyle. Participants are assisted to become involved in a variety of supportive services including mentoring, role modeling, self-help groups, and other community-based recovery maintenance resources to reinforce change. In addition, skills training in managing work and leisure time activities are provided.

Outcome studies indicate maintenance of abstinence from substances, cognitive and behavioral control over substance use, as well as reductions in criminal thinking and improvements in conduct during SSC. Twenty six hours of facilitator training sessions in SSC methods are available.

AGGRESSION REPLACEMENT TRAINING (ART)

Aggression Replacement Training, a multimodal intervention originally targeted to adolescents involved in the juvenile justice system and designed to decrease anger and violent behaviors, has been adapted for adults. It is comprised of three components: (1) Skillstreaming, which teaches prosocial behaviors through modeling and role-playing; (2) Anger Control Training, which Anger Control Training instructs participants self-control through recording anger-arousing experiences, identify trigger thoughts, and apply anger control techniques; and (3) Moral Education which exposes participants to moral dilemmas in a discussion format that focuses on increasing their level of moral reasoning. The curriculum is implemented with small groups via modeling, role-playing with opportunities to practice and rehearse behaviors, performance feedback using praise and reinstruction, and transfer training to increase the use of skills learned in vivo.

- **Social Skills Training** (the behavioral component) offers instruction in interpersonal skills to deal with anger-provoking events and consists of five cognitive and five affective social skills:
  - Making a compliment
  - Understanding the feelings of others
  - Getting ready for difficult conversations
  - Dealing with someone elseôs anger
  - Keeping out of fights
  - Helping others
  - Dealing with accusations
  - Dealing with group pressure
  - Expressing affections
  - Responding to failure
- **Anger Control Training** (the affective component) teaches a various ways to manage anger. Each participant is required to bring a description of a recent anger-arousing experience (a hassle), which is recorded in a hassle log. Participants receive training in responding to hassles with a chain of behaviors that include:
  - Identification of triggers (i.e., external events and internal self-statements that provoke anger).
  - Identification of cues (i.e., individual physical responses, such as tightened muscles, flushed faces, and clenched fists, which indicate the emotion the adolescent is experiencing is anger).
  - Use of reminders (i.e., self-statements, such as ñstay calmò, ñchill outò, ñcool downò, or non-hostile explanations/interpretations of others' behavior).
  - Use of anger reducers to lower the level of anger (e.g., deep breathing, counting backward, imagining a peaceful scene, imagining the long-term consequences of one's behavior).
  - Use of self-evaluation (i.e., considering how effectively the hassle was responded to by identifying triggers and cues, using reminders and reducers, followed by self-praise for effective performance).

After participants have effectively reduced their anger arousal using these techniques, they decide upon an appropriate social skill learned in social skills training to use in an anger-provoking situation.

- **Moral Reasoning** (the cognitive component), is comprised of a set of procedures designed to increase participantsôsense of fairness, justice, and concern with the needs and rights of others (i.e., moral reasoning).

Outcomes studies suggest ART promotes prosocial skills acquisition and behavior, improves anger control, decreases the frequency of acting-out behaviors, and increases the frequency of constructive, prosocial behaviors. Significant improvements have been found in understanding another personôs anger, handling accusations effectively, using methods to resolve conflicts that avoid fighting, avoiding problematic situations, considering oneôs abilities prior to starting a new task, apologizing to others, handling complaints in a fair manner, and being able to ascertain the causes of an interpersonal problem.

Three levels of training are offered for practitioners including Group Facilitator training which is a thirty six to forty-hour didactic seminar; Trainer of Group Facilitator training which consists of , a minimum for or five-day, thirty two to forty-hour seminar that may include up to two hundred eighty hours of additional study after group facilitators have implemented the program three times with their clients under supervision; and Master Trainer which is an individualized program for practitioners with at least five years of experience delivering the program and at least three years as a trainer of group trainers. Training information is available from G & G Consultants, LLC at www.g-gconsultants.org.

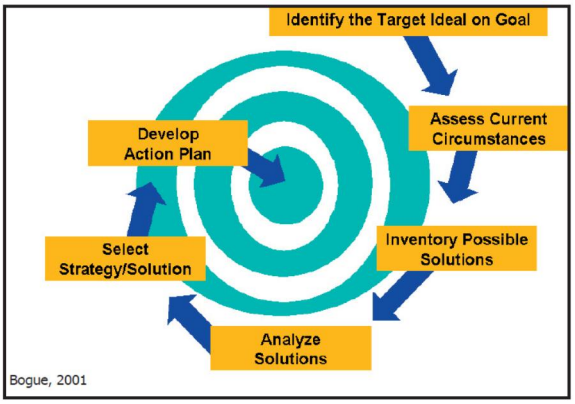
SKILLS TRAINING

CBT skills training programs include life (or so-called hard) skills development (e.g., cleaning, cooking, shopping, and money management) and so-called soft skills designed to develop a repertoire of socially appropriate interactional skills to counteract jailhouse culture, The latter entails training in behavioral and communication skills that are effective in everyday community interactions including interpersonal discussion skills (e.g., listening skills, compromise, and conflict resolution), self-advocacy, constructive assertiveness, patience, impulse control, anger management.

Cognitive skills training is designed to teach thinking skills including interpersonal problem-solving (with information gathering, developing alternative solutions, and evaluating outcomes as crucial steps), abstract thinking, critical reasoning, causal thinking, goal setting, long-term planning, and perspective taking. Role-plays and in vivo practice are used to consolidate newly acquired coping skills in situations that tend to trigger maladaptive ideation and behaviors.

The problem-solving process consists of six steps that are taught and practiced:

1. Identifying the Goal
2. Assessing Current Circumstances
3. Inventorying and Analyzing Possible Solutions
4. Analyzing Solutions
5. Selecting a Strategy
6. Developing an Action Plan



ANGER MANAGEMENT TRAINING

CBT anger management training focuses on teaching individuals to monitor their patterns of automatic thoughts to situations in which they tend to react with anger or violence. Various strategies are then rehearsed for assessing the validity of those trigger thoughts. Individuals are taught to replace biased interpretations by accurate ones and to consider non-hostile explanations of other peoplesô behavior.

A number of anger management programs have been developed and all share a number of common elements:

- Recognizing and labeling anger: Individuals learn to identify the physical signs (e.g., muscle tension and clenched fists) that indicate anger in themselves and others
- Identifying situations and cues that lead to anger
- Understanding the external circumstances as well the internal triggers that provoke anger
- Learning skills to reduce anger
- Learning to express anger in healthy, socially constructive ways
- Learning to relax using relaxation exercises and deep breathing

SUBSTANCE USE DISORDERS TREATMENT

People with substance use problems are significantly overrepresented in prison populations. It is estimated that eighty percent of individuals in state correctional institutions experience substance abuse problems. More than half of individuals who are incarcerated report the use of drugs or alcohol at the time of the commission of the crime for which they were incarcerated. It is estimated that seventy to eighty five percent of individuals who are incarcerated have a substance use disorder.

Substance use can precipitate involvement in criminal behavior (e.g., committing crimes to finance drug purchases to support an addiction). The use of illegal drugs places individuals at risk for arrest, parole violation, and re-incarceration. Reentry is a common risk factor for relapse. Returning to a former neighborhood with familiar places and friends who are associated with substance use can trigger cravings.

Substance use can have adverse effects on family relationships, employment, and health. In addition to the risk for overdoses, substance abuse increases the likelihood of developing other chronic conditions, including cardiovascular disease and cirrhosis of the liver and contributes to the transmission of several infectious diseases, most notably HIV and hepatic C.

Numerous studies have demonstrated that treatment can reduce substance use and criminal activity, especially when prison-based intervention is followed with aftercare treatment in the community. The treatment of substance use disorders has been shown to be one of the most cost-effective ways to prevent substance use-related crimes. According to the Washington State Institute for Public Policy (WSIPP), each dollar spent on prison-based substance use disorder treatment yields almost six dollars of savings, and that each dollar spent on community-based treatment yields over eighteen dollars in cost savings related to crime and health care expenditures. Additional benefits accrue in the form of increased earnings and positive outcomes for families, potential victims, and society.

Length of time in treatment has been demonstrated to have significant impact on substance use disorder treatment effectiveness. At least ninety days is required for treatment success and, for some, especially individuals receiving methadone maintenance therapy, at least at least twelve months of treatment with extended of follow-up is required. In addition, studies have shown that

treatment does not have to be voluntary to be effective; involuntary participants in treatment services experience more success than similar groups of individuals involved in the criminal justice system who are not required to receive treatment or other services.

Research suggests that pressure from families, the criminal justice system, employers, and child and family welfare agencies can reduce dropout rates, increase length of time in treatment, and result in beneficial outcomes. Supervision agents have a significant tool to promote compliance with treatment that providers lack: the ability to impose sanctions for lack of adherence to treatment regimens and provide incentives to reward adherence and recognize progress. Supervision of individuals with substance use disorders has been found to be effective when a continuum of care is provided, a system of graduated sanctions and rewards is used, frequent drug testing occurs, and when substance abuse treatment and criminal justice staff function as a team.

TREATMENT ACCOUNTABILITY FOR SAFER COMMUNITIES (TASC)

TASC is a case management and system intervention program that targets individuals with substance use disorders who are involved with the criminal justice system. The model promotes collaboration between the criminal justice and substance abuse treatment systems and includes a mix of supervision, treatment, and sanctions, and rewards. Components include screening, assessment, treatment planning, monitoring, urinalysis, and liaison to the court. Participants are referred to community-based treatment programs and their progress and compliance are monitored.

TASC Program Components
◆ Coordination between criminal justice and substance disorder treatment systems
◆ Screening, early identification, assessment, and prompt referral
◆ Access to a continuum of alcohol, drug, and other related treatment and rehabilitation services
◆ Frequent clinical status monitoring via drug testing
◆ Client monitoring
◆ Use of legal sanctions as inducements to remain in treatment
◆ Case management
◆ Client advocacy
◆ Clinical interventions
◆ Relapse prevention
◆ Staff training
◆ Data collection and management

TASC links the criminal justice and substance use disorder treatment systems by coordinating services for individuals at any point of their involvement in the criminal justice system, including those transitioning into the community. TASC has been used help alleviate prison crowding through diversion to treatment. While there is variability across jurisdictions, most TASC initiatives are comprised of identification of participants and their referral to TASC, objective, clinical assessments of substance abuse and mental health treatment and ancillary service needs, referrals for treatment, and continuous case management to ensure compliance with criminal justice orders and treatment plans.

TASC programs offer an alternative to incarceration or supplement criminal justice sanctions. They are designed to deal with multiple needs including parenting skills, medical care, family relationships, counseling, education and employment, and legal issues. TASC programs initiate case management services as early as possible including during pretrial, pre-sentence, post-adjudication, or prerelease.

Evaluations of TASC programs indicate that, while they have been shown to be effective in identifying offenders who have substance abuse problems and issues and referring them to

treatment programs, outcomes in terms of recidivism to criminal behavior and relapse have been equivocal. Some studies indicate positive outcomes while others show only rather modest reductions in substance abuse. Other studies indicate inconclusive results with regard to criminal recidivism. Nonetheless, individuals involved in TASC programs have been shown to remain in treatment longer than other clients involved in the criminal justice system (as well as those who participate in treatment on a voluntary basis).

TASC has developed a number of monographs and guidelines that include training materials, curricula and manuals. Information can be found at http://www.nationaltasc.org/.

DRUG TESTING

Drug testing, an essential part of substance use disorder treatment, is a therapeutic as well as supervision tool. Drug testing results can function as a source of motivation for abstinence and indicators of progress. As a supervisory tool, testing provides opportunities for facilitating movement through the stages of change, as well as monitoring use, tracking progress, and making adjustments to treatment plans. Research shows that frequent monitoring and drug testing can significantly reduce relapse and recidivism. It recommended that drug testing be conducted twice weekly at a minimum when positive results are obtained, and with lessening frequency when tests yield negative results.

Drug testing methodologies include urinalysis (which most frequently used in the criminal justice system); hair testing (which is effective in detecting drug use at least one week after use, and up to one year or longer, and is most commonly used to examine maintenance of abstinence following treatment); blood testing (the most accurate method of testing because it can approximate the degree of intoxication and the time of drug use); saliva testing, sweat patch tests (which attach to the skin and monitor substance use over a period of ten to fourteen days); and breathalyzers (which can detect very recent alcohol use and the amount consumed).

Sample	Invasiveness of Sample Collection	Detection Time	Cutoff Levels	Advantages	Disadvantages	Cost
Urine	Intrusion of privacy	Hours to days	Yes	High drug concentrations; established methodologies; quality control and certification	Cannot indicate blood levels; easy to adulterate	Low to moderate
Blood	Highly invasive	Hours to days	Variable limits of detection	Correlates with impairment	Limited sample availability; infectious agent	Medium to high
Hair	Noninvasive	Weeks to months	Variable limits of detection	Permits long-term detection of drug exposure; difficult to adulterate	Potential racial bias and external contamination	Moderate to high
Sweat	Noninvasive	Days to weeks	Screening cutoffs	Longer time frame for detection than urine; difficult to adulterate	High inter-individual differences in sweating	Moderate to high
Saliva	Noninvasive	Hours to days	Variable limits of detection	Results correlate with impairment: provides estimates of blood levels	Contamination from smoke; pH changes may alter sample	Moderate to high
Breath	Noninvasive	Hours	No, except for ethanol	Ethanol concentrations correlate with impairment	Very short time frame for detection; only detects volatile compounds	Low to moderate

From Peters, Bartoi, Sherman (2008)

DRUG TREATMENT COURTS (DTCS)

During the 1980s the criminal justice system became overwhelmed with cases involving people with substance use problems committing nonviolent offenses. It was clear that traditional responses such as incarceration for longer periods (under mandatory sentencing laws) or probation sentences did not address the problem. In response, drug treatment courts (DTCs) were developed during the late 1980s. DTCs provide diversion from jail or prison through expedited involvement in treatment for individuals with substance abuse problems who do not display violent behaviors. Some of these courts have expanded admission criteria to include individuals with histories of multiple prior offenses related to substance abuse. Several different diversion models are used by DTCs including pre-sentence diversion, processing through post plea or pre-sentence arrangements, and post-conviction arrangements. Successful completion of treatment programs can result in dismissal of original charges, reducing or setting aside sentences, lesser penalties, or a combination of these.

Drug courts represent an approach to the integration of substance abuse treatment with pretrial processing of criminal cases. They are a collaborative partnership between courts, substance abuse treatment providers, community supervision, and other ancillary services, and feature a rehabilitative team approach that combines mandatory treatment involvement with accountability through surveillance, monitoring, and regular feedback to the court and team. Drug courts use close supervision, drug testing, and incentives and sanctions to help participants adhere to treatment plans. These courts focus on the period of post-arrest to provide interventions designed to break the drug-crime cycle by diverting individuals into treatment and show significant promise in the engagement and retention of offenders with substance involvement in treatment and other related services and supports.

Drug courts tend to vary as they are based upon local jurisdictional needs. Some handle both defendants during the pretrial phase as well as those who have been adjudicated. Some handle only cases involving drug possession, while others accept a much broader range of criminal cases (typically of a nonviolent nature) that are instigated by substance use problems. One type, known as the Coerced Abstinence Model Drug Court, uses drug testing and sanctions without substance use disorder treatment. However, while reductions in recidivism have been shown from the use of this model, its impact on drug use is less clear.

While there is no universal model for drug courts, and not all are diversion models, they all share common elements:

- Integration of substance use disorder treatment services and supports with justice system case processing
- Promotion of public safety and protection of participantsô due process rights using nonadversarial approaches by the prosecution and defense councils
- Early identification and prompt referral of eligible participants to treatment
- Access to a continuum of substance abuse treatment services and supports
- Monitoring of abstinence via frequent substance testing
- Coordinated responses to participantsôadherence; accountability is maintained through graduated sanctions and rewards
- Ongoing judicial review, supervision, and interaction with participants
- Monitoring and evaluation to measure program goals attainment and effectiveness of the program
- Ongoing interdisciplinary education
- Partnerships among drug courts and various public community agencies

- Aftercare and support services following completion of treatment

Eligibility criteria used by drug court programs include a current charge of purchase or possession of a small quantity of illegal drugs, or possession with intent to sell or distribute; a current charge of another nonviolent offense (e.g., forgery, passing worthless checks, prostitution, or burglary) that was committed while under the influence of drugs or alcohol; a current charge of operating a motor vehicle while intoxicated or under the influence of drugs or alcohol; a history of and current substance use problems; a criminal history that does not include conviction of a felony crime or violent act, and a willingness to participate in a treatment program. In general, drug courts exclude defendants who have been charged with drug trafficking and sales, except in situations where an individualôs role in distribution is relatively minor and appears to stem from a problem with a substance use disorder. In addition, some courts will not accept defendants who have severe psychiatric problems that have not been stabilized and those with medical conditions that require immediate attention. While some courts accept defendants with extensive criminal records, federal policy precludes the use of federal funds for interventions for offenders who display violent behaviors.

A DTC team consists of a judge, prosecutor, defense counsel, treatment providers, corrections personnel, mental health providers, and social service agencies (e.g., housing authorities). Judges take an active and leading role in monitoring defendantsô progress in the treatment process through mandatory court appearances and data from urinalyses. Judges generally require defendants to appear at regularly scheduled status hearings during which their treatment progress is reviewed. While patterns vary from court to court, status hearings may be held as often as once a week during the first month or so. As treatment progresses (and especially if defendants appear to be making satisfactory progress), the frequency of status hearings decreases, but the court continues to monitor defendants. Judges encourage offenders to stay in treatment through graduated rewards and sanctions.

Prosecutors ensure that participants meet established admission criteria, review treatment progress reports (and ask judges to impose sanctions if defendants fail to comply with program requirements). Defense attorneys review charges against defendants as well as any information available from police reports or other documents disclosed by prosecutors, advise defendants about their constitutional rights (e.g., right to counsel and right to a speedy trial) and options, including participation in treatment programs, explain how various treatment program outcomes will affect the disposition of their cases, and provide encouragement and support for participation and compliance with program conditions.

A screening officer (who can be a pretrial services officer, TASC program coordinator, a member of a jail administrator's staff) reviews the list of defendants arrested each day and screens each for eligibility based on criminal justice criteria (e.g., current charges and prior record) as well as substance use problems and infectious diseases. This individual may also supervise defendants released from custody for adherence to program conditions. A court clerk or court coordinator assists with scheduling status hearings and other court appearances, organizes and prepares files for cases on each day's calendar, helps judges review the status of cases subject to judicial supervision; follows up on defendants who fail to appear in court as scheduled, and maintains communication with judges, treatment program liaison officers, and others involved in program operations. An assessment officer (typically a person with master's degree in a discipline associated with substance abuse treatment or the equivalent in actual experience) conducts assessments of substance use problems and makes recommendations regarding substance abuse treatment. Court case managers help judges manage courtsô pending caseloads and daily calendars and liaise with representatives of agencies involved (including treatment providers). Treatment case managers coordinate service and support provision, including treatment and ancillary services (e.g., housing, medical care, nutrition,

literacy training and job placement). In some jurisdictions, this function is performed by a treatment program liaison officer. Treatment Program Liaison Officers explain program operations to defendants, ensure progress reports are provided to judges, prosecutors and defense lawyers in advance of status review hearings, provide information on available treatment options, and help arrange for transportation for defendants to treatment programs.

One key aspect of judicial supervision is the use of sanctions when a defendant fails to comply with program conditions, and the use of rewards for continued adherence and abstinence. Court sanctions have been found to be an important element in treatment due to the leverage they exert on defendantsô entry into and adherence to treatment. Research shows that people involved in the criminal justice system have limited rates of retention and graduation from substance use treatment programs in the absence of such leverage.

Sanctions include verbal admonishments and warnings from the bench in open court; demotion to an earlier program phase; increased drug testing and court appearances; confinement in the courtroom or jury box; increased treatment intensity; increased monitoring; fines; community service or work program requirements; increasing periods of confinement in jail (during which treatment is provided); and termination from the program and reinstatement of regular court processing. In traditional courts, probation is revoked when defendants are found using substances in violation of conditions of probation. DTCs, in contrast, deal with renewed substance use as part of the recovery process and as an indication that treatment plans need to be reviewed and sanctions be imposed. If this is ineffective, a term in jail or a community correction facility with increasing duration for each violation may be warranted.

Incentives are used to reward progress in treatment and can include encouragement and praise from the bench; ceremonies and tokens of progress, including advancement to the next phase of treatment; decreased supervision; reduced frequency of court appearances; decreased fines or fees; dismissal of charges or decreases in terms of probation; reduced or suspended incarceration; and graduation ceremonies.

Studies indicate that DTCs are effective in producing reductions in rates of incarceration, re-arrests, longer times prior to subsequent arrests and convictions, as well as increased rates of treatment retention and aftercare linkages. In addition, they generate cost savings (at least in the short term) from reductions in the use of jails/prisons, criminal activities, other criminal justice system costs, as well as hospitalizations for health problems. Data from some research shows that ten dollars are saved for each dollar spent on drug courts.

More information on drug courts can be found on the web site of the National Association of Drug Court Professionals (http://www.nadcp.org/) and the web site of the U.S. Department of Justiceôs Drug Courts Program Office (DCPO) located at http://dcpi.ncjrs.gov/dcpi/index.html. In addition, a discussion of family dependency treatment courts can be found in *A Guide to Evidence-Based Mental Health Practices for Children, Adolescents and their Families*.

