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

Final Report

Multnomah County, Oregon
Sequential Intercept Mapping
and
Taking Action for Change

April 13 and 14, 2010

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

Table of Contents

Appendix

Executive Summary

The Mental Health/Public Safety Subcommittee of the Local Public Safety Coordinating Council (LPSCC) and multiple other stakeholders in Multnomah County requested the *Sequential Intercept Mapping* and *Taking Action for Change* workshops to provide assistance with:

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

The participants in the workshops included forty-two individuals representing multiple stakeholder systems including mental health, substance abuse treatment, human services, corrections, advocates, family members, consumers, law enforcement, and the courts. Dan Abreu, MS CRC LMHC and Patty Griffin, PhD from Policy Research Associates, facilitated the workshop sessions.

This report includes:

- A brief review of the origins and background for the workshop
- A summary of the information gathered at the workshop
- A sequential intercept map as developed by the group during the workshop
- An action planning matrix as developed by the group
- Observations, comments, and recommendations to help Multnomah County achieve its goals

Top Priorities:

- Address communication/information sharing issues
    - Non-crisis Release of Information forms that are proactive
    - Better linkage between mental health and the jail
    - Identify boundary spanners for each represented entity that can carry this work forward
        - Can act as cross-system trainers
- Develop a true diversion from jail or before jail
    - Develop the possibility of a different response to the low level criminal charges typically found with this population
    - Address prevention

Secondary Priorities:

- Develop more flexible housing options
- Expand capacity of MH Court by broadening the door
- Develop Crisis Assessment and Triage Center for police to drop people off
    - Healing environment
    - Staff willing to accept broad range of behaviors
- Include Forensic Peer Support
- Address female offenders with specialized services/treatment
- Prioritize new Intensive Case Management for this population
- Develop a community involvement group that takes advantage of citizen interest and energy
- Expand CIT training to other partners such as 911, jail staff, etc.
- Develop cross system training

- Develop active understanding and engagement from County Commissioners

Recommendations:

Recommendations contained in this report are based on information received prior to or during the workshops. Additional information is provided that may be relevant to future action planning. Multnomah County is currently doing excellent work to enhance collaboration, improve services, and increase community alternatives for people with mental illness involved in the criminal justice system. The recommendations offered below can be used to build on recent accomplishments to enhance cross-system collaboration and the current service delivery system.

Cross-Intercepts:

- At all stages of the Sequential Intercept Model, data should be developed to document the involvement of people with severe mental illness and often co-occurring substance use disorders involved in the Multnomah County criminal justice system.
- Expand forensic peer counseling, support, and specialists to promote recovery.
- Continue interaction with family members who have shown interest in collaborating to improve the continuum of criminal justice/behavioral health services.
- Review screening and assessment procedures for mental illness, substance abuse, and co-occurring disorders across the intercepts.
- Address fragmentation and breaks in continuity of care; focus on improving current linkages and continuity of care to break the cycle of repeated admissions and high use of crisis/emergency services.
- Identify frequent users, a group that tends to cycle repeatedly through the mental health, substance abuse, and criminal justice systems without long-term improvement.
- Increase information sharing to enhance rapid identification of current mental illness and history of services so diversion can be immediately initiated.
- Establish formal collaboration with the Department of Veterans Affairs by including a VA representative in local planning groups.

Intercept I: Law Enforcement and Emergency Services

- Improve coordination with law enforcement and develop crisis stabilization bed capacity.

Intercept 2: Initial Detention and Initial Hearings

- Develop Intercept II diversion options.

Intercept 4: Re-entry

- Carefully coordinate the resources offered by the jail's mental health staff, MCSO, community providers, probation, and others.
- Explore ways to enhance the "bridge medication" when a person reenters the community from the jail so there is not a lapse in treatment.
- Build on current work to systematically develop "in-reach" efforts into the jail to identify those with severe mental illness and often co-occurring disorders in order to facilitate continuity of care and alternatives to incarceration.
- Systemically expedite access to Medical Assistance, Social Security, and other benefits to facilitate successful reentry to the community.
- Explore methods to help people obtain birth certificates or other needed identification.

Intercept 5: Community Corrections and Community Support

- Carefully coordinate the resources offered by the jail's mental health staff, MCSO, community providers, probation, and others.
- Explore ways to enhance the "bridge medication" when a person reenters the community from the jail so there is not a lapse in treatment.
- Build on current work to systematically develop "in-reach" efforts into the jail to identify those with severe mental illness and often co-occurring disorders in order to facilitate continuity of care and alternatives to incarceration.
- Systemically expedite access to Medical Assistance, Social Security, and other benefits to facilitate successful reentry to the community.
- Explore methods to help people obtain birth certificates or other needed identification.

The details of these recommendations can be reviewed in PRA's technical report.

Multnomah County, Oregon
Transforming Services for Persons with Mental Illness in Contact with the Criminal Justice System

Introduction

The purpose of this report is to provide a summary of the *Sequential Intercept Mapping* and *Taking Action for Change* workshops held in Multnomah County, Oregon on April 13 and 14, 2010. The workshops were sponsored by the Mental Health/Public Safety Subcommittee of the Local Public Safety Coordinating Council. This report (and accompanying electronic file) includes:

- A brief review of the origins and background for the workshop
- A summary of the information gathered at the workshop
- A sequential intercept map as developed by the group during the workshop
- An action planning matrix as developed by the group
- Observations, comments, and recommendations to help Multnomah County achieve its goals

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

Background

The Mental Health/Public Safety Subcommittee of the Local Public Safety Coordinating Council (LPSCC) and multiple other stakeholders in Multnomah County requested the *Sequential Intercept Mapping* and *Taking Action for Change* workshops to provide assistance with:

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

The participants in the workshops included forty-two individuals representing multiple stakeholder systems including mental health, substance abuse treatment, human services, corrections, advocates, family members, consumers, law enforcement, and the courts. A complete list of participants is available in the resources section of this document. Dan Abreu, MS CRC LMHC and Patty Griffin, PhD from Policy Research Associates, facilitated the workshop sessions.

The Multnomah County Sequential Intercept Map

Objectives of the Sequential Intercept Mapping Exercise

The *Sequential Intercept Mapping Exercise* has three primary objectives:

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

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

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

The Multnomah County Sequential intercept Map created during the workshop can be found on page 15.

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

Existing Cross-Systems Partnerships

The Mental Health Public Safety Committee is a subcommittee of the Local Public Safety Coordinating Council (LPSCC) that is charged with providing coordination and oversight and implementing recommendations from the Mayor's Mental Health Public Safety Review Panel action plan (February 2007). The committee is charged to:

- Monitor implementation of the action plan;
- Oversee coordination between the mental health and public safety systems on an ongoing basis;
- Ensure accountability of city, county and state agencies in implementation systems;
- Provide advocates and others a place to raise issues pertaining to the nexus of public safety and mental health systems; and
- Report to the LPSCC Executive Committee at their regular meetings.

The Department of Community Justice Monthly Forum is composed of line providers and managers working together to address cross-training, program development, and evidence-based practices.

Consumer Involvement

Multnomah County has a strong commitment to consumer involvement and development. Five consumers, two with justice involvement, were present at the workshop. Several peer groups are active in Multnomah County, including:

- The Depression Bi-Polar Support Alliance--weekly support meetings

- The Empowerment Initiative--provides financial and housing retention support
- Hearing Voices--support groups and events for peers

Peers can be involved in county policy and decision making by serving on the Adult Mental Health and Substance Abuse Advisory Committee (AMHSAAC) advising Multnomah County Mental Health and Addiction Services Division leadership. There are similar opportunities to give Multnomah County input through the Quality Management Committee and the Children's Mental Health Advisory Council. Laura VanTosh oversees state consumer initiatives.

NAMI Multnomah provides several peer support groups:

- Young adult peer support
- Depression peer support
- Schizophrenia peer support
- NAMI --connection for any diagnosis
- Peer to Peer --provides recovery oriented classes
- NorthStar House --(in development)-peer run clubhouse
- Peer Mentor Program--trains peers to aid in accessing resources
- First Step--peer in-reach to hospitals

Representation from Key Decision Makers

The workshops included wide cross-system representation and involved many of the key decision makers. Opening remarks by the Hon. Julie Franz, Chief Criminal Court Judge, and Joanne Fuller, Director of the Department of County Human Services, set the stage and established a clear message as to the importance of the workshop. Participants included:

Amy Anderson
MCDC Cascadia MCHD

Rose-Ellen Bak
Multnomah County, DCHS

Hon. Richard Baldwin
Multnomah County Circuit Court

Greg Borders, Director of Crisis and Access Services
Cascadia Behavioral Health

Kevin Bowers, Community Justice Manager
Multnomah County Department of Community Justice

Ashleigh Brenton

Karl Brimner, Director
Multnomah County DCHS Mental Health & Addiction Services Division

Sandy Bumpus, Advocate

Doris Cameron-Minard, Advocate
NAMI, OR & Multnomah

Lorena Campbell, Staff
LPSCC Mental Health Public Safety Committee

John Connors, Multnomah County Director
Metropolitan Public Defender

Nancy Cozine, Deputy Trial Court Administrator
Multnomah County Circuit Court

Elizabeth Davies, Analyst
Multnomah County Public Safety Coordinating Council

Jean Dentinger, Supervisor
Multnomah County DCHS Mental Health & Addiction Services Division

Hon. Julie Frantz, Chief Circuit Court Judge

Chuck French, Deputy District Attorney
Multnomah County District Attorney's Office

Liesbeth Gerritsen, Crisis Intervention Training Consultant
Portland Police Bureau

Heidi Grant, Mental Health Court Coordinator
Multnomah County DCHS Mental Health & Addiction Services Division

Sandy Haffey , MHASD
Multnomah County DCHS Mental Health & Addiction Services Division

David Hidalgo, Sr. Operations Manager
Multnomah County DCHS Mental Health & Addiction Services Division

Meg Kaveny, Supervisor
Project Respond
521 SW 11th Avenue

Ann Kasper, Advocate

Kandi Leonhart, Telecare Recovery Advocate

Joanne Fuller, Director
County Human Services

Captain Bobbi Luna
Multnomah County Sheriff's Office

Kevin Mahon, Clinical Supervisor
Lifeworks NW

Traci Manning, Chief Operating Officer
Central City Concern

Brian Martinek, Assistant Chief, Operations
Portland Police Bureau

Derrick Martin, Sr.
Telecare Recovery Center

Mary Monnat, CEO
Lifeworks, NW

William Nunley
Cascadia Behavioral Health

Peter Ozanne, LPSCC Executive Director
Multnomah County COO for Public Safety

Erika Pruitt, District Manager
Multnomah County Department of Community Justice

Maureen Raczko, Program Administrator
Multnomah County Sheriff's Office

Catherine Such, Deputy Executive Director
Housing Authority of Portland

Steve Sutton, Corrections Health

Kathleen Treb, Assistant Director
Multnomah County Department of Community Justice

Elizabeth Wakefield, Special Courts
Metropolitan Public Defender

Terri Walker
NAMI Multnomah

Pat Walsh,
Portland Police Bureau

Crucita White
AOCMHP

Betty Woodward
Portland Police Bureau

Facilitators

Dan Abreu, **MS CRC LMHC**, Associate Director, National GAINS Center
Policy Research Associates, Inc.

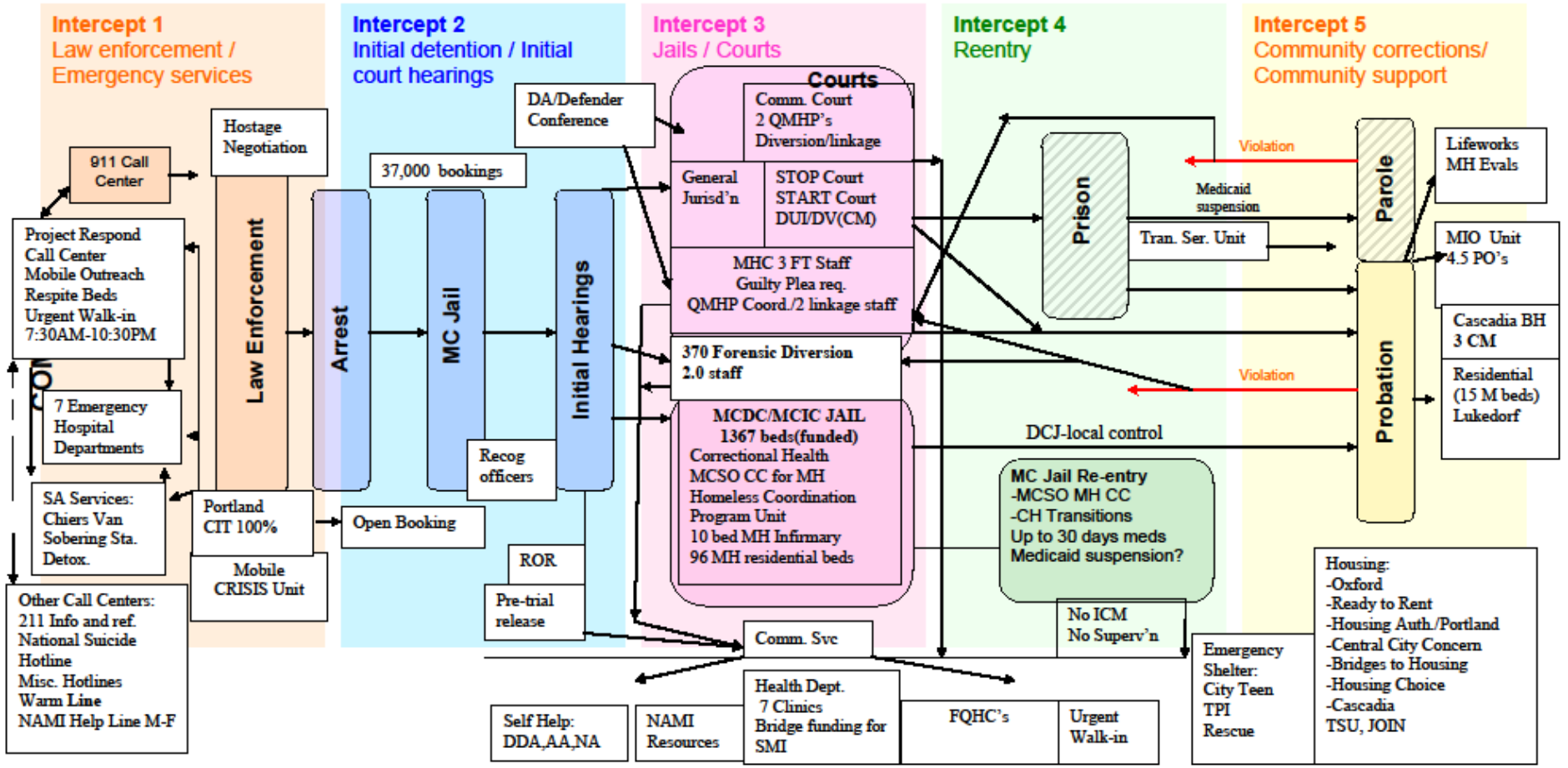
Patty Griffin, PhD, Senior Consultant
Policy Research Associates, Inc

Sequential Intercept Mapping

Multnomah County, Oregon

Multnomah County, Oregon

Sequential Intercepts for Change: Criminal Justice - Mental Health Partnerships



Note: Agency acronyms are explained in the body of the report.

Multnomah County Sequential Intercept Map

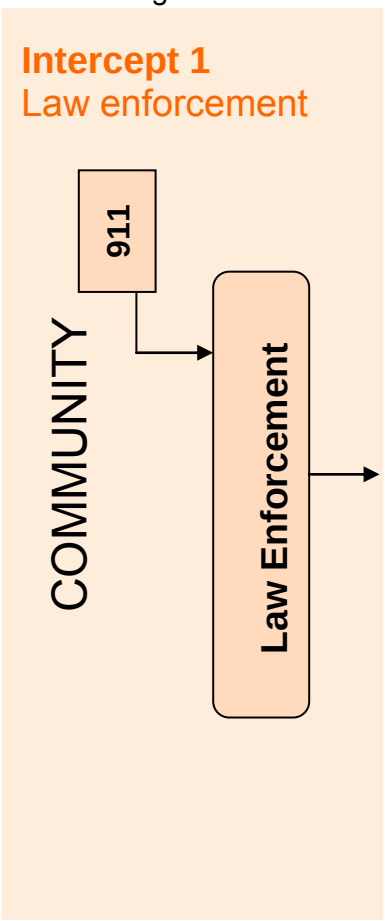
The *Sequential Intercept Mapping* exercise is based on the Sequential Intercept Model developed by Mark Munetz, MD, and Patty Griffin, PhD[1] in conjunction with the CMHS National GAINS Center. During the workshop, participants are guided to identify gaps in services, resources, and opportunities at each of the five distinct intercept points.

This narrative reflects information gathered during the *Sequential Intercept Mapping Exercise*. It provides a description of Multnomah activities at each intercept point, as well as gaps and opportunities identified at each point. This narrative may be used as a reference in reviewing the Multnomah County Sequential Intercept Map. The Mental Health/Public Safety Subcommittee of the Local Public Safety Coordinating Council may choose to revise or expand information gathered in the activity.

Intercept I: Law Enforcement / Emergency Services

Emergency Services

The Bureau of Emergency Communications operates the 911 Call Center. Dispatchers at the call center handle a large volume of frequent callers and are often the first point of contact for individuals experiencing a mental health crisis. During the mapping exercise, one consumer observed that dispatchers will sometimes give confusing instructions. Although 911 dispatchers receive basic training in mental health issues at the Police Academy, they do not receive advanced training in mental health issues. Dispatchers are trained to non-discretionary protocols and do not receive Crisis Intervention Team (CIT) training (described below, pg.18. A Portland City Commissioner is leading an effort to work with County Mental Health to revise 911 protocols and develop decision trees in order to divert police calls.



In addition to the 911 Call Center, there are several other hotlines and warm lines operating in Multnomah County. Representatives from counties in the Portland metropolitan region routinely meet to discuss their policies and procedures. Participants at the mapping exercise discussed the need for more coordination and information sharing among the various call centers and would like to see a clearer delineation of function and response at the various intake points. For example, participants reported that 911 Call Center would receive suicide calls that would be better routed through the Mental Health Crisis Call Center.

The crisis system funded by state, Medicaid and local dollars and managed by the Multnomah County DCHS Mental Health and Addiction Services Division includes:

- **Mental Health Crisis Call Center**: the information and referral „hub' of the public mental health system in Multnomah County. Staffed 24 hours a day, seven days a week by master's level professionals, the Call Center is also the front door to accessing mental health and addiction services. The Call Center can be used by any resident of Multnomah County and

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

is also the dispatch point for the 24 hour a day Mobile Mental Health Outreach Team and the Urgent Walk-in Clinic. It also contains a phone line dedicated to the police to help officers find appropriate placement when they encounter individuals with mental health issues in the community.

- **Mobile Mental Health Outreach Team:** Multnomah County's Mobile Mental Health Outreach Team is contracted out to Cascadia Behavioral Healthcare. This 24 hour team of mental health professionals performs evaluations and crisis de-escalation in a variety of community settings. The county's team can be dispatched either by the Mental Health Call Center or by the police. The goal of this service is to provide on-site crisis evaluation and assistance to stabilize and refer to the appropriate level of care. Any resident is eligible for this service regardless of insurance or income. The least restrictive plan is implemented, ideally using family, friends and other natural resources. This program has been successful in diverting individuals from higher levels of care such as hospitalization and incarceration (45 staff, 24/7 coverage).
- **Crisis Respite:** Respite is less intensive than sub-acute or hospitalization. It is appropriate when mental illness symptoms require a brief voluntary stay in a facility staffed twenty-four seven by mental health professionals in order to stabilize. For those individuals appropriate for this service respite can act as a diversion from hospitalization or incarceration. Services can include medication management, crisis management, and mental health treatment. The typical stay is from 3-7 days.
- **Urgent Walk-in Clinic:** The County's Urgent Walk-in Clinic contracted to Cascadia is open seven days a week from 7:00 a.m. to 10:30 p.m. and is available to any county resident in crisis who needs an urgent evaluation with a mental health professional. Individuals who access this clinic are generally experiencing a mental health crisis that does not require the medical services available in an emergency room. This program can be an alternative to seeking mental health services in an emergency room. The majority of individuals seen at the Urgent Walk-In Clinic are uninsured. Services may include a crisis mental health assessment by a Qualified Mental Health Professional, psychiatric services and medication evaluation. The goal is to assist individuals in stabilization and provide referral for ongoing care.
- **Flexible Funds:** Through the mental health call center and through its crisis system contractors, the county has limited flex funds to pay for emergency housing. These funds are utilized to avoid higher levels of care and keep someone in crisis stable and in the community, for example, help with emergency housing that prevents unnecessary hospitalization. Creative use of these limited funds reduces inappropriate utilization of the highest cost services in our community.

The Mental Health Crisis Call Center serves as the hub for information and referral for mental health issues and is described as the front door to access services, particularly for those experiencing a mental health crisis. Linkages between Project Respond's crisis call center and the 911 Call Center are informal. There is also a dedicated phone line to the Mental Health Crisis Call Center where police officers can consult mental health professionals about street encounters.

The Central City Hooper Inebriated Emergency Response System (CHIERS) roving response van assesses and transports alcoholics and addicts from the streets throughout the city. The emergency medical technician on board the CHIERS van is well equipped to work with street alcoholics, substance abusers and the mentally ill, thus providing significant assistance to Portland Police. Under Oregon's civil hold rules, CHIERS staff is deputized to deliver these people to care.

They spend 3-5 hours at Hooper's Sobering Station after being assessed by an Emergency Medical Technician to ensure they don't have critical medical needs.

Law Enforcement

Multnomah County is home to several local, state and federal law enforcement agencies that together make over 40,000 arrests per year. The vast majority of these arrests occur within Portland, the county's most populous city, and are made by Portland Police Bureau.

Every officer in the Portland Police Bureau has received 40 hours of Crisis Intervention Team (CIT) training in addition to the CIT training embedded in the Police Academy. There are three full time Crisis Intervention Team trainers at the Bureau. CIT is a 40 hour, required mental health training that all officers on the street and their sergeants attend. This training is taught by mental health clinicians and a nurse practitioner. It focuses on crisis management, mental health diagnoses and an overall picture of both the historical and current mental health system in our state. Along with this training is a CIT Advisory Board. This board meets monthly and provides input through the CIT Coordinator, Liesbeth Gerritsen, to the chief's office regarding concerns and suggestions regarding the police and their interface with individuals experiencing a mental illness.

Police officers have some discretion regarding pre-booking diversion, although they are required to book all individuals who have committed a felony or misdemeanor offense, and often provide transport to local Emergency Rooms where persons in crisis can be evaluated. Generally, police face a long wait when they bring someone for evaluation at an emergency department. The Mobile Outreach Team can respond to the Emergency Rooms when someone is brought in. A significant obstacle described by Sequential Intercept Mapping participants is the narrow admission criteria, which requires a finding of "imminent danger or inability to care for self or others" for admission under the involuntary commitment statute. An additional obstacle is lack of in-patient bed capacity. Voluntary admissions do not follow this same statutory criteria and are available in the manner of any hospital admission. Over the past decade, the community has seen a decrease in the number of hospital beds. However in the past two years, a new hospital has brought additional capacity to the system. If an individual is appropriate for hospitalization but no hospital bed is available in Multnomah County, the Mental Health Call Center will help facilitate placement in an out of area hospital.

Recently, in order to enhance response to crisis calls involving persons with mental illness, a Police Mobile Crisis Unit (MCU) was formed. The MCU pairs a police officer with a mental health worker from the County Mobile Crisis Unit. The MCU proactively seeks out individuals who are not in crisis, but are in need of services. The hope is they will intercept individuals and help them before they get into a mental health crisis. The Unit supports officers in the field by providing mental health assessments and referrals to resources. In addition, the Portland Police Bureau has a Hostage Negotiation Team.

Through the Multnomah Treatment Fund (MTF), the Mental Health and Addiction Services Division allocates approximately $2 million per year to pay for intensive case management and medication for indigent uninsured individuals not eligible for Oregon Health Plan. These services are prioritized for individuals who are discharging from hospitalization or incarceration. The Multnomah County Health Department sees many individuals for psychiatric medications and some treatment services in their clinics.

Participants reported that overly restrictive confidentiality and privacy laws (HIPAA) impede better integration of services, coordination of response and data sharing among partners. There are no formal data sharing mechanisms between mental health and public safety systems.

