Guidelines for Successful Transition of People with Mental or Substance Use Disorders from Jail and Prison:

Implementation Guide

assess·plan·identify·coordinate

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

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Introduction

The purpose of *Guidelines for Successful Transition of People with Mental and Substance Use Disorders from Jail and Prison: Implementation Guide* is to provide behavioral health, correctional, and community stakeholders with examples of the implementation of successful strategies for transitioning people with mental or substance use disorders from institutional correctional settings into the community. This guide serves as a direct successor to the 2013 publication *Guidelines for the Successful Transition of People with Behavioral Health Disorders from Jail and Prison* (Blandford & Osher, 2013), a collaborative product of the SAMHSA's GAINS Center with the Council of State Governments Justice Center, and the 2002 report *A Best Practice Approach to Community Re-Entry from Jails for Inmates with Co-Occurring Disorders: The APIC Model* (Osher, Steadman, & Barr, 2002). The guide is intended to promote jurisdictional implementation of the APIC Guidelines through the identification and description of various jurisdictional strategies that have been adopted in efforts to facilitate successful community reentry for justice-involved people with mental and co-occurring substance use disorders.

Jails and prisons house significantly greater proportions of individuals with mental, substance use, and co-occurring disorders than are found in the general public. While it is estimated that approximately 5 percent of people living in the community have a serious mental illness, comparable figures in state prisons and jails are 16 percent and 17 percent, respectively (Kessler et al., 1996; Ditton, 1999; Metzner, 1997; Steadman, Osher, Robbins, Case, & Samuels, 2009). The prevalence of substance use disorders is notably more disparate, with estimates of 8.5 percent in the general public (aged 18 or older) but 53 percent in state prisons and 68 percent in jails (Substance Abuse and Mental Health Services Administration [SAMHSA], 2014; Mumola & Karberg, 2004; Karberg & James, 2005). Similarly, the co-occurrence of mental and substance use disorders has been higher among people who are incarcerated in prisons or jails (33 percent to 60 percent) compared with people who are not incarcerated (14 percent to 25 percent) (Wilson, Draine, Hadley, Metraux, & Evans, 2011; Baillargeon, et al., 2010; SAMHSA, 2012; SAMHSA, 2009).

The high prevalence of mental and substance use disorders in correctional settings produces poorer outcomes for both affected individuals and correctional agencies. Compared to people

without mental or substance use disorders, individuals with mental and substance use disorders are less likely to make bail (Council of State Governments Justice Center, 2012), and more likely to—

- have longer jail stays (Council of State Governments Justice Center, 2012),
- serve time in segregation during incarceration (Metzner & Fellner, 2010), and
- experience victimization or exploitation (Wolff, Blitz, & Shi, 2007).

Within jails and prisons, justice system personnel report that individuals with mental or substance use disorders present with a range of physical, behavioral, and developmental deficits and exhibit greater difficulty coping with institutional rules (Houser, Belenko, & Brennan, 2012). In an effort to address the needs of this population, new or expanded services have been introduced (Hills, Siegfried, & Ickowitz, 2004). The additional expense of these interventions has been justified by pointing to improved individual- and system-level outcomes (Cloud & Davis, 2013).

Upon release from jail or prison, many people with mental or substance use disorders continue to lack access to services and, too often, become enmeshed in a cycle of costly justice system involvement (Pew Center on the States, 2011). Indeed, the least developed jail-based service is transition planning (Steadman & Veysey, 1997). The days and weeks following community reentry are a time of heightened vulnerability (Binswanger et al., 2007). Justice system personnel, behavioral health treatment and service practitioners, researchers, and policymakers agree that the maintenance of better individual-level outcomes and a reduction in recidivism necessitate a formalized continuity of services from institution to community settings (Griffin, Heilbrun, Mulvey, DeMatteo, & Schubert, 2015).

Local and statewide models for the assessment, design, and cross-system delivery of needed services have been developed in communities such as Allegheny County (PA), Franklin County (MA), Gwinnett County (GA), Hampden County (MA), Hancock County (OH), Montgomery County (MD), and Pima County (AZ) and in statewide initiatives such as those in Hawaii, North Carolina, and New York. This document provides examples of the actual implementation of successful strategies for transitioning people with mental or substance use disorders from institutional correctional settings into the community. While the highlighted applications necessarily reflect local needs and resources, these implementation strategies are adaptable to a wide variety of communities and justice systems.

Positive individual-level outcomes focused on personal recovery require continuity of appropriate services from institution to community settings. Improved system-level outcomes, defined as

Upon release from jail or prison, many people with mental or substance use disorders continue to lack access to necessary services and, too often, become enmeshed in a cycle of costly justice system involvement
—Pew Center on the States (2011)

diminished financial expenditures through reduced rates of recidivism, require a concomitant focus on criminogenic risk factors. Realization of enhanced system and individual outcomes depends upon effective coordination of the efforts of behavioral health, correctional, and community stakeholders. *Adults with Behavioral Health Needs under Correctional Supervision: A Shared Framework for Reducing Recidivism and Promoting Recovery* (Osher, D'Amora, Plotkin, Jarrett, & Eggleston, 2012), funded by the National Institute of Corrections (NIC), the Bureau of Justice Assistance (BJA), the Substance Abuse and Mental Health Services Administration (SAMHSA), and supported by the Association of State Correctional Administrators (ASCA), the American Probation and Parole Association (APPA), the National Association of State Mental Health Program Directors (NASMHPD), and the National Association of State Alcohol and Drug Abuse Directors (NASADAD), was developed to provide procedural guidelines for recidivism reduction, successful reentry and individual recovery.