COMMUNITY REINFORCEMENT TRAINING (CRT)

Community Reinforcement Training is designed to capitalize on instances in which individuals with alcohol use disorders are motivated to engage in treatment. It entails providing concerned others with motivational training and encouraging independence from the person. Several reinforcement techniques are taught including the provision of positive consequences for not drinking, scheduling activities that compete with drinking, ignoring the person when they are drinking alone, and allowing the person to experience the negative consequences of drinking. The concerned other takes advantage of situations in which the person is feeling regret for their actions and exhibits a higher level of motivation to make behavior changes by suggesting treatment and immediately contacting a provider to set up an appointment. A number of

sessions are held with spouses during which they are taught how to implement a safety plan if the risk of physical abuse is high, encourage abstinence and treatment seeking, and assist in treatment.

Family members are seen the day they telephone seeking help for a family member. Thus, availability during nonworking hours is critical for instances during which crises may occur and the individual requests help. Immediate office-based meetings, even during the middle of the night, are held. Studies have shown that CRT is effective in reducing alcohol consumption, and increasing rates of treatment engagement and retention.

COMMUNITY REINFORCEMENT APPROACH (CRA)

CRA is a brief systemic and behavioral family intervention provided as an office or home-based model that is designed to assist significant others, usually spouses, learn to support sobriety by reinforcing abstinence through alternative activities (e.g., family, work, social, and recreational endeavors) that are incompatible with substance use, while allowing the individual to be subjected to negative consequences of intoxication. Such alternative sources of reinforcement are made available when the individual is sober/substance-free and made unavailable when the individual engages in substance use. Significant others also learn to identify instances in which the person is willing to enter treatment, and provide encouragement in a non-confrontational manner. They are also aided in recognizing and responding to warning signs of domestic violence by de-escalating conflict to ensure their own safety. In addition, significant others participate in couples counseling and help their spouses find employment. Women who participate in CRA receive parenting skills training and can attend parenting classes to acquire knowledge regarding the normal stages of child development.

Significant others attend sessions subsequent to the individual's agreement to receive treatment and participate in communication skills training and reciprocity marriage counseling sessions to foster the development of mutually reinforcing behaviors. Significant others monitor daily disulfiram intake and respond if doses are missed. Contracts are also used between spouses to negotiate contingent interactions such as engaging in enjoyable activities when abstinent and foregoing them when using. Clients can participate in employment and social skills counseling. A Job Club component offers skills training, job application assistance, assertiveness and positive interaction practice, job interviewing practice, and job maintenance skills (e.g., punctuality, teamwork, dealing with problems that arise at work). Once a client has secured employment, their involvement in the Job Club ceases. Work with the clinician on maintenance of the job continues, however. Research supports the efficacy of providing employment assistance.

CRA has a significant base of evidence for reducing alcohol and opioid use. It has been shown to increase the engagement and retention of persons with substance use disorders and their families in treatment with or without voucher-based incentives. It has also been found to be effective for individuals with alcohol use disorders deemed treatment-resistant. Outcome studies indicate that CRA leads to significant reductions in alcohol consumption and, when applied during the precontemplation phase, leads to increased entry into treatment. CRA Plus Vouchers has been shown to be of significant benefit to individuals with cocaine dependence and is effective for adolescents. A CRA manual for treating cocaine dependence is available from the National Institute on Drug Abuse located on the web at http://www.drugabuse.gov/pdf/CRA.pdf.

COMMUNITY REINFORCEMENT AND FAMILY TRAINING (CRAFT)

CRAFT is an enhanced modification of CRA that is designed to engage adults with substance use problems in treatment and consists of two phases. During the first phase the concerned

other employs reinforcement techniques to help reduce substance use. When the person demonstrates motivation for treatment, the concerned other immediately calls the provider to set up an intake appointment that is scheduled within forty-eight hours. Phase II is designed to engage the person in treatment by using motivational enhancement techniques. Treatment goals are developed and drug refusal training, social skills training, and relapse prevention training are provided.

CRAFT emphasizes communication skills for significant others to use which include clear, specific and positive interactions, as well as labeling feelings, expressing understanding of the others' perspective, acceptance of partial responsibility when warranted, and offers for assistance. The welfare of significant others is stressed; they are encouraged to reduce their own levels of stress by enhancing self-care and seeking positive social supports. Significant others also help in analyzing behavior patterns surrounding substance use. Interpersonal cues, triggers and consequences are identified along with positive consequences to enhance sober and adaptive behaviors. The risk of domestic violence is assessed using the Conflict Tactics Scale. A safety plan and strategies are developed.

Outcome studies indicate CRAFT is very effective in engaging individuals in treatment. In addition, significant others display reductions in anxiety, anger and depression irrespective of the client's treatment status. A manual for CRAFT is available for download from http://www.bhrm.org/guidelines/CRAmanual.pdf.

BRIEF INTERVENTION

Brief intervention focuses on the reduction or elimination of substance use to minimize or prevent the harm associated with such use either via the technique itself or through referral for treatment. It is conducive to primary care and other opportunistic settings because it can be conducted within a limited number of (three ten to fifteen-minute) sessions that encompass assessment and motivational counseling to decrease substance abuse or promote entry into treatment.

Brief intervention incorporates five basic steps irrespective of the number of sessions or length of intervention:

1. Introduction of the issues within the context of the individual's health
2. Screening, evaluation, and assessment
3. The provision of feedback regarding screening results, impairment, and risks
4. Discussion of change strategies and goal-setting
5. Summarization and reaching closure

There are six components of brief intervention designed to alter substance use behavior captured in an acronym called **FRAMES**:

- **F**eedback regarding personal risk or impairment is given in a non-confrontational manner following assessment of substance use patterns and associated problems. Such feedback usually entails presenting information from standardized instruments and compares consumers'scores with normative data from the general population or groups receiving treatment.
- **R**esponsibility for change is placed directly and explicitly on consumers in a manner that respects their rights to make choices for themselves in order to empower them so they are more invested in the process of change. Consumers are thus deemed the leading experts regarding their own needs.

- **A**dvice regarding changing (i.e., reducing or stopping substance use) is given clearly in a nonjudgmental manner. This is best accomplished via suggestions rather than directives. Research indicates that educational advice based on scientific evidence is effective.
- **M**enus of self-directed change options and treatment alternatives are offered. A menu of options contributes to enhancing the effectiveness of treatment and reducing premature termination from treatment and resistance to change.
- **E**mpathic counseling offered in a warm, respectful, and understanding manner using reflecting listening skills. Positive outcomes are associated with this style.
- **S**elf-efficacy, or optimistic empowerment, is engendered to encourage change.

The 5 As of Brief Intervention for Tobacco use
Ask about tobacco use. Identify and document tobacco use status for every patient at every visit.
Advise to quit. In a clear, strong, and personalized manner urge every tobacco user to quit.
Assess willingness to make a quit attempt. Is the tobacco user willing to make a quit attempt at this time?
Assist in quit attempt. For the patient willing to make a quit attempt, use counseling and pharmacotherapy to help him or her quit.
Arrange follow-up. Schedule follow-up contact, preferably within the first week after the quit date.

Brief intervention has been demonstrated to be effective in reducing or eliminating alcohol consumption and associated problems in adolescents, adults, and older adults in a variety of settings. Studies have found that a reduction in drinking occurs after the first follow-up visit, and, even without repeated follow-up sessions, discernible behavior change occurs immediately. Some research indicates that individuals who experience recurrent and significant substance use difficulties that have led to social, interpersonal or legal problems, and have previous histories of substance abuse treatment are less apt to be responsive to brief intervention.

MOTIVATIONAL ENHANCEMENT THERAPY (MET)

Motivational Enhancement Therapy combines MI with systematic feedback of assessment results and incorporates strategies to induce rapid and internally motivated change (rather than providing guidance in a stepwise fashion through the recovery process). MET consists of an initial assessment, followed by two to four individual treatment sessions. The first treatment session focuses on providing feedback generated from an initial assessment to stimulate discussion regarding personal substance use and elicit self-motivational statements. The principles of Motivational Interviewing are used to strengthen motivation and construct a plan for change. Coping strategies for dealing with high risk situations are suggested and discussed. During subsequent sessions change is monitored, cessation strategies being used are reviewed, and encouragement for commitment to change or sustained abstinence is provided. MET can be used as a stand-alone brief intervention or can be integrated with other interventions (e.g., Cognitive-Behavior Therapy). Significant others are sometimes included in sessions.

Research has demonstrated that MET is associated with increased participation in treatment and beneficial treatment outcomes (e.g., decreased consumption of substances, increased abstinence, better social adjustment, and successful treatment referrals). MET with a family component has been found to be effective for adolescents by improving commitment to treatment and motivation, as well as reducing substance abuse and high risk behaviors (e.g., drinking and driving, and unsafe sexual practices). Project MATCH, the largest clinical trial conducted to compare various treatment approaches for alcohol use disorders, found that a

four-session course of motivational enhancement therapy resulted long-term outcomes similar to those of other more intensive outpatient treatment methods and that it is applicable to diverse cultural and socioeconomic groups.

CONTINGENCY MANAGEMENT (CM)

Contingency management, a form of operant behavioral conditioning, is designed to reinforce an individualôs commitment to abstinence and to attenuate substance use through the systematic application of rewards and negative reinforcers (punishers) in response to desired and undesired behaviors. It is typically used to enhance behaviors such as adherence to medication regimens or treatment plans, maintaining abstinence, participating in group and individual therapies, and achieving specific goals. Behaviors that are incompatible with substance use are fostered. Reinforcers typically consist of prizes, vouchers, retail items, and privileges.

Contingency management entails the identification and selection of a specific measurable target behavior (e.g., substance-free urine samples) ascertained through a functional analysis. Explicit and desirable contingencies are identified and selected to be used as rewards given each time the target behaviors are displayed. While it is recommended that rewards not be exchangeable for cash (to avoid funding purchases of substances), they can have a cash equivalent (e.g., nonrefundable movie or meal passes). Reinforcers need to be of a sufficient magnitude to alter behavior and also be desirable. In addition, links between targeted behaviors and rewards need to be specified. Tailoring contingencies to meet clientsô needs has been found to be more effective.

Clients with co-occurring psychiatric and substance use disorders and those involved in the justice system have been found to benefit from CM as a means to enhance engagement and retention in treatment. CM can be used to address co-occurring interpersonal, legal, and employment problems through activity reinforcement. In such procedures clients select two or three goal areas to focus on. Each week one activity related to each goal is selected (e.g., calling GED programs, attending a medical appointment, filling out a job application, etc.).

Contingency management has a significant base of empirical evidence to support its use for difficulties with a variety of substances (e.g., marijuana, opioids, cocaine, and alcohol) and has been found to have the strongest support of any intervention for individuals who use stimulants, even those who have a high degree of treatment-resistance. Contingency management is most effective when used within a comprehensive treatment program, not as a stand-alone intervention. It has been demonstrated to increase adherence to treatment, attainment and maintenance of abstinence as evidenced by negative drug tests, attendance at counseling and medical appointments, as well as employment and volunteering for participants in methadone maintenance therapy. When used in combination with progressive muscle relaxation and systematic desensitization, contingency management has been found to be effective eliminating opioid use.

Written contracts have been shown to be a helpful component of CM, especially for adolescents as they confer a sense of control and personal investment in oneôs own welfare during a period of life when authority issues and the establishment of oneôs identity are paramount. Written contracts are used to specify the duration and any changes over time in contingencies. Contingency contracts have been demonstrated to lead to decreases in relapses and increases in treatment retention. Contracts that focus on goals that support recovery (e.g., saving money, attending vocational training, attending therapy sessions, etc.) have been shown to lead to more beneficial outcomes than those that focus on substance use (e.g., negative drug screens). Moreover, contracts have been found to be more effective when the consequences that can

result from a breach are more severe. Such contracts with people who have co-existing disabilities may need to be more explicit, and the consequences for relapses in particular may need to be individually tailored to individual capacities for achievement.

GROUP THERAPY

Group therapy is one of the most frequently used modalities for the treatment of substance use disorders although the base of evidence for its effectiveness is rather limited. Groups offer a number of advantages including economies of scale leading to cost effectiveness (since one therapist can provide services for several clients simultaneously), the provision of positive peer support for abstinence, reduced social isolation, assistance from peers in the development of effective coping and problem-solving skills, the provision of role models of people in recovery, opportunities for social skills development and rehearsal, and acculturation into the traditions of recovery. Groups also offer the opportunity to acquire skills to cope with problems through seeing how others deal with such problems, as well as interaction within a safe, supportive, substance-free environment. Groups can be conducted in outpatient, inpatient, and residential settings. Time-limited group therapies typically last from six to twelve sessions and are ninety minutes to two hours in length. Research indicates that the majority of clients in group therapy experience improvement within two to three months.

Because recovery is an ongoing process, clients may require different groups as they progress or encounter impediments. Clients may also participate in more than one group at the same point in time. The types of groups that are beneficial are determined by stage of change and needs at specific points in time. It should be noted that not all clients derive benefits from all groups and there is no single model of group therapy required or appropriate for all clients.

Studies show that groups need to explicitly articulate the reasons for each member's participation to reduce dropouts. Acceptance of the contract prior to participation has been found to be the most significant factor in successful groups in outpatient settings. It is recommended that prior to participation in groups, clients receive orientation regarding group rules, appropriate behavior, confidentiality and expectations regarding attendance, participation, honesty, and giving feedback to others. During group therapy sessions, excessive retelling of substance use stories (i.e., drugalogues) is prohibited as such narratives can extol use, generate euphoric recall, and become triggers for cravings and relapse.

Most groups are comprised of heterogeneous members who share similar needs. However, group therapy has been shown to be more effective when membership is comprised of individuals who have shared commonalities including culture, gender, and sexual preference because members are more likely to feel comfortable with others who have shared backgrounds. For example, same sex groups are more effective for women as they are more likely than men to have experienced traumatic events. Since perpetrators are most often male partners, male family members, or male acquaintances, women can be less willing to disclose and discuss their victimization in mixed gender groups. Research indicates that women derive more benefits from groups that are comprised of all women rather than mixed gender groups. These include improved treatment retention and completion of treatment programs. In addition, participants avail themselves of more services during treatment and are more apt to feel they are successful in treatment.

Research indicates that older adults bond into groups at a more rapid rate than younger adults and age-specific groups for older adults are more effective. It is recommended that groups for individuals who are lesbian, gay, bisexual, and transgender (LGBT) include attention to safe-sex practices and feelings regarding same-sex experiences. If groups are inclusive of heterosexual

and LGBT clients, sensitivity training regarding LGBT issues and concerns needs to be conducted; homophobic behavior in groups can have a deleterious effect.

A number of different types of groups are used in substance abuse treatment several of which are described in the paragraphs that follow.

Educational programming is often a component of correctional facility-based substance abuse treatment and is designed to help participants become aware of the risks and consequences associated with substance use and encourage behavioral change. Moreover, education is cost-effective and can address other related issues including:

- The medical effects and consequences of drug use and abuse
- Understanding addiction (including the signs and symptoms)
- Introduction to 12-step programs
- Denial and other defense mechanisms
- Effects of substance use on families
- Thinking errors and risky behaviors
- Human sexuality
- HIV/AIDS and other infectious diseases
- Coping skills
- Communication skills

Psychoeducational groups are designed to provide education regarding substance abuse, related behaviors, and its consequences to clients and families. Such groups are highly structured and often follow a manual or curriculum, use videos or lectures designed to have direct applications to clients' lives and instill self-awareness, offer options for growth and change, identify community resources that can aid in recovery, develop an understanding of the process of recovery, and prompt people using substances to take action on their own behalf (e.g., enter a treatment program). Techniques such as role playing, group problem-solving exercises and structured experiences are used to foster active learning. Handouts and homework assignments are used adjunctively. Psychoeducational groups actively engage participants in discussion and encourage them to relate what they are learning to their own issues.

Psychoeducational groups are used to help individuals in the precontemplative or contemplative stages of change to reframe the impact of substance use on their lives, develop an internal need to seek help, and discover avenues for change. They are also effective in helping clients in early recovery learn more about their disorders, recognize barriers to recovery, and enhance understanding of avenues for recovery.

Topics typically covered in psychoeducational groups can include, but are not limited to:

- The dynamics of addiction and the addiction process
- The role and process of treatment and recovery
- The medical aspects of addiction
- The importance of abstinence from substances
- Appropriate uses of prescription and over-the-counter drugs
- Maximizing the use of self-help and support groups
- Spirituality and the development of external sources of support
- The roles of nutrition, exercise, leisure, and recreation in recovery
- Relationship skills
- Sex, sexuality, and recovery
- Conflict resolution and confrontation skills
- The family dynamics of addiction, healthy relationships, and family functioning

- Avoidance and diffusion of triggers for craving and relapse
- Relapse management skills
- Substance refusal skills
- Minimizing risks for HIV/AIDS and sexually transmitted diseases

Group-based didactic and experiential sessions are provided for family members and significant others to help engage them in treatment and enhance their understanding of the treatment and recovery process. Groups can help families understand the behavior of a person with substance use disorder in a way that allows them to support the individual in recovery and learn about their own needs for change. They also help clients and families learn about other resources that can be helpful in recovery (e.g., meditation, relaxation training, anger management, spiritual development, and nutrition). Multifamily groups can be used to show benefits others have received from treatment. Topics covered in family educational sessions include, but are not limited to:

- The dynamics of addiction, treatment, and recovery in the family
- Relapse and relapse prevention
- Family dynamics and issues commonly experienced by families with a member who has a substance use disorder
- Healthy family functioning
- Communication and problem-solving in the family
- Management of family social functions
- Introduction to Al-Anon, Alateen, and other supports for family members

Psychoeducational groups for older adults have been found to effective when they include information about the developmental tasks of the later stages of life (e.g., retirement, loss, illness of a partner/spouse, nutrition, household management, and exercise), support systems, and the medical aspects of aging and substance use disorders. Groups tailored for older adults need to consider accommodations for sensory deficits by maximizing multi-sensory inputs (e.g., simultaneous visual and auditory presentation of material, documents with enlarged print, voice enhancers, blackboards, overhead projectors, and flip charts).

Psychoeducational groups have been shown to be beneficial for clients of all age groups as well as those with co-occurring psychiatric disorders. Such groups are considered a useful and necessary, but not sufficient, component of substance abuse treatment.

Skills development groups are designed to help participants develop skills needed to attain and maintain abstinence (e.g., anger management, relaxation, and coping with urges to use substances). A number of different skills development groups are used in treatment, the majority of which use a cognitive-behavioral approach. The most common type is the coping skills training group designed to promote the achievement and maintenance of abstinence. The skills focused on can be directly related to substance use (e.g., ways to refuse offers of drugs, avoid triggers for use, or cope with urges to use) or apply to broader areas relevant to continued sobriety (e.g., ways to manage anger, solve problems, or relax). Skills development groups are usually time-limited and include eight to ten participants during which the skills being taught during sessions are practiced.

Relapse prevention groups focus on helping participants recover from relapse or maintain abstinence and are designed for clients who have attained abstinence but need skills to maintain abstinence, are experiencing a crisis, or are at risk for returning to substance use. Such groups focus on skills and knowledge to anticipate, identify, and manage high risk situations that lead to relapse, develop alternative ways of coping with stressful situations, and reduce the intensity of relapses. Relapse prevention groups use activities, problem-solving, and

skill-building, and incorporate techniques found in other types of groups, particularly cognitive-behavioral, psychoeducational, skills development, and process-oriented groups.

Relapse prevention groups appear to be more effective than other approaches for clients who have more severe levels of substance use, greater levels of negative affect, and more pronounced deficits in coping skills. Potential participants need to achieve a period of abstinence prior to participation. It has been found that there is little measurable difference in outcomes between relapse prevention conducted in individual and group formats.

Cognitive-behavioral groups have long played a significant role in treatment, particularly for individuals in early recovery. The majority of cognitive-behavioral groups emphasize structure, goal orientation, and a focus on immediate problems. In general, techniques include those which (1) teach group members about self-destructive actions and thinking that leads to ineffective behavior, (2) focus on problem-solving and short and long-term goal setting, and (3) help clients monitor feelings and behavior, particularly those associated with substance use. Cognitive restructuring is used to promote change in learned behaviors by altering thinking patterns, beliefs, and perceptions. Various interventions including identification of conditioned stimuli associated with specific substance use-related behaviors, avoidance of such stimuli, development of enhanced contingency management strategies, and response-desensitization are incorporated to increase awareness of behaviors that may lead to relapse and develop strategies to persist in recovery. These types of groups help participants develop social networks that support continued abstinence. Treatment manuals are available for a number of different kinds of cognitive-behavioral groups.

Support groups are a frequently used treatment component and originated in the tradition of self-help. They are designed to strengthen participantsô efforts to develop and maintain the ability to manage thinking and emotions, develop more effective interpersonal skills, and improve self- esteem and self-confidence. Support group members also help each other with pragmatic concerns (e.g., maintaining abstinence and managing day-to-day living). Participants typically talk about their current situations and recent problems that have arisen. Discussions tend to focus on practical issues related to maintaining abstinence (e.g., ways to deal with legal issues or avoid places that tempt people to use substances). Group members are encouraged to share and discuss their common experiences. Support groups provide guidance through peer feedback, and group members generally require accountability from one another. Group leaders minimize confrontation in order to reduce anxiety.

Support groups have been developed for all stages of treatment in all treatment settings (inpatient, outpatient, continuing care, etc.), the purpose of which varies in accordance with participantsô motivation and stage of recovery. Groups can be open-ended, with a changing population of members, or closed. Many reflect the twelve-step tradition, but others are based on recovery tools, such as relapse prevention. Interventions tend to be more interpretive and observational and less directive than in other types of groups in order to encourage and facilitate supportive interaction among group members. Support groups can be particularly helpful for clients who are apprehensive or new to abstinence.