Gaps Identified in the Strategic Planning Session

- Opportunities
- Gaps

Communication

- Need data on mental health calls
  - 911
  - Law enforcement
- Oregon has strong laws that protect individuals' right not to share information
  - Macro issue
  - "Time is right to tweak this" with legislation
  - Other strategies need to be considered:
    - Staff need to be proactive in getting Release of Information forms signed at intake
    - Need further examination of the Jail Data Link approach used in other localities
- No accurate measurement of the true need because of lack of information sharing
- Significant systems issues re sharing information
  - Need better coordination re disability issues and accessing community services

Capacity/Resources/Community Supports for Diversion

- Lack of a fully funded, comprehensive, recovery focused mental health system
- Need to develop alternatives to a fully funded behavioral health system
  - Should be systemic and holistic
  - First responders should be from mental health system
  - Would require:
    - Different priorities for the community as a whole
    - Legislative support
- Inconsistent response from 911, emergency departments, and mental health providers
  - Can lead to more calls to 911 and more crisis episodes
- Very high criteria for involuntary commitment
  - Standards have become more and more restrictive
- Few effective resources for people who are unable or unwilling to access care and/or don't meet involuntary hospitalization criteria
- Need for creative, comprehensive outreach strategies to be developed
- Need more capacity in community services, especially for crisis
  - Delays in accessing services leads to frustration on part of families, consumers, probation, law enforcement, etc. and perception of lack of services
- Many people with mental health needs do not have health insurance
- No team available to follow up with those who do not have insurance
  - Mobile Crisis typically follows those with health insurance
- Lack of voluntary bed capacity
  - Voluntary inpatient stays of uninsured indigent individuals are not paid
- Need for more proactive follow up after crisis
  - Information sharing limited to crisis
  - Needs to include family members and/or natural supports
- Clients have difficulties getting to follow-up appointments
  - Sometimes not organized enough to get there
- Availability of walk-in appointments at clinics:
  - Need better publicity
  - Diverted people from jail are turned away

- Inconsistent access

Training/Education

- Need more training for 911, etc.
- First responders to mental health crises should not be police
- CIT training:
  - Officers like the use of scenarios in CIT training and more could be included
    - Consider using consumer groups that perform the scenarios as some counties do
  - Younger officers have different learning styles and training could be modified to fit those styles better
  - Consider adding a second level of CIT training that would be more intensive
    - Voluntary only
    - Act as secondary responders
- Some individuals with a history of domestic violence would prefer that a female CIT officer be sent to the scene

Opportunities Identified in the Strategic Planning Session

Communication

- County employee looking at frequent callers to 911
- Meetings with all hotlines, 211, 911, and regional counties.
- Police Academy and Dispatch Academy are both located in same building so it is easy to work with both of them
- Oregon has strong laws that protect individuals' right not to share information
- Crisis Services share information with County client database
  - Including services received, connections, and past crises

Capacity/Resources/Community Supports for Diversion

- Dedicated police line to Mobile Crisis
- Mobile crisis has strong relationship with 911 staff
- Health Department's Building Better Care" delivery model reserves time at clinics for walk-in appointments for mental health clients
  - Address mental health, social work, and physical health
  - Regardless of ability to pay
  - Set aside funds
- $2 m in county funds for people with most intensive illnesses
- New co-responder police/mobile crisis team just starting
- Wide variety of hotlines in county
  - Meetings have been occurring with all hotlines
- 75% of call from community
- 25% are from police from BOAC
- 211 Info and Referral
- National Suicide Hotline connected w/ Veterans' Administration
- David Romprey Warm Line. State funded and consumer operated.
- NAMI has a help line M-F
- Peer support networks could be better utilized
- Build on NAMI's existing community education and peer support programs

- Into schools
- Resources for family members

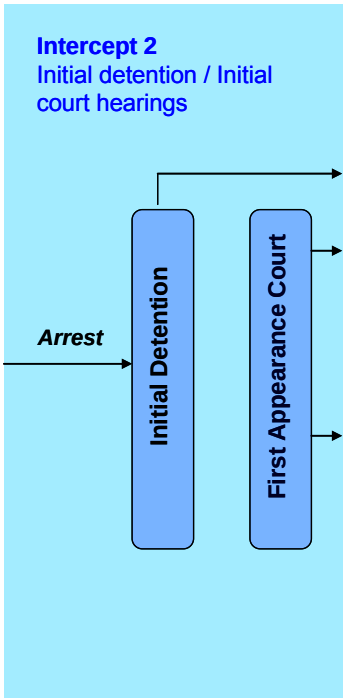
Training/Education

- Urgent Walk In staff continuing to do roll call outreach/training with law enforcement
  - Training focuses on most efficiently accessing services
- CIT training provided for all Portland Police Bureau patrol officers

Recommendations

- Improve coordination with law enforcement and develop crisis stabilization bed capacity

Intercept II: Initial Detention / Initial Court Hearing



There are over 37,000 bookings (28,000 unduplicated) into the Multnomah County Detention Center (MCDC) per year. Staff at the jail are responsible for inmate classification and also perform multiple entry screenings for each person booked into the facility, including a medical and mental health screening performed by Corrections Health medical staff and a National Institute of Justice gender specific mental health screen administered by Multnomah County Sheriffs Office (MCSO) classification officers. Approximately 75% report substance abuse involvement. An April 2010 population snapshot of inmates found 162 of 1112 males (14.56%) and 35 of 136 females (25.73%) with a total of 15.78% of all inmates in custody having a mental health alert. Corrections Health identifies 17% of bookings with mental health history.

The Department of Community Justice (DCJ) provides recognizance screening, pre-trial supervision and post adjudication supervision for probationers and parolees. Staff providing recognizance screening are called "Recog" officers and staff the jail 24 hours/7 days per week. Each year, Recog staff interview over 16,000 defendants in custody with a pending Multnomah County charge. Approximately one-third of these defendants are found eligible for release. Recog staff use a standardized risk-assessment form which rates each defendant's risk based on criminal history and other factors to determine who can be released prior to their initial court appearance. Release decisions are made based upon the probability the defendant will appear for arraignment, while protecting victims, witnesses, and the community. (http://www.co.multnomah.or.us/dcj/asd.shtml)

At or immediately after arraignment, defendants can be referred by the court to the Pre-Trial Supervision Program (PSP) to be supervised in the community until their trial date. PSP supervises approximately 4331 defendants who would otherwise be housed in the jail. The primary mission of PSP is to evaluate the risk of releasing defendants prior to trial, supervise defendants in the community and ensure that defendants attend court hearings. PSP staff use evidence-based criteria during their investigation to determine if a defendant is likely to pose a safety risk or is unlikely to attend subsequent court hearings once released from custody. When a defendant is released under PSP supervision, the assigned case manager monitors the defendant's behavior and actions through regular home, community, office and telephone contacts, as well as electronic and Global Positioning Software (GPS) monitoring if applicable. PRSP is not targeted at mental health clients but many mental health clients maybe supervised by PRSP. There are no mental health treatment resources attached to PRSP.

Note: Close Street, operated by the Sheriff's Office, is one of two pretrial supervision program operated by the County. Close Street is an intensive custody and supervision program that provides services to pretrial arrestees and sentenced offenders. This program supports both offender accountability and reentry of the offender into the community while increasing available jail beds. Defendants are typically assigned to Close Street based on the seriousness of their charge.

There is no standard or routine mental health screening provided by Recog. Due to the volume and short time frame for screening (people are arraigned within 24 hours), adding another form or procedure for mental health screening would be difficult. One participant in the mapping exercise described booking as "the worst place to fit in another piece of work."

Although Multnomah County Sheriffs Office and Corrections Health staff both provide mental health screening, it is likely that people with mental illness are released to supervision or on their own recognizance without appropriate service linkages. However, if someone is identified as suicidal during the booking process, upon release, they are transported to a local ER. Volume is estimated at 3-8 per month.

There is no reported formal jail diversion or linkage option at arraignment in the various general court jurisdictions. There is also concern that revealing mental health information at this stage could jeopardize liberty interests. If an inmate is to remain in custody following arraignment, he or she will return to the Multnomah County Detention Center. The Sheriff's Office attempts to keep the majority of the inmates with mental illness at this central detention center; however, inmates who are more stable and requesting less restrictive housing can move to Multnomah County Inverness Jail, which has open dorm housing. The flow of inmates depends on their individual classification and their changes in behavior (positive and negative) while in custody.

Gaps Identified in the Strategic Planning Session

Communication

- Quick intake form used at booking
  - Produces limited information
- Jail and Recog Officers receive little information from law enforcement as they bring in arrested individuals
- The process of expedited recognizance release for misdemeanors means that these offenders will be released within hours of booking, even if these offenders are identified by Corrections Health as suffering from significant mental health issues. There is no current capacity to make service linkages.
- Recog interviews are restricted to self reported information

Capacity/Resources/Community Supports for Diversion

- Need systematic pre-jail interventions for misdemeanors with severe mental illness
  - Need a treatment alternative to jail
- Police could cite and take to Walk-In Clinic but rarely happens
- Booking is a high demand/stress time
- Approximately 75 to 80% of those being booked have alcohol and/or drug involvement
- Do not want to add activities to a setting designed to hold people for four hours only
  - Booking is "worst place to fit in another piece of work"
- Tension in system regarding use of self-reported mental health information at this stage
  - Defense attorneys are not appointed at this point
- No mental health professionals in booking area
  - Only screenings being performed along with self-reported information
- Need to walk through this process with a fresh set of eyes and from the client's point of view
- Repeated jail admissions for people with severe mental illness or seriously physically ill
- Open Booking initiative widened door for who is admitted to the jail, including those with misdemeanor offenses
- Internal Portland Police Bureau policy allows few exceptions to taking arrestees to Booking
- Need mechanisms to ensure that people will show up for their required court hearings
- "Carnival of agencies" involved in booking
  - Each agency has a different data system

Opportunities Identified in the Strategic Planning Session

Communication

- Sheriff's Office has been leading on sharing of information
- Release agreement recently validated by Department of Criminal Justice

Capacity/Resources/Community Supports for Diversion

- Open Booking initiative began in July 2009
- Consumer Survivors of Oregon lobbying for an Office of Consumer Affairs to advocate for more services
- Addition of Forensic Peer Specialists could improve engagement of clients in treatment

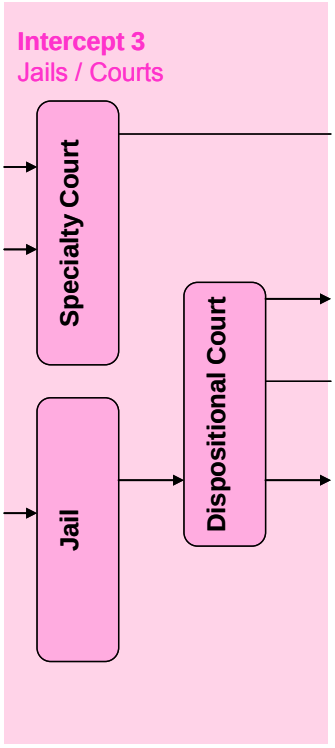
Training/Education

- Small pilot study has been completed with Call Center to identify people currently in treatment or in treatment in the past

Recommendations

- Develop Intercept II diversion options.

Intercept III: Jails / Courts



Jails

The Multnomah County Detention Center (MCDC) houses the majority of inmates with mental illness. As noted above, it also serves as the intake and booking facility for all Multnomah County. In the last fiscal year, the jail system was funded at 1,367 beds and typically ran at 94 percent capacity. Twenty percent of the population is female. Mental health care is provided by Corrections Health operated by the County Health Department. It is estimated that 24% of the MCDC population is on psychotropic medication accounting for 63% of the monthly medication budget. There is a ten bed psychiatric infirmary and four units for male inmates with mental illness and one unit for female inmates with mental illness. Total Corrections Health mental health staffing includes:

- two psychiatric nurse practitioners
- two mental health professionals
- one psychiatric registered nurse

Multnomah County Sheriffs Office (MCSO) Corrections Counselors also play key roles in programming for inmates with mental illness. Three MCSO Corrections Counselors who are assigned to designated mental health housing areas at MCDC provide individualized and specialized reentry planning for inmates with mental health issues by coordinating services with other public service agencies and community partners to improve offender outcomes and thereby reduce recidivism.

Current caseloads are listed below:

Counselor 1 – (46 inmates)

- 4A (10 male/female): Medical Infirmary – fragile/high needs medical, detox protocol, some suicide watches, high-profile inmates
- 4B/C (16 male): Administrative Segregation – history of assaults (staff or inmate), behavior issues, can be aggressive, Violent Person A Felony, many with mental health issues
- 4D (10 male/female): Psychiatric Infirmary – inmates with severe mental illness, requiring acute care, most awaiting A&A
- 4E/F (10 male/female): Discipline – recent disciplinary write-up, walk alone, many with mental health issues
-

Counselor 2 - (96 inmates)

- 6D (32 males): Mid-level functioning inmates with mental health issues. Many on medication or engaged in treatment in custody with Correctional Health but stable.
- 6A (32 males): higher functioning inmates with mental health issues. Opportunities for groups and many actively involved in treatment. Entire module walks together.
- 8D (32 males): Protective Custody- Victim. Many have one or more issues: first time in custody, measure 11 sex crimes, younger/older compared to GP, high profile, past victim of assault in custody, labeled a “snitch”, gay/transgender. Entire module walks together. Low inmate turnover in this area.

Counselor 3 - (80 inmates)

- 6B (16 males): Low functioning mental health inmates. Likely decompensated and in need of mental health treatment. Some refusing care. Some awaiting A&A process. Some waiting for placement in 4D..
- 6C (16 males): Low functioning inmates with mental illness. Many decompensated and in need of mental health treatment. Some refusing care. Some awaiting A&A process. Some psychotic with unpredictable/unstable behavior. Walk time by tier, if deputy feels they are able.
- 7B (16 males): Classification. Newly incarcerated men awaiting review for MCIJ, general population. High inmate turnover in this area.
- 7C (16 males): Protective Custody- Threat. Inmates who have behavior that no longer allows them to be housed in general population. Could be security threat, past strong-arming, off lockdown yet not able to assimilate back in previous housing.
- 8B (16 females): mental health unit closed, PC, ad-seg, disciplinary. Variety of females who may have mental health issues, protective custody concerns, on lockdown, or post-lock down status. Issues are varied and do not allow placement in general population female area.

The Multnomah County Inverness Jail (MCIJ) is a medium security facility housing both men and women. The Transition Services program provides assessment of reentry needs, transition classes, resource education, linkage, and planning activities. In addition the program assists in obtaining essential identification documents, e.g. driver's license, birth certificate etc. As noted above, most inmates with serious mental illness remain at the Multnomah County Detention Center.

The following is a snapshot taken Tuesday, June 8, 2010:

Jail	Pre-trial	Sentenced	Male	Female	MH Alert
MCIJ	589 (76%)	218 (24%)	188(86%)	30(14%)	17
MCDC	357 (80%)	94 (20%)	*	*	48**

*not reported

**Population with Mental Health Alert is housed in the following areas:

Mental Health Floor:	20
Special Housing:	11
Male General Housing:	8
Female:	9
	48

There is not a jail-based diversion program operating. In jail-based diversion a mental health worker would identify potential mental health jail diversion candidates and work with community providers and the courts to arrange appropriate treatment and ancillary services to reduce time spent in jail or prevent further penetration into the criminal justice system. There is, however, a Forensic Diversion Program established pursuant to Oregon statute 161.370 to divert persons who lack capacity to stand trial from Oregon State Hospital. This is a state funded pilot program operating since 2009 and staffed by two full-time Mental Health professionals and a part-time supervisor. They provide in-reach service into the jail. There is potential for Forensic Diversion Program staff to enhance jail diversion capacity. They also identify persons for diversion through civil commitment. There are approximately 18 persons diverted through civil commitment annually.

The Courts

There are 26 criminal courts and six Specialty Courts in Multnomah County. Specialty Courts include:

- Community Court – diversion for violations and low level misdemeanors. Includes defendants with mental illness. In addition to other social service staff, there are two full time Qualified Mental Health Providers staffing the courts.
- DUI Court
- Domestic Violence Court
- STOP Court – "Sanction Treatment Opportunity Progress" drug court
- START Court – processes property offenses
- Mental Health Court (below)

The Mental Health Court is presided over by Judge Richard Baldwin. Referrals result from settlement conference between defense counsel and the prosecution, from judges or from probation officers. Individuals referred to the Court are not necessarily in custody while awaiting referral or while awaiting determination of whether they can participate in the Court. Staffing includes three full-time mental health staff that serve as boundary spanners linking people to services and benefits.

Legal criteria for participation in Mental Health Court include:

- Must be eligible for a probation sentence and plead to the charge
- Probation violation cases may also be referred to the court

Clinical criteria include:

- Persons with a primary Axis I diagnosis of either: Schizophrenia, Schizoaffective Disorder, Bipolar Disorder, or Major Depression. Individuals with Axis II diagnoses are eligible if there is a co-occurring serious mental illness.

The Mental Health Court was developed in 2008. Five individuals completed the program by April 2010. After a slow start, there has been a steady flow of referrals though the court is still not at its capacity of 60 clients. As of April 30, 2010, there were 37 clients participating in Mental Health Court.

Gaps Identified in the Strategic Planning Process

➢ Opportunities
◘ Gaps

Communication

◘ System for collecting community behavioral health history data is "not robust"
  - Quick pilot of this "did not work as well as it could"
  - Lot of potential that we're not realizing to create a continuum of care
    - Too much an isolated clinic: "as if you went to Mars"

◘ Gap in info from current mental health service provider and what is happening in the person's court case
  - Jail mental health program starting to address by assigning someone from their program as a link to the courts
  - Limited access for jail mental health staff to get community mental health history for use in treatment planning
  - Interested in keeping people from languishing in jail
    - Initiate the linkages and communication with the courts
  - Perhaps a short report could be provided to the judge and DA and defense?
    - What would defense say?

◘ Mental Health Court needs to have access to strong data

- No way to demonstrate that they reduce recidivism
- No system to do this now

Capacity/Resources/Community Supports for Diversion

- Jail does not have 24 hours a day availability of mental health professionals
- People in jail are not funded by Medicaid
  - People admitted to jail are cut off from the Oregon Health Plan (i.e., Medicaid) and may have difficulties getting access to Oregon Health Plan after release
- No jail based jail diversion program
- Some defendants excluded from Mental Health Court because they have been charged with particularly violent crimes.
- DA had been concerned that may not get enough buy in from defense for these mental health kinds of alternatives but seems to be working out okay
- Defense counsel: Act at direction of our clients
  - Some clients with low level misdemeanants may prefer to "do the time"
  - Some clients not interested in engaging in mental health system or the police or anyone
    - Last thing they want is participating in Mental Health Court
- Many not aware of the objectives of the Mental Health Court; for instance, numbers to be served
- Still capacity left for Mental Health Court
  - Capacity set at 60 but have served 37
  - Eight to ten clients in referral process that they hope to take in next couple of weeks
  - Relatively new court; started approximately 18 months ago
  - Now fully staffed and up and running, but delays in receiving appropriate referrals
  - "Disappointing 18 months later that we're not at the numbers we were originally talking about" given the numbers of people with mh in the jail
  - Pool of people potentially eligible for Mental Health Court shrinks with the various criteria and gate-keeping processes
  - For bench probation transfers, it can take six to eight weeks to get records on mental health diagnosis in order for Heidi to do her mental health assessment
    - No attorney involved to help facilitate access to records
  - Focusing now on referrals from Mentally Ill Offender probation officers
- Relatively little jail space available
  - Approximately 600 beds taken out of the jail system
  - As a result, options for misdemeanors are limited
  - "Suppress the numbers" for Mental Health Court
- Lack of consumers involved in the operations of Mental Health Court
- Inclusion of low level charges in Mental Health Court is perceived as a gap because there is a lack of incentive to participate in on-going court monitoring when usual court processing would result in short court supervision. Typical low level charges include:
  - Urinating in public
  - Public disorder
  - Mostly interfering with public transportation
- Limited in-reach into the jail
  - Perhaps could engage folks when they're a "captive audience"
- Growing awareness of the need to address co-occurring mental illness and substance use disorders more effectively
- Much work to be done in creating the continuum of care
- Increase services for women such as dual diagnosis groups, DBT

Training/Education

- No specialized mental health training for correctional officers --- could be improved
  - Security staff in jail do not have adequate tools to manage this population in the jail

Opportunities Identified in the Strategic Planning Process

Communication

- Corrections Health communicates well with Sheriff's Office

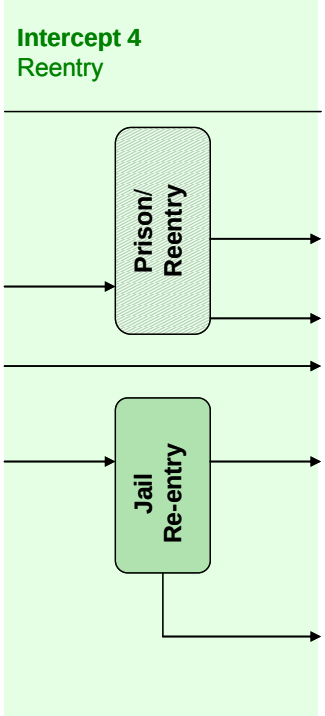
Capacity/Resources/Community Supports for Diversion

- Corrections Health looking at more effective approaches to addressing co-occurring disorders (prescribing practices, links to the community, etc.)
- Corrections Health could be more involved in diversion
- Good collaboration with judges re implementing civil commitment of most acutely ill
- Funding used for Mental Health Court is state funding used to get people out of jail
  - State general fund, not Medicaid
  - Fewer restrictions
  - Could shape things to do this differently
- Mental Health Court has "made a huge difference for some of our clients"
- Two full-time equivalent mental health staff in Community Court --- Qualified Mental Health Professionals
- Could add forensic peers to Mental Health Court and build pro-social support

Training/Education

- Could expand CIT to the jail

Intercept IV: Re-Entry



Jail based Corrections Health and Multnomah County Sheriff's Office Corrections Counselors focus on in jail screening, assessment, and treatment. Primary functions pertaining to transition activities performed by MCSO Corrections Counselors assigned to the MH team include, but are not limited to:

- Contacting each inmate in MH housing areas prior to their projected release to identify possible transitional needs upon release.
- Using motivational interviewing techniques and individualized assessment such as the Multnomah Community Ability Scale to aid in determining the inmate's needs and, with the inmate's involvement, tailor a transition plan that addresses criminogenic factors *(i.e. safe and affordable housing, medication management, substance abuse treatment, employment, cognitive-behavioral treatment, education, etc)*.
- Developing transition plans to provide the inmate with appropriate referrals to community resources *(food stamps, shelter, housing, etc.)* and/or contacting mental health treatment providers *(i.e. Cascadia, Lifeworks, Lukedorf)* to ensure consistent support and follow up is provided.
- Collaborating and coordinating with the judicial system to develop alternative sentencing and/or treatment plans for the mentally ill offender. For example, when an inmate is too unstable, and needs to be evaluated and treated in a mental health facility/hospital, the counselor initiates and expedites movement to a more appropriate care facility.

Correction Counselors provide the inmate with lists of community resources, for example the Rose City Resource Guide, prior to their release from custody. The transition plan often addresses both short term needs and goals *(i.e. those pertinent on the day of their release)* and longer term needs, such as ongoing access to medical providers), mental health treatment, and to prescription medications. Current resource lists are also available in the jail lobby.

Both MCSO Corrections Counselors and Corrections Health have staff who act as designated discharge coordinators and court liaisons. The discharge coordinator provides transition services upon referral from Correctional Health staff, MCSO MH counselors, judges, attorneys and others. As the court liaison, the discharge coordinator is present during court hearings and provides linkages to services when people are released, updates the court on persons incarcerated who are "treat to fit" (persons in jail receiving treatment to restore competency). While not a formal diversion program, the discharge coordinator's role may provide diversion alternatives to the court.

In Multnomah County, the Health Department partners with the Sheriff's Office to provide access to health care for citizens detained in jail; Corrections Health is the division of the Health Department tasked with providing that care. Due to the great number of seriously mentally ill people detained in Multnomah County jails, Corrections Health employs a team of mental health professionals. The Corrections Health Mental Health Team is distinct from Corrections Counseling in that they are a division of the Health Department and are stationed in the jails for the sole purpose of providing health care. The Corrections Health mental health team consists of four masters prepared mental health professionals who perform mental health assessments and therapy, three psychiatric nurse

practitioners filling 2.0 FTE who prescribe and manage psychiatric medication, seven day per week coverage on one shift of psychiatric RN who help manage the therapeutic milieu in the psychiatric infirmary, and a program manager who also acts as the clinical supervisor.

The Mental Health Team has a system for transferring care from the clinic within the jail system to a community clinic operated by the health department. Once the patient has been released from custody and their care has been transferred, the patient will be assigned a medical home within the health department and they will have access to a primary care provider as well as behavioral health providers. Building Better Care is a system that the Health Department has developed to more proactively meet the needs of its patient population. The basic tenets of the system are creating a team of medical and behavioral health professionals that will stay with their patient group and provide care in a highly accessible and proactive manner.

Jail in-reach services to inmates on Mental Health modules at the Multnomah County Detention Center include:

- Mental Health Court team,
- 370 team, now called the Forensic Diversion Program
- MIO Mentally Ill Offender Probation Officers
- Cascadia Behavioral Healthcare/Project Respond
- DHS
- VA
- LukeDorf/Bridge City Recovery
- Dual Diagnosis Anonymous of Oregon
- Meditation Volunteers
- High School Completion
- Up to four weeks of medication for inmates with needs identified prior to release

Incarcerated inmate medical assistance benefits are temporarily suspended based upon Senate Bill 913. There is no opportunity prior to release to access benefits and inmates are instructed to go to social services for assistance upon release. A letter is provided to the inmate to take to the local Social Security Office that documents dates of incarceration and release from custody. Oregon does have a Medicaid suspension law but there is no data indicating how well Medicaid suspension works for released inmates.

While there are several housing providers, access to housing for the jail and prison reentry population is limited. Lack of benefits, low housing vacancy rate, fear of criminal justice clients and lack of case management for this population were cited as barriers. Still, participants felt that a more systematized and collaborative approach could improve housing access.

The Housing Authority has experimented with several approaches to expanding housing options for this target population. One approach has been to work with private landlords. Another approach has been the development of a pilot using HUD Section 8 vouchers that are project or agency based. This provides a modest amount directly to a provider, allows the Housing Authority to navigate the housing bureaucracy, takes advantage of the provider's ability to provide case management and other supportive services, and provides more flexibility overall. Case management and navigating the complex service provider system are seen as keys to success in housing this population. The lack of income is typically not the major barrier to their housing. Only nineteen percent of those served by the Housing Authority have zero income.