This framework (Osher et al., 2012) directs behavioral health, justice system, and community stakeholders to work collaboratively across systems to design and implement evidence-based programming to forward the dual goals of individual recovery and risk reduction. The APIC model (Osher, Steadman, & Barr, 2002) provides guidance to assist jurisdictions in this task. The acronym APIC stands for Assess, Plan, Identify, and Coordinate. The 10 associated guidelines are listed on the following pages.

assess▪plan▪identify▪coordinate

Assess the individual's clinical and social needs and public safety risk

Guideline 1: Conduct universal screening as early in the booking/intake process as feasible and throughout the criminal justice continuum to detect substance use disorders, mental disorders, co-occurring substance use and mental disorders, and criminogenic risk. Valid and reliable screening instruments for the target population should be used.

Guideline 2: For individuals with positive screens, follow up with comprehensive assessments to guide appropriate program placement and service delivery. The assessment process should involve obtaining information on

- Basic demographics and pathways to criminal involvement;
- Clinical needs (e.g., identification of probable or identified diagnoses, severity of associated impairments, and motivation for change);
- Strengths and protective factors (e.g., family and community support);
- Social and community support needs (e.g., housing, education, employment, and transportation); and
- Public safety risks and needs, including changeable (dynamic) and unchangeable (static) risk factors, or behaviors and attitudes that research indicates are related to criminal behavior.

Plan for the treatment and services required to address the individual's needs, both in custody and upon reentry.

Guideline 3: Develop individualized treatment and service plans using information obtained from the risk and needs screening and assessment process.

- Determine the appropriate level of treatment and intensity of supervision, when applicable, for individuals with behavioral health needs.
- Identify and target individuals' multiple criminogenic needs in order to have the most impact on recidivism
- Address the aspects of individuals' disorders that affect function to promote effectiveness of interventions.
- Develop strategies for integrating appropriate recovery support services into service delivery models.
- Acknowledge dosage of treatment as an important factor in recidivism reduction, requiring the proper planning and identification of what, where, and how intensive services provided to individuals will be.

Guideline 4: Develop collaborative responses between behavioral health and criminal justice that match individuals' levels of risk and behavioral health need with the appropriate levels of supervision and treatment.

assess▪plan▪identify▪coordinate

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

Guideline 5: Anticipate that the periods following release (the first hours, days, and weeks) are critical and identify appropriate interventions as part of transition planning practices for individuals with co-occurring mental and substance use disorders leaving correctional settings.

Guideline 6: Develop policies and practices that facilitate continuity of care through the implementation of strategies that promote direct linkages (i.e., warm hand-offs) for post-release treatment and supervision agencies.

Coordinate the transition plan to ensure implementation and avoid gaps in care with community-based services

Guideline 7: Support adherence to treatment plans and supervision conditions through coordinated strategies.

- Provide a system of incentives and graduated sanctions to promote participation in treatment; maintain a "firm but fair" relationship style; and employ problem-solving strategies to encourage compliance, promote public safety, and improve treatment outcomes.
- Establish clear protocols and understanding across systems on handling behaviors that constitute technical violations of community supervision conditions.

Guideline 8: Develop mechanisms to share information from assessments and treatment programs across different points in the criminal justice system to advance cross-system goals.

Guideline 9: Encourage and support cross training to facilitate collaboration between workforces and agencies working with people with co-occurring mental and substance use disorders who are involved in the criminal justice system.

Guideline 10: Collect and analyze data to evaluate program performance, identify gaps in performance and plan for long-term sustainability.

Strategic Implementation of APIC Guidelines

Assess the individual's clinical and social needs and public safety risks

Guideline 1: Conduct universal screening as early in the booking/intake process as feasible and throughout the criminal justice continuum to detect substance use disorders, mental disorders, co-occurring substance use and mental disorders, and criminogenic risk. Valid and reliable screening instruments for the target population should be used.

A screen is a standardized instrument that is designed to flag individuals who are at risk for a targeted problem, such as mental or substance use disorder. These tools do not provide diagnostic information nor do they provide guidance on the severity of any mental or substance use disorder. Jurisdictions across the United States have applied the universal screening guidelines in ways that reflect the human and fiscal resources of their institutions, the strength of community collaboration, and the availability of treatment options. The 2016 SAMHSA publication, "Screening and Assessment of Co-occurring Disorders in the Justice System" (SMA15-4930), reviews screening and assessment instruments for use with criminal justice populations. The publication examines instrument that screen or assess for mental disorders, substance use disorder, co-occurring mental and substance use disorders, motivation and readiness for treatment, trauma history and posttraumatic stress disorder (PTSD), and suicide risk. Refer to the SAMHSA Store (http://store.samhsa.gov) to obtain the publication.

The **Gwinnett County (GA)** Jail documents over 36,000 bookings annually. For each individual booked, there is universal screening for veteran status and the presence of a mental illness. At this first contact, the jail identifies housing needs, treatment needs, employment and education needs, and safety precautions, and diversion opportunities are charted. The results of the screen are used to initiate discharge planning as early as possible, acknowledging the short length of stay of many individuals.

A comprehensive strategy has been adopted by the **Hancock County (OH)** Justice Center. Located in a county with a population of approximately 75,000 people, the jail has a capacity of 98 beds, an average daily population of 106, and an average length of stay of 15 days. Through a grant from the Ohio Department of Mental Health and Addiction Services, jail personnel administer the 23-item Global Appraisal of Individual Needs Short Screener (GAIN-

SS)[1] to screen all recently booked inmates for behavioral health issues and propensity for criminal behavior. Inmates who are released quickly receive an information sheet that outlines available behavioral health and social services in the community.