> **Support Together for Emotional/Mental Serenity and Sobriety (STEMSS)** is a supported, self-help, recovery-oriented, open-ended group approach for individuals with co-occurring psychiatric and substance use disorders that was developed in 1984. It is psychoeducational in nature and uses facilitators (e.g., counselors, clinicians, nurses, or paraprofessional staff) to promote peer leadership and consumer governance of group meetings which complement participation in twelve-step programs. While most groups begin with trained facilitators, and a number maintain a central role for facilitators, the model encourages peer facilitation to the maximum extent possible. Facilitators and

professionals function as resources for the provision of accurate information, guidance, and assistance in the achievement of self-empowerment, peer leadership, and self-governance, rather than as leaders.

The program is comprised of six steps that are designed to complement those of Alcoholics Anonymous and Narcotics Anonymous:

1. I admit and accept that my mental illness is separate from my chemical dependency, and that I must work a double-recovery program.
2. As a result of this acceptance, I am willing to accept responsibility for my life and help for my recovery.
3. As a result of this acceptance I came to believe that, with help and understanding, recovery is possible.
4. As a result of this belief, I accept the fact that medical management must play a large part in my recovery process. This may include prescribed medications taken as directed.
5. As part of this recovery process, I accept the fact that I must maintain a lifestyle free from all recreational chemicals including alcohol and drugs.
6. In following these steps throughout my life, I will reach my goals and help others to begin the recovery process.

Members are encouraged to pursue their own ongoing therapy and attend support groups especially Alcoholics Anonymous, Narcotics Anonymous, and mental health groups. Emphasis is placed on accepting responsibility for one's own recovery and coming to grips with the emotional growth necessary to break the cycle of dependency, disease, and despair. The medical aspects of mental health are emphasized, and members are encouraged to discuss their symptoms, medications, and side effects as full partners in the treatment partnership. The goal is to help members remain stable and substance free in order to fully participate in society. The model recognizes the role of pharmacology in psychiatric treatment and acknowledges the ease of confusion between a medication and a drug. Various adaptations to the format include:

- Step Education Groups to introduce the model and the steps. Facilitators can provide information about the steps and members can volunteer to speak about a step. Discussion may be used to begin modeling group skills. A variation is the Speaker Meeting which entails presentation on a topic of interest by an invited guest.
- Step Exercise Groups use pen and paper worksheets to examine the steps in order to help participants consider recovery concepts and become acquainted with one another.
- Step Discussion Groups select one of the six steps (in rotation) for discussion by each member in turn in a manner that is similar to Twelve-Step meetings. This is the most common format for STEMSS.
- Step Process Groups are highly interactive and cover the steps and group process in greater depth. These can be of particular benefit for consumers in later stages of change for obtaining feedback on personal issues and working on relapse prevention skills.
- Open Topic Process Groups are often led by clinicians and consist of rounds and agenda-setting by members.

STEMSS is currently in use throughout the United States and Canada in settings including treatment centers, community support programs, and homeless shelters in urban and rural areas. It has been translated into Spanish.

Other types of groups used in treatment include expressive groups, communal and culturally-specific groups, problem-focused groups, and interpersonal process groups (which explore developmental issues that contribute to substance use disorders or interfere with recovery).

SELF HELP AND MUTUAL SUPPORT

Self-help programs include twelve-step groups such as Alcoholics Anonymous (AA) for people with alcohol abuse problems, Narcotics Anonymous (NA) for people with problems of drug abuse and addiction, Double Trouble and Double Trouble in Recovery for people with co-occurring psychiatric and substance use disorders, and Alanon, for relatives and friends of persons with mental illness or addiction problems are highly cost-effective. These programs sometimes offer sponsors who volunteer to provide support and guidance to other individuals at earlier stages of recovery. Self-help groups provide support for recovery in conjunction with or after treatment for maintenance and reinforcement of sobriety.

SOS, Secular Organizations for Sobriety (or Save Our Selves) is a mutual support program for persons with substance use disorders who are uncomfortable with the spiritual contact of twelve-step programs. Women for Sobriety is an organization as well as self-help program for women with alcohol addiction. Women Helping Other Women is a self-help program for women struggling with multiple issues including mental illness, substance abuse, and trauma from physical or sexual abuse.

SMART Recovery (Self-Management and Recovery Training) offers face-to-face and online mutual help groups for individuals with addictive disorders using a secular science-based approach that incorporates non-confrontational motivational and cognitive-behavioral methods derived from Motivational Enhancement Therapy (MET) motivational interviewing and Rational Emotive Behavior Therapy (REBT). The program emphasizes four areas (called the Four Points) in the process of recovery: Building Motivation, Coping with Urges, Problem Solving, and Lifestyle Balance. The SMART Toolbox is a collection of various MET, CBT and REBT methods which address the Four Points. SMAMT is an alternative to anonymous, twelve-step, self-help groups (e.g. AA, NA, etc.) although it can be used as a supplement to twelve-step programs. The meetings are free of charge and provide information as well as support to attendees. Online resources are also available from http://www.smartrecovery.org/. Concerned Significant Others (CSO) is an online support group for family and friends of SMART Recovery participants which is based on the Community Reinforcement and Family Training (CRAFT) approach.

Research supporting the efficacy of self-help groups is inconsistent, but such programs can provide a prosocial support network to increase motivation and can function as a helpful adjunct to formal treatment.

TWELVE STEP FACILITATION THERAPY (TSF)

Twelve-Step Facilitation Therapy is a brief, structured, manualized outpatient treatment designed to facilitate early recovery that is conducted on an individual basis for twelve to fifteen sessions. It is based on the behavioral, spiritual, and cognitive principles that form the basis of twelve-step fellowships which incorporate acceptance of the need for abstinence from substance use and surrender (i.e., the willingness to participate actively in twelve-step fellowships as a means of sustaining sobriety). Treatment goals are broken down into a series of cognitive, emotional, relationship, behavioral, social, and spiritual objectives. The model facilitates active participation and involvement with twelve-step self-help organizations, such as Alcoholics Anonymous and Narcotics Anonymous. A component of TSF includes conjoint sessions with significant others.

TSF encourages the provision of adjunctive therapies for interpersonal difficulties (e.g., marital conflicts and family problems) until participants have achieved about six months of sobriety. It can be provided in combination with pharmacotherapy for substance use disorders, major

affective disorders, and psychotic disorders. The model has been adapted for use in a group format. Another adaptation has been made for cocaine use in which clients are seen twice a week for the first three weeks followed by the standard hourly once per week format.

TSF has been found to be effective for alcohol use disorder and concurrent alcohol and cocaine abuse and dependency in individuals from diverse socioeconomic, educational, and cultural backgrounds. Outcome studies show that it leads to increased rates of abstinence and twelve-step group involvement. Individuals who have severe symptoms of cocaine or opiate use, are unemployed, and have no source of spousal or other family support appear to benefit the least from TSF. This therapy is not compatible with interventions designed for the controlled use of substances. TSF is listed on SAMHSA's National Registry of Evidence-based Programs and Practices (NREPP) at http://nrepp.samhsa.gov/ViewIntervention.aspx?id=55.

THERAPEUTIC COMMUNITIES (TCS)

Research shows that highly intensive residential programs are the most effective in reducing substance use and criminal behavior. Prison-based therapeutic communities[29] which isolate participants from the general population and provide intensive treatment have been found to be are highly effective, particularly when followed by community-based treatment. Beneficial outcomes include reductions in re-incarceration, use of injection drugs, hospital stays for drug and alcohol problems, and recidivism. The majority of prison-based therapeutic communities last for a minimum of six months in duration, although research indicates that the most beneficial outcomes are derived from prison-based TCs of nine to twelve months in duration.

Program components include:

- Community meetings, events, and ceremonies
- Seminars
- Group encounters
- Group therapy
- Individual counseling (both from staff and peers)
- Tutorial learning sessions
- Remedial and formal education classes
- Participant job/work responsibilities
- Explicit treatment phases that are designed to provide incremental degrees of psychological and social learning including:
    - Orientation to acquaint participants with the rules of the TC and establish routines
    - Group and individual counseling to work on issues of recovery
    - Recovery maintenance and relapse prevention
    - Reentry planning

Prison-based TCs have been found to be highly effective treatment programs. Outcome studies show reductions in re-arrests and relapses when aftercare in the community is provided; lack of continuity in the form of aftercare leads to high relapse rates subsequent to release from incarceration. It has also been found that separation from the prison subculture during treatment is the most effective approach for engendering attitudinal and behavioral changes among participants.

Community-based therapeutic communities have been adapted to address the needs of mothers and involvement of children and function as alternatives to prison and halfway houses

[29] Prison-based TCs were developed as a result of evidence that New York's Stay 'N Out program, started in 1974, has been highly effective in decreasing rates of recidivism for both men and women.

and include services for residentsô children. Other modified TCs have been developed for people with co-occurring psychiatric and substance use disorders.

MODIFIED THERAPEUTIC COMMUNITIES (MTCS)

MTCs for individuals with co-occurring disorders use adaptations to the therapeutic community model to accommodate psychiatric symptoms, neurocognitive impairments, and reduced urge control. Four types of interventions are used in MTCs: community enhancement, therapeutic/educative, community/clinical management, and vocational. In general, MTCs offer more flexibility, lower intensity, and more individualization of supports. They adhere to the basic tenets of TCs (i.e., the creation of milieus that are designed to promote cultures of mutual self-help and affiliation with the community to promote change). Encounter groups that are used in the TC model have been replaced by conflict resolution groups which are led by staff and emphasize education and learning new behaviors as well as reduced emotional intensity. MTCs also include families in activities including weekend visits, education and counseling. Classes on prevention are offered to children. The inclusion of families occurs during the later part of treatment in order to promote reintegration into the family and community.

Research on MTCs indicate they produce a number of beneficial outcomes including reductions in substance use, depression, and incarceration, as well as improvements in measures of psychological well-being, and increases in employment. The model has been reported to be cost-effective with one study showing a $6.00 benefit for each dollar spent on the program. SAMHSAôs National Registry of Effective Programs and Practices (NREPP) rates MTCs for individuals with co-occurring disorders as a promising approach.

THERAPEUTIC COMMUNITIES FOR WOMEN

TCs have been demonstrated to be effective for women who are incarcerated as well as those who are not involved in the justice system. Adaptations of the TC model to meet the needs of women include reductions in the levels of confrontation (which is provided in a supportive manner emphasizing participantsôpower to make their own decisions). An empowerment model is used to foster independence, coping, and decision-making skills. Issues such as substance abuse, parenting, relationships, domestic violence, sexual abuse, and others germane to women are addressed.

It has been shown that the inclusion of children is an important element in TCs for women. Programs that permit women to enter with their children have been demonstrated to increase treatment retention and improve outcomes (e.g., reductions in relapses and increased employment). This is supported by research that shows that continued interactions between mothers and their children are beneficial to both. In addition, research indicates that women receive the most benefit from TCs (and other substance abuse treatment programs) that provide comprehensive services for meeting their basic needs including:

- Food, clothing, and shelter
- Transportation
- Job counseling and training
- Legal assistance
- Literacy training and educational opportunities
- Parenting training
- Family therapy
- Couples counseling
- Family planning services
- Medical care
- Child care
- Social services
- Social support
- Mental health care
- Assertiveness training
- Family planning services
- Medical care
- Social services

Forever Free is an example of a prison-based residential treatment program for women. It is an intensive twenty-hour a week program that lasts for a minimum of six months and uses a

cognitive-behavioral curriculum designed for women that emphasizes relapse prevention. Participants are also involved in a prison-based work program an additional twenty hours per week. The programôs components include anger management, assertiveness training, self-esteem, understanding healthy versus disordered relationships, posttraumatic stress disorder, parenting, sex and health, and abuse. Additional aftercare components have been added since its inception in 1997 including community-based residential treatment. Evaluation studies have shown that participants display reductions in arrests and drug use as well as increases in employment with more significant improvements for those who are involved in aftercare.

Sister in Sober Treatment and Empowered Recovery (SISTER) is a jail-based modified therapeutic community that offers a range of services including individual and group counseling, acupuncture, GED, literacy, work training, HIV education and counseling, and a program for prostitutes called the EX-SEX Workers Group. There are specific groups for lesbian and bisexual women, African Americans, Hispanics, and Pacific Islanders. AA and NA meetings are held on-site in English and Spanish. Pre-release planning includes educational and vocational assessments, job training, and relapse prevention. Residential treatment is provided subsequent to release. Outcome studies indicate decreases in recidivism and violent crimes. Participants who are involved in community residential treatment following incarceration have been shown to benefit the most.

MEDICATION-ASSISTED TREATMENT (MAT)

Pharmacotherapy for substance use disorders is prescribed: (1) to replace a harmful substance with a safer drug of the same class (e.g., methadone); (2) to suppress symptoms of withdrawal; (3) to discourage continued substance use by precipitating an unpleasant reaction or reducing the euphoric effects of a substance (e.g., disulfiram and naltrexone); (4) for agonist substitution therapy (which replaces an illicit drug with a prescribed medication); (5) to treat co-occurring psychiatric disorders; and (6) to decrease potential relapses.

Pharmacotherapy can be used effectively to facilitate recovery, but, in and of itself, does not promote the lifestyle changes required for long-term recovery and is therefore rarely adequate as a stand-alone intervention for successful treatment on a long-term basis. Medications have been found to be most effective when used in conjunction with psychosocial interventions. Multimodal approaches that combine maintenance medication with behavioral interventions have been shown to lead to more beneficial outcomes (e.g., enhanced motivation, adherence to treatment regimens, and cessation of opioid abuse). For example, medication assisted treatment programs for opioid use disorders have been shown to lead to significant reductions in substance use, HIV risk, and criminal behavior, as well as substantial improvements in health and employment, when treatment is provided in combination with psychotherapeutic interventions (e.g., individual psychotherapy for clients with co-occurring psychiatric disorders, family therapy, contingency contracting, and vouchers).

Generic	Brand
Alcohol	
Alcohol withdrawal agents	
benzodiazepines (e.g., lorazepam)	Ativan
anticonvulsants (e.g., carbamazepine, divalproex sodium, gabapentin)	Tegretol, Depakote, Neurontin
barbiturates	
Alcohol relapse prevention agents	
disulfiram	Antabuse
naltrexone hydrochloride	ReVia, Depade
acamprosate	Campral

Generic	Brand
nalmefene hydrochloride	Revex
topiramate	Topamax
Opioids	
Opioid withdrawal agents	
buprenorphine	Subutex
buprenorphine and naloxone	Suboxone
clonidine	Catapres
methadone hydrochloride	Methadone
nalmefene hydrochloride	ReVia, Depade
naltrexone hydrochloride	Revex
Opioid maintenance agents	
buprenorphine	Subutex
buprenorphine and naloxone	Suboxone
LAAM (levo-alpha-acetyl-methadol)[30]	
methadone hydrochloride	Methadone
Nicotine	
Nicotine replacement agents	
Nicotine	Nicoderm CQ, Nicotine Transdermal System, Nicotrol Inhaler, Nicotrol NS
nicotine polacrilex	Commit, Nicorette, Nicotine Gum
Nicotine cessation agents	
bupropion SR	Zyban
varenicline tartrate	Chantix

CO-OCCURRING DISORDERS (CODS)

Co-occurring substance use disorders affect more than seventy five percent of persons with mental illnesses who are incarcerated, fifty nine percent of whom are reported to have been under the influence of alcohol or drugs at the time of the commission of the crime for which they are incarcerated. These individuals are also more likely to have histories of homelessness, sexual and physical abuse, are overrepresented among probation and parole populations, and are twice as likely to have their community supervision revoked.

Individuals with co-occurring disorders often experience rapid cycling through different parts of the criminal justice and social service systems, including law enforcement, jails, emergency services, and shelters. These individuals frequently experience housing instability and homelessness, unemployment, vocational skills deficits, inadequate financial and social supports, serious medical problems, more frequent hospitalizations, poor engagement and retention in treatment, depression and suicidality, and criminal justice recidivism.

Co-occurring psychiatric and substance use disorders pose a number of challenges in terms of diagnosis and treatment. Mental health problems can function as a trigger for substance use which, in turn, can exacerbate mental health problems. Substance use can produce mental health symptoms, or trigger the emergence of mental health disorders. Mental health disorders can also precipitate substance use disorders. Mental health symptoms can be exacerbated by

[30] Levo-alpha-acetyl-methadol (LAAM) suppresses opioid withdrawal symptoms for forty eight to seventy two hours. The Food and Drug Administration approved LAAM for use in (opioid treatment programs (OTPs) in 1990, but in 2003 strengthened warnings in the product's labeling due to cardiac-related adverse events, including QT interval prolongation (slowing of cardiac induction) and death from torsade de pointes arrhythmia. In 2003 the manufacturer announced it would cease production in 2004. While LAAM has been shown to be as effective as methadone and buprenorphine in decreasing opioid use and enhancing treatment retention, it is no longer available.

alcohol or drug use. Mental health symptoms or disorders are sometimes mimicked by alcohol and drug use. And, alcohol and drug use can mask existing psychiatric symptoms or disorders.

PRINCIPLES OF TREATING CO-OCCURRING MENTAL HEALTH & SUBSTANCE USE DISORDERS

- Comorbidity should be expected, not considered an exception
- Psychiatric and substance use disorders should be regarded as primary disorders when they coexist, each requiring specific and appropriately intensive assessment, diagnosis and treatment, in accordance with established practice guidelines
- Serious psychiatric and substance use disorders are chronic, relapsing illnesses that can be conceptualized by using a disease and recovery model, with parallel phases of treatment or recovery
- Within each subtype of the treatment population, consumers are in different stages of change with regard to their illness. Thus a comprehensive array of intervention that are phase and stage specific is required
- Whenever possible, treatment of persons with complex comorbid disorders should be provided by individuals, teams, or programs with expertise in mental health and substance use disorders
- The system should promote a longitudinal perspective on the treatment of consumers with dial diagnoses, emphasizing the value of continuous relationships with integrated treatment providers, independent of participation in specific programs
- Admission criteria should not be designed to prevent consumers from receiving services, but rather to promote acceptance of consumers at all levels of motivation and readiness and with any combination of comorbid disorders
- The service system should not begin or end at the boundaries of formal treatment programs; rather, it should include interventions to engage the most detached individuals (e.g., those who are homeless)
- The fiscal and administrative operation of the system should support the accomplishment of the system's mission and the implementation of these principles
- Assessment for either disorder should begin as early as possible, without the imposition of arbitrary waiting periods of sobriety, and without a requirement of psychiatric stabilization, on the basis of data collection for an integrated, longitudinal history
- For each disorder, assessment should include a definition of the stage of change or level of motivation
- When mental illness and a substance use disorder coexist, each disorder should be considered primary, and integrated dual primary treatment should be provided; the treatment for each disorder should be matched to the diagnosis and the stage of change
- Medication for known serious mental illness should never be discontinued on the grounds that the consumer is using substances
- Benzodiazepines are not recommended in the ongoing treatment of consumers with known substance dependence with or without a comorbid psychiatric disorder. If a prescriber believes that an exception is warranted, this belief should be considered an indication for peer review, expert consultation, or a second opinion

It is recommended that individuals with co-occurring disorders who are involved in the criminal justice system receive regular drug testing, with more frequent testing for those at high risk for relapse, beginning immediately after an arrest or contact with the justice system, and continuing at random intervals during the course of treatment, supervision, and incarceration. Weekly (and optimally twice) testing during the first few months of community treatment and supervision with tapering off as the individual displays the ability to remain abstinent is recommended. In addition, research indicates that comprehensive prison-based treatment programs for co-occurring disorders leads to reductions in recidivism and, when combined with community reentry services and aftercare, can significantly reduce recidivism.

INTEGRATED TREATMENT FOR CO-OCCURRING DISORDERS

Substance abuse is the most common and clinically significant comorbid disorder among adults who have a serious mental illness. It is estimated that up to fifty nine percent of consumers who a serious mental illness have experienced a co-occurring substance use disorder in their lifetimes. Moreover, these co-occurring disorders are associated a number of negative outcomes including increased rates of relapse, hospitalization, violence, legal problems, incarceration, suicide attempts, homelessness, and serious infections such as HIV and hepatitis. Consumers with co-occurring disorders challenge traditional service delivery systems, frequently are high utilizers of costly services, and rarely fit into the parallel substance abuse and mental health systems where they are often extruded or drop out. Studies show that these separate systems do not deliver appropriate services for this population and are ineffective.

In integrated dual disorders treatment (IDDT), mental health and substance abuse treatment are integrated to meet the needs of people with co-occurring disorders in a stage-wise fashion with different services provided at different stages i.e., engagement, persuasion, active treatment, and relapse prevention). Motivational interventions are used to treat consumers in all stages, but especially in the persuasion stage. Substance abuse counseling, using a cognitive-behavioral approach, is used to treat consumers in the active treatment and relapse prevention stages. Services are available in multiple formats, including individual, group, self-help, and family. Medication services are integrated and coordinated with psychosocial services. Psychiatric medications are prescribed even when there is active substance use. Potentially addictive medications are avoided while those that can help reduce addictive behavior are used.

Research shows that consumers in IDDT programs lead to more beneficial outcomes including reductions substance use, improvements in psychiatric symptoms and functioning, decreases in hospitalization, increases in housing stability, fewer arrests, and improved quality of life. Information on this evidence-based practice can be found at http://store.samhsa.gov/product/Integrated-Treatment-for-Co-Occurring-Disorders-Evidence-Based-Practices-EBP-KIT/SMA08-4367.