Gaps Identified in the Strategic Planning Session

- ➢ Opportunities
- ◘ Gaps

Communication

- ◘ Jail mental health folks encourage folks to go to Urgent Walk-In Clinic but do not coordinate with Clinic
- ◘ If inmate is willing to share information about previous treatment history, the jail can verify current medications
- ◘ Limited data re need for housing or homelessness with this population
- ◘ No system behind the walls to reinstate or start access to Social Security benefits upon release
- ◘ No data to assess whether individuals are receiving prompt access to Medicaid upon reentry
  - Anecdotal evidence suggests few problems

Capacity/Resources/Community Supports for Diversion

- ◘ Able to plan for discharge for only a fraction of the released inmates
- ◘ Few discharge and reentry systems
- ◘ Limited community support upon reentry
- ◘ Challenge of providing reentry plans for those unexpectedly released
- ◘ No specific funding for dedicated staff to focus on reentry planning for this target population
- ◘ Need to reach out to the community
  - Not a politically popular thing "if source of the solution is from inside the jail"
- ◘ No systematic case management for reentry of people with severe mental illness although it takes place in some individual cases
  - Prostitution Support Team
  - ACT (Assertive Community Treatment) Teams
    - Generally need to be on ACT
    - Some opportunity to expand ACT
      - State funds directly
  - Cascadia case managers assigned to MIO Unit
    - Probation violators
- ◘ All of this stuff is really "ad hoc" --- doesn't happen systematically
- ◘ Some folks very reluctant to access service
  - Don't think they have a mentally illness
- ◘ Some probation officers never see their clients because they disappear after release
- ◘ No proactive outreach
- ◘ Reentry housing options are significantly limited
- ◘ People often lose housing when people go to jail
  - Not clear what can be done about this
- ◘ Inability to initiate/reactivate Social Security benefits
- ◘ Major gap in services for sex offenders with severe and persistent mental illness
  - Probation caseload with 30 on them
- ◘ Lack of Transition Case Managers who have capacity to reach-in to engage
- ◘ Lack of counseling staff in booking area
- ◘ Increased reach-in by community providers

Training/Education

- ◘ Need more education for attorneys regarding what tools they have at their disposal

- Re possibilities available

Opportunities Identified in the Strategic Planning Session

Communication

- Could look at police reports for data on individuals' homelessness
- Public housing reduced criteria
- Prison system to access Medicaid benefits "working well." Jails asked to work with state MA agency for "cross-notice"
  - Jails give ongoing notice to MA of who is in their custody
  - Get notice of who has had their Oregon Health Plan suspended
    - Jail provides a letter at time of release to assist in reinstatement of Medicaid

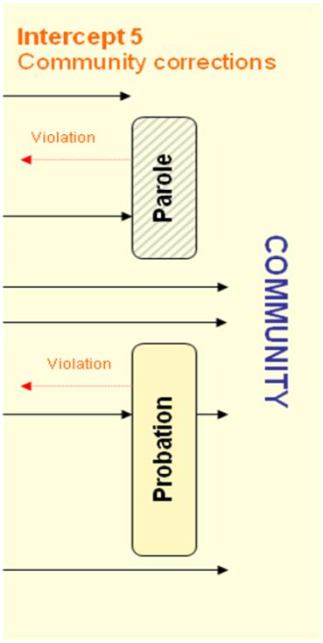
Capacity/Resources/Community Supports for Diversion

- Forensic Diversion Program could be used more
- "In-jail mental health treatment is a part of diversion"
  - People who are stable are more likely to be placed in a community alternative
- Some case management provided for subgroups of population
- Bridges to housing
- Housing Authority's pilot with Section 8 project-based housing with providers
- Multnomah County piloted a program for rapid access to Social Security benefits
- Medicaid suspension
  - Haven't heard of complaints about people having difficulties getting back on Medicaid after leaving jail
    - "Something's working and we're not doing it"

Recommendations

- Carefully coordinate the resources offered by the jail's mental health staff, MCSO, community providers, probation, and others.
- Explore ways to enhance the "bridge medication" when a person reenters the community from the jail so there is not a lapse in treatment.
- Build on current work to systematically develop "in-reach" efforts into the jail to identify those with severe mental illness and often co-occurring disorders in order to facilitate continuity of care and alternatives to incarceration.
- Systemically expedite access to Medical Assistance, Social Security, and other benefits to facilitate successful reentry to the community.
- Explore methods to help people obtain birth certificates or other needed identification.

Intercept V: Community Corrections / Community Support



The Department of Community Justice supervises about 8600 clients that have been either sentenced by the Multnomah County Courts to a term of probation and or released from state prison on parole or post-prison supervision. Offenders undergo several assessments at intake that help officers determine that offender's risk of recidivism and need for service and support; about a quarter of clients are high-risk offenders and a quarter of which are medium-risk. A little over 3200 clients reside on a specialized caseload that focuses on specific high-risk subpopulations of offenders, such as domestic violence offenders or those with mental health issues; remaining clients reside on a geographically-based "generic" caseload (~3100) or a reduced caseload (~2300) that focuses on the lowest-risk offenders on supervision and involves minimal contact between PO and client. The Mentally Ill Offender Unit (MIO) has 4.5 officers that are trained in issues around mental illness, co-occurring substance use, and trauma. Not all clients with mental health issues are placed on this specialized caseload.

The Department of Community Justice partners with treatment and support providers. DCJ contracts with Cascadia for three case coordinators to assist probationers with mental illness with housing, reinstatement of Social Security benefits, and addressing issues that might create difficulties adjusting to the community. DCJ also has a contract with Lifeworks NW to provide mental health evaluations and a contract with Lukedorf to provide 15 residential beds. DCJ has funding to access Alcohol and Drug treatment for mentally ill individuals including some housing for persons in the MIO unit.

Another diversion alternative is bench probation where a judge supervises community release. However, there are no formal linkages to treatment. In the past, individuals convicted of felonies and serious misdemeanors could be placed under formal DCJ supervision, either directly from sentencing or following a stay in prison or jail. Now, due to a persistent lack of resources, many of the individuals who would have received formal supervision have been placed on bench probation, including misdemeanants and some felons. There were approximately 10,974 individuals on bench probation at the time of this report.

Individuals on bench probation are not assessed for their criminogenic needs or for their risk of recidivism and do not receive programming or services *directly* through the Courts; however, many defendants on bench probation are referred to outside agency programs as a condition of probation. Failure to comply with probation conditions could result in a violation and sanction. The most common sanction is jail, in part because resources do not easily allow for jail alternatives. Anecdotal evidence and reports on the prevalence of mental health issues in other parts of the criminal justice system suggest that the number of individuals with mental health issues on bench probation is quite high.

A broad range of community resources for this target population include extensive, trauma specific treatment programs, robust Dialectical Behavioral Therapy (DBT) programs, Wellness Recovery Action Plan (WRAP) programs, and programs run by NAMI and consumer/peer groups. Dual Diagnosis Anonymous groups started in Oregon and are offered in the jails, state prisons, state hospitals, and the community.

Pilots for modified Assertive Community Treatment (ACT) team will allow for more flexibility in serving the target population. They are strengths based and include the evidence based practice of Integrated Dual Diagnosis Treatment (IDDT).

The local National Alliance for Mental Illness (NAMI) organization provides a wide variety of activities:

- Peer to Peer
- Family to Family
- In Our Own Voice --- Consumer do presentations on their recovery to CIT officers, churches, Portland State University, and others; There is no charge for the training; Consumers are paid stipends for their presentations.
- NAMI Basics --- Provided for parents of school age children
- Drop in support
- NAMI Connections
- Systems Navigators
- Participation on many advisory groups
- Prescription Assistance Program --- Extends beyond prescription scholarships to housing and food assistance
- First Step --- Volunteers go into hospitals to connect for recovery

Additionally, there are several peer-run groups:

- Depression Bipolar Support Alliance (DBSA),
- Empowerment Initiatives, Inc. -- works directly with people in jails to assist with housing, and also provides scholarships and housing retention support for peers,
- Portland Hearing Voices -- offers a support group for people who have had extreme states and sponsors events for peers. (This organization is not deeply involved with people in the justice system, may be a potential partner), and
- Multnomah County's Adult Mental Health and Substance Abuse Advisory Committee (AMHSAAC) -- a group of peers and advocates who have been in the mental health system and are involved in Mental Health and Addiction Services Division policy and decision making.

Gaps Identified in the Strategic Planning Session

➢ Opportunities
▫ Gap

Communication

- ▫ Need greater communication/education between criminal justice and NAMI/families

Capacity/Resources/Community Supports for Diversion

- ▫ Probation and Parole supervises according to risk so low risk offenders probably don't have enough history necessary for referrals to Mental Health Court
- ▫ Limited capacity in MIO Unit
  - Must prioritize by severity of mental illness and level of risk
- ▫ Few resources for offenders with severe mental illness and a history of sex offenses
- ▫ Need improved access to community services
- ▫ Young adult population has some specific challenges across the intercepts ---
  - Underserved population
  - In process of acquiring skills for adulthood
  - Systems in place don't necessarily respond to their needs in a developmentally appropriate way
- ▫ Not enough assessment of trauma for those involved in the criminal justice system
  - Leads to under-referral of trauma services

- NAMI could do more for school-aged individuals
- Need more Dual Diagnosis Anonymous groups
- Difficulties with those not eligible for Medicaid --- A lot of people aren't covered
- Need strategies for what to do while waiting for Multnomah Treatment Fund (MTF) indigent funds
- Lack of affordable housing for the target population
  - Housing Authority has long waiting lists
  - Private landlords are typically unwilling to take individuals with criminal histories
  - NIMBY concerns re placement of housing --- Neighbors will say "We don't want those people in our neighborhoods "
  - Restricted by neighborhoods that control access to building
  - Community as a whole has a very low vacancy rate for rental units
    - This population tends to be excluded
  - Need more dialogue to get housing providers to take this population
    - Often bias against taking criminal justice clients
  - Behavioral health providers sometimes do not want to refer to their own housing

Training/Education

- General population probation officers need some education regarding the probationers with severe mental illness they serve who can't be served by the MIO Unit
- Need more trauma informed care training and intervention
- Limited use of WRAP plans (Wellness, Action, and Recovery Plans) used in forensic settings (or in the general population)
- Need more cross system training
  - Would like to hear more about facilitating this and the skills needed to do the work

Opportunities Identified in the Strategic Planning Session

Communication

- If police have contact with a probationer or parolee and run their name, police are required to contact P & P to update them on probationer's behavior helping P & P be aware of potential problems
- Systems Navigators program is well respected

Capacity/Resources/Community Supports for Diversion

- Dual Diagnosis Anonymous groups started in Oregon and are offered in the jail, prisons, and state hospitals
- Wide variety of trauma specialty services offered in county
- Housing Authority's interest in this population and willingness to experiment to find successful approaches
- Housing Authority's agency-based Section 8 pilot facilitates case management which is an important key to success in stable housing for the target population ®
- The behavioral health system can assist the Housing Authority and other housing providers by providing case management, supportive services, and other efforts to navigate the complex services system
- NAMI activities wide variety of activities along with interest in addressing this target population
- Prescription Access Program is much broader than simply focus on accessing prescriptions
- NAMI interested in expanding from the organization's initial focus on families to consumers also

- Significant consumer interest and energy to address these issues

Recommendations

- Carefully coordinate the resources offered by the jail's mental health staff, MCSO, community providers, probation, and others.
- Explore ways to enhance the "bridge medication" when a person reenters the community from the jail so there is not a lapse in treatment.
- Build on current work to systematically develop "in-reach" efforts into the jail to identify those with severe mental illness and often co-occurring disorders in order to facilitate continuity of care and alternatives to incarceration.
- Systemically expedite access to Medical Assistance, Social Security, and other benefits to facilitate successful reentry to the community.
- Explore methods to help people obtain birth certificates or other needed identification.

Taking Action for Change

Multnomah County, Oregon

Objectives of the Action Planning Activity

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

Action Planning Process

The stakeholders assembled for the workshop were enthusiastic participants in the development of a strategic action plan. A copy of the Multnomah County Action Plan can be found beginning on page 30 of this document. The action planning process promotes the development of specific objectives and actions steps related to each of the priority areas, the individuals responsible for implementation of each action step, and a reasonable timeframe for completion of the identified tasks.

Multnomah County Priorities

Subsequent to the completion of the *Sequential Intercept Mapping* exercise, the assembled stakeholders began to define specific areas of activity that could be mobilized to address the gaps and opportunities identified in the group discussion about the sequential intercept map. A number of distinct priorities were identified, including both opportunities for tactical interventions to promote "early quick victories" and more strategic interventions to stimulate longer-term systems changes. Workshop participants combined several priorities for the purpose of developing the action plans and then agreed to put some priorities on hold to be addressed at a later date.

Listed below are the priority areas as ranked by the workshop participants with the number of votes received in parentheses.

GOAL: Achieve true jail diversion

Top Priorities

- Address communication/information sharing issues (24 votes)
  - Non-crisis Release of Information forms that are proactive
  - Better linkage between mental health and the jail
  - Identify boundary spanners for each represented entity that can carry this work forward
    - Can act as cross-system trainers
- Develop a true diversion from jail or before jail (20)
  - Develop the possibility of a different response to the low level criminal charges typically found with this population
  - Address prevention

Secondary Priorities (recommendations for other collaborative bodies or ongoing work of the Mental Health Public Safety Committee):

- Develop more flexible housing options (6)
- Expand capacity of MH Court by broadening the door (5)
- Develop Crisis Assessment and Triage Center for police to drop people off (4)
  - Healing environment
  - Staff willing to accept broad range of behaviors
- Include Forensic Peer Support (3)
- Address female offenders with specialized services/treatment (3)
- Prioritize new Intensive Case Management for this population (1)
- Develop a community involvement group that takes advantage of citizen interest and energy (1)
- Expand CIT training to other partners such as 911, jail staff, etc. (1)
- Develop cross system training (1)
- Develop active understanding and engagement from County Commissioners (1)

* In planning for each priority, address financing and cost-shifting.

Other Suggested Priorities

- Align Multnomah County's Multnomah Treatment Funds with priority populations involved in the criminal justice system
- Expand Walk-In Center access
- Expand access to Social Security benefits
- Design programs not based on grant requirements but instead on helping the most people in the most effective ways

Multnomah County, Oregon:

Priority Area 1: Address communication sharing issues:

- Non-crisis release of information forms that are proactive
- Better Linkage between mental health and the jail

Objective		Action Step	Who	When
1.1	Analyze county data systems	▪ Evaluate what data is not protected ▪ Evaluate where it best works ▪ Develop 101 guide to getting information ▪ Evaluate info sharing and integrate data systems ▪ Evaluate info sharing Release of Information (ROI) process and forms ▪ Research successful info sharing laws/projects	2-4 Steve, Elizabeth, Bill, Kevin, Nancy Patty, Lorena, David, Dan	6/1/10
1.2	Consumer WRAP Plan ROI	▪ Refer to LPSSC Committee 7/27/10	Maureen	7/1/10
1.3	Engage elected officials	▪ Out of monthly meeting. Present to County Commissioners.	Matthew, Bobbi, County Atty, Nancy Bennett, Betty W., Kevin, David, NAMI, Consumers	9/1/10
1.4	Opportunity to get contract language.	▪ Determine what officials the contract should be discussed with and then discuss with those officials	David, Bill, Amy, Christy	6/1/10
1.5	Educate system providers/consumers on information sharing protocols.	▪ Identify system boundary spanners ▪ Boundary spanners educate stakeholders, providers, consumers		10/1/10
1.6	Explore data warehouse	Phase II	Christy G, Steve, Elizabeth, Bill, Kevin, Nancy	

Multnomah County, Oregon: **PRIORITY AREA 2:** Increase Intercept 1 and 2 diversion options				
Objective		Action Step	Who	When
2.1	Increase police discretion	▪ Mobile Crisis Unit ▪ Improve Urgent Care and Case Management Response to assist police with disposition ▪ Improve Officer discretion, e.g. improve response for „cite and release' cases ▪ Increase case management resources ▪ Explore one stop drop off center		
2.2	Increase diversion options at arraignment	▪ Explore DA discretion to not prosecute if person engages in services ▪ Improve screening for Recog officers to identify diversion candidates and to transfer information to jail for continuity of care ▪ Quicker screen for PRSP		

Multnomah County, Oregon: **PRIORITY AREA 3:** Develop more flexible housing options				
Objective		Action Step	Who	When
3.1	Identify gaps and resources available for housing	▪ Develop "Housing Information Warehouse" ▪ Identify greatest bottlenecks in housing system to know where to most effectively concentrate effort ▪ Identify areas of greatest inefficiency in the system (e.g. use of hotels, lack of peer support/navigators to make housing applications and appeals more effective. ▪ Maintain Housing Authority subsidy (past current 30 days) during short term hospital stay and incarceration ▪ Landlord education		

		▪ Improve communication with HAP and private landlords to prevent removal during hospitalization/jail.		
3.2	Explore funding sources to pay/assist with rent	▪ Explore expediting Social Security applications ▪ Contact local SOAR trained programs		
3.3	Address NIMBY issues	▪ Provide more peer navigator and case management support through application and appeal process to both applicant and landlord		
3.4	Develop more housing options across housing spectrum	▪ Increase capital ▪ Increase rent subsidy ▪ Redistribute/prioritize current housing funding		
3.5	Develop more options	▪ Develop "dry" housing for people not in recovery from substance abuse ▪ Develop housing strategies for sex offenders with mental illness ▪ Other?		
3.6	Review inappropriately housed "system stuck" population	▪ Identify bottlenecks: • Most efficient use of current housing stock e.g. use of hotels, cycling through jails • Where will current dollars have most impact?		
3.7	Improve housing retention	▪ Maintain housing subsidy during short term hospital/jail stays. ▪ Eviction prevention with short-term rent assistance ▪ Eviction prevention for consumers exhibiting behavioral or housing adjustment problems by utilizing peer support employed by housing or service provider.		

Multnomah County, Oregon: **PRIORITY AREA 4:** Explore options for Peer Support at each Intercept point.				
Objective		Action Step	Who	When
4.1	Explore national peer models in the justice system.	▪ Work with consultants to identify national programs that could guide development in Multnomah County ▪ Work with NAMI to explore NAMI's national initiatives relating to forensic peers.	Lorena Campbell Joanne Fuller	5/10
4.2	Develop peer support services at front end.	▪ Peers will staff proposed Crisis Assessment and Treatment Center. ▪ Peers will serve on interview committees for staff of center ▪ County is considering a proposal to fund the NAMI model for drop-in center.	David Hidalgo David Hidalgo Karl Brimner NAMI	4/11 4/11 6/10
4.3	Peers will be involved in policy and decision making	▪ County proposed peer advocate to serve as member of the Mental Health and Addictions Services Leadership Team. ▪ Peers will serve on interview committee for this position.	Karl Brimner	6/10

Conclusions and Recommendations: Summary

Participants in the *Sequential Intercept Mapping* and *Taking Action for Change* workshops showed genuine interest in improving the continuum of resources available for people with severe mental illness and often co-occurring substance use disorders involved in the Multnomah County criminal justice system. Multnomah County is poised to tackle a number of critical issues that will greatly improve services for this group.

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

Multnomah County is currently doing excellent work to enhance collaboration, improve services, and increase community alternatives for people with mental illness involved in the criminal justice system. The recommendations offered below can be used to build on recent accomplishments to enhance cross-system collaboration and the current service delivery system.

Summary of Recommendations

The priorities developed during the *Sequential Intercept Mapping* workshop along with the first draft of the Action Plan provide a strong framework to improve services for persons with mental illness and often co-occurring substance use disorders involved in the criminal justice system in Multnomah County. The expansion of the planning group to tackle the priorities established during the *Sequential Intercept Mapping* and *Action Planning* exercises is an essential first step in a true systems change process. It will be important to create effective working relationships with other groups that did not attend the workshop including the Department of Veterans Affairs. Regular meetings should be held by this larger group to facilitate information sharing, planning, networking, development and coordination of resources, and problem solving.

The recommendations are organized according to the Sequential Intercept Model. Some of the recommendations cross all intercepts and may reflect a need for larger regional or statewide initiatives or coordination.

Cross-Intercepts

- At all stages of the Sequential Intercept Model, data should be developed to document the involvement of people with severe mental illness and often co-occurring substance use disorders involved in the Multnomah County criminal justice system. More data would be useful to illustrate the scope and complexity of the problems discussed during the workshop.
  - Efforts should be made to summarize important information on a regular basis and share with the larger planning group, other stakeholders, and funders
  - Consider the "Mental Health Report Card" used by the King County, Washington Mental Health, Chemical Abuse and Dependency Services to document progress in meeting relevant client outcomes
    - For example, one outcome measure asks: Are we decreasing the number of times adults and older adults are incarcerated?

- See: http://www.kingcounty.gov/healthservices/MentalHealth/Reports.aspx

- Expand forensic peer counseling, support, and specialists to promote recovery. Build on the energy and interest of consumers who attended the workshop by expanding the work of the peer specialists to criminal justice-involved populations. The consumers attending the workshop were knowledgeable, experienced, and had many thoughtful ideas about ways services can be improved in Multnomah County.
  - A number of localities around the country (New York City and Memphis, for example) have found that peer specialists with a personal history of involvement in the mental health and criminal justice systems have been effective in engaging individuals who have previously resisted traditional mental health efforts
    - The Oklahoma Mental Health Consumer Council provides jail diversion and reentry programming using the WRAP (Wellness Recovery Action Plan) program and peer bridgers. www.omhcc.org .
    - Howie the Harp Peer Advocacy Center provides forensic peer specialist training and supported employment for justice involved persons with mental illness. The Center is available for consultation to assist communities with development of forensic peer specialist programs. Contact Dwayne Mayes at: (212) 865-0775 ext. 2118 or visit: www.communityaccess.org/what-we-do/employment-a-recovery/hth-peer-advocacy-ctr .
    - Forensic peer specialists support reentry from the jail in The Main Link Forensic Peer Support program in Bradford and Sullivan Counties in Pennsylvania. The program has recently started a small work release program.
      - See: http://www.themainlink.net/peer.php
      - Contact D.J. Reese at jdjrees@gmail.com or (570) 265-0620
  - Integrate peer support into the current crisis response process
    - Peer support at this level of care could help reduce crisis and contact with law enforcement
    - Consider the peer run „hospital diversion" program of PEOPLe Inc. in Ulster County, New York.
    - Contact Steve Miccio, www.projectstoempower.org
  - Continue to include consumers in future planning efforts

- Continue to include and build upon the work of the family members who have shown interest in collaborating to improve the continuum of criminal justice/behavioral health services. Many communities have found family members and consumers to be the most effective "voices" in helping to bring increased resources to the community. Forensic specific focus for NAMI or appointment of a Forensic Coordinator might improve communication and expertise in advocating and serving as a resource to justice partners across the Intercepts.
  - The Forensic liaison for NAMI in Albany, NY recently hosted a diversion seminar for judges and published a judges' mental health handbook. Contact Mame Lyttle at: mlyttle@nycap.rr.com

- Review screening and assessment procedures for mental illness, substance abuse, and co-occurring disorders across the intercepts.
  - As noted in the section on Evidence Based practices, the GAINS Center monograph by Peters, Bartoi, and Sherman, *Screening and Assessment of Co-Occurring Disorders in the Justice System,* includes the most up to date information about screening and assessment tools in criminal justice settings
  - The authors note: *Accurate screening and assessment of co-occurring disorders in the justice system is essential for rapid engagement in specialized treatment and supervision services. Screening for co-occurring disorders should be provided at the earliest possible point in the justice system to expedite consideration of these issues in decisions related to sentencing,*

release from custody, placement in institutional or community settings, and referral to treatment and other related services. Due to the high prevalence of co-occurring disorders among offenders, all screening and assessment protocols used in justice settings should address both disorders. The high prevalence of trauma and physical/sexual abuse among offenders indicate the need for universal screening in this area as well. Motivation for treatment is an important predictor of treatment outcome and can be readily examined during screening. Drug testing is also an important component of screening and serves to enhance motivation and adherence to treatment.

- Given the significant budget challenges expressed by all participants in the workshop, consider two efforts from other parts of the country that focus on proactive strategies to improve services and collaboration.
  - Address fragmentation and breaks in continuity of care; focus on improving current linkages and continuity of care to break the cycle of repeated admissions and high use of crisis/emergency services
  - One example is Florida's process improvement project, designed to improve continuity of service between persons served in detoxification and continued treatment. The project focuses on improving "conversion rates" from detoxification to follow up community services by looking at agency performance, practice, and processes
  - Other efforts to improve conversion rates include:
    - Use of recovery support personnel to do face to face contact, improve client engagement, supportive follow up phone calls
    - Having a therapist who would be assigned to a client at discharge meeting with the client and family before they walk out the door, to promote engagement and to promote recovery
    - Contact John Bryant of Florida Council for Community Mental Health at John@fccmh.org
  - Identify frequent users, a group that tends to cycle repeatedly through the mental health, substance abuse, and criminal justice systems without long-term improvement
    - The Case Assessment Management Program (CAMP) is a joint effort of the Los Angeles Department of Mental Health and the Los Angeles Police Department to provide effective follow up and management of selected referrals involving high users of emergency services, abusers of the 911 system, and individuals at high risk of death or injury to themselves or others
    - A 2007 National Association of Counties Achievement Award described the program: *CAMP* teams, consisting of a mental health clinician, a patrol officer and a detective, focus on clients who pose the highest risk for violent confrontation with the police, and are the highest utilizers of all types of emergency services. The main goals of *CAMP* are to reduce violent police encounters, arrests, prison time, psychiatric hospitalizations, and emergency mental health calls to all agencies. In 2006, *CAMP* successfully linked 48 high risk/high utilizer clients to out-patient services, thereby avoiding costs in emergency services and in-patient hospitalization. By collaborating with the staff of their mental health courts, advocating to criminal justice professionals for treatment over incarceration, and working closely with clients, their families, and the staff of intensive, out-patient, mental health treatment programs, *CAMP* is brokering care for clients who have previously fallen through the cracks. *CAMP* represents a new type of collaboration between mental health and law enforcement that promises to yield tremendous rewards-not only for these difficult clients, but also for their communities and the professionals that serve them.
    - For more information
      -- http://dmh.lacounty.gov/cms1_076076.pdf
      -- http://judiciary.house.gov/hearings/March2007/032707wall.pdf?ID=809

-- Contact Linda Boyd, Mental Health Clinical Program Head, Los Angeles County Department of Mental Health ((213) 738-4431
    - This approach fits well with the long-standing collaboration seen in Multnomah County between behavioral health and the criminal justice system

- Increase information sharing to enhance rapid identification of current mental illness and history of services so diversion can be immediately initiated.
    - Jail Mental Health Data Link Project. Data Link is an internet-based application that performs a cross-match between the daily jail census and Illinois Department of Human Services/Department of Mental Health open case records, thereby immediately identifying detainees with mental illness eligible for - and at some point receiving - state funded mental health services.
        - There has already been contact with the Illinois Department of Mental Health regarding implementing Data Link in Multnomah County and further investigation is encouraged. See Appendix T.
    - Develop "super release forms" across all relevant parties so information can be shared
    - In cases of critical mental health emergencies, develop a linkage system to the mental health crisis staff for consultation, collaboration, and information sharing to enhance law enforcement's ability to make early diversion
    - Network information across all relevant parties in this phase of diversion

- Establish formal collaboration with the Department of Veterans Affairs by including a VA representative in local planning groups. The VA has a Veterans Justice Outreach initiative that places a Veteran's Justice Outreach Coordinator in each of the 154 VA medical centers. Linda Maddy is the VJO Coordinator assigned to the Portland VA Medical Center. She can be contacted at Belinda.Maddy@va.gov. Recent information obtained from the Multnomah County Sheriffs Office MCSO indicates that 5-6% of the current jail population report being a veteran. With a jail population of over 1,300, approximately 78 veterans are incarcerated. However, if the same percentage holds true for the 37,000 yearly bookings, then it is estimated that 2,820 veterans annually are booked into MCDC. Data from other sites suggest 5% of the total number of veterans or 185 would be women.