A third approach is being utilized by the **Montgomery County (MD)** Detention Center (MCDC). At the point of entry, newly detained people are screened by jail personnel and health care practitioners. A report of any behavioral health issue on any of the screens satisfies the threshold for full assessment (see Guideline 2). These screens include—

1. Initial medical screening form;
2. Initial placement screening form (substance use history, previous hospitalizations, use of psychotropic medications);
3. Inmate past medical history report;
4. History and physical form; and
5. Suicide screening form (this information is elicited multiple times—at point of entry; in jail housing; and as needed, by correctional officers and health care practitioners)

Positive screens or observed unusual behavior at the MCDC results in an immediate referral to a team of on-site Clinical Assessment and Triage Services (CATS) therapists who conduct a comprehensive mental health assessment. CATS are full-time employees of the county Department of Health and Human Services.

In response to a study by Vaughan and Scheyett (2007) of the treatment of people with mental illness in jails in **North Carolina**, House Bill 1473 §10.49(f) (2007) required that, as of January 1, 2008, all jails in the state were to administer evidence-based screening for mental illness to all people who, at the time of booking, were "knowingly suicidal, hallucinating or delusional." A committee comprising justice system personnel, behavioral health treatment and service providers, and advocates chose the Brief Jail Mental Health Screen (BJMS) for this purpose. Due to fiscal constraints, this legislative mandate was allowed to sunset after 1 year of implementation. Nevertheless, the Division of Mental Health estimates that the vast majority of jails have continued to employ this instrument. Supplemental screening for co-occurring disorders is not mandated and there is no recommended instrument for co-occurring disorders.

Guideline 2: For individuals with positive screens, follow up with comprehensive assessments to guide appropriate program placement and service delivery. The assessment process should involve obtaining information on basic demographics and pathways to criminal involvement; clinical needs; strengths and protective factors; social and community support needs; and public safety risks and needs.

[1] Information about the administration and scoring of the GAIN-SS is available from Chestnut Health Systems at http://www.gaincc.org/gainss

In comparison to a screen, an assessment instrument provides a more in-depth examination of the nature and severity of a targeted problem. The results of assessment instruments, typically administered by qualified personnel (e.g., clinicians), can assist in the development of treatment plans. The Level of Service Inventory-Revised (LSI-R) is a validated 54-item risk/need assessment that identifies psychosocial problem areas in an individual's life, predicts criminogenic risk, assists in the allocation of resources, facilitates decision-making relative to probation and placement, and assesses treatment progress[2]. Designed for professional administration to adults (age 16 and older), this tool has been adopted by several sites in their efforts to implement APIC Guideline.[2] Administration is estimated to take between 30 and 45 minutes.

One such site is **Franklin County (MA)** where clinical assessment is conducted by contract treatment and service practitioners coming into the jail. Aside from the risk assessment, the clinical assessment consists of the PTSD Checklist,[3] the Patient Health Questionnaire (PHQ), Brief Addiction Monitor (BAM), and the Five Facet Mindfulness Questionnaire (FFMQ short form). Inmates are administered each tool pre- and post-intervention to assess treatment progress. The clinical team meets after each administration to review what behavioral health issue, if any, the individual is experiencing and to assess what challenges current symptomatology pose to recovery efforts. For individuals in the reentry program, the assessments are administered quarterly.

The **Ohio** Department of Rehabilitation and Correction (DRC) utilizes a different assessment tool in its public and private correctional settings. A decade ago, the agency contracted with the Center for Criminal Justice Research at the University of Cincinnati to develop instrumentation to assess criminogenic risk factors and identify barriers to effective treatment for people at multiple decision points in the justice system. The Ohio Risk Assessment System (ORAS)[4] is a suite of validated instruments that can be administered pretrial, while under community supervision, at prison intake, and during reentry planning. House Bill 86, effective in 2011, legislatively mandated adoption of a single validated risk assessment tool to be administered by a wide variety of justice system agencies, including courts, probation and parole authorities, state and local correctional facilities (public and private), and community correctional institutions. As a result, this instrument is now used in all DRC facilities and has been adopted by an increasing number of programs outside of Ohio. While there is no cost for use of this instrument, there is a fee for staff training in the administration and scoring of the tool.

[2] Additional information about the LSI-R instrumentation and services is available from http://www.mhs.com/product.aspx?gr=saf&prod=lsi-r&id=overview.

[3] Information regarding the PTSD Checklist is available from http://www.ptsd.va.gov/professional/assessment/adult-sr/ptsd-checklist.asp.

[4] For a comprehensive review of the ORAS instrumentation and implementation updates, see http://www.drc.ohio.gov/oras.

Plan for the treatment and services required to address the individual's needs (while in custody and upon reentry)

Well over two decades ago, Steadman, McCarty, and Morrissey (1989) identified transition planning as the weakest link in the effective reentry of individuals with mental or substance use disorders into the community. A follow up examination by Steadman and Veysey (1997) reconfirmed that this remained the least developed element of jail-based services with just over one-fourth of jails nationwide reporting that they provided any discharge planning mechanism. However, initiatives launched in the 2000s have focused more attention on jail reentry, especially following the 2003 agreement in the *Brad H. v. City of New York*[5] class-action lawsuit regarding the release practices for jail inmates with mental illness. Since that time, the Transitions from Jail to Community Initiative of the National Institute of Corrections and the Urban Institute (Warwick, Dodd, & Neustetter, 2012), the Bureau of Justice Assistance's support for the development of The Jail Administrator's Toolkit for Reentry (Mellow, Mukamal, LoBuglio, Solomon, & Osbourne, 2008), and the growth of the Sequential Intercept Model (SAMHSA GAINS Center for Behavioral Health and Justice Transformation, 2013; Griffin, Heilbrun, Mulvey, DeMatteo, & Schubert, 2015) have highlighted the need for effective transition planning services.

The reticence of justice systems to engage in transitional planning was, in some cases, attributable to fiscal constraints or beliefs about limitations of jurisdictional responsibilities. In the ensuing years, there has been a softening of perceived jurisdictional boundaries. Increasingly, but slowly, there has been cross-system recognition that improved outcomes for individuals, justice systems, and the community require comprehensive and integrated service planning that is implemented within the correctional setting and continued into the community with minimal disruption.