INTERVENTIONS FOR SEX OFFENDING

Individuals with histories of sexual offenses face significant community reintegration barriers stemming from longer minimum mandatory sentences for certain sex crimes, expanded registration and community notification policies, and the creation of so-called sex offender free zones that restrict residency, employment, or travel within prescribed areas.

A number of unintended consequences are associated with community notification and residency restrictions including the inability to find suitable housing or return to an established residence after release, forced relocation of established residences, difficulty finding employment or loss of employment, loss of positive social supports, and negative community responses (e.g., harassment and vigilantism). Partners and other family members can be impacted negatively by stigma and being placed under public scrutiny. On the other hand, healthy intimate relationships are an important protective factor in reducing the likelihood of recidivism. It is therefore recommended that couples or family therapy be provided during the course of incarceration and subsequent to release in an effort to cultivate positive intimate relationships as well as address interpersonal concerns and conflicts.

It is recommended that reentry strategies take into account the appropriateness of reunification in situations in which a child within the family was victimized as reunification may impede the victimôs healing and disrupt the familyôs the stability and security, or minimize the seriousness or impact of the returning citizenôs behavior and responsibility. Therefore, reunification planning

should include input from victim advocates, family therapists, and child welfare personnel. It is recommended that reunification be initiated as gradual process that is monitored by community supervision staff, treatment providers, victim advocates and therapists, polygraph testers, families, and victims to prevent further traumatization of the victim and other family members.

In addition, a victim-centered approach to reentry is recommended that includes appropriate safety plans, the provision of services, and supports (e.g., addressing trauma) as well as ensuring victims understand the rights afforded (e.g., compensation and restitution, victim impact statements, public information regarding individuals convicted of sex offenses, notification of release and parole or conditional release violations, including revocation hearing dates and decisions). It is recommended that victim considerations be taken into account in institutional and community supervision strategies that include protection through random home checks after curfew; reviews of driving logs; restricting access to vehicles; frequent contact with family members, roommates, friends, and employers; and the administration of unscheduled polygraph examinations.

Individuals who have committed sex offenses are from diverse racial, ethnic, and socioeconomic backgrounds, and vary significantly in age. And, although there are some shared characteristics (e.g., a lack of education; unstable employment and residence; substance abuse problems; frequent altercations with families, friends, and strangers; and an overall resistance to authority figures), most do not have extensive criminal histories or lifestyles and their range from family members and friends (who are the victims of the great majority of these acts) to strangers. Due to the social and demographic diversity of this population, no common set of characteristics (e.g., physical, mental, psychological, personality, emotional) has been identified.

While the vast majority of individuals who engage in sexual offending are male, there is increasing awareness of females who have been found, unlike their male counterparts, to have been sexually victimized almost twice as often as men, most frequently by a family member. In addition, females often have histories of substance abuse, depression, and post-traumatic stress disorder, and often have experienced childhood sexual and physical abuse. Evidence-based practices for females who engage in sexual offending behavior are lacking.

A number of dynamic risk factors have identified for individuals who engage in sexual offending behavior including negative mood, (primarily anger); substance abuse; sexual preoccupation; victim access; and noncompliance with supervision as well as intimacy deficits and conflicts in intimate relationships; deviant sexual interests; emotional identification with children; pro-offending attitudes; and an antisocial orientation. Dynamic risk factors associated with recidivism include deviant sexual arousal, interests, or preferences; sexual preoccupation; pervasive anger or hostility; emotional management difficulties; self-regulation difficulties, or impulsivity; an antisocial orientation; pro-offending attitudes, or cognitive distortions; and intimacy deficits and conflicts in intimate relationships.

Assessment explores sexual deviance and other risk-related variables (e.g., deviant arousal, interests, or preferences, sexual preoccupation, attitudes tolerant of sex offending), global issues (e.g., intellectual functioning, neurological impairment, psychological or psychiatric difficulties, psychopathy) which give information regarding responsivity and enhancement of overall health and functioning. It is recommended that interviewers ask assumptive, open-ended questions in order to evoke responses that offer detailed information needed to assess patterns of sexually abusive behavior (e.g., asking when the person began touching inappropriately rather that asking whether the person ever touched anyone inappropriately).

Several empirically-validated, sex offender-specific actuarial risk assessment tools have been developed including the Rapid Risk Assessment for Sexual Offense Recidivism (RRASOR), Static-99, Sex Offender Risk Appraisal Guide (SORAG), Minnesota Sex Offender Screening

Tool-Revised (MnSOST-R), and the Vermont Assessment of Sex Offender Risk (VASOR). These and other instruments that have been designed for sex offending are recommended to ensure more comprehensive and accurate information needed to determine the intensity and types of interventions that will be most effective in reducing risk for recidivism for this population because they consider various factors that are uniquely associated with reoffending among this population. The ACUTE 2000, which originated from the Sex Offender Need Assessment Rating instrument, is a promising empirically-guided tool that can be used by supervision agents to monitor acute dynamic factors.

Polygraphs measure specific physiological changes (e.g., respiration, blood pressure, heart rate) believed to be associated with deception and have been found to be associated with information disclosure not provided via self-report alone when used to verify an individual's sexual history. Polygraphs are being used in treatment and supervision to provide independent information regarding compliance and progress and the polygraph examiner is a key part of the case management team in many jurisdictions.

Three types of post-conviction polygraphs are commonly administered to during supervision. Full disclosure or sexual history examinations is to ensure complete disclosure of the person's sexual history typically administered subsequent to three to six months of treatment. Specific issue examinations evaluate a specific behavior or allegation during supervision and are also used when a person denies the crime of conviction (e.g., those sentenced under an Alford Plea[31] or who continue to minimize their responsibility for the abuse despite their conviction). Maintenance or monitoring examinations verify the person's compliance with treatment and supervision conditions and are administered periodically (usually every six months and not more than three times per year). However, there are concerns regarding reliability and validity of polygraphs, including the potential for some individuals to use countermeasures to control some of the physiological responses.

The penile plethysmograph measures erectile response to various stimuli and is typically used to measure the person's sexually deviant interests to develop a behavioral program to reduce the deviant arousal, and as an evaluation tool to measure the success or failure of interventions. A viewing time procedure is often used in which an individual views computer-generated pictures of children, adolescents, and adults on a screen, enters self-reported ratings of attractiveness for each slide, and advances to the next slide. The amount of time spent viewing a slide is believed to provide an objective measure of sexual interest. However, the research on viewing time is very limited, and additional examinations of its reliability and validity are needed.

While, penile plethysmography is considered one of the most invasive techniques, deviant sexual arousal is a significant contributing factor in sex offending. Research indicates that deviant sexual arousal is positively correlated with re-offending, and self-reports regarding sexual arousal are frequently unreliable. Moreover, it is the most objective and reliable method of assessing deviant arousal. However, there are no established reference norms and subjects can employ strategies to suppress their arousal.

Research indicates that strategies that combine intensive supervision, surveillance, and monitoring with specialized treatment results in the most significant reduction in recidivism. Specialized sex offender treatment programming includes limited confidentiality, an emphasis on group and cognitive-behavioral programming, tailoring the intensity and duration of treatment to the person's level of risk (e.g., providing more intensive services to those at higher risk

[31] An Alford Plea allows someone to admit there is enough evidence to convict them at trail without admitting to a crime. This type of plea can subvert treatment because of lack of admission of responsibility for a crime.

individuals and less intensive services to those at lower risk), and collaboration with other professionals involved in the management process.

Traditional psychotherapy differs from treatment for sex offending behaviors in a number of ways including a primary focus on the protection of previous and potential victims in the community; considerable attention is directed toward understanding the harm the individual has caused their victim; thinking errors that contribute to offending patterns are revealed, examined, and challenged; a great deal of the focus is on helping participants understand the harm caused to their victims; professionally facilitated group sessions are used to provide opportunities for participants to challenge one another regarding their denial, distortions, and manipulation; and information discussed in treatment sessions is shared with supervision agents, polygraph examiners, and others as needed.

Treatment programs that have been found effective incorporate relapse prevention and cognitive-behavioral techniques tailored to address multiple needs including marital and family therapy, substance abuse treatment, educational and vocational supports, medication, and individual therapy as needed.

The literature recommends a number of principles in working with people who engage in sexual offending including triage based on risk as research indicates that individuals at higher risk sex benefit from more intense services. Treatment during incarceration should be offered as close as possible to release promote transfer (generalization) of newly developed prosocial skills and competencies to the community. A more therapeutic style should be used as studies have shown that an overly confrontational style (which is used within many sex offender programs) is associated with poorer outcomes. Institutional visits and other contacts offer opportunities to facilitate the development of community support networks. Restricting access to sexually exploitative materials which reinforce preoccupations while enhancing sexual self-regulation skills can reduce recidivism potential.

Studies indicate that individuals who engage in sex offending who receive appropriate prison-based treatment followed by specialized community-based sex offender treatment while under supervision have lower rates of recidivism.

It is recommended that community supervision include collaboration among supervision and treatment provider agencies; a victim-centered approach that focuses on the needs and safety of past and potential victims of sexual assault; mandated specialized treatment that holds individuals accountable and is victim-centered and limited in confidentiality; clear and consistent polices delineating how cases will be investigated, prosecuted, and adjudicated as well as method of community supervision, roles of various agencies in the supervision process, and responses to indications of risk of relapse.

Effective interventions focus on the development of internal behavioral controls using combinations of educational, cognitive-behavioral, and family system interventions and require acknowledgement of the crimes committed and the harm cause to victims. Interventions seek to interrupt the personôs sex offense cycle (i.e., the pattern of specific thoughts, feelings, and behaviors that often lead up to and immediately follow the acting out of sexual deviance).

COGNITIVE BEHAVIORAL THERAPY FOR SEX OFFENDING

Cognitive-behavioral therapy has shown to be helpful in the treatment of men who engage in sexual offending with data indicating a thirty percent reduction in recidivism over seven years for CBT (as well as antiandrogen therapy). However, while treatment has been shown to decrease sex offenses, it does not totally eliminate sexual offending behaviors.

The cognitive-behavioral techniques that have been found to be most effective are aimed at eliminating deviant arousal by altering belief systems, eliminating inappropriate behaviors, and altering reinforcement contingencies. Cognitive restructuring, victim empathy training, social skills training, covert sensitization, imaginal desensitization, and aversion treatment are some of the specific interventions with an evidence base that are used to eliminate deviant sexual arousal and promote prosocial behaviors. (Masturbatory reconditioning is also used but does not have a strong an evidence base to recommend it.)

Cognitive restructuring involves modifying distorted beliefs that are used to justify aberrant sexual behavior through the use of confrontational and role playing techniques. Social skills training focuses on development of skills that help the individual express him or herself more effectively in social situations. Victim awareness and empathy training involves assisting the individual to understand the impact of their deviant behavior on victims. Aversion therapy consists of paring deviant fantasies with a punishment such as a noxious odor or self-administered electrical shock. Covert sensitization pairs deviant sexual fantasies with mental images of negative (or aversive) consequences such as being arrested and jailed. Imaginal desensitization entails training in deep muscle relaxation and pairing relaxed states with the chain of events leading to the deviant behavior, thus increasing tolerance of urges without acting upon them. Relapse prevention involves identification of situations that have a high risk for relapse, the decisions that lead to relapse, and coping techniques to avoid relapse.

The literature suggests that cognitive-behavioral intervention is a promising treatment for paraphilias and should include the following elements: cognitive restructuring, social skills training, victim empathy/awareness training, and relapse prevention. For individuals who are at high risk for recidivism, the research indicates that a multimodal approach is more effective ï e.g., CBT and antiandrogen medication, which has been shown to reduce sexual behavior in general, or CBT and buspirone, which has been shown to reduce paraphilic fantasies and obsessions.

SUMMARY AND CONCLUSIONS

The growth of prison populations, correctional system costs, and recognition that incarceration has failed to curb recidivism, coupled with a substantive body of evidence-based corrections practices, have altered the focus of supervision from that of monitoring and surveillance to an intervention characterized by collaboration with returning citizens, their families, communities, and public and private agencies to provide support for successful reintegration. Effective reentry is now seen as an ongoing process that begins upon admission to a correctional facility and continues beyond community supervision.

According to the Office of Justice Programs, institutionally-based correctional reentry programming should include mental health and substance use disorder treatment, basic adult education, job training, interventions for batters, family counseling, and mentoring. Studies have shown that it is critical to link programs offered in prison with those offered subsequent to reentry. Evaluations of prison-based substance abuse treatment, for example have found such interventions are only moderately effective in reducing substance use and recidivism. But, their effectiveness is significantly enhanced when combined with post-release treatment programs in the community.

The literature has identified eight principles of effective practice:

1. Assess Actuarial Risk/Needs (using validated instruments)
2. Enhance Intrinsic Motivation
3. Target Interventions
    - Risk Principle (prioritize supervision and treatment resources for individuals at higher risk)
    - Need Principle (target interventions to criminogenic needs)
    - Responsivity Principle (temperament, learning style, motivation, gender, and culture)
    - Dosage (structure 40% to 70% of the time of individuals at high-risk for 3 to 9 months)
    - Treatment Principle (Integrate treatment into full sentence/sanctions requirements)
4. Skill Train with Directed Practice (using cognitive-behavioral strategies)
5. Increase Positive Reinforcement (apply four positive reinforcements for every one negative reinforcement); rewards are more potent motivators than punishments
6. Engage Ongoing Support in Natural Communities (prosocial support networks to reinforce positive behaviors)
7. Measure Relevant Processes/Practices (including individual participants, staff performance, and outcomes)
8. Provide Measurement Feedback

There is robust research evidence supporting the ongoing, periodic assessment of individuals with criminal justice system involvement to determine criminogenic risk, need factors, and supervision levels in order to provide appropriate interventions. Studies have demonstrated that valid, reliable assessment instruments that have been normed for a specific population are more accurate predictors of an individual's risk and criminogenic need factors than individual professional judgment. In addition, instruments that are responsive to cultural, gender-specific needs, individual learning styles, and temperament increase the likelihood that individuals will be matched with the appropriate type of treatment and services. Interventions should focus on

dynamic criminogenic factors that can be changed (e.g., employment or substance use). Standardized assessments differentiate risk and problem levels.

In the past, the performance of correctional agencies was assessed on the basis of provision of service and accomplishment of activities (e.g., number of individuals confined without incident, number successfully meeting restitution requirements, etc.). The focus is now on effective reentry practices that are directed to the achievement of public safety through successful outcomes of persons under supervision. Contemporary community corrections practice has moved from counting contacts to making contacts count by utilizing skills to influence positive behavior change to achieve community safety.

Research shows that matching the intensity of interventions to the objectively assessed level of risk results in improved outcomes and that intensive strategies have a significantly greater impact on individuals at higher risk than those at lower risk. Individuals who are at low risk are less likely to recidivate and hence there is less opportunity for reducing risk Moreover, research has demonstrated that intensive correctional strategies can, in fact, increase their recidivism. In addition, the amount of treatment provided is also critical as the majority of returning citizens have multiple needs (e.g., housing, substance abuse, mental health, etc.) and the most successful interventions address psychosocial needs. A continuum of services and supports is critical; interventions provided in prison and the community should be compatible, build on one another, and share the same philosophy. Offering a continuation of treatment allows for intensification or lessening of services and supports as needed.

While no single intervention has been found to be universally effective, studies have demonstrated that cognitive-behavioral treatment (CBT) that focus on increasing skills, and competencies, adjustment, stability, lead to reductions in recidivism. A number of effective group-based cognitive-behavioral programs that address criminogenic factors have been developed to help individuals understand the relationship between their thinking (i.e., attitudes, values, problem solving skills) and behavior, and teach them methods of managing that behavior to help to develop internal controls to regulate behavior.

People who are incarcerated have been found to more likely to participate in programs when they are matched to those that are consistent with their individual strengths and goals. In addition, incentives including good conduct time, preferred living quarters, cash or commissary stipends, increased visits, certificates, or access to other services can enhance motivation for participation.

The quality of the interpersonal relationship between returning citizens and correctional staff members has been found to be critical to the effectiveness of programming; interventions are most effective when delivered within the context of a respectful, caring, concerned, interested, enthusiastic, and engaged relationship in which staff model appropriate behavior and reinforce prosocial alternatives to antisocial styles of thinking, feeling, and behaving, and provide concrete assistance, help with problem-solving efforts, and advocacy.

Effective relationships with returning citizens focus on building rapport, balancing enforcement with treatment, maintaining focus on criminogenic needs, and structuring and supporting opportunities for learning and skill acquisition through differential reinforcement and modeling. Enhancing relationships requires positive reinforcement to increase motivation for prosocial change using encouragement, reward, and reinforcement for positive behaviors. Motivational interviewing techniques can help returning citizens explore their ambivalence about change and create some discrepancy between their stated life goals and the repeated thinking and behavioral choices that prevent attainment of those goals.

Research has demonstrated that local networks of natural and informal supports (e.g., families, neighbors, schools, churches, and labor markets) function as more significant catalysts of behavior change than formal ones. Interventions that have been demonstrated to be effective with people who are at-risk include the recruitment and engagement of family members, spouses, and other supportive individuals. In addition, close relationships with communities enhances agenciesô authority and legitimacy to enforce conditions of supervision.

Place-based (also termed community-based or neighborhood-based) parole takes agents out of their offices and the confinement of standard (nine to five weekday) work hours and into the neighborhoods where returning citizens reside and work. In such a system parole agents have geographically based caseloads and may have satellite offices located in communities where high concentrations of returning citizens live and where risks are presumably higher. This offers parole agents opportunities to contribute to enhancing community safety as a result of building relationships with people who see returning citizens frequently and know them best as well as gaining familiarity with local resources and areas at high-risk. In addition, such neighborhood based supervision eliminates the burden of travel for agents and returning citizens.

Returning citizens often require a number of services and supports (e.g., health care, substance abuse treatment, mental health care, housing, education, and employment) making it critical for parole supervision agencies to partner with public and private agencies.

Partnerships and collaboration within and outside of the correctional system with public and private agencies working as a team to promote successful transition and reintegration and including returning citizens and their families in the process can help overcome barriers to successful reentry. Research shows that providing services with in a coordinated and comprehensive continuum of care and supervision (e.g., substance abuse treatment, mental health services, health care, job placement, housing, vocational training, and educational programming) can effectively reduce recidivism and improve outcomes for returning citizens. Collaboration offers opportunities for improved coordination between organizations, reduces duplicative efforts, and increases the likelihood that individuals receive needed services and supports. Case managers/boundary spanners can ensure ongoing linkages are maintained.

Housing options for returning citizens who are unable to rely on family and friends are limited. Federal law bars many returning citizens from public housing and other federally funded housing programs forcing them to depend on halfway houses, homeless shelters, housing programs, or the private market, where affordability and availability may be highly restricted.

More than half (56%) of returning citizens are parents of minor children and are at risk for or have lost custody of their children while incarcerated and may be faced with a complex legal process before reunification is even possible. Child support obligations add to these difficulties.

Many returning citizens have limited educations and academic skills, unstable employment histories and lack job skills and confront a job market that with less availability of low-skill jobs, legal prohibitions barring them from certain types of jobs, and often lack the identification documents necessary to secure gainful employment. The impact of legal prohibitions and the stigma of criminal justice system involvement affect the more than one in four people of working age who have a criminal record, more than forty seven million people.

Research shows that educational programming has enduring positive effects on individuals who are incarcerated. Classes that improve literacy and language skills been shown to reduce the likelihood of rearrest post release. Studies show that participation in prison-based education, job training, and job placement programs is associated with improved outcomes including increases in educational achievement scores, employment, higher earnings, and reductions in recidivism. Several studies have found that job training, vocational education programs, and work release

produce modest but statistically significant reductions in recidivism, and individuals who participate in work-release jobs, receive job training, and work as a condition of supervision are more likely to have a job subsequent to release.

Employers have been found to be more willing to hire returning citizens if third-party intermediaries (e.g., social service, faith-based, and community-based organizations, or parole) are involved and if they are aware of incentives (e.g., the Federal Bonding, Work Opportunity Tax Credit, and Welfare-to-Work programs).