    - The GAINS brief entitled *Responding to the Needs of Justice Involved Combat Veterans with Service-Related Trauma and Mental Health Conditions* (Appendix Q) outlines screening protocols, training needs, and collaborations required to improve identification of veterans in the justice system and to improve system response and coordination of care.
    - "Deputy used CIT training to defuse real-life crisis with troubled vet" in *The Team News (CIT International Newsletter)* (Appendix R) underscores the importance of training law enforcement about manifestations of combat trauma.

Intercept I: Law Enforcement and Emergency Services

- Improve coordination with law enforcement and develop crisis stabilization bed capacity. Participants report that lack of crisis stabilization beds is a significant problem resulting in extensive waiting time for police who bring consumers to emergency rooms and a lack of a timely response and engagement for consumers in crisis. In addition, "open booking" while an option of police is rarely used due to lack of formal diversion linkages. As a result, jail is used to insure court

appearance for low level offenders. Current MCSO policy allows for all persons brought by the police to be booked in the jail. Standing orders for Portland Police Bureau urge officers to bring individuals to the jail to be booked even if mental health interventions might be available. Many of these individuals will be booked and released under Recog supervision. This practice results in work for the booking process without linking defendants to mental health services.

- Washington State, Colorado, Montana, Florida, and the District of Columbia are seeking to expand crisis stabilization units to divert people from hospitalization, provide alternatives to incarceration for low-level misdemeanor crimes, and improve efficiency of law enforcement by reducing emergency room wait times and visit costs. Stabilization units are essential elements of police CIT response.
- San Antonio, Texas has a model crisis stabilization program and has assisted several communities in the development of crisis stabilization units. The CMHS National GAINS Center has worked with the San Antonio site to provide technical assistance to Washington State in planning and implementing its crisis stabilization unit initiatives. A site visit to San Antonio may be instructive to Oregon's efforts (See Appendix U).

Intercept 2: Initial Detention and Initial Hearings

- Develop Intercept II diversion options. Models for Intercept II diversion exist around the country. Two exemplary programs are:
  - Jericho Project-The Jericho Project is a Memphis Tennessee jail diversion program run out of the Public Defender's Office. Stephen Bush, Project Director, is a national consultant on jail diversion from the defense counsel perspective. He can be contacted at: Stephen.Bush@shelbycountytn.gov .
  - The EXIT Program is an arraignment court diversion program that operates with minimal sanctions and a high level of consumer engagement (See EXIT Program brief, Appendix J)

Intercept 4: Re-entry

- Carefully coordinate the resources offered by the jail's mental health staff, MCSO, community providers, probation, and others.
  - Examine the results of current reentry efforts by tracking individual cases. Determine who may have been missed or where efforts are not resulting in the desired outcomes for increased continuity of care and decreased return to the criminal justice system.
    - A snapshot study of consecutive mental health releases for a 2 to 4 week period can inform expansion of and coordination of release planning efforts.
      - ❖ Identify the number of inmates on the jail MH units who: are released with an appointment with a community provider within 30 days of release, are provided with a 30 day supply of medication, and keep a scheduled appointment with a provider in the community.
      - ❖ Identify the number of inmates released from booking, the number of court releases, and the number of inmates on psychiatric medications released from MCDC general population or MCIJ, who do not receive effective linkages to community providers.
  - Transition case management is an essential element of reentry planning to provide comprehensive plans, insure people keep scheduled appointment, coordinate multiple care system involved and to respond quickly to crisis that may develop during initial weeks of reentry.

While in-reach by some community providers is reported, the perception is that need greatly outweighs capacity.
    - Examine the work in Erie County, Pennsylvania where the criminal justice and behavioral health systems collaborate closely on two teams to develop discharge plans for people leaving their jail: the Aftercare Mental Health Team at the Erie County Prison and the Community Mental Health Treatment Team
        - ❖ The two teams meet on alternating weeks to anticipate, plan for, and follow up on transitions to the community; they focus on both individual cases and addressing systemic issues
        - ❖ Contact Sheila Silman, M.S. at ssilman@eccaremgt.org or (814) 528-0601

- Explore ways to enhance the "bridge medication" when a person reenters the community from the jail so there is not a lapse in treatment
    - Consider the development of rapid reentry follow up appointments with select providers for people with serious mental illness or those who are on medication that needs to be maintained to reduce recidivism and relapse
    - Consider "gap funding" for medication and services.
        - The New York State Medication Grant Program and the Alaska APIC program are examples. (Appendix V)
    - Assess utilization of Oregon's Medicaid suspension legislation

- Build on current work to systematically develop "in-reach" efforts into the jail to identify those with severe mental illness and often co-occurring disorders in order to facilitate continuity of care and alternatives to incarceration.
    - Data from Pierce County, Washington indicates that individuals with severe mental illness were four times more likely to attend their first post-release mental health appointment if someone from the community mental health system met with them while they were still in prison

- Systemically expedite access to Medical Assistance, Social Security, and other benefits to facilitate successful reentry to the community.
    - Explore more consistent, rapid reinstatement of Medical Assistance benefits and procedures to begin this process while the individual is still incarcerated.
        - Include local and state Medicaid people in the process
    - See further information about Social Security benefits and the SOAR program in the next section

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

Intercept 5: Community Corrections and Community Support

- PRA acknowledges the work of the Department of Community Justice Mentally Ill Offender (MIO) Unit.
- Multnomah County is recognized nationally for utilization of evidence-based supervision practices and utilization of specialized mental health caseloads with graduated sanctions.
- Expand supportive employment options

- Involve specialized mental health probation officers to assist in this process

- Explore expansion of housing options for people with mental illness involved with the criminal justice system. Housing is essential for successful reentry and to reduce recidivism.
  - The workshop was particularly strong on including housing staff; continue to build on that collaboration
  - Two groups are doing interesting work to develop housing alternatives for this population
    - The Corporation for Supportive Housing's Frequent Users Initiative has been implemented in a number of cities and states across the country to foster innovative cross-system strategies to improve quality of life and reduce public costs among persons whose complex, unmet need result in frequent engagement with emergency health, shelter and correctional services
      - These programs identify and target a small group of individuals whose overlapping health and mental health needs place them at high risk of repeated, costly and avoidable involvement with correctional and crisis care systems
      - The Corporation leverages local partnerships and community-based services linked with housing to improve outcomes at a reduced public cost for the frequent user
      - population
      - The New York City Departments of Correction and Homeless Services, with assistance from the Department of Health and Mental Hygiene and the New York City Housing Authority have implemented the Frequent Users of Jail and Shelter Initiative
      - Initial results show that the average number of days in jail decrease by 52% among housed participants, while jail days actually increased for members of a comparison group
      - For information about the New York City and other Frequent User initiatives: http://www.csh.org/index.cfm?fuseaction=Page.viewPage&pageId=4456&nodeID=81
    - See Pennsylvania's recent work on *Housing and the Sequential Intercept Model: A How-To Guide for the Housing Needs of Individuals with Justice Involvement and Mental Illness,* http://www.parecovery.org/documents/Housing_SEI_Final_Handbook_030510.pdfwebsite

  - Develop data to document the impact homelessness or unstable housing has upon people with mental illness and other behavioral health problems involved in the criminal justice system
    - Consider including the jail in the annual "one day count" of homelessness in the county
      - Information gained can be useful in planning for housing resources specifically targeted for this population
      - Include this information in the Multnomah County 10 Year Plan to End Homelessness
    - Document the numbers of people who lose housing after being incarcerated.
    - Document the numbers of people being held in jail who could be released if they had suitable housing
      - Compile information on jail inmates under probation supervision who are waiting for an address in order to be released from jail

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

Evidence-Based and Promising Practices

Specific screening, assessment, engagement, treatment, service or criminal justice practices were not examined during the course of the *Sequential Intercept Mapping* workshop. At some point, Multnomah County may want to assess its successful use of evidence-based and promising practices in each of these areas. Key areas to examine are listed below. Many resources to illustrate these evidence-based practices can be found in the attached appendices or at the National GAINS Center website, www.gainscenter.samhsa.gov .

Criminal Justice

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

Screening, Assessment, Engagement, and Treatment

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

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

Service

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

Closing

Multnomah County is fortunate to have a wide range of stakeholders across the mental health, substance abuse and criminal justice systems that have made significant efforts to understand and support the challenging issues discussed in this workshop. The *Sequential Intercept Mapping* and *Taking Action for Change* workshop participants displayed genuine interest in improving the continuum of criminal justice/behavioral health services in Multnomah County by developing a coordinated strategy to move forward with the identified priorities. The interest and commitment by the stakeholders in Multnomah County is further demonstrated by the county's inclusion as one of five sites chosen nationally by the Bazelon Center for Mental Health Law in their Performance Improvement Project to reduce reliance on local law enforcement to intervene in psychiatric emergencies.

By reconvening and supporting the work of the group in coming months, it will be possible to maintain the momentum created during the *Sequential Intercept Mapping* and *Taking Action for Change* workshops and build on the creativity and drive of key local stakeholders. Our understanding is that workgroups have already begun to meet to expand upon the progress made during the workshop. Policy Research Associates, Inc. hopes to continue its relationship with Multnomah County and to observe its progress. Please visit the National GAINS Center or Policy Research Associates, Inc. websites for more information and for additional services to assist in these endeavors.

Additional Resources

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

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

Sequential Intercept Mapping
Participant List
Multnomah County, Oregon
April 13-14, 2010

Amy Anderson
MCDC Cascadia MCHD
(503) 230-6936
advocate55@q.com

Rose-Ellen Bak
Multnomah County, DCHS
421 SW Oak
Portland, OR 97204
(503) 988-6295
rose-ellen.bak@co.multnomah.or.us

Hon. Richard Baldwin
Multnomah County Circuit Court
1021 SW 4th
Portland, OR
(503) 988-3052
richard.c.baldwin@ojd.state.or.us

Greg Borders, Director of Crisis and Access Services
Cascadia Behavioral Health
2415 SE 43rd
Portland, OR 97211
(503) 887-8597
greg.b@cascadiabhc.org

Kevin Bowers, Community Justice Manager
Multnomah County Department of Community Justice
2205 NE Columbia
Portland, OR 97211
(503) 988-4428
kevin.bowers@co.multnomah.or.us

Ashleigh Brenton
(503) 810-1582
ashleighpb@aol.com

Karl Brimner, Director
Multnomah County DCHS Mental Health & Addiction Services Division
421 SW Oak Street
Portland, OR
(503) 988-3371
karl.r.brimner@co.multnomah.or.us

Sandy Bumpus, Advocate
8805 SE 17th Avenue #101
Portland, OR 97202
(503) 758-8774
bumpus@pdx.edu

Doris Cameron-Minard, Advocate
NAMI, OR & Multnomah
P.O. Box 989
Wilsonville, OR
(503) 625-3288
dcamminard@aol.com

Lorena Campbell, Staff
LPSCC Mental Health Public Safety Committee
421 SW Oak, Suite 240
Portland Or 97204
503.572-1483
Lorena_campbell@centennial.k12.or.us

John Connors, Multnomah County Director
Metropolitan Public Defender
630 SW Fifth Avenue, Suite 500
Portland, OR 97204
(503) 225-9100
jconnors@mpdlaw.com

Nancy Cozine, Deputy Trial Court Administrator
Multnomah County Circuit Court
1021 SW 4th
Portland, OR 97204
(503) 988-3826
nancy.j.cozine@ojd.state.or.us

Elizabeth Davies, Analyst
Multnomah County Public Safety Coordinating Council
501 SE Hawthorne Blvd, suite 600
Portland, OR 97214
503-988-5002
elizabeth.davies@co.multnomah.or.us

Jean Dentinger, Supervisor
Multnomah County DCHS Mental Health & Addiction Services Division
Involuntary Commitment Program
Multnomah County Mental Health
421 SW Oak Street, Suite 520
Portland, OR 97204
(503) 988-5464 x 27294
jean.m.dentinger@co.multnomah.or.us

Hon. Julie Frantz, Chief Circuit Court Judge
1021 SW 4th Avenue
Rm. 512
Portland, OR 97204
(503) 988-3045
julie.e.frantz@ojd.state.or.us

Chuck French, Deputy District Attorney
Multnomah County District Attorney's Office
1021 SW 4th Avenue
Portland, OR 97204
(503) 988-3725
charles.french@mcda.us

Liesbeth Gerritsen, Crisis Intervention Training Consultant
Portland Police Bureau
7214 North Philadelphia
Portland, OR
(503) 823-0183
liesbeth.gerritsen@portlandoregon.gov.

Heidi Grant, Mental Health Court Coordinator
Multnomah County DCHS Mental Health & Addiction Services Division
421 SW Oak
Portland OR
503 988-6320 #2
heidi.l.grant@co.multnomah.or.us

Sandy Haffey , MHASD
Multnomah County DCHS Mental Health & Addiction Services Division
421 SW Oak
Portland, OR
(503) 988-5464 x26659
sandy.j.haffey@co.multnomah.or.us

David Hidalgo, Sr. Operations Manager
Multnomah County DCHS Mental Health & Addiction Services Division
421 SW Oak Street, Suite 520
Portland, OR 97204
(503) 988-3076
david.a.hidalgo@co.multnomah.or.us

Meg Kaveny, Supervisor
Project Respond
521 SW 11th Avenue
Portland, OR 97205
(503) 944-1227
Margaret.kaveny@cascadiabhc.org

Ann Kasper, Advocate
628 NE Sacramento Street
Portland, OR 97212
(503) 287-4124
pretcoregon@yahoo.com

Kandi Leonhart, Telecare Recovery Advocate
31857 S. Shady Dell Road
Molalla, OR 97038
(503) 989-0873
coachkandi@aol.com

Joanne Fuller, Director
County Human Services
Multnomah County
1221 SW 4th Avenue,
Portland, OR 97204
(503) 988-5599
joanne.fuller.@co.multnomah.or.us

Captain Bobbi Luna
Multnomah County Sheriff's Office
1120 SW 3rd, Room 320
Portalnd, OR 97204
(503) 988-4326
bobbi.luna@mcso.us

Kevin Mahon, Clinical Supervisor
Lifeworks NW
400 NE 7th Street
Gresham, OR 97030
(503) 661-5455
kevinm@lifeworksnw.org

Traci Manning, Chief Operating Officer
Central City Concern
232 NW 6th
Portland, OR 97209
(503) 200-3918
tmanning@centralcityconcern.org

Brian Martinek, Assistant Chief, Operations
Portland Police Bureau
1111 SW 2nd
Portland, OR
(503) 823-0009
bmartinek@portlandpolice.org

Derrick Martin, Sr.
Telecare Recovery Center
1605 E. Lincoln Road
Woodburn, OR 97071
(503) 989-3013
derrickmartinsr@ymail.com

Mary Monnat, CEO
Lifeworks, NW
14600 NW Cornell
Portland, OR 97220
(503) 617-3822
marym@lifeworksnw.org

William Nunley
Cascadia Behavioral Health

Peter Ozanne, LPSCC Executive Director
Multnomah County COO for Public Safety
Multnomah County Building
Portland, OR
(503) 988-5777
peter.a.ozanne@co.multnomah.or.us

Erika Pruitt, District Manager
Multnomah County Department of Community Justice
(503) 988-6793
erika.l.preuitt@co.multnomah.or.us

Maureen Raczko, Program Administrator
Multnomah County Sheriff's Office
1120 SW 3rd, Room 307
Portland, OR 97204
(503) 988-3205
maureen.raczko@mcso.us

Catherine Such, Deputy Executive Director
Housing Authority of Portland
135 SW Ash, 6th Floor
Portland, OR 97204
(503) 802-8505
catherines@hapdx.org

Steve Sutton, Mental Health Manager
Corrections Health
1120 SW 3rd Avenue, 4th Fl. Med
Portland, OR 97208
(503) 988-4883
steven.c.sutton@co.multnomah.or.us

Kathleen Treb, Assistant Director
Multnomah County Department of Community Justice
501 SE Hawthorne Blvd; Suite 250
Portland, OR 97214
(503) 988-6131
kathleen.a.treb@co.multnomah.or.us

Elizabeth Wakefield, Special Courts
Metropolitan Public Defender
630 SW Fifth Avenue, Suite 500
Portland, OR 97204
(503) 225-9100
ewakefie@mpdlaw.com

Terri Walker
NAMI Multnomah
524 NE 52nd Avenue
Portland, OR
(503) 890-4805
terri.pdx@gmail.com

Pat Walsh
Portland Police Bureau
1111 SW 2nd
Portland, OR
(503) 823-0537
PWalsh@PortlandPolice.org

Crucita White
AOCMHP
1201 Court Street, Suite 301
Salem, OR
(503) 364-0680
cwhite@aocweb.org

Betty Woodward
Portland Police Bureau
1111 SW 2nd
Portland, OR 97204
BWoodward@PortlandPolice.org

Facilitators

Dan Abreu, **MS CRC LMHC**, Associate Director, National GAINS Center
Policy Research Associates, Inc.
345 Delaware Avenue
Delmar, NY 12054
dabreu@prainc.com

Patty Griffin, PhD, Senior Consultant
Policy Research Associates, Inc.
345 Delaware Avenue
Delmar, NY 12054
(518) 439-7415
pgriffin@navpoint.com


Policy Research Associates

Sequential Intercept Mapping & Taking Action for Change

Appendix A: Multnomah County Documents and Materials

Policy Research Associates


Policy Research Associates

Multnomah County Sheriff's Office
11540 NE INVERNESS DRIVE • Portland, OR 97220

Exemplary service for a safe, livable community

DANIEL STATON
SHERIFF

503 988-4300 PHONE
503 988-4500 TTY
www.mcso.us

Mental Health Screening
(*Male*)

---

1. Have you ever had worries that you just can't get rid of?
2. Some people find their mood changes frequently, as if they spend everyday on an emotional roller coaster. Does this sound like you?
3. Do you get annoyed when friends or family complain about their problems? Or do people complain that you're not sympathetic to their problems?
4. Have you ever felt like you don't have any feelings, or felt distant or cut off from other people or from your surroundings?
5. Has there ever been a time when you felt so irritable that you found yourself shouting at people or starting fights or arguments?
6. Do you often get in trouble at work or with friends because you act excited at first but then lose interest in projects and don't follow through?
7. Do you tend to hold grudges or give people the silent treatment for days at a time?
8. Have you ever tried to avoid reminders, or to not think about, something terrible that you experienced or witnessed?
9. Has there ever been a time when you felt depressed most of the day for at least two weeks?
10. Have you ever been troubled by repeated thoughts, feelings, or nightmares about something you experienced or witnessed?
11. Have you ever been in a hospital for non-medical reasons such as in a psychiatric hospital? (*Do **NOT** include going to an Emergency Room if you were not hospitalized*)
12. Have you ever felt constantly on guard or watchful even when you didn't need to, or felt jumpy and easily startled?

Multnomah County Sheriff's Office
11540 NE INVERNESS DRIVE • Portland, OR 97220

Exemplary service for a safe, livable community

DANIEL STATON
SHERIFF

503 988-4300 PHONE
503 988-4500 TTY
www.mcso.us

PREA Interview

1. Did the assault occur in a Multnomah County Facility?

   If not, where? **STATE** _____ **COUNTY** _____

2. Did the assault occur in a Multnomah County Facility?

3. Were you housed in an **ADULT** or **JUVENILE** facility?

4. Did you report the assault?

   Details: _____

5. Were criminal charges filed?

   Details: _____

Comments:

_____

_____

_____

_____

Multnomah County Sheriff's Office
11540 NE INVERNESS DRIVE • Portland, OR 97220

Exemplary service for a safe, livable community

DANIEL STATON
SHERIFF

503 988-4300 PHONE
503 988-4500 TTY
www.mcso.us

Security Threat Group Interview

---

1. What is your status with the gang? **CURRENT** / **FORMER**

2. Which gang are you affiliated with?

3. Where is your gang located? **AREA** _____ **REGION** _____

4. Do you have any tattoos? **GANG RELATED** / **ART STYLE** / **BOTH**

Sequential Intercept Mapping & Taking Action for Change

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

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

New Freedom Commission on Mental Health, *Subcommittee on Criminal Justice: Background Paper*. DHHS Pub. No. SMA-04-3880. Rockville, MD: 2004.

Primm, A., Osher, F, & Gomez, M. Race and Ethnicity, Mental Health Services and Cultural Competency in the Criminal Justice System: Are We Ready to Change? Community Mental Health Journal, Volume 1, Number 5, 557-569, 2005.

"Statement on Cultural Competence." In *Evidence –Based Practices: Shaping Mental Health Services Toward Recovery*. http://mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/cooocurring/competence.asp. Retrieved 8-14-07.

U.S. Department of Health and Human Services. *Mental health: culture, race, and ethnicity: A report of the Surgeon General.* Rockville, MD: Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health. Rockville, MD: 2001.


Policy Research Associates

Sequential Intercept Mapping & Taking Action for Change

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

Policy Research Associates


Policy Research Associates

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

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

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

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

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

History of SPECTRM

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

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

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

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

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

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

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

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

Features

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

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

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

Conclusion

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

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

Resources

Broner, N. (2002). *Evaluation of SPECTRM implemented with male and female shelter populations: A final report*. North Carolina: RTI International.

Lamb, HR, & Weinberger, LE. (1998). Persons with severe mental illness in jails and prisons: A review. *Psychiatric Services*, 49, 483-492.

National Center for Cultural Competence (2006). *Conceptual Frameworks / Models, Guiding Values and Principles*. Retrieved November 7, 2006, from http://www11.georgetown.edu/research/gucchd/nccc/foundations/frameworks.html

Rotter, MR, Larkin, S, Schare, ML, Massaro J, & Steinbacher, M. (1998). *The Clinical Impact of Doing Time: Mental Illness and Incarceration*. Albany, New York: New York State Department of Labor.

Rotter, MR, Larkin, S, Schare, ML, Massaro J, & Steinbacher, M. (1999). *The clinical impact of doing time: Mental illness and incarceration, Resource manual*. Albany: New York State Department of Labor.

Rotter, M, McQuistion, HL, Broner, N, & Steinbacher, M. (2005). The impact of the "incarceration culture" on reentry for adults with mental illness: A training and group treatment model. *Psychiatric Services, 56*(3), 265-267.

Rotter, M, & Steinbacher, MA. (2002, October). *Reducing ward violence by working with mentally disordered offenders*. Paper presented at the Annual Meeting of the Institute of Psychiatric Services, Chicago, IL.

Sequential Intercept Mapping & Taking Action for Change

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

Policy Research Associates


Policy Research Associates

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

Fred Osher, M.D., Henry J. Steadman, Ph.D., Heather Barr, J.D., M.A.

Published by the National GAINS Center

September 2002

Funded by the Center for Mental Health Services and the Center for Substance Abuse Treatment

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

Fred Osher, M.D.[1], Henry J. Steadman, Ph.D.,[2] Heather Barr, J.D., M.A. [3]

September, 2002

[1]Associate Professor and Director
Center for Behavioral Health, Justice, and Public Policy
Baltimore, MD
3700 Koppers Street, Suite 402
Baltimore, MD 21227
(410) 646-3511
Fax (410) 646-5324
Email: fosher@psych.umaryland.edu

[2]Policy Research Associates, Inc.
345 Delaware Avenue
Delmar, NY 12054
(518) 439-7415
Fax (518) 439-7612
Email: hsteadman@prainc.com

[3]Urban Justice Center/Mental Health Project
666 Broadway, 10th Floor
New York, NY 10012
(646) 602-5671
Fax (212) 533-4598
Email: hbarr@urbanjustice.org

This work was conducted under support to the SAMHSA-funded National GAINS Center for People with Co-occurring Disorders in the Justice System. The input of Susan Davidson, M.A., and Michelle Naples, M.A., both of the GAINS Center, and attendees of the GAINS Center's Re-entry Roundtable on September 5–6, 2001 is gratefully acknowledged.

The suggested citation for this monograph is Osher, F., Steadman, H.J., Barr, H. (2002) A Best Practice Approach to Community Re-entry from Jails for Inmates with Co-occurring Disorders: The APIC Model: Delmar, NY: The National GAINS Center.