Guideline 3: Develop individualized treatment and service plans using information obtained from the risk and needs screening and assessment process.

Jurisdictions have taken a diverse set of strategies to address Guideline 3. While some sites have added clinical support staff to correctional staffing rolls, other jurisdictions contract with external behavioral health agencies to administer and score assessments and to develop appropriate treatment and service plans. A common goal is the design of programming that integrates evidence-based mental or substance use disorder treatment with an emphasis on

[5] Additional information on *Brad H. v. City of New York* is available from the Urban Justice Center: http://mhp.urbanjustice.org/mhp-bradH.v.cityofnewyork

the reduction of criminogenic risk. The targeted delivery of the agreed-upon services and interventions may be the responsibility of internal or contract staff; may occur in general population or in specialized housing units; may be voluntary or court ordered; and may emphasize medication management, counseling, education, employment, transitional planning, or other factors.

A comprehensive approach to individualized treatment and service planning has been adopted by the **Hampden County (MA)** jail. The Sheriff's Department has established a four-phase continuum of graduated levels of security for sentenced inmates. The first three of the four Phase protocols are illustrative of APIC Guideline 3. This continuum of supervision and care identifies people who are high risk or who present with mental, substance use, or co-occurring disorders, and delivers appropriate treatment interventions. Noting that there is an optimal time frame for effecting meaningful behavioral change prior to reentry, discharge planning begins as early as possible during an individual's period of incarceration. Upon admission, all individuals enter Phase 1: Fundamental Planning. This is essentially an institutional orientation after which individuals are relocated to another unit within the Hampden Medium Security Facility. Here they enter Phase 2: Transitional Program. During this period, they participate in a mandatory 4-week Basic Inmates' Intensive Regimen. Programming includes units on substance use education, pre-employment training ("Learn 2 Earn"), anger management, cognitive thinking skills, victim impact, family relationships, religion, health education, and educational orientation. Upon successful completion of this general inmate program, individuals proceed to Phase 3: Program Mapping. Results from the administration of the Level of Service Inventory-Revised: Screening Version are used to design an Individualized Service Plan that addresses behavioral health and criminogenic risk factors. The individualized treatment plans are open ended in duration. Participants must meet expectations of each program element to receive additional privileges and to gain eligibility for lower security consideration[6].

Guideline 4: Develop collaborative responses between behavioral health and criminal justice that match individuals' levels of risk and behavioral health need with the appropriate levels of supervision and treatment.

The days and weeks following community reentry are a time of heightened vulnerability for individuals. Justice system personnel, behavioral health treatment and service practitioners, researchers, and policymakers agree that the maintenance of better individual-level outcomes and a reduction in recidivism necessitate a formalized continuity of services from institution to community settings.

The development of comprehensive treatment and integrated services for justice-involved individuals with mental and substance use disorders produces better outcomes in terms of

[6] A description of the Hampden County Sheriff Department's Phase III vocational and treatment programming options is available at http://hcsdma.org/wp-content/uploads/2015/08/Programs-Overview-Website.pdf.

recovery. Jurisdictions must explore strategies to link the dosage and modality of risk-focused interventions with the assessments for criminal risk and need and behavioral health.

Hancock County (OH) has implemented a comprehensive strategy for placement and treatment planning that matches an individual's risk level and behavioral health needs with varying levels of supervision and modes of treatment. People who score positively on the GAIN-SS, and for whom there is an anticipated jail stay of less than 72 hours are quickly screened using the Screening, Brief Intervention, and Referral to Treatment (SBIRT) approach. Low scorers are offered general facility programming while high scorers are referred to substance use treatment and focused behavioral health discharge planning in addition to the general programming. For people expected to be in custody for more than 72 hours, administration of the seven-item ORAS-PAT (Pretrial Assessment Tool) allows for the assignment of people into one of eight groupings. This empirical classification system outlines options for general versus specialized services, treatment referrals, case management, transition planning, and support, as well as general programming.

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

Guideline 5: Anticipate that the periods following release (the first hours, days, and weeks) are critical and identify appropriate interventions as part of transition planning practices for individuals with mental health and co-occurring substance use disorders leaving correctional settings.[7]

In one Midwestern state, justice system personnel estimate that nearly one in four individuals incarcerated in the state prison system takes prescribed medications in response to behavioral health issues. Upon release from state confinement, the typical individual is supplied with 2 weeks of medication and a prescription for subsequent short-term dosing (Hertel, 2013).

Lack of access to medication, employment, housing, food, social supports, and health care can produce poor outcomes for many people who find themselves caught up in a revolving cycle of jail admissions and releases. Comprehensive and collaborative transition planning for individuals with mental and substance use disorders can disrupt this cycle and improve individual- and system-level outcomes.

The **Gwinnett County Jail (GA)** provides a notable illustration of comprehensive cross-system planning and practice for individuals with mental or substance use disorders. A local study had revealed that the jail housed a large population of homeless people for whom services upon release were deemed to be deficient. People with mental, substance use, or co-occurring disorders were disproportionately represented in this group. In 2011, with a dual goal of assisting individuals who were exiting incarceration to become self-sufficient and reducing recidivism, County Commissioners funded the Gwinnett Reentry Intervention Program (GRIP). Initially established as a collaboration between the Sheriff's Office and United Way, the program has expanded substantially to include more than 30 agencies that provide community-based services for people released pretrial as well as those transitioning back into the community post-sentence. GRIP works to link all people in need, regardless of behavioral health issues, with housing and employment services and access to physical and behavioral health care.