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APPENDIX B: SELECTED RESOURCES

ADVOCACY:

Citizens United for Rehabilitation of Errants (CURE): www.curenational.org
Innocence Project: www.innocenceproject.org
Open Society Institute After-Prison Initiative: www.soros.org
Vera Institute of Justice: www.vera.org
Legal Action Center: http:///www.lac.org
National Alliance for the Mentally Ill (NAMI): http://www.nami.org
Crime and Justice Institute (CJI): http://www.cjinstitute.org/

Benefits and Entitlements:

Benefits.Gov: www.govbenefits.gov/govbenefits_en.portal
DisabilityInfo.gov: www.disabilityinfo.gov
GovBenefits.gov: www.govbenefits.gov
Medicaid: www.cms.hhs.gov/home/medicaid.asp
Medicare: www.cms.hhs.gov/home/medicare.asp
National Council on Disability: www.ncd.gov
National Law Center on Homelessness & Poverty: www.nlchp.org
Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193): www.acf.hhs.gov/programs/ofa/law-reg/finalrule/aspesum.htm
Soar (SSI/SSDI Outreach, Access and Recovery): http://www.prainc.com/soar/
Social Security Administration: www.socialsecurity.gov
- **Community after Incarceration—How We Can Help:** www.socialsecurity.gov/pubs/10504.pdf
- **Disability Benefits Applicants Information:** www.ssa.gov/pubs/10029.html
- **Helping someone apply for benefits:** www.ssa.gov/thirdparties.htm
- **What Prisoners Should Know about Social Security:** www.socialsecurity.gov/pubs/10133.pdf

Supplemental Nutrition Assistance Program (Food Stamps): www.fns.usda.gov/FSP/ and www.ssa.gov/pubs/10101.html#howapply
- **Food Stamp Facts:** www.ssa.gov/pubs/10101.html#howapply
- **SNAP Pre-Screening Eligibility Tool:** www.snap-step1.usda.gov/fns/
- **Ten Steps to Help You Fill Your Grocery Bag Through SNAP:** www.fns.usda.gov/snap/applicant_recipients/10steps.pdf

Supplemental Security Income (SSI): http://www.ssa.gov/ssi/
Temporary Assistance to Needy Families (TANF): www.acf.hhs.gov/opa/fact_sheets/tanf_factsheet.html
Veteran's Administration: http://www.vba.va.gov/VBA/

CHILDREN AND FAMILIES:

Administration for Children and Families (ACF): http://www.acf.dhhs.gov
Amachi: http://www.amachimentoring.org/
Angel Tree: http://www.angeltree.org/
The Annie E. Casey Foundation: http://www.aecf.org/
Center for Children of Incarcerated Parents: http://www.e-ccip.org

Center for Law and Social Policy: http://www.clasp.org/
The Center for Strength-Based Strategies: http://www.buildmotivation.com/
Child Welfare League of America: http://www.cwla.org
Resource Center for Children of Prisoners: www.cwla.org/programs/incarcerated/cop_03.htm**Children and Family Networks:** www.childrenandfamilynetworks.org
Family & Corrections Network: http://www.fcnetwork.org/
Family Justice: http://www.familyjustice.org/
Federal Resource Center for Children of Prisoners: http://www.cwla.org/programs/incarcerated/
Foreverfamily: http://foreverfam.org/
Friends Outside: www.friendsoutside.org
Girl Scouts Beyond Bars: http://www.girlscouts.org/program/program_opportunities/community/gsbb.asp
National Association for Children of Incarcerated Parents: http://www.npjs.org/nacip.html
National Clearinghouse on Child Abuse and Neglect Information: http://nccanch.acf.hhs.gov/
National Maternal and Child Health Clearinghouse http://www.nmchc.org
Office of Child Support Enforcement (CSE): http://www.acf.dhhs.gov/programs/cse**The Osborne Association:** http://www.osborneny.org/
The Rebecca Project for Human Rights: http://www.rebeccaproject.org/
San Francisco Children of Incarcerated Parents Partnership: http://www.sfcipp.org
The Urban Institute: http://www.urban.org
U.S. Dream Academy: http://www.usdreamacademy.org
Women's Prison Association: http://www.wpaonline.org/

COMMUNITY COLLABORATION:

Collaborative Justice: http://www.collaborativejustice.org/corrections/main.htm

CONFIDENTIALITY AND PRIVACY:

42 CFR: http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&tpl=/ecfrbrowse/Title42/42cfr2_main_02.tpl
HIPAA: http://www.hhs.gov/ocr/privacy/
Office of Civil Rights of the US Department of Health and Human Services (OCR): www.hhs.gov/ocr/hipaa

EDUCATION:

Correctional Education Association (CEA): http://www.ceanational.org/
Criminon International: http://www.criminon.org/
Higher Education Act: www.raiseyourvoice.com and www.fafsa.ed.gov
John Jay College of Criminal Justice Prisoner Reentry Institute: http://www.jjay.cuny.edu/centersinstitutes/pri/
National Institute of Correction's Offender Workforce Development Division: www.nicic.org
Office of Correctional Education: http://www2.ed.gov/offices/OVAE/AdultEd/OCE/index.html

EMPLOYMENT:

America's Service Locator: http://www.servicelocator.org

Alternative Staffing Alliance: altstaffing.org/
America Works, Inc.: www.americaworks.com/
Saginaw (Michigan Works!): http://www.servicelocator.org/Search/detail-info.asp?Category=CenterInformation&ParentID=1792748&state=MI
The Annie E. Casey Foundation: www.aecf.org/
Bureau of Labor Statistics: http://www.bls.gov/
Center for Employment Opportunities: www.ceoworks.org
Center for Law and Social Policy: www.clasp.org/
Charles Stewart Mott Foundation: www.mott.org/
The Corps Network: www.corpsnetwork.org/
Economic Mobility Corporation: http://economicmobilitycorp.org/
Equal Employment Opportunity Commission (EEOC): http://www.eeoc.gov
Federal Bonding Program: http://usworkforce.org/onestop/FBP.htm
Goodwill Industries International: www.goodwill.org/
Heartland Alliance: www.heartlandalliance.org/
The Joyce Foundation: www.joycefdn.org/
National Association of Workforce Boards: www.nawb.org/
National Correctional Industries Association: www.nationalcia.org
National Employment Resources:
www.ncwp.uscourts.gov/crlinks/National_Links/nl_resources_em.htm
National Transitional Jobs Network: www.transitionaljobs.net/
National H.I.R.E. (Helping Individuals with criminal records Re-enter through Employment) Network: http://www.hirenetwork.org/
Safer Foundation: www.saferfoundation.org/
Saginaw One-Stop Career Center: 614 Johnson Street, Saginaw, MI 48607
U.S. Department of Labor: http://www.dol.gov
Employment and Training Administration: http://www.doleta.gov
Welfare to Work Division: http://wtw.doleta.gov
Work Opportunity and Welfare to Work Tax Credits:
http://workforcesecurity.doleta.gov/employ/wotc.asp
Workforce Investment Act: http://usworkforce.org
Work Opportunity Tax Credit: www.ows.doleta.gov/employ/tax.asp

EVIDENCE-BASED PRACTICES:

Center for Effective Public Policy: www.cepp.com
Center for Evidence-Based Corrections: http://ucicorrections.seweb.uci.edu/
Reentry Policy Council: www.reentrypolicy.org/

FAITH-BASED INITIATIVES:

Center for Faith-Based and Community Initiatives, U.S. Department of Labor:
www.dol.gov/cfbci/
Faith-Based Initiative Information: www.whitehouse.gov/news/releases/2001/01/20010129-3.html
Faith and Service Technical Education Network (FASTEN): www.fastennetwork.org/
The Family and Corrections Network: www.fcnetwork.org
International Network of Prison Ministries: http://prisonministry.net/
Justice Fellowship: www.justicefellowship.org
Latino Coalition for Faith and Community Initiatives: http://www.latinocoalition.org/
Prison Fellowship: www.prisonfellowship.org

Public/Private Ventures: www.ppv.org/ppv/community_faith/community_faith.asp
Reentry National Media Outreach Campaign: www.reentrymediaoutreach.org
Restorative Justice: www.restorativejustice.org/
Returning Citizens Public Health Center (Michigan):
We Care America: http://www.wecareamerica.org
U.S. Department of Health and Human Services, Administration for Children and Families, Office of Community Services, Compassion Capital Fund: www.acf.hhs.gov/programs/ccf/index.html
U.S. Department of Labor, Center for Faith-Based and Community Initiatives: www.dol.gov/cfbci/
White House Faith-Based and Community Initiatives: www.whitehouse.gov/government/fbci

FUNDING:

Justice and Mental Health Collaboration program: www.ojp.usdoj.gov/BJA/grant/JMHCprogram.html
Second Chance Act: www.ojp.usdoj.gov/BJA/grant/09SecondChanceReentrySol.pdf
U.S. Department of Health and Human Services GrantsNet: http://dhhs.gov/asfr/ogapa/aboutog/grantsnet.html

FINANCIAL OBLIGATIONS:

Brennan Center for Justice: www.brennancenter.org/content/section/category/fees_fines/
Center for Law and Social Policy: www.clasp.org/

HEALTH CARE:

Centers for Disease Control and Prevention: www.cdc.gov
Centers for Disease Control - Correctional Health Resources: www.cdc.gov/correctionalhealth/
Michigan AIDS Drug Assistance Program: http://www.michigan.gov/mdch/0,1607,7-132-2940_2955_2982-44913--,00.html
National Commission on Correctional Health Care: www.ncchc.org
National Free Clinic Directory: www.medkind.com/scripts/modules/module6/a3.idc
Robert Wood Johnson Foundation: www.rwjf.org/vulnerablepopulations/index.jsp
U.S. Department of Health and Human Services (HHS): www.hhs.gov

HOUSING AND HOMELESSNESS:

Corporation for Supportive Housing (CSH): www.csh.org
Habitat for Humanity International (HFHI): http://www.habitat.org/
Health Resources and Services Administration's Health Care for the Homeless funds
Interagency Council on Homelessness: www.ich.gov/
Legal Action Center (LAC): www.lac.org
Michigan State Housing Development Authority (MSHDA): http://www.michigan.gov/mshda/
National Alliance to End Homelessness: www.endhomelessness.org/
National Association of Housing and Redevelopment Officials (NAHRO): http://www.nahro.org/
National Housing Conference: www.nhc.org/
National Law Center on Homelessness and Poverty: www.nlchp.org/
National Low Income Housing Coalition (NLIHC): www.nlihc.org/
National Multi Housing Council: http://www.nmhc.org/

U.S. Department of Housing and Urban Development (HUD): www.hud.gov/

ID AND DOCUMENTS:

Bazelon Center for Mental Health Law: www.bazelon.org/
Birth certificates: www.cdc.gov/nchs/w2w.htm
Birth records for foreign-born citizens: http://travel.state.gov/passport/get/first/first_828.html
Center for Law and Social Policy: www.clasp.org
Henry J. Kaiser Family Foundation: www.kff.org/medicaid/index.cfm
Legal Action Center: www.lac.org/
National H.I.R.E. Network: hirenetwork.org/
National Institute of Justice: www.ojp.usdoj.gov/nij/journals/257/medical-benefits.html
National Law Center of Homelessness and Poverty: www.nlchp.org/index.cfm
Social Security cards: www.socialsecurity.gov/ssnumber/ or http://www.socialsecurity.gov/online/ss-5.html or for replacement cards for inmates: https://secure.ssa.gov/apps10/poms.nsf/lnx/0100206076!opendocument#d

LAW ENFORCEMENT:

International Association of Chiefs of Police: www.theiacp.org/
National Sheriffs' Association: www.sheriffs.org/
Office of Community Oriented Policing Services: www.cops.usdoj.gov/
Police Executive Research Forum: www.policeforum.org/

LEGAL RESEARCH/RESOURCES:

Findlaw: http://www.findlaw.com/
State Law and Legislative Information http://www.washlaw.edu/
U.S. Supreme Court Decisions http://supct.law.cornell.edu/supct/

MENTAL ILLNESSES AND SUBSTANCE USE DISORDERS:

Bazelon Center for Mental Health Law: www.bazelon.org/
Consumer Organization and Networking Technical Assistance Center (CONTAC): http://www.contac.org
Criminal Justice/Mental Health Consensus Project: http://consensusproject.org
Criminal Justice/Mental Health Consensus Project National Re-entry Resource Center: www.nationalreentryresourcecenter.org/
Criminal Justice/Mental Health Information Network: http://www.cjmh-infonet.org/
Criminon International: www.criminon.org/
Institute of Behavioral Research (Texas Christian University): www.ibr.tcu.edu/index.htm
Judge David L. Bazelon Center for Mental Health Law: www.bazelon.org
Mental Health America (formerly the National Mental Health Association): www.nmha.org
National Alliance for the Mentally Ill (NAMI): http://www.nami.org
National Association of State Mental Health Program Directors (NASHMPD): http://www.nasmhpd.org/
National Empowerment Center: http://www.Power2u.org
National Alliance on Mental Illness: www.nami.org
National Council for Community Behavioral Healthcare: www.nccbh.org
National GAINS Center: http://gainscenter.samhsa.gov/
National Institute of Mental Health: www.nimh.nih.gov/
National Institute on Drug Abuse (NIDA): http://drugabuse.gov/nidahome.html

National Mental Health Consumers' Self-Help Clearinghouse: http://www.mhselfhelp.org
Re-Entry Policy Council (RPC) of the Council of State Governments: www.reentrypolicy.org/
Substance Abuse and Mental Health Services Administration: www.samhsa.gov/
National Association of Drug Court Professionals: www.NADCP.org
National Association of State Alcohol and Drug Abuse Directors: www.nasadad.org/
National Drug Court Institute: www.NDCI.org
National Institute on Drug Abuse: www.nida.nih.gov/
Criminal Justice-Drug Abuse Treatment Studies: www.cjdats.org/
National TASC (Treatment Accountability for Safer Communities): www.nationaltasc.org/
The Network for the Improvement of Addiction Treatment: www.niatx.net
Substance Abuse and Mental Health Administration: www.samhsa.gov/
Treatment Research Institute: www.tresearch.org/
Risk and Needs Triage (RANT): www.trirant.org/
U.S. Department of Justice, Bureau of Justice Assistance Substance Abuse Programs: www.ojp.usdoj.gov/BJA/programs/substance_abu.html

MENTORING:

Amachi Mentoring Program: www.amachimentoring.org
Big Brothers Big Sisters of America: www.bbbsa.org
California Governor's Mentoring Partnership: www.mentoring.ca.gov/best_practices.shtm
Energize, Inc.: www.energizeinc.com
MENTOR/National Mentoring Partnership: www.mentoring.org
National Clearinghouse on Families and Youth: www.ncfy.com/mcp/index.htm
National Mentoring Center: www.nwrel.org/mentoring
National Mentoring Partnership: www.mentoring.org
Prison Fellowship: www.prisonfellowship.org
Public/Private Ventures: www.ppv.org/ppv/mentoring.asp

MICHIGAN:

Michigan Council on Crime and Delinquency: http://www.miccd.org/
Michigan Prisoner ReEntry Initiative (MPRI): www.michpri.com.
Michigan Department of Corrections (MDOC): http://www.michigan.gov/corrections
Tri County MPRI: Saginaw, Bay, Midland Counties: http://www.tricountympri.org/

ORGANIZATIONS:

American Correctional Association (ACA): http://www.aca.org/
American Jail Association (AJA): http://www.aja.org/default.aspx
National Commission on Correctional Health Care (NCCHC): http://www.ncchc.org/
American Probation and Parole Association (APPA): www.appa-net.org
Association of State Correctional Administrators (ASCA): www.asca.net
Corporation for Supportive Housing (CSH): www.csg.org
The Corrections Connection: www.corrections.com/
National Association of State Alcohol/Drug Abuse Directors (NASADAD): www.nasadad.org
National Association of State Mental Health Program Directors (NASMHPD): www.nasmhpd.org
National Association of Workforce Boards (NAWB): www.nawb.org

National Center for State Courts (NCSC): www.ncsconline.org
Police Executive Research Forum (PERF): www.policeforum.org
Urban Institute: www.urban.org
Association of Paroling Authorities International (APAI): www.apaintl.org
National Institute of Corrections (NIC): http://www.nicic.org/
NIC Learning Center: http://nic.learn.com/learncenter.asp?id=178409
Coalition for Evidence-Based Policies: www.excelgov.org/evidence
Urban Institute: www.urban.org
National Center for State Courts (NCSC): www.ncsconline.org
Police Executive Research Forum (PERF): www.policeforum.org
The Mentoring Center: http://www.mentor.org/
National Association of Blacks in Criminal Justice: http://www.nabcj.org/
International Association of Chiefs of Police (IACP): www.theiacp.org
International Community Corrections Association: www.iccaweb.org
Council of State Governments, Re-Entry Policy Council:
http://www.reentrypolicy.org/reentry/default.aspx
National Governors Association (NGA), Center for Best Practices:
http://www.nga.org/portal/site/nga/
Michigan Prisoner Reentry Initiative: http://www.michpri.com/index.php?page=home
Michigan Council on Crime and Delinquency: http://www.miccd.org/
National Association of Drug Court Professionals: www.nadcp.org
National Council on Crime and Delinquency: www.nccd-crc.org
Bazelon Center for Mental Health Law: www.bazelon.org
Center on Juvenile & Criminal Justice: www.cjcj.org
United States Bureau of Prisons: www.bop.gov

REENTRY:

American Correctional Association: www.aca.org
American Probation and Parole Association: www.appa-net.org/
Association of Paroling Authorities International: http://www.apaintl.org
Bureau of Justice Assistance (BJA): http://www.ojp.usdoj.gov/BJA/grant/reentry.html
Bureau of Justice Statistics (BJS): http://www.ojp.usdoj.gov/bjs/
Council of State Governments Justice Center:
http://www.reentrypolicy.org/assessments_pubs_tools
Federal Bureau of Prisons http://www.bop.gov
International Community Corrections Association: www.iccaweb.org
JEHT Foundation: http://www.jehtfoundation.org
Legal Action Center: http://www.lac.org/
National Association of Counties: www.naco.org/
National Governor's Association, Center on Best Practices: http://www.nga.org
National Institute of Corrections (NIC): www.nicic.org/
National Institute of Justice Mapping and Analysis for Public Safety Program:
www.ojp.usdoj.gov/nij/maps/
National League of Cities: www.nlc.org/
Northwest Regional Educational Laboratory: www.nwrel.org/nwreport/dec98/article8.html
The Perry School Community Services Center Asset Mapping Project:
www.coralnetwork.org/app/CBOProjects/index.cfm?Action=PublicView&CBOProjectID=76
The Pew Center on the States: http://www.pewcenteronthestates.org
Public/Private Ventures: www.ppv.org

Reentry Mapping Network: www.urban.org/content/PolicyCenters/Justice/Projects/TheRe-EntryMapping Network/overview.htm
Re-Entry Policy Council: www.reentrypolicy.org
Re-Entry Blog: www.tpci.us
State and Local Resource Map: www.reentryresources.ncjrs.gov/
The Urban Institute: www.urban.org/ and http://www.urban.org/justice
Transition from Jail to Community Initiative: www.urban.org/projects/tjc/
University of Cincinnati Corrections Institute: www.uc.edu/corrections/
U.S. Conference of Mayors: www.usmayors.org/
U.S. Department of Justice, Office of Justice Programs: http://www.reentry.gov/sar/welcome.html
Vera Institute of Justice: http://www.vera.org
Washington State Institute for Public Policy: http://www.wsipp.wa.gov

REENTRY MAPPING:

Color Brewer: http://www.colorbrewer.org/
Community Mapping, Planning & Analysis for Safety Strategies (COMPASS): www.ojp.usdoj.gov/nij/compass/welcome.html
ESRI: http://www.esri.com/
MapInfo: http://www.mapinfo.com/
MAPTool: http://www.cochsmaptool.org/
National Institute of Justice: http://www.ojp.usdoj.gov/nij/maps/welcome.htm
National Neighborhood Indicators Partnership (NNIP): http://www2.urban.org/nnip/
U.S. Census Bureau: http://www.census.gov/
American Community Survey: http://www.census.gov/acs/

SEX OFFENDERS:

The Ally Foundation: www.theallyfoundation.org
American Correctional Association: www.aca.org
American Probation and Parole Association: www.appa-net.org
Association for the Treatment of Sexual Abusers: www.atsa.com
California Coalition on Sexual Offending: www.ccoso.org
Center for Sex Offender Management: http://www.csom.org/
Colorado Sex Offender Management Board: www.dcj.state.co.us/odvsom/Sex_Offender/index.html
International Association for Chiefs of Police: www.iacp.org
National Alliance to End Sexual Violence: www.naesv.org
National Sexual Violence Resource Center: www.nsvrc.org
U.S. Department of Justice, Sex Offender Sentencing, Monitoring, Apprehending, Registering, and Tracking (SMART) Office: www.ojp.gov/smart/index.htm

SUPPORTIVE HOUSING:

The Enterprise Foundation: www.enterprisefoundation.org
The Corporation for Supportive Housing: www.csh.org

U.S. DEPARTMENT OF JUSTICE:

Bureau of Justice Assistance (BJA): http://www.ojp.usdoj.gov/bja
Bureau of Justice Statistics (BJS): http://www.ojp.usdoj.gov/bjs/

Community Capacity Development Office: http://www.ojp.usdoj.gov/ccdo/
National Institute of Justice (NIJ): http://www.ojp.usdoj.gov/nij/
Office of Community Oriented Policing Services (COPS): http://www.cops.usdoj.gov
Office of Justice Programs (OJP): http://www.ojp.usdoj.gov
Project Safe Neighborhoods (PSN): http://www.psn.gov
Office of Justice Programs, Reentry: www.reentry.gov/welcome.html

VICTIMS/VIOLENCE PREVENTION AND INTERVENTION:

American Bar Association Center on Children and the Law http://www.abanet.org/child/
American Professional Society on the Abuse of Children http://www.apsac.org/
Anti-Defamation League http://www.adl.org/hate-patrol/main.html
Bureau of Justice Assistance http://www.ojp.usdoj.gov/BJA
Bureau of Justice Statistics http://www.ojp.usdoj.gov/bjs/
Center for Substance Abuse Prevention http://www.samhsa.gov/csap
Centers for Disease Control: www.cdc.gov/violenceprevention
Child Abuse Prevention Association http://www.capa.org
Child Abuse Prevention Network http://child.cornell.edu
Childhelp USA http://www.childhelpusa.org
Child Quest International http://www.childquest.org/
Child Welfare League of America http://www.cwla.org
Community-Oriented Police Office (COPS) http://www.usdoj.gov/cops/
Concerns of Police Survivors (COPS) http://www.nationalcops.org
Family Violence Prevention Fund http://www.fvpf.org/
Higher Education Center for Alcohol and Other Drug Prevention http://www.edc.org/hec/
Institute on Domestic Violence in the African American Community
http://www.dvinstitute.org
Federal Judicial Center http://www.fjc.gov/
FBI Uniform Crime Reports–Statistical Data http://fisher.lib.virginia.edu/crime/
Mothers Against Drunk Driving http://www.madd.org
National Archive of Criminal Justice Data http://www.icpsr.umich.edu/NACJD/home.html
National Center for Missing & Exploited Children http://www.missingkids.org
National Center for Victims of Crime http://www.ncvc.org
National Center on Elder Abuse http://www.gwjapan.com/NCEA/
National Children's Alliance http://www.nncac.org
National Clearinghouse for Alcohol and Drug Information http://www.health.org/
National Clearinghouse on Child Abuse and Neglect Information
http://www.calib.com/nccanch
National Coalition Against Domestic Violence http://www.ncadv.org
National Coalition of Homicide Survivors http://www.mivictims.org
National Commission Against Drunk Driving http://www.ncadd.com
National Court Appointed Special Advocates (CASA) Association
http://www.nationalcasa.org/
National Crime Victims Research and Treatment Center http://www.musc.edu/cvc/
National Domestic Violence Hotline http://www.ojp.gov/vawo/newhotline.htm
National Fraud Information Center http://www.fraud.org
National Highway Traffic Safety Administration http://www.nhtsa.dot.gov
National Insurance Crime Bureau http://www.nicb.org
National Institute of Corrections http://www.nicic.org/
National Institute of Justice http://www.ncjrs.org/nijhome.htm
National Institute on Alcohol Abuse and Alcoholism http://www.niaaa.nih.gov