Abstract

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

Introduction

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

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

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

Current estimates suggest that as many as 700,000 adults entering jails each year have active symptoms of serious mental illness and three-quarters of these individuals meet criteria for a co-occurring addictive disorder (GAINS, 2001).

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

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

Jail Size As a Factor

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

Many homeless people with co-occurring disorders receive behavioral health services only in jail because they have been unable to successfully access behavioral health services in the community; lack of connection to behavioral health services in the community may lead some individuals to cycle through jails dozens or even hundreds of times.

Tilling the Soil for Re-entry: System Integration

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

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

The APIC Model

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

Table 1.

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

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

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

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

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

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

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

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

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

Assessment involves...

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

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

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

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

The transition plan must consider special needs related to

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

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

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

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

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

Planning involves...

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

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

Family

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

Housing

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

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

Planning involves

continued...

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

√ *ensuring that the inmate has...*

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

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

Integrated treatment for co-occurring disorders

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

Medication

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

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

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

Other behavioral health services

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

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

Medical care

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

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

Income supports and entitlements

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

Food and clothing

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

Transportation

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

Child care

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

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

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

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

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

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

Identifying involves...

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

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

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

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

Identifying involves

continued...

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

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

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

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

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

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

Coordinating involves...

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

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

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

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

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

Coordinating involves

continued...

√ *confirming that the inmate....*

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

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

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

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

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

Conclusion

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

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

References

American Association of Community Psychiatrists (2001). AACP continuity of care guidelines: *Best practices for managing transitions between levels of care*. Pittsburgh, PA: AACP.

American Psychiatric Association (2000). Psychiatric services in jails and prisons: A task force report of the American Psychiatric Association. Washington, DC: APA.

Andrew, D. (1995). The psychology of criminal conduct and effective treatment. In *What Works: Reducing Reoffending – Guidelines from Research and Practice*, McGuire J. (ed.). John Wiley & Sons Ltd., 35–62.

Barr, H. (2001). Social workers as advocates for mentally ill criminal defendants/inmates. In *Serving Mentally Ill Offenders*. Landsberg, G., Rock, M., Berg, L.K.W., Smiley, A. (eds.). Springer Publishing, 229–245.

Bazelon Center for Mental Health Law (2001). *Finding the Key to Successful Transition from Jail to Community*. Washington, DC: Bazelon Center.

Becker, D.R., Smith, J., Tanzman, B., Drake, R.E., Tremblay, T. (2001). Supported employment program fidelity and employment outcomes. *Psychiatric Services*, 52: 834–836.

Brad H. v. City of New York (2000). 712 N.Y.S.2d 336, N.Y. Misc. LEXIS 305.

Bureau of Justice Statistics (2000). Prison and jail inmates at midyear 2000. U.S. Department of Justice Statistics, NCJ-185989.

Dennis D.L. and Steadman H.J. (1991). The Criminal Justice System and Severely Mentally Ill Homeless Persons: An Overview. Report prepared for the Task Force on Homelessness and Severe Mental Illness. Delmar, NY: Policy Research Associates.

Dvoskin J.A. and Steadman H.J. (1994). Using intensive case management to reduce violence by mentally ill persons in the community. *Hospital and Community Psychiatry*, 45(7): 679–684.

Griffin, P.A. (1990). The backdoor of the jail: Linking mentally ill offenders to community mental health services. In *Jail Diversion for the Mentally Ill: Breaking Through the Barriers*. Colorado: United States Department of Justice, Federal Bureau of Prisons, National Institute of Corrections, 91–107.

Hammett, T.M., Gaiter, J.L., Crawford, C. (1998). Reaching seriously at-risk populations: Health interventions in criminal justice settings. *Health Education and Behavior*, 25: 99–120.

Hammett, T.M., Roberts, C., Kennedy, S. (2001). Health-related issues in prisoner re-entry. *Crime and Delinquency*, 47(3): 390–409.

Hartwell, S.W. and Orr, K. (2000). Release planning. *American Jails*, Nov/Dec, 9–13.

Jemelka, R., Trupin, E. ,Chiles, J.A. (1989). The mentally ill in prisons: A review. *Hospital and Community Psychiatry*, 40: 481–491.

Lamberti J.S., Weisman R.L., Schwarzkopf, S.B., Price, N. Ashton, R.M., Trompeter, J. (2001). The mentally ill in jails and prisons: Towards an integrated model of prevention. *Psychiatric Quarterly*, 72 (1): 63–77.

The National Coalition for the Homeless and the National Law Center on Homelessness & Poverty (2002). *Illegal to be Homeless: The Criminalization of Homelessness in the United States*. Washington, DC: NCH, NLCHP.

The National Coalition for Mental and Substance Abuse Health Care in the Justice System (1996). *Community Corrections in America: New Directions and Sounder Investments for Persons with Mental Illness and Co-Occurring Disorders*. Lurigio, A.J. (ed.). Seattle, WA: NCMSAHC.

The National GAINS Center for People with Co-Occurring Disorders in the Justice System (1999). *The Courage to Change: A Guide for Communities to Create Integrated Services for People with Co-Occurring Disorders in the Justice System*. Delmar, NY: Policy Research Associates.

The National GAINS Center for People with Co-Occurring Disorders in the Justice System (1999). *Maintaining Medicaid Benefits for Jail Detainees with Co-Occurring Mental Health and Substance Use Disorders*. Delmar, NY: Policy Research Associates.

Osher, F.C. (2000). Co-occurring addictive and mental disorders. In *Mental Health, United States*, Manderscheid, R.W., and Henderson, M.J., (eds.). Washington, DC: Center for Mental Health Services, 91–98.

Peters, R.H. and Bartoi, M.G. (1997). *Screening and Assessment of Co-occurring Disorders in the Justice System*. Delmar, NY: Policy Research Associates.

Substance Abuse and Mental Health Services Administration, DHHS (2000). Cooperative Agreement for a National Center for Mentally Ill and Substance Abusing Youth and Adults Involved with the Justice System: Programmatic Guidance. Catalog of Federal Domestic Assistance No. 93.230.

Steadman, H.J., McCarty, D.W., Morrisey, J.P. (1989). *The Mentally Ill in Jail: Planning for Essential Services*. New York: Guilford Press.

Steadman, H.J. and Veysey, B. (1997). *Providing Services for Jail Inmates with Mental Disorders*. National Institute of Justice: Research in Brief.

Stephan, J.J. (2001). Census of Jails, 1999. Washington, DC, United States Department of Justice Programs, Bureau of Justice Statistics.

Teplin, L.A. and Pruett, N.S. (1992). Police as streetcorner psychiatrist: Managing the mentally ill. *International Journal of Law and Psychiatry*, 15: 139–156.

U.S. Department of Health and Human Services (1999). *Mental Health: A Report of the Surgeon General*. Rockville, MD: United States Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institute of Mental Health.

Veysey, B.M., Steadman, H.J., Morrissey, J.P, Johnsen, M., Beckstead, J.W. (1998). Using the referral decision scale to screen mentally ill jail detainees: Validity and implementation issues. *Law and Human Behavior*, 22(2): 205-215.

Sequential Intercept Mapping & Taking Action for Change

Appendix E: Dispelling the Myths about Information Sharing Between the Mental Health and Criminal Justice Systems & an example of an information sharing Memorandum of Understanding

Policy Research Associates


Policy Research Associates

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

John Petrila, JD, LLM[1]

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

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

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

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

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

What is HIPAA?

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

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

Who does the HIPAA Privacy Rule cover?

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

[1] Department of Mental Health Law & Policy ◆ University of South Florida at Tampa

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Will HIPAA violations lead to severe penalties?

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

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

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

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

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

A note on the Rule on Security Standards

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

Summary

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

Useful Resources

www.hhs.gov/ocr/hipaa

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

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

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

www.hhs.gov/ocr/combinedregtext.pdf

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

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

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

Memorandum of Understanding
Pertaining to the SAMSHA Jail Diversion Grant Project

Project: SAMHSA Jail Diversion Targeted Capacity Initiative

Parties: The document constitutes an agreement between the LEAD AGENCY, applicant under the SAMHSA Jail Diversion Targeted Capacity Initiative and the following parties: EVALUATOR; SERVICE PROVIDER 1; SERVICE PROVIDER 2; PRE-TRIAL SERVICES; DEPARTMENT OF COMMUNITY CORRECTIONS; COURT 1; COURT 2; OFFICE OF THE DISTRICT ATTORNEY; OFFICE OF THE PUBLIC DEFENDER

Term of Agreement:
This agreement will commence immediately upon notification of SAMHSA's approval of the Jail Diversion Project - Strategic Plan developed by the aforementioned Parties and other Key Stakeholders and will end 3 years from the date of project approval, subject to continued federal appropriations. The LEAD AGENCY and the Parties identified in the aforementioned section, agree to provide eligible services as described in the project application and strategic plan, to clients identified as eligible. All parties further agree to complete all necessary programmatic, reimbursement and fiscal reports required and to provide information for evaluation purposes in a timely manner.

Prior to the provision of any services that require the disclosure of confidential or privileged information, all applicable Parties must have an approved release form signed by the participant. This form will provide for the exchange of information concerning the participant to the DEPARTMENT OF COMMUNITY CORRECTIONS, the court of authority, PRE-TRIAL SERVICES, all contractors and all other service providers. The legal counsel for the participant will not be required to disclose any confidential or privileged information regarding the program participant due to the attorney client/privilege and professional ethics.

Personnel and others acting under the control of the aforementioned Parties, shall at all times observe and comply with all applicable state statutes, city ordinances, city agency rules, regulations, guidelines, internal management policy and procedures, and general orders of the government agencies that are applicable, current or hereafter adopted, regarding operations and activities in and about agency property.

Further the personnel under the control of the aforementioned Parties: EVALUATOR; SERVICE PROVIDER 1; SERVICE PROVIDER 2; PRE-TRIAL SERVICES; DEPARTMENT OF COMMUNITY CORRECTIONS; COURT 1; COURT 2; OFFICE OF THE DISTRICT ATTORNEY; OFFICE OF THE PUBLIC DEFENDER, shall comply with the city/state/federal employee conduct policies and procedures.

All Parties agree to participate in the required project trainings, to participate on the applicable steering committees and to assist to the fullest extent possible with all project evaluation requirements.

This agreement shall be subject to modification only upon written agreement by and between duly authorized representatives of the Parties and the LEAD AGENCY. Any such modification shall be accomplished by a written agreement or addendum and signed by the Parties identified above. It is further agreed that the LEAD AGENCY and any Parties listed within this MOU, may terminate this agreement with our without cause, upon ninety (90) days written notice.

Purpose:
The primary purpose of this project is to improve services and transform the system of care for people with mental illness who are involved in the criminal justice system in LOCALITY. In response to the SAMHSA Jail Diversion Targeted Capacity Initiative (JDTCI), potential participants who have nonviolent offenses and are assessed for an Axis I mental illness and/or a co-occurring substance abuse problem as part of the intake process, shall after screening and intake and upon approval from the appropriate Court system, will be linked by staff to necessary treatment and support services. Support services will include, but may not be limited to: Assertive Community Treatment and Integrated treatment, Case Management, Intensive Case Management, Medication Management and Pretrial/Probation Supervision and Monitoring. Within this context other more specific and targeted support services will also be provided through direct service or referral to the appropriate community based provider.

SIGNATURES OF PARTICIPATING ENTITIES:

LEAD AGENCY	DATE
EVALUATOR	DATE
SERVICE PROVIDER 1	DATE
SERVICE PROVIDER 2	DATE
PRE-TRIAL SERVICES	DATE
DEPARTMENT OF COMMUNITY CORRECTIONS	DATE

OFFICE OF THE PUBLIC DEFENDER	DATE
OFFICE OF THE DISTRICT ATTORNEY	DATE
COURT 1	DATE
COURT 2	DATE

Release of Protected Health Information

Albany County Jail Diversion Program - Albany County, NY

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient/Recipient Name: _____

DOB: ___/___/___ Gender: ☐ Male ☐ Female ID Number: _____

I hereby authorize the use and/or disclosure of my protected health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan, health care provider, or health care clearinghouse, the released information may no longer be protected by federal privacy regulations, except that a recipient may be prohibited from redisclosing substance abuse information under the federal substance abuse confidentiality requirements. State law governs the release of HIV/AIDS information and you may request a list of persons authorized to re-release HIV/AIDS related information. Release of information relating to minors may also be protected by additional state and/or federal regulations.

- Persons/Organizations **providing** the information:

☐ Albany County Department of Mental Health
☐ Rehabilitation Support Services
☐ Capital District Psychiatric Center
☐ City of Albany Department of Public Safety
☐ St. Peter's Hospital
☐ Albany City Court
☐ Albany Citizen's Council on Alcoholism & Other Chemical Dependencies, Inc.
☐ Albany County Alcohol and Substance Abuse Services
☐ Albany County Probation Department
☐ Albany County Correctional Facility – Inmate Services Unit
☐ Clearview Center, Inc.
☐ Homeless & Traveler's Aid Society
☐ Albany County Department of Social Services
☐ Albany Medical Center Hospital
☐ St. Peter's Addiction Recovery Center
☐ Albany County Consumer Advocacy Board
☐ Homeless Action Committee
☐ Community Living Associates Program, Inc.
☐ Albany County Public Defender's Office
☐ Albany County District Attorney's Office
☐ New York State Parole

☐ All organizations listed above

- Persons/Organizations **receiving** the information:

☐ Albany County Department of Mental Health
☐ Rehabilitation Support Services
☐ Capital District Psychiatric Center
☐ City of Albany Department of Public Safety
☐ St. Peter's Hospital
☐ Albany City Court
☐ Albany Citizen's Council on Alcoholism & Other Chemical Dependencies, Inc.
☐ Albany County Alcohol and Substance Abuse Services
☐ Albany County Probation Department
☐ Albany County Correctional Facility – Inmate Services Unit
☐ Clearview Center, Inc.
☐ Homeless & Traveler's Aid Society
☐ Albany County Department of Social Services
☐ Albany Medical Center Hospital
☐ St. Peter's Addiction Recovery Center
☐ Albany County Consumer Advocacy Board
☐ Homeless Action Committee
☐ Community Living Associates Program, Inc.
☐ Albany County Public Defender's Office
☐ Albany County District Attorney's Office
☐ New York State Parole

☐ All organizations listed above

- Description of the information to be released (A request for the entire record must be accompanied by an explanation why the entire record is needed): **The information that I authorize for release includes a summary of my contacts with any of the agencies I have authorized on this form to provide my protected health information, as those contacts relate to my treatment, effective service provision to me, and linkage of services I need with other systems.**

- Purpose for release: **The purpose of the release of my protected health information is to assist in the development of a possible diversion plan. This release will include accessing pertinent clinical records for purpose of linkage to mental health services.**

- Is this disclosure for marketing purposes? ___ Yes _X_ No

  If yes, remuneration paid? ___ Yes _X_ No

The following items ***must be initialed*** to be included in the use and/or disclosure of other protected health information:

_____ HIV/AIDS related information and/or records

_____ Genetic testing information and/or records

Consent and Information Disclosure Notice

Jail Alternative With Supports (JAWS) - Oakland County, MI

NOTICE

You have been arrested for a criminal offense that occurred on ___/___/ 200 __, in the City/Township of _____

Brief description of offense: _____

The _____ police department/sheriff's office has decided to give you the opportunity to help yourself by allowing you to enter a program to improve your mental health. You are referred to _____ for mental health treatment.

The police department will not ask that criminal charges be filed against you at this time. The police department reserves the right to have criminal charges filed against you if you do not cooperate with the mental health program that is set up for you or if you engage in other unlawful activity.

_____ Name of person arrested (please print)

_____ Arresting officer

_____ Complaint #

_____ Badge #

☐ **I consent to participate in the jail diversion program and agree to comply with the treatment plan that will be set up by the treatment provider.**

Inter-Agency Authorization to Disclose or Obtain Confidential Information

☐ **I authorize the law enforcement agency named above to disclose information to the organizations below:**

Common Ground Sanctuary
44590 Woodward Avenue
Pontiac, MI 48341
(248) 456-1991 (24 hours)

Easter Seals – Michigan, Inc.
22170 W. Nine Mile Rd.
Southfield, MI 48034
(800) 395-9819

Training and Treatment Innovations
1450 S. Lapeer Road, Ste. C
Oxford, MI 48371
(800) 741-1682

Community Network Services
35 W. Huron St.
Pontiac, MI 48341
(800) 273-0258

Macomb Oakland Regional Center
1270 Doris Road
Auburn Hills, MI 48326
(866) 593-7412

Community Network Services
1885 Pontiac Trail
Walled Lake, MI 48390
(800) 615-0411

☐ Common Ground, Easter Seals, TTI, CNS, and/or MORC are authorized to disclose information to the law enforcement agency named above.

Purpose of Disclosure: **Ongoing communication to facilitate jail diversion**

1. I understand that I may withdraw this consent by written notification at any time before information is released.
2. Unless withdrawn in writing, this consent expires as follows:

NINETY (90) DAYS FROM DATE OF SIGNATURE

_____ **Signature of Participant** _____ **Date** _____ **Participant's Date of Birth**

_____ Signature of Law Enforcement Officer

NOTE TO COMMON GROUND AND/OR CORE PROVIDER AGENCY:

Please fax Notice to the Oakland County Jail Diversion Coordinator

Sequential Intercept Mapping & Taking Action for Change

Appendix F: Illness Management And Recovery

Policy Research Associates


Policy Research Associates

Illness Management and Recovery in Criminal Justice

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

CMHS National GAINS Center May 2006 *Updated August 2008*

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

Evidence Supporting IMR

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

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

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

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

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

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

Illness Self-Management Programs

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

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

Evidence Base for IMR-Related Programs in Criminal Justice Settings

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

[1] New Hampshire-Dartmouth Psychiatric Research Center ◆ Dartmouth Medical School ◆ 105 Pleasant Street, Main Building ◆ Concord, NH 03301
[2] University of North Carolina Wilmington ◆ 601 South College Road ◆ Wilmington, NC 28403-5612

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

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

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

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

Implementing IMR-Related Programs in Criminal Justice Settings

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

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

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

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

References

Gingerich, S., & Mueser, K. T. (2005). Illness management and recovery. In R. E. Drake, M. R. Merrens, & D. W. Lynde (Eds.), *Evidence-Based Mental Health Practice: A Textbook* (pp. 395-424). New York: Norton.

Illness Management & Recovery program materials website: www.mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/default.asp.

Lovell, D., Allen, D., Johnson, C., & Jemelka, R. (2001a). Evaluating the effectiveness of residential treatment for prisoners with mental illness. *Criminal Justice & Behavior, 29*, 83 – 104.

Lovell, D., Johnson C., Jemelka, R., Harris, V., & Allen, D. (2001b). Living in prison after residential mental health treatment: A program follow-up. *Prison Journal, 81*, 473-490.

MacKain, S. J., & Messer, C. (2004). Ending the inmate shuffle: An intermediate care program for inmates with a chronic mental illness. *Journal of Forensic Psychology Practice, 4*, 87-100.

MacKain, S.J. & Streveler, A. (1990). Social and independent living skills for psychiatric populations in a prison setting: Innovations and Challenges. *Behavior Modification, 14*, 490-518.

Mueser, K. T., Corrigan, P. W., Hilton, D., Tanzman, B., Schaub, A., Gingerich, S. et al. (2002). Illness management and recovery for severe mental illness: A review of the research. *Psychiatric Services, 53*, 1272-1284.

Rotter, M. and Boyce, K.O. (2007, September 6). Bronx mental health court/illness management and recovery. Presentation at the CMHS National GAINS Center Expert Panel on Adapting Evidence-Based Practices to Criminal Justice Settings in Bethesda, MD.

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

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

Acknowledgements: *Special thanks are due to the attendees of the GAINS Center's Expert Panel Meeting on Illness Management and Recovery held in Bethesda, MD, on October18, 2005, where an earlier version of this paper was presented and discussed.*

Sequential Intercept Mapping & Taking Action for Change

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

Policy Research Associates


Policy Research Associates

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

Fred C. Osher, MD[1]

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

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

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

The History and State of COD Treatment

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

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

Services Integration for COD as an EBP

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

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

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

Integrated Treatment Programs for Justice-Involved Persons with COD

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

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

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

[1] Associate Professor of Psychiatry and Director ◆ Center for Behavioral Health, Justice and Public Policy ◆ University of Maryland Medical Center
3700 Koppers Street, Suite 402 ◆ Baltimore, MD 21227

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

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

COD Across the Continuum of Criminal Justice Settings

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

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

Future Directions

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

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

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

References

Center for Substance Abuse Treatment. (2005b). Substance abuse treatment for Adults in the Criminal Justice System. Treatment Improvement Protocol (TIP) Series, No. 42. DHHS Publication No. (SMA) 05-4056. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Cohen F (2003). The Mentally Disordered Inmate and the Law: 2003 Cumulative Supplement. Kingston, NJ: Civic Research Institute.

DeLeon, G. (1993). Modified therapeutic communities for dual disorders. In: Solomon, J., Zimberg, S., and Shollar, E., eds. Dual Diagnosis: Evaluation, Treatment, Training, and Program Development. New York: Plenum Medical Book Co.

Drake R.E., Osher F.C., & Wallach, M.A. (1991): Homelessness and Dual Diagnosis. *American Psychologist*, 46 (11), 1149–1158.

Grant, B.F., Stinson, F.S., Dawson, D.A., Chou, S.P., Dufour, M.C., Compton, W., Pickering, R.P. & Kaplan, D. (2004) Prevalence and co-occurrence of substance use disorders and independent mood and anxiety disorders. *Archives of General Psychiatry*, 61, 891–896.

Havassy, B.E., Shopshire, M.S., & Quigley, L.A. (2000). Effects of substance dependence on outcomes of patients in randomized trial of two case management models. *Psychiatric Services,* 51, 639–644.

Michaels, D., Zoloth, S., Alcabes, P., Braslow, C., & Safyer, S. (1992). Homelessness and indicators of mental illness among inmates in New York City's correctional system. *Hospital and Community Psychiatry* 43(2):150–155.

Morrissey, J. & Piper, P. (2005). Extending ACT to Criminal Justice Settings: Applications, Evidence, and Options. Delmar, NY: National GAINS Center.

Mueser, K.T., Noordsy, D.L., Drake, R.E., & Fox, L. (2003). Integrated Treatment for Dual Disorders: A Guide to Effective Practice. New York: Guilford Press.

Peters, R.H. & Bartoi, M.G. (1997). Screening and Assessment of Co-Occurring Disorders in the Justice System. Delmar, NY: National GAINS Center.

Peters, R.H. & Matthews, C.O. (2002). Jail Treatment for Drug Abusers. In: Leukefeld, C.G., Tims, F.M. & Farabee, D.F., eds. Treat of Drug Offenders: Policies and Issues. New York: Springer Publishing Company, 2002. pp. 186–203.

Reuland, M. & Cheney, J. (2005). Enhancing Success of Police-Based Diversion Programs for People with Mental Illness. Delmar, New York: GAINS Technical Assistance and Policy Analysis Center for Jail Diversion.

Sacks, S., Sacks, J., McKendrick, K., Banks, S., & Stommel, J. (2004). Modified therapeutic community for MICA offenders. Crime outcomes. *Behavioral Sciences and the Law* 22:477-501.

Steadman, H.J. & Veysey B. (1997). Providing Services for Jail Inmates with Mental Disorders, National Institute of Justice: Research in Brief, January.

Substance Abuse and Mental Health Services Administration (2003). Co-Occurring Disorders: Integrated Dual Disorders Treatment: Implementation Resource Kit. Rockville, Maryland: Center for Mental Health Services.

Substance Abuse and Mental Health Services Administration (2004) Results from the 2003 National Survey on Drug Use and Health: National Findings. Rockville, MD: Office of Applied Studies.

Sequential Intercept Mapping & Taking Action for Change

Appendix H: Addressing Histories of Trauma and Victimization through Treatment

Policy Research Associates


Policy Research Associates

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

Addressing Histories of Trauma and Victimization through Treatment

4 of 8

SAMHSA Substance Abuse and Mental Health Services Administration

Colleen Clark, PhD

September 2002

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

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

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

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

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

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

Trauma-Sensitive Treatment

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

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

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

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

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

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

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

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

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

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

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

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

Identifying Trauma

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

Trauma-Specific Service Planning and Program Development

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

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

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

Trauma-Specific Therapies and Treatment Approaches

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

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

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

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

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

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

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

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

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

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

Re-entry

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

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

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

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

Promising program…

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

For more information: rie@wwa.com

Tools & Resources

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

* Sample screening forms available upon request.

References

American Correctional Association. (1990). *The Female Offender: What Does the Future Hold?* Washington, DC: St. Mary's Press.

Alexander, M.J. (1996). Women with co-occurring addictive and mental disorders: An emerging profile of vulnerability. *American Journal of Orthopsychiatry*, 66(1): 61-70.

Beck, A.J. & Karberg, J.C. (2001) *Prison and Jail Inmates at Midyear 2000*. Washington D.C.: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics.

Bureau of Justice Statistics (2001) *National Correctional Population Reaches New High: grows by 117,400 during 2000 to Total 6.5 Million Adults* Washington DC: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics.

Bloom, B. and Owen, B, 2002 *Gender-Responsive Strategies: Research, Practice, and Guiding Principles for Women Offenders*. U.S. Department of Justice, National Institute of Corrections. (In press.)

Brady, K.T., Dansky, B.S., Back, S.E., Carroll, K.M. & Foa, E.F. (2001). Exposure therapy in the treatment of PTSD among cocaine-dependent individuals: Preliminary findings. *Journal of Substance Abuse Treatment*. (In press.)

Chesney-Lind, M. (2000) Women and the criminal justice system: Gender matters. *Topics in Community Corrections* 5: 7-10.