Also in Gwinnett County, the Community Bridge Program is a second reentry track that was managed by Corizon Health staff to meet the needs of people with serious mental illnesses. The Community Bridge liaison works with the GRIP Coordinator and community collaborators to develop reentry plans based on an individual's needs. Recognizing that access to medications in the first hours and days post-release is critical in maintaining people in the community and preventing recidivism, the outreach efforts of program personnel have been successful in ensuring inmates have a minimum of a week's supply of medication upon release, with

[7] Refer to the article by Bandara et al. (2015) on the challenges related to health coverage for justice-involved individuals following passage of the Affordable Care Act.

provisions for additional supplies to bridge any gap before scheduled appointments. In addition, the Community Bridge caseworker coordinates with the community mental health treatment and service provider to recommend diversion, as appropriate, to Pretrial Diversion (for misdemeanor cases), Mental Health Court (nonviolent felony cases), or Veterans Court (nonviolent felony cases). The Community Bridge Liaison and the Director of Mental Health serve on the advisory committees of the mental health court and the veteran's court.

Within the **Hampden County (MA)** Jail, individualized treatment plans are designed and delivered by two groups of facility clinicians. Upon intake screening, people who are identified as being in crisis or who present with serious behavioral health issues are immediately assigned to the Evaluation and Stabilization Unit, one of only two intensive psychiatric units in the state jail system. While here, they receive appropriate crisis intervention until their conditions stabilize, at which time they are transferred to the non-crisis behavioral health pod. In this step-down unit, staff counselors utilize LSI-R assessment results and information derived from clinical interviews to identify needs and to design individualized service plans. As release dates draw near, sentenced individuals meet with state-employed peer mentors from the After Incarceration Support System (AISS). The mentors introduce prospective releases to the services and treatment options available through the regional Behavioral Health Network (BHN), a coalition of approximately 300 community agencies committed to providing behavioral health services to adults and children in western Massachusetts. BHN reviews the treatment plans developed by institutional clinicians and assumes the delivery of this care upon reentry, promoting personal recovery and improving overall individual outcomes. Peer mentors follow discharged individuals into the community, transporting them to appointments and encouraging compliance with treatment plans (see Guideline 7 description). Institutional personnel are working to streamline the treatment delivery continuum by facilitating the reactivation of private or public insurance coverage.

Guideline 6: Develop policies and practices that facilitate continuity of care through the implementation of strategies that promote direct linkages (i.e., warm hand-offs) for post-release treatment and supervision agencies.

The long-term efficacy of institutional programming for recovery and risk reduction is greatly diminished if intervention services are terminated or disrupted when the individual transitions from one institution to another or from an institutional setting back into the community. Program termination may be the result of restricted budgets or narrow philosophical approaches that view institutional and community interventions as limited in time and place. Nevertheless, the inadvertent or negligent disruption of services continues to contribute to negative individual and justice system outcomes. Suspended or delayed access to insurance coverage, for example, may result in deferred scheduling of physical and behavioral health care appointments, incomplete sharing of physical and behavioral health information, and lapses in medication dosages.

In support of APIC Guideline 6, an increasing number of jurisdictions are engaging in significant in-reach to connect or reconnect inmates with Medicaid or other forms of health insurance coverage in advance of their scheduled release dates. Sometimes referred to as Benefits Counselors, Prerelease Coordinators, or Specialized Reentry Probation/Parole Officers, these specialists work with individuals to identify and plan for necessary physical health care, behavioral health care, justice system, and community supports. On a continuum of care, and as appropriate, these staff may simply provide all transitional support information to the individual, or may personally transport and introduce the released individual to a mental health or substance use counselor, a coordinator of a local FACT team, or a community resource caseworker. These "warm hand-offs" ensure that, upon reentry, individuals will have timely access to people and supports that will promote recovery and reduce risk of recidivism.

An illustration of a statewide promotion of the APIC principle of continuity of care within a jail setting can be seen in **New York State**. In 2012, the New York State Division of Criminal Justice Services, in collaboration with the New York State Office of Mental Health, received funding from the Bureau of Justice Assistance to establish a Justice and Mental Health Collaboration Program (JMHCP) to examine sites and consequences of criminal justice and mental health interactions. County-level pilot projects have created or expanded services that improve individual- and system-level outcomes by strengthening cross-system linkages in the design, management, and delivery of care plans. One such initiative, in conjunction with general Medicaid Redesign at the state level, has been JMHCP's identification of six of the Medicaid Health Homes as pilot sites, addressing the disparities in physical and behavioral health care for justice-involved individuals with chronic health conditions. Health Home Care Managers work with jail staff to identify detained individuals within 3 months of release who are Medicaid eligible and who meet the federally established eligibility threshold for enrollment in a Health Home (two or more qualifying chronic conditions or a diagnosis of serious mental illness and/or HIV). With the consent of the identified individuals, the care managers work to open or reactivate Medicaid coverage; discuss housing; identify social, physical health, and behavioral health issues; and devise a community treatment plan. Upon discharge, the care manager meets the individual at the jail and transports him or her to the Health Home to activate Medicaid coverage and to enroll in Health Home services. The care manager also transports the individual to treatment and services providers to minimize disruption in services. Health Home care managers are also assigned to specialized courts to meet with and provide services to those individuals who are diverted out of the justice system at an early stage.[8]

[8] Additional information about the New York State Division of Criminal Justice Services' JMHCP grant is available from http://www.criminaljustice.ny.gov/opca/justice-mental-health.htm.

Coordinate the transition plan to ensure implementation and avoid gaps in care with community-based services

Guideline 7: Support adherence to treatment plans and supervision conditions through coordinated strategies.

Policies and practices that support Guideline 7 address both public safety and behavioral health concerns through coordinated strategies. The assignment of released individuals to community-based pre-release centers or to intensive probation caseloads with specialized mental health probation officers are two approaches for achieving this goal. A third approach, utilized in a growing number of jurisdictions, is assignment to problem-solving courts. All of these strategies can provide a system of incentives and sanctions that encourage compliance with treatment plans while promoting public safety through close supervision.