National Institute on Drug Abuse http://www.drugabuse.gov
National Organization for Victim Assistance http://www.try-nova.org
National Sexual Violence Research Center http://www.nsvrc.org
National Sexual Violence Resource Center: www.nsvrc.org
National Victim Assistance Academy (OVC) http://www.ojp.usdoj.gov/ovc/assist/vaa.htm
National Victim Assistance Academy (VALOR) http://www.nvaa.org
National Victims Constitutional Amendment Network http://www.nvcan.org
National Violence Against Women Prevention Research Center
http://www.violenceagainstwomen.org
NCJRS Justice Information Center http://www.ncjrs.org
Neighbors Who Care http://www.neighborswhocare.org
Nonprofit Gateway http://www.nonprofit.gov
Office of Justice Programs http://www.ojp.usdoj.gov
Office of Juvenile Justice Delinquency and Prevention http://www.ojjdp.ncjrs.org
Office for Victims of Crime (OVC) http://www.ojp.usdoj.gov/ovc/
Office of National Drug Control Policy Information Clearinghouse
http://www.whitehousedrugpolicy.gov
Parents of Murdered Children (POMC) http://www.pomc.com
Prevention Connection: www.preventconnect.org
Safe Campuses Now http://www.uga.edu/~safe-campus/
Security on Campus http://www.campussafety.org/
THOMAS: Federal Legislation http://thomas.loc.gov
U.S. Department of Justice, Office for Victims of Crime: www.ojp.usdoj.gov/ovc/
VictimLaw: www.victimlaw.info/victimlaw/
Victims' Assistance Legal Organization (VALOR) http://www.valor-national.org
Violence Against Women Electronic Network: www.vawnet.org
U.S. Department of Education Campus Security and Safety
http://www.ed.gov/offices/OPE/index.html
U.S. Department of Justice http://www.usdoj.gov
U.S. Department of Justice, Office on Violence against Women:
www.usdoj.gov/ovw/
U.S. Department of Veterans Affairs National Center on PTSD http://www.ncptsd.org
U.S. Parole Commission http://www.usdoj.gov/uspc/parole.htm
U.S. Supreme Court http://www.supremecourtus.gov
Violence Against Women Office http://www.ojp.gov/vawo/

VICTIMS ORGANIZATIONS:

American Correctional Association http://www.corrections.com/aca
American Correctional Health Services Association http://www.corrections.com/achsa/
American Jail Association http://www.corrections.com/aja
American Probation and Parole Association http://www.appa-net.org
American Prosecutors Research Institute http://www.ndaa-apri.org
Association of State Correctional Administrators http://www.asca.net
Center for Juvenile and Criminal Justice http://www.cjcj.org
Center for Restorative Justice & Peacemaking http://ssw.che.umn.edu/rjp/default.html
Center for Sex Offender Management http://www.csom.org
Community Anti-drug Coalitions of America http://www.cadca.org
Community Justice Exchange http://www.communityjustice.org
Community Policing Consortium http://www.communitypolicing.org
Correctional Education Association http://metalab.unc.edu/icea

Council of State Governments http://www.csg.org
Institute for Law and Justice http://www.ilj.org
International Association of Campus Law Enforcement Administrators http://www.iaclea.org/
International Association of Chiefs of Police http://www.theiacp.org
Join Together to Reduce Substance Abuse http://www.jointogether.org
Justice Policy Institute http://www.cjcj.org/jpi
Michigan Coalition Against Domestic & Sexual Violence: http://www.mcadsv.org/
Michigan Crime Alliance: http://www.mivictims.org/index.html
Michigan Crime Victim Notification Network (MCVNN): http://www.appriss.com/VINE.html
Minnesota Center Against Violence and Abuse: http://www.mincava.umn.edu/about/
National Association for Community Mediation http://www.nafcm.org/
National Association of Attorneys General http://www.naag.org
National Association of Counties (NACo) http://www.naco.org
National Association of Drug Court Professionals http://www.nadcp.org
National Association of Police Organizations http://www.napo.org
National Center on Addiction and Substance Abuse http://www.casacolumbia.org
National Center for State Courts http://www.ncsc.dni.us
National Coalition Against Domestic Violence: http://www.ncadv.org/resources/NCADVResources_70.htm
National Conference of State Legislatures http://www.ncsl.org
National Consortium for Justice Information and Statistics http://www.search.org
National Council of Juvenile and Family Court Judges http://www.ncjfcj.unr.edu/
National Criminal Justice Association http://www.sso.org/ncja/index.htm
National District Attorneys Association http://www.ndaa.org
National Governors Association http://www.nga.org/
National Indian Justice Center http://www.nijc.indian.com/
National Institute for Dispute Resolution http://www.crenet.org/
National Judicial College http://www.judges.org
National Juvenile Detention Association http://www.corrections.com/njda/top.html
National Law Enforcement and Corrections Technology Center http://www.nlectc.org
National League of Cities http://www.nlc.org
National Mental Health Association http://www.nmha.org
National Network of Violence Prevention Practitioners http://www.edc.org/HHD/NNVPP/index.html
National Organization for Black Law Enforcement http://www.noblentnl.org
National Sexual Violence Resource Center: http://www.nsvrc.org/
National Sheriffs' Association http://www.sheriffs.org/
Office of Correctional Education http://www.ed.gov/offices/OVAE/OCE/
Office on Violence Against Women, US Department of Justice: www.ovw.usdoj.gov
Police Executive Research Forum http://www.policeforum.org
Police Foundation http://www.policefoundation.org
Restorative Justice Project http://www.fresno.edu/dept/pacs/rjp.html
Safe Return: www.safereturn.info
Southern Poverty Law Center http://splcenter.org
State Justice Institute http://www.statejustice.org
Victim Offender Mediation Association http://www.voma.org/

Women:

Children of Incarcerated Mothers Project of the Centre for Children and Families in the Family and Corrections Network: http://www.fcnetwork.org
Justice System: http://www.lfcc.on.ca/cimp.html
Women's Prison Association (WPA): http://www.wpaonline.org/
Texas Woman's University: http://www.twu.edu/as/wcrim/

APPENDIX C: GLOSSARY

42 CFR Part 2: Part of the Code of Federal Regulations in the Public Health chapter that deals with the confidentiality of alcohol and drug use patient records. These regulations apply to all programs (i.e., individuals or entities other than general medical care facilities that provide substance abuse diagnosis, treatment or referral for treatment; indentified units within general medical facilities that provide substance abuse diagnosis, treatment or referral for treatment; and medical personnel or other staff in general medical care facilities whose primary function is the provision of substance abuse diagnosis, treatment, or referral for treatment and are identified as such providers) that provide substance abuse treatment that receive federally assistance (i.e., derive some benefit from the U.S. government, such as accepting Medicaid payments or receiving nonprofit status under the federal tax code

Activities of Daily Living (ADLs): Activities that are basic to survival, including bathing, toileting, eating, and ambulation. See also Instrumental Activities of Daily Living.

Advance Directives: Documents written while a person is competent specifying how decisions about treatment should be made if that person becomes incompetent.

Affordable Housing: Rental or ownership housing provided at lower-than-market cost through public subsidies that is developed or offered by non-profit community-based organizations, private for-profit developers, as well as Public Housing Authorities (PHAs) which includes known as public housing or Section 8 Housing Choice Vouchers. See also Low-Income Housing.

Appeal: a process for requesting a formal change to an official decision.

Arraignment: A hearing before a court having jurisdiction in a criminal case, in which the identity of a defendant is established, the defendant is informed of the pending charges, and their rights (to counsel and trial by jury), and is required to enter a plea.

Arrest: Taking a person into custody by a peace officer or by a private citizen in the manner authorized by law.

Assertive Community Treatment (ACT): A transdisciplinary team-based approach to the provision of treatment, rehabilitation, and support services for persons with serious persistent mental illnesses. The team serves as the fixed point of responsibility for all care for a fixed group of consumers. ACT is designed to help consumers increase daily-task functioning, residential stability, and independence, and reduce hospitalizations. See also Program of Assertive Community Treatment (PACT).

Assessment: A comprehensive examination of needs and problems (e.g., the severity of mental and substance use disorders and medical conditions) that may include psychological, laboratory, or other testing, and compilation of collateral information.

Atypical Antipsychotics: Drugs used to treat psychosis that are also known as second-generation antipsychotics (SGAs), These include the following chemical classes: dibenzoxazepine (e.g., Clozapine), thienobenzodiazepine (e.g., Olanzapine), and benzisoxazole (e.g., Risperidone). Such medications are known as atypical because they differ from the earlier generation of antipsychotic medications (i.e., first generation antipsychotics, for FGAs) in their side-effect profile.

Bail: A condition of pretrial release in which an individual who has been arrested must pay a specified amount to obtain release with the agreement that they will return to court when

ordered to do so. The court sets the bail amount or value depending on several factors, including seriousness of the charges and the likelihood that the defendant will attempt to flee prior to the required court appearances. The purpose of bail is to assure the appearance of the accused at all court proceedings. Bail is forfeited to the court if the defendant fails to return to court.

Behavioral Health Care: A that term includes assessment and treatment of psychiatric and/or psychoactive substance use disorders.

Best Practices: A continuum ranging from practices that are well established and have clearly demonstrated effectiveness to those that show promise or may be exemplary, but have yet to be fully evaluated and their results documented.

Blood Levels of Medication: The amount of a medication present at any given time within a person's blood system which is used to determine whether a correct, or optimal, dosing regimen is being used to achieve therapeutic effects.

Broken Windows Model: An approach that views citizens as partners in crime control as well as customers of the services provided by police.

Burden of Proof: The burden carried by the state in establishing beyond a reasonable doubt that a person accused of a crime committed the offense they are charged with.

Case Management (CM): A range of services provided to assist and support the development of skills to gain access to needed medical, behavioral health, housing, employment, social, educational, and other services and supports essential to meeting basic needs. Linkages with services and support are developed and monitoring of overall service delivery is conducted.

Certificate of Rehabilitation: A state-authorized and documented presumption of rehabilitation which allows qualified individuals with criminal records to demonstrate they have paid their debts to society and have earned the right to have statutory bars to jobs or other services lifted. Also called Certificates of Relief from Disabilities and Certificates of Good Conduct.

Character Disorder: See Personality disorder.

Charge: A formal allegation that a specific person has committed a specific offense or a formal accusation filed by a prosecutor's office that a specific person has committed a specific crime.

Circle Sentencing: A community-directed process, conducted in partnership with the criminal justice system, to develop consensus regarding an appropriate sentencing plan that addresses the concerns of victims and their supporters, the individuals who committed crimes and their supporters, judges and court personnel, prosecutors, defense counsel, police, and all interested community members. The experience is intended to give all parties an opportunity to speak openly, try to come to terms with the event, and mutually identify the steps necessary to assist in healing and prevent future crimes.

Classification: A system for determining and reviewing the level of security required by each inmate based on their history, current charges, behavior, and perceived risk of violence or elopement.

Clubhouse: A psychosocial rehabilitation model for people with serious mental illnesses (developed at Fountain House in New York) that provides support services through a comprehensive self-help community-based center in which staff and members work as teams to perform the tasks necessary for the operation of the clubhouse.

Cognitive Behavioral Therapy (CBT): A manual-driven course of structured counseling aimed at increasing a person's awareness of their thoughts, behaviors, and actions, and the consequences of them. CBT is often used to address specific problem areas such as anger

management, moral reasoning, criminal thinking, addiction, relapse prevention, and relationships.

Community-Based Treatment: Community services offered through a system of local services and support rather than in an institution.

Community Corrections: The provision of corrections services to persons under supervision within a community or neighborhood, rather than in an institution. Community corrections includes probation/parole, electronic monitoring, home confinement, day fine programs, work release, halfway houses, restitution, community services, check-in programs, curfews, home and community-based correctional facilities (i.e., low-security living arrangements where individuals under supervision may have access to paid or volunteer work).

Community Mental Health (CMH): The system designed to provide publicly-funded mental health services to individuals with the communities in which they reside. The Community Mental Health Centers Act of 1964 provided funding for the development of community-based alternatives to institutional care.

Community Policing: A philosophy of law enforcement that includes prevention, partnering, collaboration, and problem solving.

Comprehensive Mental Health Evaluation: A face-to-face interview, review of health care records and collateral information, diagnostic formulation, and an initial treatment plan.

Communicable Disease: A disease that can be transmitted from one person to another (e.g., tuberculosis, viral hepatitis, HIV, and sexually transmitted diseases). Correctional facilities often have a high prevalence of people with communicable diseases which can place individuals at risk for infection.

Community Development Block Grant (CDBG): Begun in 1974, administered by local government agencies, and funded through the US Department of Housing and Urban Development (HUD), the program provides annual grants on a formula basis to many different types of grantees through several programs for community development activities. More information can be found at www.hud.gov/offices/cpd/communitydevelopment/index.cfm.

Community Development Corporations (CDCs): Non-profit housing and community development organizations that provide affordable housing for individuals with low incomes and economic development in low-income communities by combining expertise in housing, development and management with their roles as community builders and organizers. CDCs often play a key role in many local continuums of re-entry assistance.

Community Service: A type of restorative activity that allows individuals with criminal convictions to improve their skills, develop community connections, and complete sentencing requirements.

Community Supervision: The placement of a defendant under supervision for a specified length of time, as ordered by a court, with court-imposed rules and conditions in lieu of or as follow-up to confinement. The defendant must abide by conditions imposed by the court which are designed to help them lead a more pro-social lifestyle. Failure to abide by these conditions can result in the imposition of a term of imprisonment through revocation of supervision by the court.

Conditional Release: The release of an individual from prison to a period of community supervision following completion of a portion of the term for the remainder of the sentence, typically with a standard set of conditions they must abide by to remain in the community on post-release supervision. Conditions may include regular reporting, maintenance of a known residence, drug testing, compliance with a curfew, etc. Violation of the conditions of supervision

may result in the imposition of sanctions permitting the person to remain in the community, and/or the revocation of parole and return to prison. Compliance with conditions of supervision may result in rewards or other positive reinforcements.

Conditions of Parole/Conditions of Release: Requirements placed individuals leaving prison under supervision such as requirements to report to parole officers, participate in treatment, pay fees, and secure and maintain keep a job. Violation of conditions is grounds for revocation and return to prison. Conditions of release is also known as or a green sheet.

Conditions of Supervision (probation/parole): There are two types of conditions: **general conditions** that apply to all individuals under supervision (e.g., obeying all laws, abstaining from alcohol and drug use, maintaining employment, and reporting regularly to the probation/parole officer); and **special conditions** that are directed toward specific individuals and the risks they pose (e.g., attending treatment, drug testing, avoiding certain places such as bars or areas where children congregate, or staying away from certain people such as previous victims or gang members).

Consumer: The term most frequently used to describe a person who receives public mental health services.

Continuum of Care: A range of services and supports of increasing intensity that may be developed through collaboration and coordination between providers, agencies, or service systems or through a single agency or system.

Conviction: A judgment of the court, based on the decision of a jury or judge, that a defendant is guilty of the crime for which they were tried.

Co-occurring Disorders (COD): Two or more disorders occurring simultaneously, most typically a mental health (psychiatric) and substance abuse disorder due to the prevalence of these. Other co-morbid disorders include psychiatric, medical, and developmental disorders, Co-occurring disorders are diagnosed when at least one disorder of each type can be established independently of the other and is not a cluster of symptoms resulting from a single disorder. Comorbidity worsens the clinical course and outcomes for individuals with mental disorders; it is associated with symptom exacerbation, non adherence to treatment, more frequent hospitalizations, more significant depression and likelihood of suicide, incarceration, family friction, and high services, use, and cost. See also Dual Diagnosis.

Corrections Agencies: Includes jails, prisons, and community corrections. Jails are used to detain people after arrest while they await trial and for short sentences (generally less than one year). Prisons provide long-term incarceration (generally one year or longer) for more serious crimes. Community corrections agencies, such as probation and parole, supervise people in the community, either in lieu of or in addition to jail and prison time.

Crime: A violation of the law.

Criminogenic Factors: Elements of an individual's character and environment that contribute to their commission of offenses and can be used to predict and respond to recidivism.

Criminogenic Ideation: Thinking errors that are often manifested in antisocial stances, blaming others, minimizing responsibility, rationalization and excuse-making, justifying harmful behavior, and a false sense of entitlement. Thinking that includes exhibiting a victim stance (i.e., feeling unfairly treated and hence the real victim in a crime), entitlement (i.e., the right to unrestricted freedom), righteous rage (i.e., anger, retribution, and license to conduct oneself as one pleases without regard to rules or consequences and the need for force another person to lose in order for them to win), or a combination of all three leading to the development of a defiant, hostile

attitude toward society and sometimes to life itself. The manifestations include contemptuousness toward authority and authority figures.

Criminogenic Needs: Factors in that affect the likelihood of recidivism and include low self-control, anti-social personality, anti-social values, criminal peers, substance abuse, and dysfunctional family.

Crisis Intervention Team (CIT): A program comprised of designated police officers who are called upon to respond to mental health calls and crises (e.g., attempted suicides). Officers participate in specialized training in de-escalating potentially volatile situations, gathering relevant history, and assessing medication information and the individual's social support system under the instructional supervision of mental health providers, family advocates, and mental health consumer groups.

Cross-Training: The implementation of a training program to educate individuals from different systems (e.g., criminal justice, mental health, child welfare, etc.) on the issues and concerns each confronts to build awareness and develop a more coordinated approach to the needs of people involved with those systems.

Cultural Competence: Recognition of and response to cultural concerns of ethnic and racial groups, including their histories, traditions, beliefs, and value systems to create better services and ensure their adequate utilization by diverse populations. Cultural competence entails a set of behaviors, attitudes, and policies that foster effective service delivery in cross-cultural situations.

Culture: A framework of values, beliefs, and means of organizing experiences.

Current Situational Stressors: Circumstances that can threaten an individual's ability to function in a healthy, productive manner.

Custodial Transport: The transportation of an individual who is under arrest and not free to leave.

Decompensation: A temporary return to a lower level of psychological adaptation or functioning, often occurring when an individual is under considerable stress or has discontinued psychiatric medication against medical advice.

De-escalation Techniques: Verbal and nonverbal interpersonal skills to defuse violent behavior without the use of force to preserve an individual's safety and dignity.

Defendant: An individual who has been charged with committing a specific crime but not yet convicted of a criminal charge.

Defense Attorney or Counsel: A lawyer who represents a defendant in a legal proceeding.

Defer Sentencing: A judgment by the court that sentencing shall be postponed for a specified amount of time during which an individual who has been convicted will be on probation.

Delusion: A fixed false belief that is resistant to reason or confrontation with actual fact.

Deposition: Sworn testimony of a witness taken outside of court in the presence of the attorneys for the defense and prosecution that can be used at trial to impeach or discredit a witness's testimony or can be read to a jury if the witness is unavailable.

Determinate Sentencing: A sentence with a fixed term of incarceration that that is determined by a judge, statute, or sentencing guidelines. Under determinate sentencing, the exact prison term is set at the time of sentence, and the person is released following a prescribed period of confinement. In some instances, the person may have served the entirety of an indeterminate sentence and thus must be released.

Detoxification: The physical removal of drugs from the body that is the first step to addressing drug and alcohol problems. The process includes observation, support, as well as medical monitoring and treatment for drugs that can cause dangerous medical conditions (e.g., seizures) when leaving the body such as sedative-hypnotics, alcohol, benzodiazepines and barbiturates.

Developmental Disability: A condition that involves physical or mental impairments, develops before age 22, is expected to continue throughout the lifetime of the individual and is manifested through impairments in multiple domains of functioning.

Discharge Plan: A written plan that provides a person with guidance to help them make a successful transition that usually addresses housing, employment or education, transportation, continued treatment, social services, as well as required supervision (i.e., probation/parole) in correctional system discharges.

Discretionary Release: A release from prison by decision of a parole board or similar authority, rather than completion of a determinate sentence, that usually follows the service of a minimum period of imprisonment, but short of the maximum term of confinement.

Dismissal: A decision by a judicial officer to end a case for legal or other reasons

Disposition: The final decision which ends a criminal proceeding by judgment of acquittal or dismissal, or which sets the sentence if the defendant has previously been convicted.

Dispositional Alternative: A dispositional option in which a judge defers or withholds adjudication of a criminal case for a specified period with the charges dismissed or reduced upon successful completion of the deferral period.