Fearday, F., Clark, C., Martin, C.L. & Rich, A. (2001) *Routine Inquiry for Violence in the Lives of Homeless Mothers.* Unpublished.

Galbraith, S. (1998). *And So I Began to Listen to Their Stories: Working with Women in the Criminal Justice System.* Delmar, NY: The National GAINS Center for People with Co-occurring Disorders in the Justice System.

Harris, M. (1998). T.R.E.M. *Trauma Recovery and Empowerment: A Clinician's Guide for Working with Women in Groups*. New York: The Free Press.

Maine Trauma Advisory Groups Report (1997). Maine Department of Mental Health, Mental Retardation and Substance Abuse Service, Office of Trauma Services.

Navajits, L.M. (2002). *Seeking Safety: A Treatment Manual for PTSD and Substance Abuse*. New York: Guilford Press.

Norman, J. (2000). Constructive narrative in arresting the impact of post-traumatic stress disorder. *Clinical Social Work Journal* 28: 303-319.

Salasin, S. (2000). SAMHSA Women, Co-Occurring Disorder and Violence KDA Study. Slides (unpublished).

Teplin, L.A. (2001). Personal Communication.

Teplin, L.A., Abram, K.M., McClelland, G.M. (1996). Prevalence of psychiatric disorders among incarcerated women: 1 Pretrial jail detainees. *Archives of General Psychiatry* 53: 505-512

The TAMAR Project. Gillece, J. (1998). SAMHSA Women, Co-Occurring Disorders and Violence KDA Study. Maryland Department of Mental Health and Mental Hygiene.

Trauma Initiative Design Center (1998). *Trauma Assessment & Treatment Resource Book*. Albany, NY: New York State Office of Mental Health.

Triad Women's Project (2000). *Group Facilitator's Manual*, Triad Women's Project Clinical Interventions Committee.

Triffleman, E., Carroll K., & Kellogg, S. (1999). Substance dependence post-traumatic stress disorder therapy: An integrated cognitive-behavioral approach. *Journal of Substance Abuse Treatment*, 17(1/2): 3-14.

Veysey, B., De Cou, K., & Prescott, L. (1998). Effective management of female jail detainees with histories of physical and sexual abuse *American Jails* (May/June: 50-54).

The suggested citation for this article is Clark, C. (2002). Addressing Histories of Trauma and Victimization in Treatment. In Davidson, S. and Hills, H. (eds.) *Series on Women with Mental Illness and Co-Occurring Disorders*. 4. Delmar, NY: National GAINS Center.

The National GAINS Center for People with Co-Occurring Disorders in the Justice System is a national center for the collection and dissemination of information about effective mental health and substance abuse services for people with co-occurring disorders who come in contact with the justice system. The GAINS Center is funded by two centers of the Substance Abuse and Mental Health Services Administration—the Center for Substance Abuse Treatment (CSAT) and the Center for Mental Health Services (CMHS)—and works in partnership with these agencies as well as the National Institute of Corrections, the Office of Justice Programs and the Office of Juvenile Justice and Delinquency Prevention.

To obtain additional copies of this document, visit our website at: gainscenter.samhsa.gov or contact the National GAINS Center at (800) 311-4246.

The GAINS Center
Policy Research Associates, Inc.
345 Delaware Avenue
Delmar, New York 12054
(800) 311-GAIN
(518) 439-7612 (fax)
E-mail: *gains@prainc.com*

Sequential Intercept Mapping & Taking Action for Change

Appendix I: Extending Assertive Community Treatment to Criminal Justice Settings

Policy Research Associates


Policy Research Associates

Extending Assertive Community Treatment to Criminal Justice Settings

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

CMHS National GAINS Center May 2006 *Updated August 2008*

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

Evidence-Base for ACT

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

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

FACT Adaptations

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

Can ICM Substitute for ACT?

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

FACT Evidence-Base

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

FICM Evidence-Base

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

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

[1] Cecil G. Sheps Center for Health Services Research ◆ University of North Carolina at Chapel Hill

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

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

Conclusions

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

References

Bond, G.R., Drake, R.E., Mueser, K.T., & Latimer, E. (2001). Assertive community treatment: Critical ingredients and impact on patients. *Disease Management and Health Outcomes, 9*(3), 141-159.

Broner, N., Lattimore, P.K., Cowell, A.J., & Schlenger, W.E. (2004). Effects of diversion on adults with co-occurring mental illness and substance use: outcomes from a national multi-site study. *Behavioral Sciences & the Law, 22*(4), 519-541.

Cosden, M., Ellens, J.K., Schnell, J.L., Yamini Diouf, Y., & Wolfe, M.M. (2003). Evaluation of a mental health treatment court with assertive community treatment. *Behavioral Sciences and the Law, 21*(4), 415-427.

Cuddeback, G.S., Morrissey, J.P., & Cusack, K.J. (2008). How many forensic assertive community treatment teams do we need? *Psychiatric Services*, 59(2), 205-208.

Dixon, L. (2000). Assertive community treatment: Twenty-five years of gold. *Psychiatric Services, 51*(6), 759-765.

Godley, S.H., Finch, M., Dougan,L., McDonnell, M., McDermeit, M., & Carey, A. (2000). Case management for dually diagnosed individuals involved in the criminal justice system. *Journal of Substance Abuse Treatment, 18*(2), 137-148.

Lamberti, J.S., Weisman, R., & Faden, D.I. (2004). Forensic assertive community treatment: Preventing incarceration of adults with severe mental illness. *Psychiatric Services, 55*(11), 1285-1293.

Lamberti, J.S., Weisman, R.L., Schwarzkopf, S.B., Price, N., Ashton, R.M., & Trompeter, J. (2001). The mentally ill in jails and prisons: Towards an integrated model of prevention. *Psychiatric Quarterly, 72*(1), 63-77.

LewinGroup. (2000). *Assertive community treatment literature review*. Falls Church, VA: Lewin Group

Marshall, A., Gray, A., Lockwood, A, Green R. (1998). Case management for people with severe mental disorders. *The Cochrane Database of Systematic Reviews* Issue 2, Art. No.: CD000050.

Marshall, A., & Lockwood, A. (2004) Assertive community treatment for people with severe mental disorders (Cochrane Review). In: *The Cochrane Library*. Issue 3. Chichester, UK: Wiley.

McCoy, M.L., Roberts, D.L., Hanrahan, P., Clay, R., & Luchins, D.J. (2004). Jail linkage assertive community treatment services for individuals with mental illnesses. *Psychiatric Rehabilitation Journal, 27*(3), 243-250.

Morrissey, J., Meyer, P., & Cuddeback, G. (2007). Extending assertive community treatment to criminal justice settings: Origins, current evidence, and future directions. *Community Mental Health Journal, 43*(5), 527-544.

Phillips, S.D., Burns, B.J., Edgar, E.R., Mueser, K.T., Linkins, K.W., Rosenheck, R.A., et al. (2001). Moving assertive community treatment into standard practice. *Psychiatric Services, 52*(6), 771-779.

Rapp, C.A., & Goscha, R.J. (2004). The principles of effective case management of mental health services. *Psychiatric Rehabilitation Journal, 27*(4), 319-333.

Solomon, P., & Draine, J. (1995). One-year outcomes of a randomized trial of case-management with seriously mentally-ill clients leaving jail. *Evaluation Review, 19*(3), 256-273.

Steadman, H.J., & Naples, M. (in press). Assessing the effectiveness of jail diversion programs for persons with serious mental illness and co-occurring substance use disorders. *Behavioral Sciences and the Law*.

Stein, L.I., & Santos, A.B. (1998). *Assertive Community Treatment of Persons with Severe Mental Illness*. New York, NY: W. W. Norton and Co., Inc.

Weisman, R.L., Lamberti, J.S., & Price, N. (2004). Integrating criminal justice, community healthcare, and support services for adults with severe mental disorders. *Psychiatric Quarterly, 75*(1), 71-85.

Wilson, D., Tien, G., & Eaves, D. (1995). Increasing the community tenure of mentally disordered offenders: An assertive case management program. *International Journal of Law and Psychiatry, 18*(1), 61-69.

Ziguras, S., & Stuart G. (2000) A meta-analysis of the effectiveness of mental health case management over 20 years. *Psychiatric Services* 51(11): 1410-1415.

Acknowledgements: *Work on this paper was supported by the GAINS Center and by the John D. and Catherine T. MacArthur Foundation Mental Health Policy Research Network. The helpful comments of Fred Osher, Kim Mueser, and Robert Drake on an early version of this paper are gratefully acknowledged. Special thanks are due to the attendees of the GAINS Center's Expert Panel Meeting on Assertive Community Treatment held in Bethesda, MD, February 18, 2005, where an early version of this paper was presented and discussed.*

Sequential Intercept Mapping & Taking Action for Change

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

Policy Research Associates


Policy Research Associates

The EXIT Program: Engaging Diverted Individuals Through Voluntary Services

Gerald Foley[1] and Elisa Ruppel[2]

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

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

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

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

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

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

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

Participant Characteristics

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

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

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

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

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

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

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

Results

Criminal Justice Buy-In

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

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

Consumer Engagement

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

Recidivism

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

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

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

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

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

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

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

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

Discussion

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

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

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

Recommended citation: Foley, G., & Ruppel, E. (2008). *The EXIT program: Engaging diverted individuals through voluntary services.* Delmar, NY: CMHS National GAINS Center.

Sequential Intercept Mapping & Taking Action for Change

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

Policy Research Associates


Policy Research Associates

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

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

SAMHSA Substance Abuse and Mental Health Services Administration

Summer 1999/*Revised Spring 2002*

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

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

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

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

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

The Federal Guidelines on Medicaid

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

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

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

Lane County's Experience

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

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

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

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

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

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

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

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

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

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

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

The suggested citation for this fact sheet is National GAINS Center for People with Co-Occurring Disorders in the Justice System. (2001) Maintaining Medicaid Benefits for Jail Detainees with Co-Occurring Mental Health and Substance Use Disorders. Fact Sheet Series: Delmar, NY: The National GAINS Center.

Sequential Intercept Mapping & Taking Action for Change

Appendix L: SOAR: Access to Benefits Enable Successfully Reentry

Policy Research Associates


Policy Research Associates

SOAR: Access to Benefits Enables Successful Reentry

By Deborah Dennis and Daniel J. Abreu

Reentry for state prisons and jails has become a national priority. Ninety-five percent of state prisoners will eventually return to their communities, and an estimated 600,000 people return to their communities from state prison each year.[1] In addition, there are more than 12 million bookings into jail each year, with the majority of people detained less than one month.[2]

Reentry and Mental Illness

The Bureau of Justice Statistics (BJS) reports that 16 percent of people in jail have a mental illness, and a similar proportion is estimated for people in prisons.[3] Advocacy groups and federal agencies alike have addressed diversion and reentry for people with mental illness, with comprehensive reviews of barriers and thoughtful recommendations for legislation, policy change and program design.[4]

Transition or reentry services for people with mental illnesses and co-occurring substance use disorders include service linkage processes used in diversion and jail or prison reentry programs. Transition services reflect the shift of care from one system to another. They acknowledge the shared responsibilities of multiple systems to ensure continuity of care and service engagement as people move between the community and the criminal justice system.[5]

Providing transition services from jails or prisons is complex due to many factors: quick turnover of jail cases; the distance between prisons and home communities; the array of services needed to comprehensively address multiple needs; perceptions by the provider community that justice-involved people with mental ill-

ness are not responsive to services; and post-transition gaps in benefits that limit access to treatment and essential medications.

Despite the difficulty, there are compelling reasons to address transition. First, transition services are important from a public health standpoint. *The New England Journal of Medicine* reported that within the first two years of release, the death rate for those released from prison is 3.5 times higher than that of the general population.[6]

Second, poor reentry planning is costly. A study of releases from New York state prisons to shelters showed increased rearrest rates.[7] In a recent study, providing people with transition and supportive services demonstrated a 53 percent reduction in jail days and an annual cost reduction of almost $3,000 per person.[8]

Lastly, there may be an emerging liability for jails and prisons that neglect reentry planning. The Brad H. case in New York City (NYC) found that inmates with mental illness were released from the Rikers Island Jail with a MetroCard and a bag of medication.[9] The court ruled that the NYC Department of Corrections had to develop specific release plans for inmates with mental illness and ensure community linkages, which included applying for Medicaid benefits for high-need inmates.

Importance of Benefits

Key to successful transition is obtaining access to Medicaid and Social Security disability benefits. Although benefit programs provide essential funding for mental health services and medications, few states or communities have developed legislation or policy to ensure their availability for people with mental illness upon release.[10] Consequently, hundreds of thousands of people with mental illness are released each year without the ability to pay for needed health and behavioral health treatment and medications. Without medication and comprehensive services to address housing and mental health and substance abuse treatment needs, people with mental illness have a greater risk of violation and rearrest.[11]

States and communities struggle to develop timely and efficient procedures that result in access to public benefits upon release from jail or prison. Many initiatives have focused almost exclusively on access to Medicaid. While helpful, focusing on Medicaid alone has some serious limitations. First, legislation enacted in some states, including Oregon, Illinois, New York and Florida, allows for Medicaid to be suspended rather than terminated upon incarceration. Few states have fully implemented this, however, and the full impact of this legislation has not yet been demonstrated.[12] Second, most people with mental illness are not receiving benefits upon incarceration,[13] so Medicaid suspension does not help them. Few communities have developed procedures to process new Medicaid applications prior to release.[14] Finally, Medicaid provides only medical benefits and does not address the need for basic subsistence or housing.

In contrast, the Social Security Administration (SSA)'s Supplemental Security Income (SSI) program is automatically accompanied by federal Medicaid benefits in most states.[15] SSI provides a monthly payment that can be used to provide for basic needs and to access many subsidized housing programs. Housing is critical for justice-involved people with mental illness. BJS reports that inmates with mental illness are more than twice as likely to be homeless in the 12 months prior to arrest than inmates without mental illness.[16] Shelter use, both before and after prison, is associated with increased risk of return to prison.[17] Thus, housing is key to successful reentry, and for people with mental illness leaving jail or prison, SSI is key to accessing housing.

SSI focuses limited local and state resources on people with the highest needs and on people who utilize a disproportionate amount of unreimbursed services in the community. For example, a study in Rhode Island found that 48 "high utilizers" used almost $32,000 per year of services. Once provided with supportive housing and case management, costs for services were reduced by $8,800 per person per year.[18] Without SSI in place upon release, many prison and jail detainees with mental illness are destined to be homeless for extended periods and to face delays in treatment because of inability to pay.

The process of applying for SSI, however, can be difficult. This is particularly true for people with mental illness or co-occurring substance use disorders. Recently, best practices have emerged to address the complexity and challenges inherent in the SSI application process, and specific programs have begun to show consistent success in access to SSI upon release.[19]

SSI focuses limited local and state resources on people with the highest needs and on people who utilize a disproportionate amount of unreimbursed services in the community.

The SOAR Initiative

The SSI/Social Security Disability Insurance (SSDI) Outreach, Access and Recovery (SOAR) initiative evolved to address the difficulties associated with applying for SSI for people who are homeless. Funded by the federal Substance Abuse and Mental Health Services Administration, SOAR provides technical assistance to help states and communities increase access to SSI/SSDI for adults with disabilities who are homeless. The initiative is based on an SSA demonstration project for people experiencing homelessness in Baltimore, through which 96 percent of individuals identified as eligible received approval upon initial application. SOAR, currently implemented in 34 states, combines strategic planning among key players; training of case managers and others to complete SSI applications using a specific approach; and follow-up technical assistance to address challenges along the way.

In 2009, 32 states in the SOAR program reported that 71 percent of 4,386 initial applications were approved in an average of 89 days.[20] These results stand in stark contrast to the estimated approval rate of 10 to 15 percent for people who are homeless and the approval rate of 37 percent for all people who apply for SSI. There are limited, but positive, indications that SSI approval leads to quicker placement in housing. In Atlanta, all people approved for SSI through SOAR were placed in housing after being homeless for an average of three years. SSI applicants assisted in Nashville, Tenn., homeless for an average of seven years, found housing within 40 days after receiving benefits.

Application of SOAR to criminal justice settings. Some states and communities have developed prerelease agreements with SSA that allow submission of SSI applications prior to release from prison, and there is early evidence that the SOAR approach can be generalized to jail and prison settings with results equal to those seen in community settings. Implementing SOAR in jail and prison settings requires partnerships with community providers, including SSA and community mental health providers; training for jail/prison staff on sharing of information and improving procedures for acquiring preprison medical evidence; and translating prison functioning as it relates to ability to work in the community.

SSI outreach in prison. In New York, the Center for Urban and Community Services (CUCS) was funded to coordinate the entitlement process for people with serious mental illness exiting Sing Sing Prison. Beginning in 2005, CUCS piloted the SOAR approach and currently has an approval rate of 88 percent on initial applications in 59 days on average.[21] In Oklahoma, the departments of correction and mental health collaborated to initiate SSI applications using SOAR-trained staff. According to Randy May of the Oklahoma Department of Mental Health, approval rates approached 90 percent. In both New York and Oklahoma, adaptations to the SOAR approach and curriculum[22] were required to successfully implement prison-based SOAR initiatives.

SSI outreach in jail. The SOAR approach has also been used in jails. The Miami-Dade County jail diversion program is using SOAR-trained staff to assist inmates to apply for SSI. Most individuals entering the program were homeless at the time of arrest, and more than 70 percent have co-occurring substance use disorders. Roughly 85 percent of program participants are diagnosed with schizophrenia or another psychotic disorder. With 146 SSI decisions received thus far, the Miami-Dade County SOAR initiative has an application approval rate of 84 percent in 61 days on average. The SOAR program is credited with relieving crowding in the county jail as well as providing immediate access to safe housing with the necessary treatment and wraparound services. According to Cindy Schwartz of the Miami-Dade jail diversion program, early results show recidivism decreasing from 70 to 22 percent.

Using SOAR to make the outcomes of SSI applications more predictable, the Miami-Dade jail diversion program leveraged pending SSI and Medicaid benefits to advance county dollars for housing and medications. The expectation is that upon approval of SSI and receipt of Medicaid (both of which are retroactive to date of filing or date of release from incarceration), the funds could be reimbursed for use with other program participants. The individual consumer has the benefit of immediate access to housing upon admission to the jail diversion program and release from jail. In Miami, this strategy is an effective and cost-efficient way to improve the transition of individuals from the criminal justice system to the community.

In Atlanta, judges frequently require housing and treatment options to be in place before people with mental illness are released from the Fulton County Jail. Thus, many people arrested primarily on misdemeanors spend unnecessarily long periods of time in jail waiting for mental health assessments and post-release housing and treatment linkages. Working with the public defender's office, the chief jailer and the local Social Security office, the Georgia state SOAR team leader helped to establish a prerelease procedure that includes SOAR assistance with SSI applications. Members of the SOAR team were given security clearance and access badges for the Fulton County Jail to conduct assessments and work on SSI applications on the units. Though a fairly new pilot, the SOAR Fulton County Jail project, according to former Georgia state SOAR team leader Kristin Lupfer, has already secured benefits for people almost immediately upon release.

Case Study[23]

A.D. is a 22-year-old single male who was diagnosed with paranoid schizophrenia at age 18. He was raised in a low-income neighborhood with limited resources amidst family turmoil. His mental health began to deteriorate but went largely untreated and undiagnosed until he was involuntarily committed in 2005 with an acute exacerbation of symptoms, including delusions and psychosis. A.D. dropped out of school in the ninth grade and for the next three years was in and out of crisis units. His family lacked the economic resources and health care benefits to access treatment and services. They could not afford medications and did not know where to go or whom to ask for help.

In 2008, A.D. was arrested for aggravated assault after becoming irate, throwing a large rock at his mother and yelling, "Next time I will kill you." He spent the next 20 days in jail where the chief psychiatrist contacted the Miami-Dade jail diversion program. Program staff interviewed A.D. in jail several times until he agreed to a voluntary psychiatric hospitalization. The jail diversion team immediately began requesting records from previous hospitalizations and compiled a complete application for SSA disability benefits utilizing the SOAR model. His SSI application was approved in four days. Upon discharge from the hospital, A.D.'s housing and medication were paid for by county "gap" funds until he got his Medicaid card and started receiving SSI checks.

Today, A.D. has a positive outlook on life that he attributes to the people who helped him obtain benefits and housing when he got out of prison. He lives in what he describes as a "shockingly beautiful" home in a middle-class neighborhood where he has his own private room. A.D. has not been hospitalized and has not been arrested since reentry. He has achieved a level of recovery that enables him to help others as a volunteer at a nearby

outpatient clinic where he also receives treatment and support services.

Conclusion

People with mental illness face extraordinary barriers to successful reentry. Without access to benefits, they lack the funds to pay for essential mental health and related services, such as medication, and they frequently face long waiting lists before being able to access care. They cannot access supportive housing and, without family, frequently become homeless upon release.

Acquiring benefits is essential to the success of any reentry plan. The SOAR approach has been implemented in more than 34 states, and there is programmatic evidence that the approach is transferable to correctional settings. The SOAR Technical Assistance Center is positioned to assist new states and communities wherever there is the commitment to implement the SOAR approach. Acquiring Social Security and Medicaid benefits provides the foundation for the reentry plans to succeed. For more information about implementing SOAR in your jurisdiction, contact the SOAR Center at soar@prainc.com.

ENDNOTES

[1] Hughes, T. and D.J. Wilson. 2003. *Reentry trends in the United States*. Washington, D.C.: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics.

[2] Sabol, William J. and H. Couture. 2007. *Prison and jail inmates at midyear 2006*. Washington, D.C.: U.S. Department of Justice, Bureau of Justice Statistics.

[3] Ditton, P.M. 1999. *Mental health and treatment of inmates and probationers*. Washington, D.C.: United States Department of Justice, Office of Justice Programs.

[4] New Freedom Commission on Mental Health. 2004. *Subcommittee on criminal justice: Background paper*. Rockville, Md.: Department of Health and Human Services. Pub. No. SMA-04-3880; Council of State Governments. 2002. *Criminal justice/mental health consensus project*. New York: Council of State Governments; Bazelon Center for Mental Health Law. 2009. *Lifelines: Linking to federal benefits for people exiting corrections*. Available at www.bazelon.org/issues/criminalization/publications/Lifelines/Lifelines.htm; Osher, F., H. J. Steadman and H. Barr. 2002. *A best practice approach to community re-entry from jails for inmates with co-occurring disorders: The APIC model*. Delmar, N.Y.: The National GAINS Center.

[5] Osher, F., H. J. Steadman and H. Barr. 2002.

[6] Binswanger, I.A., M.F. Stern, R.A. Deyo, et al. 2007. Release from prison — A high risk of death for former inmates. *The New England Journal of Medicine*, 356 (2): 157-165.

[7] Metraux, S., D. Culhane and T. Hadley. 2001. *The New York/New York agreement cost study: The impact of supportive housing on services use for homeless people with mental illness in New York City*. Philadelphia, Pa.: Center for Mental Health Policy and Services Research, University of Pennsylvania.

[8] Corporation for Supportive Housing. 2009. *Getting out with nowhere to go: The case for supportive reentry housing*. New York: Corporation for Supportive Housing. Available at www.csh.org.

[9] *Brad H. et al. v. The City of New York et al.* 2003. Stipulation of Settlement of the Supreme Court of the State of New York. Jan. 8.

[10] Council of State Governments. 2005. *Report of the Re-Entry Policy Council: Charting the safe and successful return of prisoners to the community*. New York: CSG Reentry Policy Council.

[11] Porporino, F. 1995. The prison careers of mentally disordered offenders. *International Journal of Law and Psychiatry*, 18(1):29-44.

[12] Bazelon Center for Mental Health Law. 2009.

[13] Ditton, P.M. 1999.

[14] Council of State Governments. 2002.

[15] In 11 states, known as 209(b) states, the state uses at least one criterion that is more restrictive than the SSI program's criteria for determining eligibility for Medicaid. The 11 states are: Connecticut, Hawaii, Illinois, Indiana, Minnesota, Missouri, New Hampshire, North Dakota, Ohio, Oklahoma and Virginia.

[16] Ditton, P.M. 1999.

[17] Metraux, S., D. Culhane and T. Hadley. 2001.

[18] Hirsch, E. and I. Glasser. 2007. *Housing first program first year evaluation*. Providence, R.I.: State of Rhode Island and the United Way of Rhode Island.

[19] Dennis, D., Y. Perret, A. Seaman and S. Wells. 2007 *Expediting access to SSA disability benefits: Promising practices for people who are homeless*. Delmar, N.Y.: Policy Research Associates, Inc. Available at www.prainc.com/soar/soar101/PromisingPractices.pdf.

[20] SOAR Outcomes. 2009. Available at www.prainc.com/soar101/pdfs/SOAROutcomes2009.pdf.

[21] SOAR Outcomes. 2009.

[22] Perret, Y. and D. Dennis. 2006. *Stepping stones to recovery: A training curriculum for case managers assisting adults who are homeless with SSA disability and supplemental security income applications, participant guide*. Rockville, Md.: SAMHSA.

[23] Personal communication. Oct. 27, 2009. Cindy Schwartz, Miami-Dade jail diversion program.

Deborah Dennis is vice president of Policy Research Associates Inc. Daniel J. Abreu is associate director of the National GAINS Center.

Sequential Intercept Mapping & Taking Action for Change

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

Policy Research Associates


Policy Research Associates

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

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

The CMHS National GAINS Center May, 2008

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

What Is Peer Support?

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

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

What Do Forensic Peer Specialists Do?