In **Hampden County (MA),** when eligible individuals are within 90 days of release (see earlier discussion in Guideline 3), they enter the fourth and final phase in the continuum of graduated levels of security for sentenced inmates. Phase IV: Release Planning entails mandatory enrollment in the After Incarceration Support System (AISS). In existence since 1996, AISS was established with a three-prong goal of personal recovery, public safety, and recidivism reduction. Prior to release, AISS staff (community aftercare coordinators, a faith-based community liaison, peer mentors) work closely with individuals in the facility to optimize treatment plans and to prepare for successful reentry. Upon release, if still under correctional jurisdiction, male participants are again relocated, this time to one of two minimum security options, a nearby residential PreRelease Minimum Center (PMC) or the Western Massachusetts Correctional Addictions Center (WMCAC). At the PMC, a condition of discharge is that residents continue to meet with AISS staff to review their service plans and to garner assistance in scheduling appointments with parole officers, treatment and services practitioners, and other collateral professionals. Discharged individuals who are no longer under correctional supervision are encouraged to continue their utilization of AISS resources on a voluntary non-residential basis, and a significant number continue to be engaged.[9] Mentoring, crisis intervention, referral and advocacy, case management, outreach and support group involvement are examples of available resources. Incarcerated females in Hampden County are housed in a regional facility which maintains its own prerelease center. AISS mentors work closely with those women who will be returning to Hampden County.

[9] Data published by the Sheriff's Department indicate that nearly 80 percent of people introduced to AISS within the jail reported a willingness to continue utilizing these services after correctional supervision was terminated (http://hcsdma.org/aiss-3.htm).

In addition to standard enrollment in AISS, high risk individuals in the PMC (defined as those with a firearms charge, a very violent criminal record, or serious management problems in the jail) are linked with, and closely monitored by, one of two specially trained program managers. These AISS program managers encourage compliance with established service plans and court-ordered restrictions by routinely transporting identified high risk individuals to treatment appointments and mandatory meetings with justice system personnel.

If the Central Classification Committee has determined that substance use disorder is a significant issue, the individual may be assigned to the WMCAC, a regional, community-based residential center that promotes education, treatment, and recovery through an emphasis on abstinence.[10] This facility has 182 beds, 18 of which are reserved for females. All participants are court ordered to complete a 12-week treatment program. Upon completion, males who remain under the jurisdiction of the justice system may be relocated to the PMC. For males who are no longer justice involved, and for whom there is a real risk of homelessness, placement in one of 20 to 30 beds in the WMCAC-affiliated Foundation House may be requested. If the request is granted, public health insurance will be reactivated and the individual may access AISS staff and resources.

Beginning in 2010, the federally funded Behavioral Health Treatment Court Collaborative (BHTCC) was instituted as a mechanism for coordinating all problem-solving courts within the **Pima County (AZ)** jurisdiction. The primary focus of the initiative was the Drug Treatment Alternative to Prison (DTAP) Program, with goals of individual recovery, crime reduction, and fiscal savings. DTAP was designed to provide an alternative to incarceration for individuals—

- with a substance use or co-occurring disorder,
- whose current conviction reflects a third (or subsequent) felony drug crime or qualifying felony property crime,
- with no history of violent or sex offenses,
- who have exhausted all other non-incarcerative options, and
- for whom a prison term would otherwise be legislatively mandated.

DTAP provides behavioral health treatment and individualized service planning in either residential or outpatient settings. This programming promotes personal recovery, while holding individuals accountable for criminal offending and reducing the risk for recidivism. Eligibility is determined, in part, by the individual's prior enrollment in the statewide Arizona Health Care Cost Containment System (AHCCCS).[11] AHCCCS-registered individuals whose results on the probation-administered Offender Screening Tool (OST) identify them as high risk, high

[10] Additional information on the Hampden County Sheriff Department's WMCAC is available from http://hcsdma.org/wmcac-2/.

[11] AHCCCS maintains a statewide registry of all persons who have received publicly funded treatment for serious mental illness, general mental health disorders or substance use disorder. Persons receiving privately funded treatment for general mental health issues or for substance use disorders are not included in this listing.

need, highly motivated, and presenting with severe addiction[12] may be offered a 3-year post-conviction referral to DTAP. Program participants are housed in a gender-specific treatment facility for the first 90 days before relocation to supervised transitional community housing and the activation of wrap around services. During this phase of DTAP, under the coordination of an on-site Residential House Manager, residents are offered life skills training, education, and counseling and are encouraged to seek employment in the community. Adherence to DTAP program requirements is monitored by means of drug testing, probation supervision, and regular drug court participation. On-site Residential House Managers, a DTAP Resource Coordinator, and a DTAP Job Developer coordinate DTAP services and post-discharge treatment and wrap-around services in conjunction with the DTAP Probation Officer. DTAP program administrators report that successful program participation has resulted both in substantial cost savings for the justice system[13] and a significant reduction in recidivism.[14]

Guideline 8: Develop mechanisms to share information from assessments and treatment programs across different points in the criminal justice system to advance cross-system goals.

Because many justice system and behavioral health agencies did not, until fairly recently, have the motivation, resources, or legal authority to share individual information, coordination of services and continuity of service delivery from the correctional setting to the community were often inefficient or nonexistent. In some sites, physical health care records were housed in different management information systems than were behavioral health care records (if these records were systematically maintained at all). With systems designed by different programmers for agency-specific purposes, it was not uncommon to learn that electronic exchanges were not physically possible, or if possible on the macro-level, that the assignment of non-corresponding identification numbers prohibited micro-level case file linkages.