Distance Education: Education or training courses delivered to remote locations in which time, location, or both separate the instructor and students and provided in real-time, online, instructor-led interaction or through intermittent, time-delayed interaction. Instruction can include written correspondence, text, graphics, audio and video recordings, CD-ROM, online learning, audio and videoconferencing, interactive TV, and FAX. Distance education does not preclude the use of a traditional classroom.

Diversion: A process that offers an individual charged with a criminal offense an alternative to traditional criminal justice proceedings on a voluntary basis. Diversion occurs in the period between the filing of formal charges and a final adjudication, and results in a dismissal of charges, or its equivalent, if the divertee successfully completes the diversion process.

Diversion Program: A program that addresses the specific needs of individuals with psychiatric disorders who have been redirected to treatment from the criminal justice system before arrest or prior to trial.

Domestic Violence (DV): A pattern of coercive behavior, often including physical violence; economic, emotional, sexual, and psychological abuse; as well as isolation, threats, and intimidation, that adults and adolescents perpetrate against their intimate partners and loved ones.

Drop-In Center: A component of psychosocial rehabilitation that typically occurs in nonclinical settings with minimal, if any, professional facilitation. Drop-in centers usually focus on normalization and empowerment of people with severe and persistent mental illnesses.

Dual Diagnosis: A classification for an individual with severe and persistent mental illness who is simultaneously addicted to alcohol or other drugs.

Dynamic Criminogenic Factors: Changeable individual characteristics and environmental conditions that can contribute to criminal behavior, including attitudes, beliefs, thinking patterns, and peer groups.

Entitlements: Publically funded benefits provided to individuals with disabilities such as Supplemental Security Income (SSI), Social Security Disability Insurance (SSDI), Medicaid, and Medicare.

Evaluation: A face-to-face interview of a patient and a review of health care records and collateral information. Evaluation includes a diagnostic formulation and, at minimum, an initial treatment plan. See also Assessment.

Ethnicity: Shared nationality, tribal affiliation, religious faith, language, or cultural and traditional origins and backgrounds, and distinguished from race which is rooted in the biological classification of homo sapiens to subspecies according to morphological features such as skin color or facial characteristics.

Evidence-Based Practices (EBPs): Interventions and treatment approaches that have been proven effective through rigorous scientific evaluation. In reentry, the term often refers to practices that have demonstrable, positive outcome in reducing recidivism, increasing victim satisfaction, or decreasing expenditures.

Expungement: The process by which a record of arrest or conviction is destroyed.

Failure to Appear: The failure of a defendant to appear in court as required.

Fair Market Rent (FMR): The assessed value of actual market rent for a unit of housing based on the cost of building and managing a rental property, or the prevailing rent in an area. The Department of Housing and Urban Development (HUD) updates FMR on a yearly basis.

Family Group Conference (FCG): Voluntary meetings to decide the resolution of a criminal incident involving the network of people most affected by the crime: the victim, the individual who committed the crime, and the support groups of both. Trained facilitators convene meetings to discuss how the affected parties and others have been harmed by the offense and how that harm might be repaired.

Family Psychoeducation (FPE): Activities to provide information and education to families and significant others regarding mental disorders and their treatment to engage support systems to help consumers maintain treatment and recover.

Federal Bonding Program: A U.S. Department of Labor program designed to alleviate employer concerns regarding at-risk job applicants by allowing employers to cover people who, like individuals with criminal convictions, cannot be covered by commercial insurance. Fidelity bonds issued through the Federal Bonding Program insure an employer, at no cost, against theft, forgery, larceny, or embezzlement by an employee. An employer or job applicant can request the issuance of a bond.

Felony: A serious criminal offense punishable by at least one year or more in prison.

Functional Skills: Essential cognitive and interpersonal abilities needed for success in the workplace, including reading, writing, arithmetic, the capacity to think and solve problems; communicate information in oral, written, and electronic forms; work effectively alone and in teams; and take personal responsibility.

Gatekeeper Functions: Functions performed by law enforcement personnel and crisis intervention teams for people with mental illnesses and who are often responsible for referring individuals to mental health services.

Gender Differences: Social constructs related to expected social roles rather sex differences which are biologically determined.

Gender Responsiveness: Taking into account the differences in experiences that men and women bring to the criminal justice system and adjusting strategies and practices in ways that are appropriately responsive to those differences.

Geomapping: Computer-based mapping that identifies the geographic distribution of resources and services in comparison with a target population. Geomaps can be used to identify gaps between available resources and the needs of returning citizens, as well as the funding which is directed to particular areas.

Good Time: The amount of time deducted from the time to be served in prison on a given sentence as a consequence of good behavior.

Good Time Credit: Credit earned towards a reduced sentence for good behavior, such as program participation that reduces the total length of stay in prison.

Halfway House: A highly supervised residential environment designed to help individuals returning to the community from an institution.

Hallucination: Perception of visual, auditory, tactile, olfactory, or gustatory experiences without an external stimulus and with a compelling sense of their reality, usually resulting from a mental disorder or as a response to a drug.

Health Insurance Portability and Accountability Act (HIPAA): Legislation intended to provide portability of employer-sponsored insurance from one job to another in order to prevent the inability to change jobs because of the fear of losing health insurance. This act also makes it illegal to exclude people from coverage because of pre-existing conditions and offers some tax deductions to self-employed people who pay their own health insurance premiums. The Health Insurance Portability and Accountability Act of 1996, together with regulations promulgated by the U.S. Department of Health and Human Services (HHS), available at 45 CFR Parts 160, 162, and 164 establish federal standards for the privacy and security of protected health information (PHI), including mental health information. HIPAA includes a Privacy Rule and a Security Rule, which deals with the security requirements for information technology (IT) systems transmitting health information.

Hearing: A legal proceeding in which arguments, witnesses, and/or evidence are heard by a judicial officer or administrative body.

High risk: A term that describes individuals who are likely to recidivate based on factors such as criminal history, attitudes toward crime, unemployment, poor family relationships, mental health issues, and substance abuse.

High severity: A term that describes crimes that are serious or violent in nature, and are typically felony offenses.

Housing Choice Voucher (HCV) Program: See Section 8.

Housing Tax Credit Program (HTC): A program that provides federal income tax credits to individuals or organizations that develop affordable housing through new construction or acquisition and rehabilitation. Tax credits can also be used by nonprofit or public developers to attract investment to an affordable housing project by syndicating, or selling, the tax credit to investors. The tax credits provide a dollar for dollar reduction in the developerôs tax liability for a ten-year period.

Illness Self-Management: Programs in which consumers learn to recognize symptoms of their mental illness as well as factors that exacerbate or ameliorate them in order to acquire skills to alleviate acuity and gain confidence in their ability to achieve recovery.

Indeterminate Sentence: A sentence to prison with a minimum and maximum (not fixed) term which is established at the time of sentencing.

Infraction: A violation of a statute in which the only punishment authorized is a fine and which is expressly designated as an infraction.

Inmate: An individual remanded to the custody of a local, county, state, or federal correctional facility (i.e., jails and prisons).

Inpatient Facility: A medical facility, usually a hospital, where patients stay for a period of time to receive treatment.

Institutionalization: The process by which inmates are shaped and transformed by the institutional environments in which they reside. When it occurs in correctional settings it is sometimes referred to as prisonization and involves the incorporation of the norms of prison life into a person's habits of thinking, feeling, and acting.

Instrument/Instrumentation: Forms or other written tools (e.g., surveys, questionnaires) used to obtain information that have been field-tested for validity and reliability to maximize the likelihood that they measure what they are intended to consistently measure.

Instrumental Activities of Daily Living (IADs): Activities that allow an individual to live independently in the community. IADLs include shopping, housework, meal preparation, taking medications, managing money, and using a telephone and technology.

Intake: A set of procedures for a person into a correctional facility that includes obtaining a personal history and information, searching personal belongings, and assigning housing, among other procedures.

Integrated Services: The provision of an array of services and supports that may include braided or blended funding to cover the cost of multiple services. This term is used in mental health when referring to services for co-occurring mental illnesses and substance use disorders.

Intimate Partner Violence (IPV): Actual or threatened physical, sexual, psychological, or emotional abuse by a current or former spouse, dating partner, or boyfriend or girlfriend.

Jail: A correctional facility administrated by an agency of local or county government (typically a law enforcement agency) used to detain individuals pending judicial hearings or provide brief periods of incarceration, generally less than one year or less. Individuals who have been sentenced to prison are also housed in county jails while awaiting transfer.

Job-Seeking Skills: The skills necessary to search, apply for, and obtain employment.

Job Skills: Specific knowledge, skills or abilities needed to perform required tasks related to specific jobs.

Judicial Officer or Judge: An officer of the court who determines causes between parties or renders decisions in a judicial capacity. The judge generally decides questions of law, except in the case where a jury-trial is waived when the court also then functions as a fact-finder.

Leveraged Treatment: An approach designed to ensure individuals receive treatment they may not otherwise accept. Examples include conditional treatment and mandated treatment.

Life Skills: Skills needed for daily routines of life including cleaning, cooking, shopping, and money management.

Low-Income Housing: A type of affordable housing that is developed and offered for households with incomes less than eighty percent (80%) of area median income that is usually

subsidized through federal, state or local programs, of which the federal Low-Income Housing Tax Credit is the largest.

Maladaptive Thinking: Thought patterns and decision-making processes that result in negative consequences rather than the promotion of productive and healthy solutions,

Managed Care: An approach to the funding and delivery of health care services that provides a specific level of funding to serve a defined population and includes approved providers and services.

Mandatory Minimum Sentencing: Sentencing statutes or regulations requiring individuals convicted of crimes to serve a period of incarceration based on the type of offense and/or the individual's criminal history. Other types of mandatory sentencing guidelines include determinate sentencing and Truth-in-Sentencing laws.

Mandatory Release: The release of a person from incarceration that is determined by statute or sentencing guidelines and not by the discretionary decision-making authority of a parole board or other authority.

Maximum Expiration: The completion of the full term of a sentence, including both incarceration and post-release supervision portions.

McKinney-Vento Act: 1987 legislation that empowers the Department of Housing and Urban Development (HUD) to create homeless and supportive housing programs.

Medicaid: A jointly funded, federal/state health insurance program for people with low incomes and people with disabilities who meet needs-based eligibility requirements.

Medicare: A federal health insurance program primarily for older adults and people who retire early as a result of disability.

Memorandum of Understanding (MOU): An interagency agreement that serves as a guideline for shared activities. More specific information about methods of achieving declared goals may be provided in an associated Statement of Work (SOW).

Mental Disorders: Health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress and/or impaired functioning. A mental illness diagnosis is made only when particular clusters of symptoms are present for a specified period of time, other clusters of symptoms are not present, and the symptoms that are present cause significant distress or impairment in social, occupational, or other areas of functioning. See also Mental Illness.

Mental Health: A state of successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with diversity. One person's understanding of mental health may differ from another's based on cultural values and other factors.

Mental Illness: A diagnosable mental disorder or a reference collectively to all diagnosable mental disorders. Signs and symptoms of mental illness include: loss of memory/disorientation, delusions (false beliefs that are not based in reality), depression (deep feelings of sadness, hopelessness, or uselessness), hallucinations (hearing imaginary voices, seeing, smelling, tasting, or feeling imaginary things), mania (accelerated thinking and speaking or hyperactivity with no apparent need for sleep and sometimes accompanied by delusions of grandeur), and anxiety.

Meta-analysis: An analytical approach that systematically and rigorously identifies the results of a wide range of studies regarding a specific topic. Unlike conventional reviews, which can be subject to the unintended or intended biases of authors and the inability to succinctly and

empirically summarize the evidence for or against various interventions, meta-analyses rely on quantitative techniques that examine specific characteristics of studies and programs and thus provide a more scientifically sound basis for effective practices, programs, treatments, and interventions. A meta-analysis employs systematic methods and statistical techniques to combine results from different studies to obtain a quantitative estimate of the overall effect of a particular intervention or variable on a defined outcome. This combination may produce a stronger conclusion than any individual study can provide. It is also known as data synthesis or quantitative overview.

Misdemeanor: A crime that is less serious crime than a felony and generally punishable by up to one year of confinement, usually in a jail or other local facility, and/or a fine.

Mobile Crisis Team (MCT): A team of mental health treatment professionals who provide on-scene responses to mental health emergencies.

Moral Reconation Therapy (MRT): A cognitive-behavioral therapy designed to systematically alter an individual's reasoning abilities in order to foster social and moral growth and support appropriate decision-making.

Morbidity: State of ill health produced by any deviation from a state of physiological or psychological well-being.

Motivational Enhancement Therapy (MET): A therapy based on cognitive and social psychology that is designed to overcome ambivalence to treatment and motivate a person to change. MET is an evidence-based intervention that is particularly effective for alcohol addiction and marijuana dependence.

Motivational Interviewing (MI): A directive, client-centered counseling style designed to elicit behavior change through the exploration and resolution of ambivalence.

Need Principle: The targeting of services to criminogenic needs including low self-control, anti-social personality, anti-social values, peers who engage in criminal acts, substance abuse, dysfunctional family, and criminal thinking patterns.

NIMBY ("Not In My Backyard"): A term for community-driven resistance to the placement of special-needs housing or other types of facilities in neighborhoods.

Offender: An individual who has been convicted of a criminal charge.

One-Stop Career Centers: One-Stops are the entry point for any person seeking job training or employment services and any employer seeking workforce services such as hiring or training. They are the foundation of the workforce development system under the Workforce Investment Act (WIA) which requires that local workforce investment areas establish at least one physical One-Stop to serve employers and job seekers. Local workforce boards can establish more than one physical One-Stop as well as virtual One-Stops at partner agencies, in community-based organizations, or other facilities, such as prisons or churches.

Outpatient Treatment: Treatment that takes place on an outpatient basis rather than in an inpatient or residential setting.

Outstanding Warrant: A warrant that indicates an individual has not properly resolved a police or court order, or has eluded the service of an arrest warrant.

Pardon: Relief from the legal consequences of a crime or the excusing or forgiving of a conviction.

Parole: The conditional release of an individual from prison (but not from legal custody) prior to the expiration of their sentence with a period of community supervision imposed by a

discretionary authority (such as a parole board). In other words, a person on parole has served part of their sentence in prison and completes the sentence on community supervision and parole agencies play a critical role in overseeing the reintegration of returning citizens.

Parole Board: A discretionary panel of individuals, usually appointed by the governor, which examines an individual's institutional adjustment and future life plans to determine readiness for release the terms and conditions of release.

Parole Revocation: The administrative action of a paroling authority removing a person from parole status in response to a violation of lawfully required conditions of parole, including commission of a new offense, and usually resulting in a return to prison.

Parole Supervision: The legal responsibility of a parole supervision agency to supervise an individual who has been conditionally released from prison. Supervision includes monitoring for compliance with conditions of release and routine contacts with parolees.

Parole Violation: Non-compliance with some condition of supervised release that may be criminal or technical (failure to comply with a condition that if the individual was not on parole would not be considered criminal).

Paroling Authority: The legal entity responsible for considering and authorizing discretionary release from prison; setting conditions of release; and revocation of parole. Also known as parole board, parole commission, and parole hearings board.

Peer Educators: Primary or secondary (family) mental health consumers who work with their peers on a volunteer or paid basis to help them understand and more effectively manage their mental illnesses on an individual or group basis (family education) and provide recovery supports.

Personality Disorders: Enduring styles of thought, emotion, or behavior that usually appear in childhood or early adolescence and involve maladaptive and rigid patterns of perceiving and relating to other people.

Phased-Permanent Housing: A housing model in which residents have month-to-month occupancy agreements rather than leases, which confers some rights of tenancy. This type of housing is short-term and focuses on the provision of help with moving on to more permanent forms of housing. This type of housing gives tenants the option to leave at any time after they no longer need the assistance that a supportive setting provides. Phased-permanent housing is often co-located near emergency housing and serves as safe and stable transitional settings while also providing a longer-term housing option linked to supportive services.

Plea: A defendant's formal answer in court to the criminal charge(s) made against them (e.g., guilty, not guilty, or no contest).

Post-Acute Withdrawal: A cluster of symptoms typically manifest subsequent to the initial period of physical withdrawal from the use of addictive substances (e.g., agitation or depression.

Prebooking Diversion: A response strategy through which a police officer can avoid detaining and filing criminal charges against a person with a possible mental illness by making an immediate referral to community mental health services or directly transporting the individual to a designated hospital or drop-off center.

Presentence Investigation (PSI): A document of the examination of the background of a person convicted of a crime including their past behavior, family circumstances, physical and mental health, and impact of the crime on its victims, conducted prior to sentencing and after a plea or verdict of guilt, by probation officers and submitted to sentencing authorities. A PSI is used to assist the court in determining the most appropriate sentence.

Pretrial Detention: Holding a defendant in custody while the criminal case is pending adjudication.

Pretrial Diversion: A dispositional option in which the prosecutor offers a person charged with a criminal offense an alternative to having the case prosecuted in traditional criminal proceedings, with the charges dismissed or reduced upon successful completion of the diversion period.

Pretrial Release/Detention Hearing: The hearing at which the judge considers whether to release or detain a defendant.

Pretrial Release: The release of a person accused of a crime from custody for all or part of the time during prosecution upon their promise to appear in court when required.

Pretrial Services Program: A program that provides background information about a defendant to the judge at the pretrial release/detention hearing, and that supervises conditions of pretrial release imposed by the court.

Prison: A correctional facility that houses inmates generally sentenced to a period of incarceration exceeding one year. Prisons hold individuals convicted of the commission of a felony.

Prison Industries: Manufacturing or service-oriented operations in correctional facilities that are designed to employ and provide skills training for inmates. Prison industries produce market-price, goods for sale to federal and state governments and the public.

Probation: A sentence imposed by the court on an individual who has committed an offense that requires him or her to abide by specified conditions for a specified period of time under community supervision by a probation officer. Probation can occur as an alternative to or be imposed in addition to incarceration.

Probation Revocation: A court order taking away probationary status and usually withdrawing the conditional freedom associated with that status in response to a violation of the conditions of probation.

Problem-Solving/Problem-Oriented Policing: A community policing strategy in which officers analyze the reasons for repeated incidents of a particular crime(s) and address the underlying problems, factors, or issues that might be responsible for these repeated incidents.

Program of Assertive Community Treatment (PACT): See Assertive Community Treatment.

Prosecution: The pursuit of criminal charges against an individual in court.

Prosecutor: A lawyer employed by the government to represent the general public's interests in court proceedings against people accused of committing crimes. Prosecutors bring charges in court and represent the government in prosecuting those charges.

Protected Health Information (PHI): Health information about an individually identifiable patientõs physical or mental health, including their condition (past, present, future) or provision of health care to that individual.

Protective Order: An order of the court that is issued to provide immediate, short-term protection of a person or property.

Psychiatric Advance Directive (PAD): A legal document specifying a patientõs preferences for particular medications or treatment alternatives that is executed prior to a crisis.

Psychiatric Symptomatology: The symptoms of a mental illness that may be exhibited.

Psychosocial Difficulty: The problems an individual may experience in relating to others due to a psychiatric disorder.

Psychosocial Rehabilitation (PSR): Professional mental health services that combine pharmacological treatment, skills training, and psychological and social support to consumers and families in order to improve their lives and functional capacities.

Psychosis: A loss of contact with reality, usually including false beliefs about what is taking place or who the person is (delusions) and seeing or hearing things that are not present (hallucinations).

Psychotropic Medications: Prescription drugs that target psychiatric symptoms (e.g., anxiety, depression, and psychosis).

Public Assistance: Benefits provided by state or federal programs to eligible recipients such as Temporary Assistance to Needy Families (TANF).

Public Health: A branch of medicine concerned with improving the health of the population, rather than the treatment of diseases of individual patients. Public health functions include health surveillance and analysis; investigation of disease outbreaks; establishing and managing health promotion and disease prevention programs; enabling and empowering communities to promote health and reduce inequalities; creating and sustaining intergovernmental partnerships to improve health; ensuring compliance with regulations and laws to protect and promote health; and maintaining a well educated and trained, multidisciplinary public health workforce.

Public Housing: Housing assisted under the provisions of the U.S. Housing Act of 1937 or under a state or local program having the same general purposes as the federal program.

Public Housing Authority (PHA): Any state, county, municipality, or other governmental entity or public body authorized under state enabling legislation to engage in the development or administration of low-rent public housing or slum clearance.

Public Workforce System: A market-driven employment training, placement, and support system which brings together public funding, One-Stop career development services, and members of state and local Workforce Investment Boards in an effort to increase employment, job retention, and earnings; reduce welfare dependency; and enhance national productivity and competitiveness.

Quality of Life Crimes: Minor illegal behaviors (generally misdemeanors), that are also known as nuisance crimes, that jeopardize a communityôs sense of wellbeing and safety (e.g., loitering, aggressive panhandling, vandalism, littering, public urination, graffiti, and noise violations).

Recidivism: The repetition of criminal behavior. The return of an individual previously released from custody in a correctional facility which typically results from either an arrest for a new crime or from a technical violation such as failure to meet conditions of release (probation/parole).

Recidivism Rate: Instances of arrest, conviction, correctional commitment, or correctional status change related to repetitions of these events within a given period of time.

Recovery: The National Consensus Statement on Mental Health Recovery defines as a journey of healing and transformation that enables a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential. SAMHSA defines recovery from alcohol and drug problems as a process of change through which an individual achieves abstinence and improved health, wellness and quality of life.