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

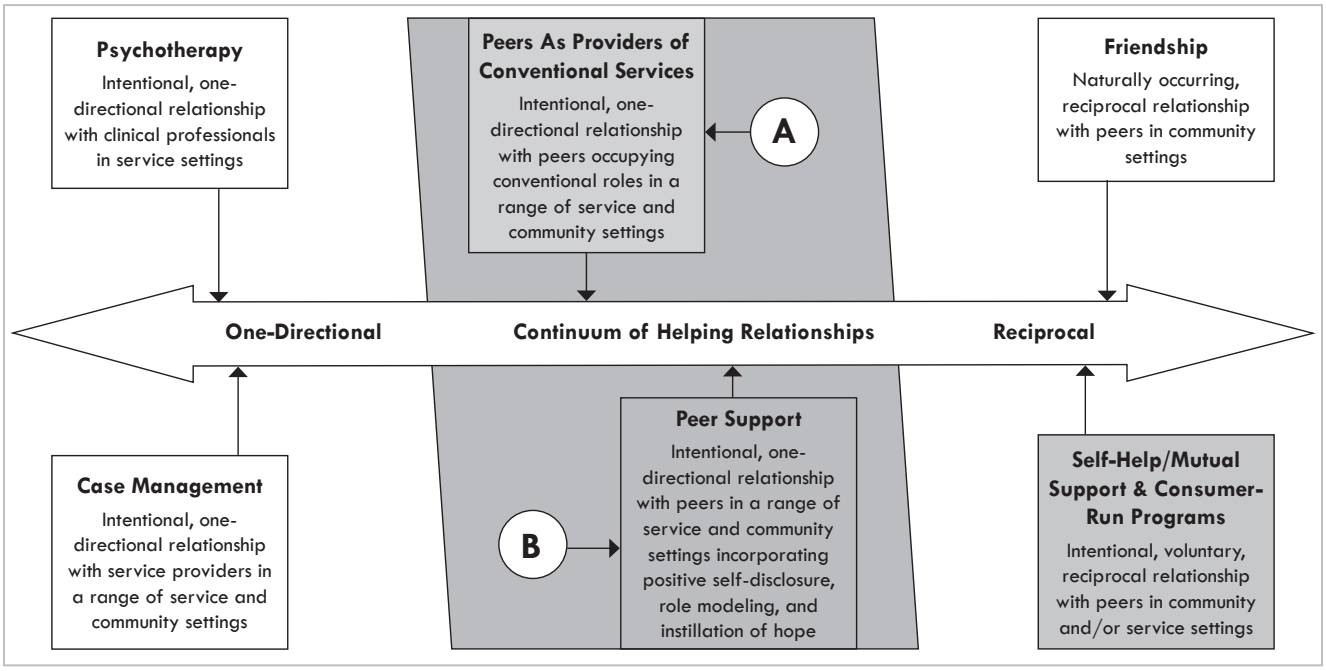


Figure 1. A Continuum of Helping Relationships

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

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

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

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

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

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

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

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

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

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

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

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

local and state departments of health, and the judiciary.

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

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

Future Directions

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

Resources

Davidson, L., Chinman, M., Kloos, B., Weingarten, R., Stayner, D. & Tebes, J.K. (1999). Peer support among individuals with severe mental illness: A review of the evidence. *Clinical Psychology: Science and Practice*, 6: 165-187.

Davidson, L., Chinman, M., Sells, D. & Rowe, M. (2006). Peer support among adults with serious mental illness: A report from the field. *Schizophrenia Bulletin,* 32: 443-450.

Felton, C.J., Stastny, P., Shern, D., Blanch, A., Donahue, S.A., Knight, E., & Brown, C. (1995). Consumers as peer specialists on intensive case management teams: Impact on client outcomes. *Psychiatric Services,* 46: 1037-1044.

Lyons, J.S., Cook, J.A., Ruth, A.R., Karver, M., & Slagg, N.B. (1996). Service delivery using consumer staff in a mobile crisis assessment program. *Community Mental Health Journal,* 32: 33-40.

Mowbray, C.T., Moxley, D.P., Thrasher, S., Bybee, D., McCrohan, N., Harris, S., & Glover, G. (1996). Consumers as community support providers: Issues created by role innovation. *Community Mental Health Journal,* 32: 47-67.

Rowe, M., Bellamy, C., Baranoski, M., Wieland, W., O'Connell, M., Benedict, P., Davidson, L., Buchanan, J. & Sells, D. (2007). Reducing alcohol use, drug use, and criminality among persons with severe mental illness: Outcomes of a Group- and Peer-Based Intervention. *Psychiatric Services,* 58(7): 955-961.

Sells, D., Davidson, L., Jewell, C., Falzer, P., & Rowe, M. (2006). The treatment relationship in peer-based and regular case management services for clients with severe mental illness. *Psychiatric Services,* 57(8): 1179-1184.

Sherman, P.S., & Porter, R. (1991). Mental health consumers as case management aides. *Hospital and Community Psychiatry,* 42:494-498.

Solomon, P.S. (2004). Peer support/peer provided services: Underlying processes, benefits, and critical ingredients. *Psychiatric Rehabilitation Journal,* 27(4): 392-401.

Solomon, P.S., & Draine, J. (1995). The efficacy of a consumer case management team: Two year outcomes of a randomized trial. *Journal of Mental Health Administration,* 22:135-146.

Solomon, P.S., Draine, J., & Delaney, M.A. (1995). The working alliance and consumer case management. *Journal of Mental Health Administration,* 22:126-134.

Stoneking, B.C., & Greenfield, T. (1991). *Adding trained consumers to case management teams as service coordinators*. Paper presented at the Annual Meeting of the American Public Health Association, Atlanta, Georgia.

Recommended citation: Davidson, L., & Rowe, M. (2008). *Peer support within criminal justice settings: The role of forensic peer specialists*. Delmar, NY: CMHS National GAINS Center.

Sequential Intercept Mapping & Taking Action for Change

Appendix N: Overcoming Legal Impediments To Hiring Forensic Peer Specialists

Policy Research Associates


Policy Research Associates

Overcoming Legal Impediments to Hiring Forensic Peer Specialists

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

The CMHS National GAINS Center May, 2008

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

Impediments

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

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

Employment Laws

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

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

Public Information

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

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

Current Legal Status

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

1. Director, Howie T. Harp Peer Advocacy Center ◆ 2090 Adam Clayton Powell Boulevard ◆ New York, NY 10027
2. Director of Training, Policy Research Associates, Inc. ◆ 345 Delaware Avenue ◆ Delmar, NY 12054

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

Avoiding Impediments

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

Awareness of Employment Laws

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

Preparing for Employment.

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

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

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

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

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

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

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

Glossary

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

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

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

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

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

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

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

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

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

Future Directions

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

Resource

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

Recommended citation: Miller, L.D., & Massaro, J. (2008). *Overcoming legal impediments to hiring forensic peer specialists*. Delmar, NY: CMHS National GAINS Center.

Sequential Intercept Mapping & Taking Action for Change

Appendix O: Supported Employment

Policy Research Associates


Policy Research Associates

Supported Employment

William Anthony, PhD[1]

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

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

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

Supported Employment as an Evidence Based Program

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

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

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

Supported Employment Applications to Criminal Justice System Clients

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

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

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

[1] Professor/Director Center for Psychiatric Rehabilitation ◆ Boston University ◆ 940 Commonwealth Avenue West ◆ Boston, MA 02215

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

Suggestion for Practice

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

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

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

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

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

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

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

References

Anthony, W. A., & Blanch, A. (1987). Supported employment for persons who are psychiatrically disabled: An historical and conceptual perspective. *Psychosocial Rehabilitation Journal, 11*(2), 5-23.

Anthony, W. A., Cohen, M. R., Farkas, M. D., & Gagne, C. (2002). *Psychiatric rehabilitation* (2nd ed.). Boston, MA: Boston University, Center for Psychiatric Rehabilitation.

Bond, G. R. (2004). Supported employment: Evidence for an evidence-based practice. In R. Ancill (Ed.) *Exploring the Spectrum of Psychosis*. New York: Wiley & Sons.

Cook, J. A., Leff, H. S., Blyler, C. R., Gold P. B., Goldberg, R. W., Mueser, K. T., et al. (2005a). Results of a multisite randomized trial of supported employment interventions for individuals with severe mental illness. *Archives of General Psychiatry* (62), 505-512.

Cook, J. A., Lehman, A., Drake, R., et al. (2005b). Integration of psychiatric and vocational services: A multi-site randomized implementation effectiveness trial of supported employment," *American Journal of Psychiatry, 162*, 1948-1956.

Legal Action Center. (2004). After prison: Roadblocks to reentry: A report on state legal barriers facing people with criminal records. www.lac.org/roadblocks.html.

Massaro, J. (2004). Working with people with mental illness involved in the criminal justice system: What mental health service providers need to know. Delmar, NY: National Gains Technical Assistance and Policy Analysis Center for Jail Diversion.

Sequential Intercept Mapping & Taking Action for Change

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

Policy Research Associates


Policy Research Associates

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

Caterina Gouvis Roman[1]

The CMHS National GAINS Center

May 2006, *Updated May 2009*

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

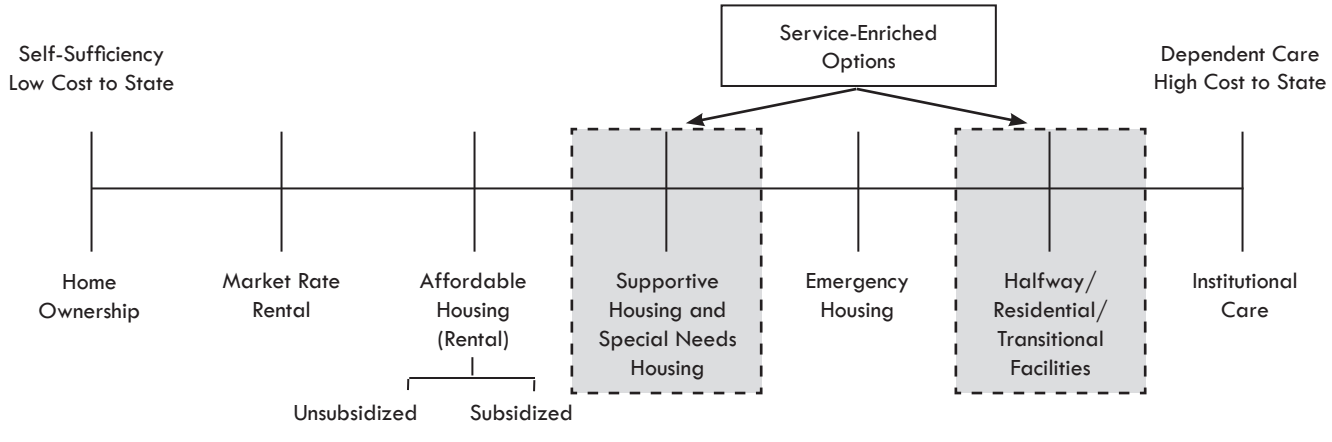
The reentry population may have differing needs than individuals with mental illness who have *not* had contact with the justice system. The *type* of criminal justice contact can play an important role in determining the best housing options for consumers as well. Persons returning from prisons and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

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

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

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

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



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

[1]Senior Research Associate ◆ Justice Policy Center, The Urban Institute ◆ 2100 M Street NW ◆ Washington, DC 20037

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

References

Brekke, J.S., C. Prindle, S.W. Bae, & J.D. Long. 2001. Risks for individuals with schizophrenia who are living in the community. *Psychiatric Services 52*(10): 1358-1366.

Burt, M.R. & J. Anderson. 2005. AB2034 Program Experiences in Housing Homeless People with Serious Mental Illness. Oakland, CA: Corporation for Supportive Housing. Retrieved January 25, 2006 (http://documents.csh.org/documents /ca/csh_ab2034.pdf).

Clark, R.E., S.K. Ricketts, G.J. McHugo. 1999. Legal system involvement and costs for persons in treatment for severe mental illness and substance use disorders. *Psychiatric Services 50*: 641-647.

Corporation for Supportive Housing. 2007. Illinois demonstration program for frequent users of jail, shelter, and mental health services. Chicago: Corporation for Supportive Housing.

Malone, D. K. 2009. Assessing criminal history as a predictor of future housing success for homeless adults with behavioral health disorders. *Psychiatric Services 60*: 224-230.

Mayberg, S.W. 2003. *Effectiveness of Integrated Services for Homeless Adults with Serious Mental Illness*. A Report to the Legislature. Sacramento, CA: California Department of Mental Health.

Metraux, S. & D.P. Culhane 2004. Homeless shelter use and reincarceration following prison release. *Criminology and Public Policy 3*(2):139-160.

Sequential Intercept Mapping & Taking Action for Change

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

Policy Research Associates


Policy Research Associates

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

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

August 2008

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

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

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

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

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

Combat Veterans, Trauma, and the Criminal Justice System Forum

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

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

Recommendations for Screening and Service Engagement Strategies

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

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

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

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

Did you ever serve in the National Guard or Reserves?

Yes
No

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

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

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

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

When were you last discharged?
- Month
- Year

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Background

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

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

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

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

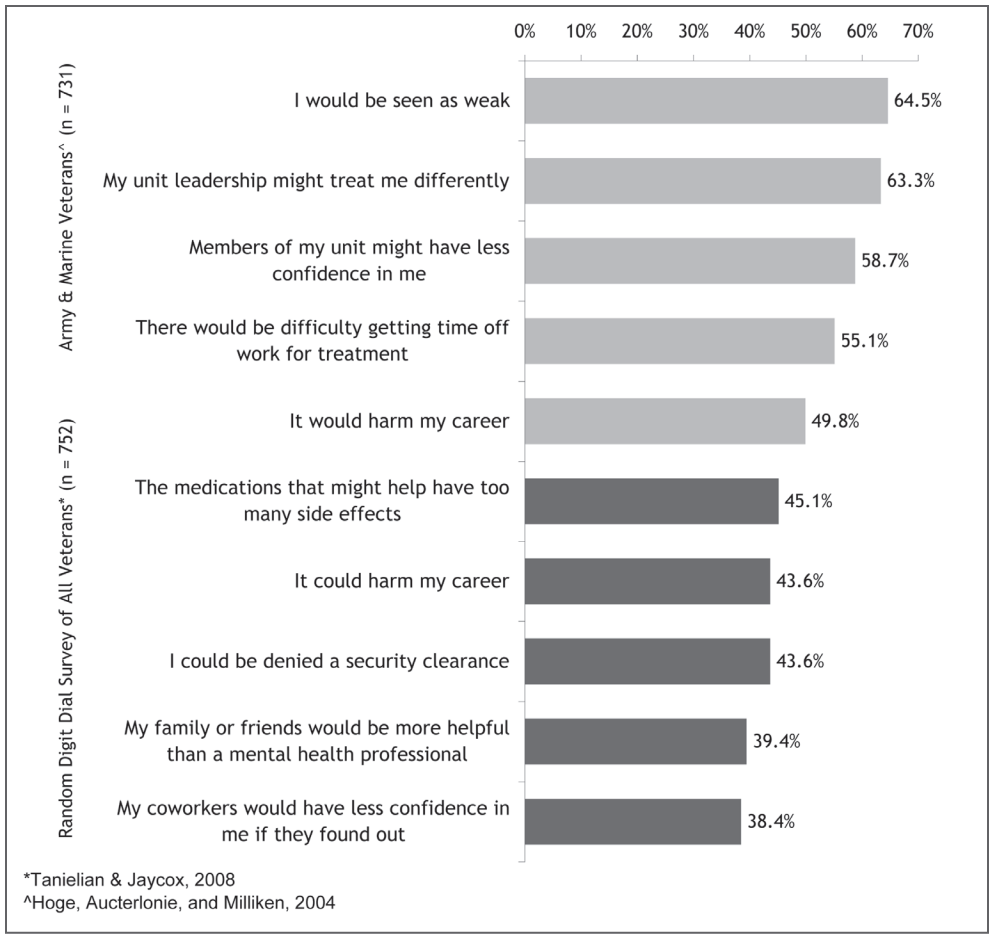


Figure 2. Most Reported Barriers to Care from Two Surveys of Individuals Who Served in OEF/OIF & Who Met Criteria for a Mental Health Condition

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

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

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

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

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

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

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

Justice System Involvement Among Veterans

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

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

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

Conclusion

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

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

References

Bureau of Justice Statistics. (2006). *Survey of inmates in local jails, 2002*. ICPSR04359-v2. Ann Arbor, MI: Inter-University Consortium for Political and Social Research.

Congressional Research Service. (2008). *CRS report for Congress: National Guard personnel and deployments: Fact sheet*. Washington, DC: Library of Congress, Congressional Research Service.

Davidson, L. & Rowe, M. (2008). *Peer support within criminal justice settings: The role of forensic peer specialists*. Delmar, NY: CMHS National GAINS Center.

Greenberg, G. & Rosenheck, R. (2008). Jail incarceration, homelessness, and mental health: A national study. *Psychiatric Services*, *59*, 170-177.

Hoge, C.W., Castro, C.A., Messer, S.C., McGurk, D., Cotting, D.I., & Koffman, R.L. (2004). Combat duty in Iraq and Afghanistan, mental health problems, and barriers to care. *New England Journal of Medicine, 351*, 13-22.

Mcguire, J., Rosenheck, R.A., & Kasprow, W.J. (2003). Health status, service use, and costs among veterans receiving outreach services in jail or community settings. *Psychiatric Services, 42,* 201-207.

Mental Health Advisory Team Five. (2008). *Operation Iraqi Freedom 06-08: Iraq and Operation Enduring Freedom 08: Afghanistan*. Washington, DC: U.S. Army Medical Command, Office of the Surgeon General. Available from: http://www.armymedicine.army.mil/news/mhat/mhat_v/mhat-v.cfm

Miles, D. (2008, May 1). Gates works to reduce mental health stigma. *American Forces Press Service*. Available from: http://www.defenselink.mil/news/newsarticle.aspx?id=49738

Milliken, C.S., Auchterlonie, J.L., & Hoge, C.W. (2007). Longitudinal assessment of mental health problems among active and reserve component soldiers returning from the Iraq war. *Journal of the American Medical Association, 298*, 2141-2148.

Nash, W.P. (n.d.). *PTSD 101: Medical issues: Combat stress injuries*. White River Junction, VT: National Center for PTSD. Available from: http://www.ncptsd.va.gov/ptsd101/modules/nash_combat_stress.html

National Center for PTSD. (n.d.) *Epidemiogical facts about PTSD*. White River Junction, VT: Author. Available from: http://www.ncptsd.va.gov/ncmain/ncdocs/fact_shts/fs_epidemiological.html

National Center for PTSD. (2007). *PTSD Information Center*. White River Junction, VT: Author. Available from: http://www.ncptsd.va.gov/ncmain/information/

National Commission on the National Guard and Reserves. (2007). *Second report to Congress*. Arlington, VA: Author.

Noonan, M. & Mumola, C. (2007). *Veterans in state and federal prison, 2004*. Washington, DC: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics.

Saxon, A.J., Davis, T.M., Sloan, K.L., McKnight, K.M., McFall, M.E., & Kivlahan, D.R. (2001). Trauma, symptoms of posttraumatic stress disorder, and associated problems among incarcerated veterans. *Psychiatric Services, 52*, 959-964.

Seal, K.H., Bertenthal, D., Maguen, S., Gima, K., Chu, A., & Marmar, C.R. (2008). Getting beyond "don't ask; don't tell": An evaluation of U.S. Veterans Administration postdeployment mental health screening of veterans returning from Iraq and Afghanistan. *American Journal of Public Health, 98,* 714-720.

Tanielian, T. & Jaycox, L.A., Eds. (2008). *Invisible wounds of war: Psychological and cognitive injuries, their consequences, and services to assist recovery.* Santa Monica, CA: RAND Center for Military Health Policy Research.

U.S. Department of Veterans Affairs. *VA healthcare eligibility and enrollment*. Accessed July 8, 2008. Available from: http://www.va.gov/healtheligibility/

Veterans Health Administration. (2008a). *Uniform mental health services in VA medical centers and clinics*. VHA Handbook 1160.1. Washington, DC: U.S. Department of Veterans Affairs, Veterans Health Administration.

Veterans Health Administration. (2008b). *Analysis of VA health care utilization among US Global War on Terrorism (GWOT) veterans: Operation Enduring Freedom Operation Iraqi Freedom (OEF/OEF)*. Washington, DC: U.S. Department of Veterans Affairs, Veterans Health Administration, Office of Public Health and Epidemiology.

Yusko, D. (2006, November 12). War's pain comes home: Veterans back from war zones sometimes carry an invisible wound—post-traumatic stress disorder. *Albany Times Union*.

Walter Reed Army Institute of Research. (2005). *Battlemind training I: Transitioning from combat to home.* Rockville, MD: Author.

Recommended citation: CMHS National GAINS Center. (2008). *Responding to the needs of justice-involved combat veterans with service-related trauma and mental health conditions: A consensus report of the CMHS National GAINS Center's Forum on Combat Veterans, Trauma, and the Justice System*. Delmar, NY: Author.

Appendix

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

May 8, 2008, Bethesda, MD

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

Richard Bebout, PhD
Community Connections
Washington, DC

Thomas Berger
Vietnam Veterans of America
Columbia, MO

Mary Blake
Center for Mental Health Services
Rockville, MD

Judith Broder, MD
Soldiers Project
Los Angeles, CA

Neal Brown
Center for Mental Health Services
Rockville, MD

Sean Clark
U.S. Department of Veterans Affairs
Washington, DC

Karla Conway
Community Alternatives
St. Louis, MO

Jim Dennis
Corrections Center of Northwest Ohio
Stryker, OH

Jim Driscoll
Vets4Vets
Tucson, AZ

Alexa Eggleston
National Council for Community Behavioral Health
Rockville, MD

Guy Gambill
Minneapolis, MN

Justin Harding
National Association of State Mental Health Program Directors
Alexandria, VA

Thomas Kirchberg, PhD
Veterans Affairs Medical Center – Memphis
Memphis, TN

Larry Lehman, MD
U.S. Department of Veterans Affairs
Washington, DC

James McGuire, PhD
U.S. Department of Veterans Affairs
Los Angeles, CA

David Morrissette, DSW
Center for Mental Health Services
Rockville, MD

Lt. Jeffry Murphy
Chicago Police Department
Chicago, IL

Fred Osher, MD
Council of State Governments Justice Center
Bethesda, MD

Matthew Randle
Vets4Vets
Tucson, AZ

Frances Randolph, DPH
Center for Mental Health Services
Rockville, MD

Maj. Cynthia Rasmussen
U.S. Army Reserve
Ft. Snelling, MN

Cheryl Reese
Educare Systems
Washington, DC

Hon. Robert Russell, Jr.
Drug Treatment Court Judge
Buffalo, NY

Susan Salasin
Center for Mental Health Services
Rockville, MD

Lt. Col. Andrew Savicky, PhD
New Jersey Department of Corrections
Glassboro, NJ

William Schlenger, PhD
Abt Associates
Bethesda, MD

Paula Schnurr, PhD
National Center for PTSD
White River Junction, VT

Elizabeth Sweet
Center for Mental Health Services
Rockville, MD

Charlie Sullivan
National CURE
Washington, DC

Sequential Intercept Mapping & Taking Action for Change

Appendix R: CIT International article, The Team News

Policy Research Associates


Policy Research Associates

THE TEAM NEWS

Official Voice of Crisis Intervention Team International

Winter/Spring 2009

More than 900 from across US attend CIT National Conference

By Donald Turnbaugh
Board Member, CIT International

The scene at the national CIT conference in Atlanta reminded one of a cross between an AARP seminar and a Bowflex distributors' convention. Parents, consumers, and providers in their 50s, 60s, and 70s mingled with officers, deputies, and troopers in their 20s, 30s, all there for the same reason.

Participants had more than 50 workshops to choose from, making selection difficult as every presentation had something to offer. The choices ranged from communicating to suicide to diversion to decriminalization, and covered juveniles to veterans.

Georgia Governor Sonny Perdue was the kickoff speaker, describing the conference as "a collaboration of professionals." He said that CIT put "public safety officers and the intersection of the mentally ill and criminal behavior." He said CIT was "good for the state," and closed by thanking conference participants for "being compassionate."

B. J. Walker, head of the Georgia Department of Human Resources, said that CIT has "changed law enforcement's face." She added she is glad to see that law enforcement officers are now "partners with families and communities."

(Award winners are listed on the last page)

Keynote speaker emphasizes the art of listening

Keynote speaker Xavier Amador, PhD, a clinical psychologist and noted author, focused on using Motivational Interviewing strategies to communicate with individuals experiencing a psychiatric crisis. Amador's approach emphasizes LEAP: Listen. Empathize. Agree. Partner.

Amador reminded the audience that in 1955, 500,000 persons with mental illness were hospitalized. By 1995, the number has dwindled to 70,000.

He said 50 percent of people with mental illnesses do not believe they are ill. This lack of insight and non-compliance is known as *anosognosia*. Despite a lack of insight about their illness, individuals in a psychiatric crisis will tell people what they want to hear in an effort to get out of a hospital or jail.

Crisis responders need to remember that families are frightened, angry and frustrated**.** Amador said. He advised conference participants to "stop confronting and start listening."

Eric Hipple, a former quarterback for the Detroit Lions and league MVP, told two compelling stories. First, he described the loss of his 15-years-old son to suicide. Second was his own story of bailing out of a car going 60-mph when he became overwhelmed by fear of an impending meeting.

At the Awards Banquet, CIT founder Sam Cochran reminded the audience of some of the key aspects of CIT: thinking outside the box; more than just training; leadership and ownership; passion and peace; and, responsibility and accountability.

In its 20th Anniversary year, CIT has arrived. The more than 900 people attending the conference were from all points of the compass. States represented were: Georgia, Tennessee, Florida, Ohio, Arizona, Illinois, Utah, Kentucky, Texas, Oklahoma, Louisiana, Maryland, New York, California, Oregon, New Jersey, Washington, Iowa, Virginia, Kansas, Massachusetts, Alaska, Maine, Pennsylvania, Colorado, Michigan, Connecticut, West Virginia, and Indiana.

Now, there are over a 1,000 programs in 39 states, Canada, Australia, and Sweden.