National health reforms passed in the first decade of this century have dramatically transformed the landscape for information exchange. Provisions of the Affordable Care Act,[15] Health Information Portability and Accountability Act (HIPAA),[16] Health Information Technology for Economic and Clinical Health (HITECH),[17] and Mental Health Parity and Addiction Equity Act

[12] See Offender Screening Tool (OST) at http://www.azcourts.gov/apsd/Evidence-Based-Practice/Risk-Needs-Assessment/Offender-Screening-Tool-OST

[13] Maimon Research LLC. (2013). *Cumulative second year cost-benefit analysis of Pima County's Drug Treatment Alternative to Prison Program*. Tucson, AZ: Maimon Research LLC. Available at http://www.pcao.pima.gov/documents/DTAP%20FINAL%20REPORT%205-Sep-13.pdf

[14] See http://www.pcao.pima.gov/dtap.aspx

[15] The Affordable Care Act is summarized at http://medicaid.gov/affordablecareact/affordable-care-act.html

[16] Information on HIPAA is available from http://www.hhs.gov/ocr/privacy/

[17] The Health Information Technology for Economic and Clinical Health (HITECH) Act is described at http://www.hhs.gov/ocr/privacy/hipaa/administrative/enforcementrule/hitechenforcementifr.html

(MHPAEA)[18] have bolstered efforts to broaden the nature and scope of healthcare coverage among people under justice system jurisdiction (e.g., by extending eligibility for coverage and enhancing parity in the treatment of behavioral health issues) and to establish protocols for the secure and reliable exchange of this information (e.g., by encouraging interagency agreements for information sharing, working towards compatibility of management information systems, and systematically employing multiple medical releases to satisfy legal thresholds).

The justice system and behavioral health representatives to the Justice and Mental Health Collaboration Program (JMHCP) grant in **New York State** (see discussion of Guideline 6) proposed a cluster of solutions to address barriers to effective data sharing and connectivity in that state. One proposal called for the creation of expansive confidentiality agreements between justice agencies and treatment and service providers that would allow justice system identification numbers (NYSID) and Medicaid enrollment data to be linked. In view of the mobility of individuals with mental or substance use disorders and the frequency with which these individuals risk suspension of Medicaid coverage due to repeated justice system admissions, such a data-sharing system could greatly facilitate insurance reenrollment and minimize disruptions in the continuity of care. A more ambitious data-sharing proposal would have correctional authorities provide NYSID information on previously incarcerated individuals to allow insurers to more easily identify people who might be Medicaid eligible. In terms of connectivity, JMHCP collaborators have proposed the creation and maintenance of a Web-based portal for exchanges between the justice system, treatment and service practitioners, and other collateral professionals. The implementation of such a system could provide community treatment and service practitioners with timely electronic notification that an individual receiving care had come into contact with the justice system. Similarly, upon booking, justice system employees could have immediate information on the nature and intensity of an individual's previous behavioral health utilization.

Guideline 9: Encourage and support cross training to facilitate collaboration between workforces and agencies working with people with mental and co-occurring substance use disorders who are involved in the criminal justice system.

Individual and system outcomes are more easily achieved when correctional and behavioral health personnel work as a team, within facilities, in the community, and during reentry (Osher et al., 2012). The best outcomes are achieved when there is cross-agency knowledge and appreciation of the language, goals, and processes of all stakeholders. Correctional personnel are supportive when they understand the presentation of mental illness, substance use, and co-occurring disorders. Likewise, behavioral health experts benefit from an understanding of the

[18] The Mental Health Parity and Addiction Equity Act (MHPAEA) is summarized at https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet.html

criminogenic factors and correctional management issues contributing to public safety concerns. For both constituencies, cross-agency exchanges can reduce mistrust and tension.

In the design and implementation of strategies grounded in APIC principles, there are numerous opportunities for valuable interdisciplinary linkages that allow personnel to span deep-rooted disciplinary boundaries. The utilization of in-reach behavioral health counselors and case managers who operate alongside correctional staff is a common approach. In other sites, personnel from behavioral health and correctional agencies meet regularly to discuss barriers to recovery and public safety and to devise procedural protocols that serve the interests of individuals and agencies. A bolder approach at implementing APIC principles entails active cross-disciplinary training of agency personnel.

Cross-training of staff has been embraced throughout **New York State**, in large part due to the efforts of the Justice and Mental Health Collaboration Project (JMHCP). In an increasing number of counties, the week long Emotionally Disturbed Persons Response Team (EDPRT) training is made available to law enforcement officers, and communities throughout the state are developing Crisis Intervention Teams (CIT). County probation officers who complete training in Motivational Interviewing, the impact of trauma, assessment, and dynamics of mental illness are credentialed as supervision specialists. In Monroe County, home to the city of Rochester, trauma-informed care training has been proposed for all 500 jail employees.

Research over the past two decades has found that early life trauma can impair decision making, negatively affect neural development, and influence the development of behavioral disorders, all of which can contribute to engagement in risky behavior, and in some cases, criminal offending.[19] Consistent with evidence-based practice, correctional personnel in some jurisdictions have instituted universal screening for trauma histories; adopted trauma-informed strategies for treatment planning with the goal of bolstering resiliency, promoting personal recovery, and reducing the risk of subsequent criminal offending; and incorporated comprehensive cross-training to familiarize correctional staff, clinicians, and collateral professionals with the sources and effects trauma histories.

One strategy adopted in **Hancock County (OH)** provides jail personnel with an understanding of behavioral health issues, risk assessment/management, and trauma-informed responses. All correctional staff now complete the 40-hour Memphis model CIT training. Facility contacts anecdotally report that the positive effects of this cross-training were evident when a correctional officer successfully, and without the use of force, de-escalated a crisis involving an inmate with a trauma history.