Reentry: The process of transitioning from a correctional institution (prison or jail) to the community or also individuals discharged from parole, and those under probation. Conceptually,

reentry involves any program, initiative, or partnership that addresses the issues (e.g., lack of education, job training or vocational experience, housing, and/or substance abuse and mental health treatment) necessary to ensure that successful transition and the maintenance of a crime-free existence post-release.

Reentry Court: A specialized court that monitors and addresses any violations in the terms and conditions of supervised release, allowing for community-based collaboration, control, and decision-making. Reentry courts can eliminate some of the complications resulting from multiple tiers of the supervision process if empowered to sanction violations and reward compliance.

Reentry Housing: Provides post incarceration transition planning services that, like supportive housing, blends a multitude of funding sources, usually involves partnerships and linkages among multiple non-profit providers with different areas of expertise, and offers tenants/residents a comprehensive array of service options in addition to affordable housing.

Registration: A statutory requirement that an individual convicted of a sex offense must notify authorities of their address, identity, or other personal facts for a determined period of time based on a number of statutory requirements, including the type of offense for which they were convicted; whether they have multiple convictions or a history of convictions for crimes that constitute sexual offenses; or if they have been convicted of specified crimes against victims who are minors.

Reintegration: The process of adjusting from a socially isolated correctional environment back into active community involvement.

Relapse: Resumption of addictive behavior, worsening of a chronic medical condition.

Relapse Prevention: The steps taken in mental health and/or substance abuse treatment to avert relapse.

Release Date: The date a prisoner returns to the community, according to terms set by a parole board, mandatory release statute, or sentencing guidelines.

Release From Supervision: Successful completion of the guidance, treatment, and regulation process by an individual under community supervision.

Releasing Authority: The decision-making body (parole board or parole commission), and/or individual, with responsibility for granting, denying, and revoking discretionary release from a correctional institution or program of supervision. See also Parole Board.

Remand: To order a person accused of a crime to be kept in custody pending further court appearance.

Reparative Activities: Community service programs designed to repair community relationships and focus on the harm that the crime caused.

Reparative Board: A community-sanctioning device that develops sanction agreements with individuals convicted of crimes, monitors compliance, and submits compliance reports to the court. These boards are typically composed of a small group of citizens prepared for their role by training. Board members conduct public, face-to-face meetings with participants.

Responsivity Principle: The principle in correctional practice which stresses the importance of delivering correctional treatment services using methods and techniques matched to individual learning style and motivational level. **General responsivity** refers to treatment programming and modes of service delivery that employ cognitive-behavioral and social learning techniques and methods, and that rely on positive reinforcements over negative reinforcements by a ratio of 4:1. **Specific responsivity** addresses the issue of matching learning styles with program structures and techniques that best meet the characteristics of the participants. It emphasizes

the significance of the quality of the interpersonal relationship between the individual and the correctional change agent (e.g., counselor, probation/parole officer).

Restitution: Payments, generally monetary, made by a person convicted of a crime to a victim or victim's family to compensate for harm caused to the victim. The payments are often allocated from wages earned either while in prison or in post-release employment.

Restorative Justice: A non-punitive justice approach that emphasizes the importance of the roles of the victim, the individual who committed the offense, and the community in fashioning effective solutions to crime. Remedies are sought that instill accountability and the opportunity for positive change in the person who committed the crime; restoration of financial losses for the victim; and the re-establishment of community ties that have been damaged and/or broken by the commission of a crime rather than on punishment and retribution. A variety of restorative justice mechanisms have been developed including victim-offender mediation, family conferencing, and community circles of support.

Returning Citizens: A term that connotes the civil rights of individuals who have paid their debt to society, and accentuates their current, rather than former, characteristics.

Revocation: A sanctioning mechanism whereby a technical violation of the conditions of probation or parole is punishable by re-imprisonment.

Revocation of Parole: An action taken by a paroling authority to revoke conditional release typically due to a violation of a condition of parole which, in most instances, results in return to prison for some period, up to the original length of the sentence.

Risk Factor:

Risk and Needs Assessment: A comprehensive examination of dynamic and static criminogenic factors and usually includes a recommendation for interventions, supervision levels, and sentencing in the event of the commission of a new crime.

Risk Management: Case management that minimizes the risk to the public posed by a returning citizen by addressing the specific areas of risk through supervision, special conditions, treatment, or any combination of these.

Risk Principle: The Risk Principle identifies the level of service needed. Individual with high levels of risk require high-intensity services, while those at low risk should be referred to low-intensity programs because recidivism rates increase when they participate in intensive programs.

Safety Plan: A plan developed for and/or by a crime victim to increase their feelings of security and safety as the release date for the person who perpetrated the crime against them nears.

Scan Analysis Response Assessment (SARA): A problem-solving model developed by police officers and researchers in the1980s which provides a helpful framework for crime control and crime reduction activities.

Scattered Site Housing: Affordable housing in which rental units are not in a single location. This type of housing is often utilized by returning citizens and their families.

Schizophrenia: A group of psychotic disorders characterized by withdrawal from reality, illogical patterns of thinking, delusions, and hallucinations, and accompanied in varying degrees by other emotional, behavioral, or intellectual disturbances. The symptoms of schizophrenia are divided into two classes: positive symptoms and negative symptoms. Positive symptoms generally involve the experience of something in consciousness that would not normally be present (e.g., hallucinations and delusions), while negative symptoms reflect the absence of thoughts and behaviors that would otherwise be expected.

Screening: The detection of the presence of a condition or a risk factor for a condition. For example, a suicide screen consists of an interview or questionnaire designed to determine whether an individual is currently experiencing thoughts, feelings, impulses, or actual plans to commit suicide.

Sealing: The process by which access to a record of arrest or conviction is suppressed or restricted. The record typically remains available to the individuals working in the criminal justice system. In some cases, when a record has been sealed or expunged, the subject of the record is legally permitted to deny the existence of the record if asked about it on an employment application. See also Expungement.

Section 8 Housing Program: A federal rental subsidy program that provides assistance to an individual or a property provided by the U.S Department of Housing and Urban Development (HUD) that is also known as the Housing Choice Voucher (HCV) Program. Vouchers are provided to individuals and subsidies to landlords for the difference between the contract rent (set by HUD at Fair Market Rent) and the total tenant payment. Tenants in the Section 8 program generally pay 30 to 40 percent of their household income for rent. Project-based Section 8 housing provides subsidies for the units, rather than the tenants.

Sedative Hypnotics: Drugs that depress central nervous system function and used as tranquilizers for anxiety reduction, to aid in sleep, anticonvulsants, and muscle relaxants.

Selective Serotonin Reuptake Inhibitors (SSRIs): A class of antidepressant medications that primarily blocks the action of the transporter protein for serotonin (a neurotransmitter) leaving more serotonin to remain at the synapse. SSRIs are primarily used to treat depression and obsessive compulsive disorder. These medications appear to be effective because serotonin is directly involved in the bodyôs ability to regulate moods. Examples include Prozac, Paxil, Celexa, and Zoloft.

Sentencing: The imposition of a criminal sanction by a judicial authority.

Sentencing Hearing: A hearing before a judge to determine the appropriate sanction to be imposed upon a person convicted of a crime.

Serious Mental Illness (SMI): A term defined by federal regulations that generally applies to mental disorders (e.g., psychosis and major mood disorders) that interfere with some area of social functioning (e.g., work, school, family, leisure).

Severe and Persistent Mental Illness (SPMI): Diagnoses that include schizophrenia, severe depression, bipolar disorder, panic disorder, and obsessive-compulsive disorder and result in a high level of functional impairment.

Sexual Violence: A completed or attempted sex act against a victimôs will or involving a victim who is unable to consent; abusive sexual contact; and non-contact sexual abuse, including sexual harassment.

Shelter Allowance: A component of public assistance for offsetting the cost of housing.

Sheriff: The chief law enforcement officer of a county whose general duties include keeping the peace within the county, apprehending persons who break the peace, serving as custodian to the county jail, and performing services to the countyôs courts.

Social Security Disability Insurance (SSDI): A federal program in the Social Security Administration that monthly benefits to workers who are disabled and their dependents. Disability is defined as an inability to engage in substantial gainful activity because of any medically determinable, permanent physical or mental impairment. The disability length of time necessary for eligibility is at least five months. Individuals who worked earn eligibility from the

Social Security taxes (F.I.C.A.) that are withheld from their earnings which are used to replace part of their earnings upon retirement, disability, or for survivors when a worker dies. The amount received is dependent upon how many years an individual has worked and the individual must apply to determine if they are eligible for benefits. See also entitlements.

Social Service Agency: Governmental and community agencies that provide services to assist returning citizens achieve success in the community. Services include housing assistance; obtaining or satisfying basic educational requirements (i.e., GED); job counseling, vocational training or employment assistances; mental health and substance abuse treatment and support; and family reunification and re-connection.

Split Sentence: A sentence that requires a person convicted of a crime to serve a period of confinement in a local, state, or federal facility followed by a period of probation supervision to be served after release from prison or jail. The balance of the sentence is suspended while the person serves a period of community supervision as a probationer, rather than as a parolee. If the person violates the terms of probation during that community supervision period, they may be brought for a hearing before the sentencing judge, instead of a parole board. The judge may then choose to revoke the period of probation and impose some additional sanction up to and including a period of incarceration equal to the suspended balance of the original sentence.

Static Criminogenic Factor: An unchanging condition of an individual's character and environment that might contribute to criminal behavior, including personal employment, family, substance abuse, and medical histories.

Subpoena: A court order requiring a person to appear in court on a specified day and time to give testimony, and may also include an order to produce documents or records. Failure to appear constitutes contempt of court.

Substance Abuse Prevention and Treatment Block Grant (SAPT): A federal grant issued to the states by the Substance Abuse and Mental Health Services Administration (SAMHSA) to support projects for the development and implementation of prevention, treatment and rehabilitation for alcohol and drug use disorders.

Substance Use Disorder (SUD): the misuse of or dependence upon any substance. Substance abuse disorders can mimic many mental disorders, mask many mental disorders; and some somatic disorders (e.g., diabetes or Parkinson's) may appear to be mental and/or substance abuse disorders.

Suicidality: A term that encompasses suicidal thoughts, ideation, plans, suicide attempts, and completed suicide.

Supervised Release: Transferring an individual from the custody of a correctional facility into community supervision.

Supervision: A comprehensive set of tools focused on changing attitudes and behaviors of returning citizens to enhance public safety which requires motivating them to change, helping them acquire prosocial skills, and ensuring compliance with supervision obligations that are goal-oriented. See also community supervision.

Supervision Plan: A probation or parole plan for supervising individuals under community supervision based on assessments of their needs and level of risk.

Supplemental Security Income (SSI): A Federal income supplement program funded by general tax revenues rather than Social Security taxes. SSI is designed to help individuals who are aged, blind, and disabled and have limited or no income and resources by providing cash to meet basic needs for food, clothing, and shelter.

Support Services: Rehabilitative services that are not strictly medical in nature but nonetheless are considered necessary to the recovery process. Such services are designed to develop and/or restore functional capacities and may include support to enable individuals to maintain independent housing, education, employment, or other activities associated with community integration.

Supported Employment (SE): An evidence-based service that matches and trains persons with severe developmental, mental, or physical disabilities to jobs where their specific skills and abilities make them valuable assets to employers.

Supportive Housing: Also known as supported housing, this is housing that is enriched with on-site or easily accessible services that are available but not mandated. Services can include regular staff contact, assistance with household chores, crisis services or other services designed to prevent relapse, mental health treatment, substance abuse treatment, and employment services. Supportive housing, unlike public or affordable housing, relies on a variety of sources of funding and resources.

Technical Violation: An infraction of parole conditions which may include behaviors that would otherwise not be considered crimes, such as consumption of alcohol, failure to attend mandated programs, defaulting on court fee payment plans, failure to report as instructed, or changing an address without prior permission.

Telehealth: Telecommunications-based healthcare which can include diagnosis, consultation, and treatment as well as non-clinical health functions such as the transfer medical data, education, and the dissemination of public health advisories or alerts via email or other technology.

Telemedicine: The use of technology (often videoconferencing) to connect medical clinicians and patients who are geographically distant from each other.

Telepsychiatry: The provision of mental health care via electronic telecommunication in which a qualified mental health professional is able to interview and examine a patient from another location. See also Telehealth.

Temporary Aid to Needy Families (TANF): A federal program that provides assistance and work opportunities to families with low incomes by granting states federal funds and flexibility to develop and implement their own welfare programs. TANF was created by the Welfare Reform Law of 1996, and replaced what was then commonly known as welfare: Aid to Families with Dependent Children (AFDC) and the Job Opportunities and Basic Skills Training (JOBS) programs and is overseen by the Office of Family Assistance (OFA) in the US Department of Health and Human Services,

Therapeutic Communities (TCs): Highly structured units of residential treatment which provide intensive treatment for substance dependencies. Prison-based TCs cluster selected inmates away from the general population for a year or longer and offer comprehensive, integrated treatment; facilitate transfer to similar community-based programs; and the involvement of community and faith-based services.

Timed-Out/Maxed-Out: Individuals convicted of crimes serve the full length of their sentences in prison or jail and are released unconditionally without any community supervision.

Transition Planner: Correctional facility based case managers who develop and administer a programming plan to ensure that inmates are taking steps to prepare for reentry throughout their incarceration. Transition planners coordinate with a multidisciplinary team of professionals, including representatives from facility and community-based organizations, to work on programming that address transition into the community.

Trauma: A response to violence or the injury engendered by violence and physical and emotional abuse that often requires treatment intervention. Trauma is not limited to suffering violence, but also includes witnessing violence, as well as stigmatization due to age, gender, race, ethnicity, poverty, incarceration, or sexual orientation.

Trauma-Informed Services: Services provided for problems other than trauma but that require knowledge concerning the impact of trauma. Trauma-informed services take trauma into account, avoid triggering trauma reactions and/or re-traumatizing the individual, support the individual's coping capacity and effectively manage their trauma symptoms in order to access, retain, and benefit from these services.

Traumatic Brain Injury (TBI): An injury to the brain characterized by symptoms including poor judgment or poor impulse control and personality changes.

Treatment Accountability for Safer Communities (TASC): A case management and system intervention program that links the criminal justice system with the substance abuse treatment system by coordinating services at any point in the criminal justice system including reentry. TASC programs vary but usually include identification and referral of individuals with justice system involvement who have substance use issues, clinical assessment of substance abuse treatment needs, referral into an appropriate treatment placement, and; continuous case management to ensure compliance with criminal justice orders and treatment plans.

Treatment Principle: The view that treatment, particularly in cognitive-behavioral therapy, should be applied as an integral part of the sentence/sanction process through case management and delivery of targeted and timely treatment interventions.

Trial: A proceeding in civil or criminal, in court where the law and evidence are reviewed, and the guilt, liability, or other issues are determined by jury or judge.

Trigger: An event, situation, person, place, or object that evokes a behavior.

Truth-in-Sentencing Laws: Sentencing statutes that require individuals convicted of a crime to serve a substantial portion of their sentence in a correctional facility rather than under community supervision, thereby reducing the apparent discrepancy between the sentence imposed and actual time served in prison. It is a type of mandatory sentencing guideline, which also includes determinate sentencing, mandatory minimum sentencing, and Truth-in-Sentencing laws.

Validated Risk-Assessment Instrument: A mechanism for making discretionary release decisions that facilitates informed, effective, and appropriate decision-making, diminishing the effect of prejudice and personal opinion in the release decision process.

Victim: A person, family, and/or community harmed by someone's behavior.

Victim Impact Statement (VIS): A statement given by victim(s) subsequent to a verdict and prior to sentencing that depicts how a crime has affected them and the sentence they believe would be appropriate (in noncapital cases). An oral or written description of the physical, financial, and emotional effects a crime has on an individual victim, family, neighborhood, or community.

Vocational Rehabilitation (VR): A range of services designed to assist individuals with disabilities in regaining skills needed to function in the workplace generally delivered under the auspices of a state department of vocational rehabilitation and supported by state and federal appropriations. Eligibility for VR programs is established under the federal Rehabilitation Act. State VR agencies may offer programs including supported employment, Ticket to Work, Pathways to Independence, and work-readiness programs.

Welfare-to-Work Tax Credit: A federal income tax credit established by the Taxpayer Relief Act of 1997 that encourages employers to hire long-term public assistance recipients, which can include returning citizens and their family members. This tax credit can reduce employersô federal tax liability by as much as $8,500.00 per new hire (depending on the amount that the new hire earns) over the first two years.

Work Opportunity Tax Credit (WOTC): A Federal tax credit incentive that the Congress provides to private-sector businesses for hiring individuals from twelve target groups who have consistently faced significant barriers to employment.

Workforce Investment Act (WIA): 1998 federal legislation designed to integrate national, state, and local job training programs to increase employment, job retention, and earnings of participants; reduce welfare dependency; and enhance national productivity and competitiveness. WIA replaced the Job Training Partnership Act (JTPA) and streamlined federal job training programs into local service delivery systems built around One-Stop career centers.

Workforce Investment Area: The local area which serves as the administrative region for Workforce Investment Boards; regional designations are determined by the governor, and may be done in consultation with local officials.

Workforce Investment Board (WIB): A panel of individuals who serve at the state and local levels to design and implement workforce development and employment strategies in a designated workforce investment area established by the Workforce Investment Act of 1998.

Work Release: A form of correctional work that permits individuals to work outside a correctional institution during the day and to return to the prison, a halfway house, or other secure facility in the evenings.

Unconditional Release: The release of a person from prison to the community without a requirement for a period of supervision by a community corrections agency. Upon release, the person is no longer under the jurisdiction of the correctional system, or the justice system, and hence is not required to abide by any conditions of supervision and cannot be returned to prison absent a conviction for the commission of a new crime.

Wraparound Services: A holistic and culturally sensitive plan for each individual that draws on a coordinated continuum of services located within a community that includes nonclinical supportive services (e.g., child care, vocational, educational, and transportation services) designed to improve the individualôs access to and retention in primary supportive services.

APPENDIX D: QUICK REFERENCE GUIDE

Target	Effective Interventions/Programs*	Unproven/Ineffective Interventions	Comments
Substance Use Disorders (SUDs)	• Drug courts • Therapeutic Communities (TCs) • Prison-based treatment followed by community-based treatment • Community Reinforcement Training • Brief Intervention • Motivational Enhancement Therapy (MET) • Contingency Management (CM) • Twelve Step Facilitation Therapy (TSF) • Medication Assisted Treatment (MAT) • Peer Support & Self-Help programs • Pre- and post-booking diversion • Specialty supervision • Drug Testing • Treatment Accountability for Safer Communities (TASC) • Pharmacotherapy	• Shock incarceration programs • Scared Straight programs • Restitution programs • Boot camp programs • Intensive supervision probation and parole programs • College coursework programs • Programs providing training in job-seeking skills and job placement services • Guided group interaction and positive peer culture programs Faith-based programming	
Co-occurring Disorders (CODs)	• Integrated Dual Disorder Treatment	• Faith-based programming • Parallel or sequential treatment	
Domestic Violence	• Domestic Violence Courts • Batterers Intervention Programs (BIPs)	• Faith-based programs • Education	Limited effectiveness of interventions
Sex Offending	• CBT • Circles of Support and Accountability (COSA) • Antiandrogen medications • Specialty Supervision	• Traditional Psychotherapy	Limited effectiveness of interventions
Intermediate Sanctions	• Treatment-oriented intensive supervision • Graduated response systems	• Surveillance-oriented intensive supervision • Boot camps • Electronic monitoring • Restorative justice programs for individuals who are at lower risk • Day fines	
Work & Educational	• Prison-based correctional industries programs		

* Effective interventions/programs lead to statistically significant reductions in recidivism rates.

Target	Effective Interventions/Programs*	Unproven/Ineffective Interventions	Comments
Programs	• Prison-based adult education Prison-based vocational education • Work release programs • Community-based employment training, job search, and job assistance programs • Education in prison (basic education or post-secondary) • Employer Incentives • Supported Employment (SE) • Supported Education (SEd)		
Mental Illness	• Modified Therapeutic Communities (MTCs) • Pharmacotherapy • Pre- and postbooking diversion programs • Specialty Supervision • Peer Support • Forensic Assertive Community Treatment (FACT) • Forensic Intensive Case Management (FICM) • Psychiatric Advance Directives (PADs) • Illness Management and Recovery (IMR) • Family Psychoeducation (FPE) • Critical Time Intervention (CTI) • Solution-Focused Brief Therapy (SFBT)		
Criminogenic Need/Risk	• Reasoning and Rehabilitation (R&R) • Moral Reconation Therapy (MRT) • Thinking for a Change (T4C) • Relapse Prevention Therapy (RPT) • Strategies for Self-Improvement and Change (SSC) • Aggression Replacement Training (ART) • Reentry Courts • Restorative justice programs	• Faith-based programs • Surveillance-oriented supervision • Intensive Supervised Probation/Parole (ISP) programs • Boot Camps	Boot camp programs are ineffective because they target factors unrelated to crime, offer opportunities for modeling aggressive behavior and bonding for individuals who engage in criminal acts
Supervision	• Motivational Interviewing (MI) • Supportive Inquiry • Collaborative partnerships with returning citizens, families, community stakeholders, and		

Target	Effective Interventions/Programs*	Unproven/Ineffective Interventions	Comments
	service and support providers		
Housing	• Supportive Housing • Subsidized housing		
Trauma	• Seeking Safety • Trauma Recovery and Empowerment (TREM) • Traumatic Incident Reduction Therapy (TIR) • Prolonged Exposure Therapy (PE) • Dialectical Behavior Therapy (DBT) • Helping Women Recover • Beyond Trauma		
Children/Families	• Mentoring • Family strengthening programs • Parenting programs • Family Case Management (FCM)		