[19] The effect of trauma on physical, social, and behavioral health and well-being has been the focus of a growing body of literature. For example, see the website of SAMHSA's National Center for Trauma-Informed Care at http://www.samhsa.gov/nctic. In addition, the major findings from the Adverse Childhood Experiences (ACE) study, conducted jointly by the Centers for Disease Control and Kaiser Permanente, can be viewed at http://www.cdc.gov/violenceprevention/acestudy/about_ace.html

In **Hawaii,** the Women's Community Correctional Center (WCCC) has instituted a statewide trauma-informed approach that implements evidence-based practice. In 2009, in response to inconsistencies in the administration of trauma screening, WCCC administrators, in collaboration with a diverse group of institutional, civic, academic, clinical, and religious stakeholders, piloted the Trauma Informed Care Initiative (TICI) (Patterson, Uchigakiuchi, & Bissen, 2013). In contrast to the traditional correctional setting, but consistent with native Hawaiian cultural practices and existing policy concerning justice-involved girls, the philosophical shift was guided by the belief in the transformative nature of a *pu'uhonua*, a protected site for healing. The multi-year TICI pilot included a 10-week post-sentence orientation program during which behavioral health staff administered universal screening for trauma histories as well as for mental and substance use disorders. While funding and personnel reallocations have delayed utilization of screening results in individualized treatment planning, WCCC remains committed to the provision of intensive training for staff, institutional contractors, treatment and service practitioners, and justice-involved individuals. Relying heavily on training materials developed by SAMHSA's National Center on Trauma Informed Care, WCCC provides several days of instruction on the guiding principles of trauma-informed care, including the—

- Identification of systemic sources of trauma;
- Recognition of the psychological, physiological, neurobiological, and social effects of trauma;
- Minimization of further trauma caused by incarcerative practices such as seclusion and restraint.

For correctional staff, the trainings provide knowledge and develop skills that mitigate the effects of traumatic experiences on behavioral health concerns and criminogenic risk. For justice-involved individuals, the creation of the *pu'uhonua* reinforces trauma-informed principles by promoting empowerment and personal recovery and strengthening family and community relationships.

Guideline 10: Collect and analyze data to evaluate program performance, identify gaps in performance, and plan for long-term sustainability.

The design and adoption of evaluation processes should be an essential component of overall program planning. Meaningful evaluation of program performance to improve system- and individual-level outcomes is, at a minimum, dependent upon clearly defined measures of success, consistently applied approaches for operationalizing agreed-upon goals, documentation of program application, and physical and legal access to a sufficient threshold of cross-system data to allow statistically significant analysis and interpretation. Feedback loops among affected stakeholders must be in place to identify and correct barriers to effective service delivery and to plan for long-term program sustainability.

Comprehensive program planning can be expected to be time and labor intensive. Because front-end decisions about individual placement and mode of intervention can affect later decisions on reentry planning, all affected stakeholders—institutional and community—should be consulted during the planning phase. Ideally, baseline data on individual and system outcomes should be collected prior to the introduction of revised programming so that the impact of these programmatic changes can be measured. The **Hancock County (OH)** jail employed a program-planning document that was developed by the stakeholders to identify areas of cross-agency concerns, specific tasks to be performed to address these concerns, people responsible for task completion, tentative dates for task completion, and progress made towards task completion.

Program implementation has progressed further in **Franklin County (MA).** Jail personnel at that site have collaborated with staff from the Justice Policy Center of the Urban Institute and with Alternative Solutions Associates, Inc., to design an evaluation protocol for this program. Although the program has been operational for less than 2 years, baseline recidivism data have been collected. A decision was made to compare recidivism rates at 1-year and 2-years post-release, with the measure for recidivism operationalized as reincarceration. The evaluation team has acknowledged that data exchange has been a significant challenge. The structure of the existing management information system has hampered the generation of reliable data. Because the jail information system was designed to document population status and movement within the facility, researchers found it difficult to match these data with information on subsequent justice-system involvement or compliance with community-based treatment or probation services.

The **Allegheny County (PA)** Jail Collaborative also contracted with the Urban Institute's Justice Policy Center to compare and assess justice system impacts of two reentry programs that had been instituted in Allegheny County in 2010 and 2011 upon receipt of grant funding from the Bureau of Justice Assistance Second Chance Act Adult Offender Reentry Demonstration Program initiative. The reentry initiatives were both designed to improve system outcomes by reducing recidivism (defined as new arrests or new probation violations) for medium to high risk individuals through coordinated reentry planning. Both programs provided comprehensive pre- and post-release needs assessment, treatment, and service provision; however, the programs differed in several other respects. Participation in one program that linked inmates with Reentry Specialists (case managers) was voluntary. Participation in the second program, linking inmates with designated Reentry Probation Officers was required as a condition of post-release supervision. The efficacy of each approach was assessed by several means, including comparisons with matched samples and across programs. In brief, the researchers concluded that, while both reentry initiatives produced positive justice system outcomes, more substantial impacts were recorded for individuals participating in the voluntary program (Willison, Bieler, & Kim, 2014).

Conclusion

People with mental and substance use disorders are disproportionately represented in jails and prisons. Research has shown that the high prevalence of these disorders in jails and prisons consistently produces poor outcomes for both affected people and correctional agencies. In 2002, stakeholders generated evidence-based APIC guidelines to assist treatment and service practitioners, case managers, and justice system personnel in the development of effective strategies to improve behavioral health outcomes by promoting personal recovery and reducing criminogenic risk for individuals transitioning to the community (Osher, Steadman, & Barr, 2002). While an increasing number of jurisdictions have embraced the guidelines, practitioners have requested further assistance in the design of effective strategies, particularly in the area of discharge planning. This implementation guide provides specific examples of policies and practices that have been adopted at local and state levels to incorporate APIC model guidelines in cross-system responses to individuals with mental or substance use disorders and justice system involvement.

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