Memories of this conference will linger for some time. Its power was best summed-up by a parent's comment: "I know when I die a CIT officer will be there to take care of my son when in crisis."

Deputy used CIT training to defuse real-life crisis with troubled vet

By Deputy K. Leah Stephens
St. Lucie County (Florida) Sheriff's Office

Editor's note: The following first-person account was received shortly after Deputy Stephens attended the national CIT Conference

I do not even know how to begin to thank you for your session on *Improving Police Encounters with Returning Veterans* at the CIT Conference in Atlanta.

I had been home just over a week, and was confronted by a Marine veteran (Operation Iraqi Freedom) with PTSD. It was a textbook situation. "Our" vet had the same reactions and experiences as the vet in the training video, whose crisis was triggered by a trunk slamming shut. As a result, I was able to immediately recognize and identify his symptoms, and the situation did not escalate.

The training saved us from having to go hands on, because I was able to reach out to him with the verbal skills I learned in your class. In fact, because of that video and scenario where the veteran had the handgun, I was able to ask the right question and that question was, "Do you have any weapons?"

He looked me straight in the eye and began to weep and asked me to take the weapon for safekeeping until he felt he was ready to have it back. What a heart-wrenching sight to have this honorable Marine hand over his weapon to me.

I reassured him over and over that there were people who cared and I had had the pleasure of meeting a few of them in Atlanta. I gave him and his wife the Veteran Suicide phone number that I put in my contacts during your class/session. I pray that he will make the call. On Monday, I will contact the VA in my area and have them follow-up.

I spoke with "Matthew" today (December 6, 2008) and he sounded a little more hopeful. He was appreciative of the phone call from the director of the local VA office, who offered him vocational training so he can get a better job that is more suitable for him. He also called his AA sponsor and is talking to him on a daily basis. He wants to go to the support groups, but he said he cannot afford to take time off from work.

Sadly, he is far from better, but he is hopeful. I will continue to check on him from time to time to remind him we care. You know better than me that there is a fine line between help and harassment. Looking back, I believe if we had not interceded that day, "Matthew" would not be here today. I again give the credit to my CIT Training.

January 26 Update: The veteran and family are doing OK. Everyday is a struggle, but he says but he feels at least someone cares and that helps him keep things in perspective.

I hope that by sharing my story, others will be encouraged to look beyond the external. I just don't understand why so many in the law enforcement community have a hard time understanding and adapting to CIT.

Article showcases value of CIT training in aiding vets in crisis

The value of CIT training in helping U.S. veterans battle their mental wounds was chronicled recently in article appearing in both the *Orlando (FL) Sentinel* and the *Miami Herald.*

The article by Sentinel reporter Darryl E. Owens describes how Orlando and Daytona Beach area law enforcement officials are beefing up crisis intervention training with an eye to getting help for troubled veterans instead of putting them in jail.

Finding ways to deal effectively with veterans in crisis is an ongoing issue. A 2008 RAND Corp. study found nearly 20 percent of returning troops, about 300,000, have PTSD or major depression. Yet only slightly more than half have sought treatment.

Experts say it's not uncommon for that to lead to run-ins with the law that start over something trivial but have the potential to turn tragic, Owens reported.

The article spotlighted the Orange County, FL Sheriff's Office CIT training program and its partnership with local provider, Lakeside Alternatives. It also gave an overview of CIT training and its history—describing some of the CIT classroom training.

CIT International board member Michele Saunders is quoted in the article, explaining that keeping vets out of the justice system is an important payoff of crisis intervention training.

Also featured in the article was the CIT training program undertaken by Act Corp., a Daytona Beach community mental-health center. The agency has trained 468 police officers and community leaders in Volusia and Flagler counties, including 157 this past year.

Clinical skills are critical to assessing risk of suicide

The following is excerpted from the report, Suicide Prevention Efforts for Individuals with Serious Mental Illness, prepared by the National Association of State Mental Health Program Directors, March 2008. The full report can be found at: www.nasmhpd.org.

Individuals with serious mental illness constitute about 8% of the U.S. population, but account for several times that proportion of the 32,000 suicides that occur each year in the country. For people with virtually every category of serious mental illness (SMI), suicide is a leading cause of death.
Inadequate assessment of suicide risk and insufficient access to effective treatments are major contributing factors. Still, a large majority of those with SMI neither attempt nor die by suicide and predicting those who will presents a daunting clinical challenge.

Absent foolproof methods to predict suicidal behavior, mental health professionals must rely on clinical skills and judgment to identify, accurately assess, and manage the care of those at heightened risk for suicide.

Suicide attempts and deaths by suicide send ripples through the U.S. economy, costing up to $25 billion per year. However, the cost cannot be measured solely in dollars. One must also factor in the emotional toll extracted from attempt survivors and the family members and friends who are so deeply affected by both attempted and completed suicides.

Stigmatizing reactions add to the burdens survivors already bear, often intensifying isolation and secrecy. The complicated grief that can accompany surviving a loved one's suicide may itself elevate the risk for suicide.

People with serious mental illnesses who have previously attempted suicide advocate for a more robust and supportive system of care. They also seek opportunities to share their personal experiences with others facing similar situations and find relief when they do.

Survivors of a loved one's suicide seek greater access to survivor support groups for all who are bereaved by suicide—places where they can connect with others who are experiencing similar grief.

In the days and weeks prior to their suicides, those who die by their own hand commonly had sought services from an array of community-level service providers.

Consequently, telephone crisis services, emergency departments, inpatient and outpatient mental health services, and primary care settings all hold the potential of significantly reducing the toll of suicide by improving internal practices and inter-agency collaboration.

These improvements must include training staff to deliver the various effective treatments that have been shown to reduce attempts and completed suicides in those with mental illnesses.

Such evidence-based treatments must be combined with more comprehensive risk management strategies, including reducing access to lethal means such as firearms and pharmaceuticals.

Delivering effective care through integrated delivery systems is key to achieving meaningful reductions in suicidal behaviors by people with SMI. These improved delivery systems should be complemented by initiatives to reduce stigma and increase understanding and support for individuals with mental illness.

San Antonio police fields specialized mental health unit

Spurred by the tasering two years ago of a man with schizophrenia, the San Antonio Police Department has launched a Mental Health Police Detail, a two-officer unit that seeks to avoid such outcomes and improve how police interact with people with mental illness.

The detail coordinates with mental health professionals and has been active since early December 2008. The special unit is in addition to the department's other initiatives, including crisis intervention training.

Considered local exemplars in crisis intervention, Officers William Kasberg and Earnest Stevens work the detail together, according to a January 14 article in the *San Antonio Express-News*. Officers who encounter people with mental illnesses are trained to call on the pair, who show up with a licensed professional counselor.

"We de-escalate and calm and separate people who do not need to be there," Kasberg said. The health care services counselor then assesses the situation and determines if the patient should be taken to a private hospital, an outpatient clinic or some other destination

Assistant Police Chief Harry Griffin, who oversees the new detail, said the officers also seek to identify and treat those he called "high utilizers" —mentally ill residents who repeatedly call 911.

"They know the resources," he said. "They know who to call, know how to get services quickly." .

You can read the complete news article at:
http://www.mysanantonio.com/news/Police_unit_strives_to_avoid_force.html

Police chiefs recognize Georgia CIT

The Georgia Bureau of Investigation (GBI**)** recently received the Civil Rights Award from the International Association of Chiefs of Police (IACP) for its leadership in developing a statewide Crisis Intervention Team (CIT) program in partnership with NAMI Georgia and other law enforcement organizations.

The Civil Rights Award recognizes outstanding law enforcement achievements in protecting civil and human rights. The award underscores a fact too often overlooked: that law enforcement professionals are among the primary guarantors of civil, human, and constitutional rights in democratic societies.

Since 2004, more than 2,000 Georgia law enforcement officers from 150 agencies have received the 40 hours of specialized training.

CIT protects the rights of people with mental illness and other brain disorders who are in crisis by training officers in techniques to deescalate the crisis and, in many cases, to refer the individuals for treatment instead of arresting and incarcerating them.

Congratulations GBI and NAMI Georgia!

Members of the CIT International Board of Directors post for their official photo during Atlanta conference. From left, they are: Officer Ron Bruno, Dr. Randy Dupont, Sgt. William Lange, Lt. Jeff Murphy, Joe Mucenski, Major Sam Cochran (retired), Director Vernon Keenan, Michele Saunders, Lt. Mike Woody (retired), Nora Lott-Haynes and Donald Turnbaugh

NATIONAL CIT AWARD WINNERS
2008-Atlanta

CIT Officer of the Year: Officer Eric Chimney, Houston Police Department
Coordinator of the Year: Lt. Trudy Boyce, Atlanta Police Department
Police Chief of the Year: Chief Mike Gibson, University of Virginia Police Department
Sheriff of the Year: James Wilson**,** Williamson County Sheriff's Office, Texas
Consumer of the Year: Steven Saunders, Certified Peer Specialist, Georgia CIT Program
Consumer of the Year: Gary Sjolander, Clark County/Vancouver Police Dept. CIT, Oregon
Advocate of the Year: Mayor Richard Crotty, Orange County, Florida
Behavioral Healthcare Professional of the Year: Kim Kornmayer, MHMR Authority of Harris County, Texas
Court Official of the Year: Judge Mark Speiser, 17th Judicial Circuit, Miami, Florida
CIT Pin of the Year: Chicago Police Department

A Message from the President

I hope that as one of CIT International's close to 200 members (and growing) you enjoy this newsletter. It's coming out a little later than we would have liked but be patient with us please – we're new at this! Speaking of members, we could use your help in recruiting new ones. So, if you know of someone or an organization that could benefit from belonging to CIT International encourage them to go to our website at www.citinternational.org and get an application or fill out the form in this newsletter and send it in. I have received numerous communications from our members wanting to know when the next Convention will be. We are in the process now of looking at proposals from interested parties and will be making a selection within the next month. The next convention will be in 2010. If you have ideas as to what you think should be included in our convention please let us know; after all, this is your organization and now is the time to help steer us in the right direction! Send your ideas to michael.s.woody@earthlink.net

Yours Truly,

Michael S. Woody

Please Join Today
CIT International, Inc.

Membership Dues Structure

____Regular Member	$25.00
____Corporate Member	$200.00
____Non-Profit Member	$50.00

Name:_____

Organization/Agency:_____

Address:_____

_____

Phone:_____ Email:_____

Please check which applies to you
(You may check more than one.)
___Law Enforcement
___Consumer
___Family Member
___Mental Health Provider
___Substance Abuse Provider
___Other:_____

Please make checks payable to

CIT International, Inc.

C/O NAMI, Peggy Stedman, CFO
2107 Wilson Blvd., Suite 300
Arlington, VA 22201-3042

THE FAMILY OF CIT THANKS YOU

Sequential Intercept Mapping & Taking Action for Change

Appendix S: Targeting Criminal Recidivism in Justice-Involved People with Mental Illness: Structured Clinical Approaches

Policy Research Associates


Policy Research Associates

Targeting Criminal Recidivism in Justice-Involved People with Mental Illness: Structured Clinical Approaches

Merrill Rotter, MD[1] & Amory Carr, PhD[2]

The CMHS National GAINS Center May 2010

Of all community treatment outcomes for justice-involved individuals with mental illness, among the most valued by programs, policymakers, and funders is decreased criminal recidivism, particularly a decrease in new crimes with new victims. This outcome is intended to capture improved individual stability and public safety while offering support for the promised cost savings from reduced jail days (Almquist & Dodd, 2009; Milkman & Wanberg, 2007).

Evidence-based practices (EBP) with track records of effectiveness in treating serious mental illness, co-occurring substance use, and trauma have been utilized with some success among people in contact with the justice system (Osher & Steadman, 2007). However, recent reviews have reported that receipt of behavioral health services by justice-involved people with mental illness, such as assertive community treatment and its forensic adaptation (Morrissey, Meyer, & Cuddeback, 2007) or symptom reduction among participants in jail diversion programs (Steadman, 2009), were not necessarily associated with reductions in subsequent contact with the justice system.

Specialized case management and clinical services that specifically focus on factors associated with criminal recidivism are recommended as a necessary adjunct to symptom-focused services for this justice-involved population (Skeem, Manchak, Vidal, & Hart, 2009). These factors, some of which are targeted by existing evidence-based practices, include substance abuse, education and vocational opportunities, family support, leisure activities, antisocial associates, personality traits, and cognitions (Lamberti, 2007). In this brief, we present structured clinical interventions that were developed or adapted to specifically target the antisocial traits or cognitions, that is, the thoughts, feelings, and behaviors associated with criminal justice contact. Our primary focus is on cognitive behavioral interventions developed for criminal justice populations that are effective in reducing recidivism.

Specialized case management and clinical services that specifically focus on criminal recidivism are recommended as a necessary adjunct to symptom-focused services for justice-involved people with mental illness (Skeem, Manchak, Vidal, & Hart, 2009)

Cognitive-Behavioral Therapy and Adaptations for Justice-Involved Populations

Cognitive-behavioral therapy (CBT) is an intervention for ameliorating distressing feelings, disturbing behavior, and the dysfunctional thoughts from which they spring.[3] Improvements in target symptoms, such as anxiety and depression, are mediated through identifying and disputing the automatic thoughts that generate those feelings. Behavioral techniques, such as skills training and role-playing are well-established ways of addressing phobias and posttraumatic reactions. These techniques also help patients develop coping mechanisms for managing the thoughts and feelings identified during the intervention.

While the original focus of CBT was intrapersonal (i.e., symptom relief for the individual with the goal of feeling and functioning better), recidivism-related antisocial cognitions and maladaptive emotional reactions are largely interpersonal and may not be associated with individual distress (other than

1. Albert Einstein College of Medicine

2. University of New Haven

3. For reviews of traditional CBT interventions, see Butler, Chapman, Forman, & Beck (2006) and Leichsenring & Leibing (2008).

undesired legal consequences). As a result, a CBT intervention with a goal of reducing an individual's contact with the justice system requires more than an emphasis on symptom relief. In fact, the intervention must target interpersonal skills and the acceptance of community standards for responsible behavior (Milkman & Wanberg, 2007).

While the original focus of CBT was intrapersonal … recidivism-related antisocial cognitions and maladaptive emotional reactions are largely interpersonal and may not be associated with individual distress …

Recidivism-Focused CBT Programming: General Principles

CBT programming is most effective in reducing recidivism when moderate- or high-risk individuals are targeted, their criminogenic needs are the focus of intervention, and the intervention method is responsive to their style of learning (Andrews & Bonta, 1998; Lipsey, Chapman, & Landengerger, 2001). Criminogenic needs are characteristics specific to an individual that are relevant to criminal behavior, such as criminal attitudes, values, beliefs, thinking styles, and cognitive emotional states (Andrews, 1996). These characteristics have been described in individuals with mental illness who are in contact with the justice system (Lamberti, 2007). Thus, while recidivism-focused CBT programming was not initially developed for a target population of individuals with mental illness, it may be an appropriate intervention given that it is a structured approach focused on problem behavior and criminogenic needs (Rosenfeld et al., 2007).

Recidivism-focused programs employ traditional CBT elements, such as homework assignments, role plays, and multimedia presentations, to improve relevant areas of cognitive functioning, such as critical thinking, assertiveness, interpersonal cognitive problem solving, negotiation skills, and pro-social values. An exhaustive survey of programs is beyond the scope of this brief, but the following represent typical CBT interventions used in correctional settings:

- Thinking for a Change (T4C) (Golden, 2002)
- Moral Reconation Therapy (MRT) (Little & Robinson, 1988)
- Lifestyle Change (Walters, 1999)
- Reasoning & Rehabilitation (R&R) (Ross, Fabiano & Ewles, 1988)
- Options (Bush & Bilodeau, 1993)

Providers who plan to use a CBT program must keep in mind that implementation quality directly impacts the overall effectiveness of the program. Implementation quality is determined by factors such as the employment of an empirically valid theory that underlies the treatment, the use of printed manuals and materials, and delivery by trained, enthusiastic providers who receive adequate clinical supervision (Lamberti, 2007).

Recidivism-Focused CBT Programs

Developed by the National Institute of Corrections (Golden, 2002), the T4C program employs a problem-solving approach that teaches individuals to work through problems without resorting to criminal behavior. T4C emphasizes introspection, cognitive restructuring, and social skills training. MRT was designed to facilitate the acquisition and application of higher levels of moral reasoning among individuals (Little & Robinson, 1988). Lifestyle Change, designed for long-term prison inmates (Walters, 1999), teaches a structured, self-reflective, cost-benefit analysis of choices and consequences, with a focus on thinking styles that have been found to support criminal activity (i.e., an overly optimistic view of legal outcomes, thinking that one can easily undo past transgressions, and the externalization of responsibility). R&R was developed by Ross and Fabiano (1985) to target cognitive processing and pro-criminal thinking. It was first piloted with people on parole in Canada (Ross, Fabiano, & Ewles, 1988). Developed through support from the National Institute of Corrections, Options focused on attitudes and social problem-solving skills (Bush & Bilodeau, 1993).

While T4C has not been integrated into a mental health program, MRT is part of the service package afforded participants in the Bonneville County Mental Health Court in Idaho (Eric Olson, personal communication, 2009), and Treatment Alternatives for Safe Communities (TASC) in New York City has incorporated a criminal thinking journaling component of the Lifestyle Change program into

its case management services for diversion program participants in Brooklyn.[4] Both programs report that the interventions are well accepted and appreciated by the participants; however, to date no research has documented the effectiveness of T4C, MRT, or Lifestyle Change with the population enrolled into diversion programs.

The effectiveness of Options (Ashford, Wong, & Sternbach, 2008) and R&R (Donelly & Scott, 1999) has been studied with people with mental illness in contact with the justice system. While R&R was effective in improving problem solving and social adjustment, Donnelly and Scott (1999) did not determine the program's effect on recidivism. However, Kunz and colleagues (2004) examined a program that combined elements of R&R with an institutionalized token economy for a sample of people (n=85) with persistent violent and criminal histories in an inpatient setting. While the study lacked a control group and was hampered by a small sample size, Kunz and colleagues (2004) determined that the program compared favorably to previously published re-arrest rates of justice-involved people with and without mental illness in that 17 individuals (20 percent) were rearrested within the six-month follow-up period, of whom 5 were rearrested for violent offenses. A version of R&R developed specifically for justice-involved people with mental illness is currently being evaluated (Young & Ross, 2007).

In the study of Options, Ashford and colleagues (2008) compared an intended treatment group (n=47), a completed treatment group (n=24), and a control group (n=29) on criminal attitude and hostile attribution bias measures in addition to criminal outcomes. The intended treatment and treatment completion groups were associated with reduced arrests, including violent arrests, compared to the control group. Participants in the Options groups were more likely to receive technical violations of probation compared to the control, but this may be related to the increased correctional supervision that such persons received, as opposed to an index of program ineffectiveness.

In a meta-analysis conducted by the Washington State Institute for Public Policy (Aos, Miller & Drake, 2006), the authors determined that CBT programs aimed at the general population of justice-involved people achieved an average reduction in recidivism of 8.2 percent. However, comparative recidivism research faces several confounds, including differences in measures of success (re-arrest vs. re-conviction vs. re-incarceration); difference in target population (high or low risk); and in the content, intensity, and length of the interventions, not to mention variation in research rigor.

New Directions in Criminal Behavior Focused Structured Interventions

While the programs developed for use with the general criminal justice population are structured around traditional criminogenic needs (e.g., antisocial attitudes, problem solving, or thinking styles), programs with a basis in mental health services address other clinical features associated with criminality, such as frustration intolerance, social skills deficits, and misperceptions of the environment (Galietta, Finneran, Fava, & Rosenfeld, 2009). Two such programs are forensic-focused dialectical behavioral therapy (DBT) and schema-focused therapy (SFT). Both DBT and SFT were developed within traditional mental health services and later applied to forensic settings.

DBT was recognized as the first empirically supported treatment for borderline personality disorder and has been successful at reducing the self-harm behaviors and emotional instability in people diagnosed with the disorder (Linehan et al, 1991). The employment of DBT with people with borderline personality disorder in forensic psychiatric settings has been associated with fewer violent incidents and a reduction in self-reported anger (Evershed et al., 2003; Berzins & Trestman, 2004). DBT has also been used with people who engage in stalking, who are disproportionately likely to suffer from narcissistic, antisocial, or borderline personality disorders. In a study by Rosenfeld and colleagues (2007), people who completed a six-month program were less likely to be rearrested for stalking compared to treatment non-completers or published rates of recidivism for stalking.

SFT is an integrative long-term psychotherapeutic treatment that combines elements of cognitive,

4. Implemented by the first author.

behavioral, psychodynamic, and humanistic approaches. It is designed for working with people with personality disorders in an individual setting. SFT is based on the theory that early maladaptive schemas are fixed patterns of thoughts, feelings, and behaviors that arise from negative childhood experiences and continue into adulthood (Young, 1999). It has recently been implemented in forensic settings that include persons with the most severe form of antisocial personality disorder, psychopathy (Bernstein, 2007). Bernstein (2008) reported that rates of approved, supervised leave were significantly greater for persons who completed treatment. However, the criminal justice outcomes of SFT have not yet been studied.

Most of the programs discussed in this brief presume a level of motivation and engagement to participate and learn that is not necessarily present. Where motivation is poor or lacking, a more direct intervention may be required as a precursor to the program.

A point to consider is the role of individual motivation and engagement in treatment. Most of the programs discussed in this brief presume a level of motivation and engagement to participate and learn that is not necessarily present. Where motivation is poor or lacking, a more direct intervention may be required as a precursor to the program. Motivational Interviewing is one well-established approach that has also been used with justice-involved populations (McMurran, 2009). Structured approaches to engagement specifically designed for justice-involved individuals include Focusing on Reentry (Porporino & Fabiano, 2007), a manualized intervention for motivational enhancement and goal setting, and the SPECTRM Reentry After Prison (RAP) group (Rotter, McQuistion, Broner, & Steinbacher, 2005). The latter approach was developed with the particular experience of people with mental illness in mind. No controlled studies have assessed their effectiveness.

Summary

Although connecting individuals with mental illness to appropriate and effective community-based services is important for the improvement of individual and public health, there is little reason, based on the available evidence, to expect such services to result in a demonstrable reduction in subsequent contact with the justice system. Integrating such services with structured clinical interventions that are focused on recidivism may help programs achieve their desired public health and public safety outcomes. Recidivism-focused CBT programming is an established approach with a promising research base for working with justice-involved people with mental illness.

References

Almquist, L., & Dodd, E. (2009). *Mental health courts: A guide to research-informed policy and practice.* New York: Council of State Governments Justice Center.

Andrews, D. A. (1996). Criminal recidivism is predictable and can be influenced: An update. *Forum on Corrections Research, 8,* 42-44.

Andrews, D. A., & Bonta, J. (1998). *The psychology of criminal conduct* (2nd ed.). Cincinnati, OH: Anderson.

Aos, S., Miller, M., & Drake, E. (2006). *Evidence based adult corrections programs: What works and what does not.* Olympia, WA: Washington State Institute for Public Policy.

Ashford, J. B., Wong, K. W., & Sternbach, K. O. (2008). Generic correctional programming for mentally ill offenders: A pilot study. *Criminal Justice and Behavior, 35,* 457-473.

Bernstein, D. P. (November, 2008). *A new method for rating schema modes in forensic patients.* Paper presented at the Annual Fall Congress of the Vereniging voor Gedrags en Cognitieve Therapie, Eindhoven, The Netherlands.

Bernstein, D. P., Arntz, A., & Vos, M. E. de (2007). Schema focused therapy in forensic settings: Theoretical model and recommendations for best clinical practice. *International Journal of Forensic Mental Health, 6,* 169-183.

Berzins, L. G., & Trestman, R. L. (2004). The development and implementation of dialectical behavior therapy in forensic settings. *International Journal of Forensic Mental Health, 3,* 93-103.

Bush, J., & Bilodeau, B. (1993). *Options: A cognitive change program.* Longmont, CO: National Institute of Corrections.

Butler, A. C., Chapman, J. E., Forman, E. M., & Beck, A. T. (2006). The empirical status of cognitive-behavioral therapy: A review of meta-analyses. *Clinical Psychology Review, 26,* 17-31.

Donnelly, J. P., & Scott, M. F. (1999). Evaluation of an offending behavior programme with a mentally disordered offender population. *British Journal of Forensic Practice*, *1*, 25-32.

Evershed, S., Tennant, A., Boomer, D., Rees, A., Barkham, M., & Watson, A. (2003). Practice-based outcomes for dialectical-behavioural therapy targeting anger and violence, with male forensic patients: A pragmatic and non-contemporaneous comparison. *Criminal Behaviour and Mental Health*, *13*, 198-213.

Galietta, M., Finneran, V., Fava, J., & Rosenfeld, B. (2009). Treatment refractory populations and clinical problems: Antisocial and psychopathic personalities. In D. McKay, S. Taylor, & J. Abramawitz (Eds.), *Cognitive-behavior therapy: Lessons learned from refractory cases* (pp. 385-405). Washington, DC: American Psychological Association.

Golden, L. (2002). *Evaluation of the efficacy of a cognitive behavioral program for offenders on probation: Thinking for a change.* Retrieved April 26, 2010, from the National Institute of Corrections Web site: http://www.nicic.org/pubs/2002/018190.pdf

Kunz, M., Yates, K. F., Czobor, P., Rabinowitz, S., Lindenmayer, J. P., & Volavka, J. (2004). Course of patients with histories of aggression and crime after discharge from a cognitive-behavior program. *Psychiatric Services*, *55*, 654-659.

Lamberti, J. S. (2007). Understanding and preventing criminal recidivism among adults with psychotic disorders. *Psychiatric Services, 58*, 773-781.

Leichsenring, F., & Leibing, E. (2003). The effectiveness of psychodynamic therapy and cognitive behavior therapy in the treatment of personality disorders: A meta-analysis. *American Journal of Psychology, 160,* 1223-1232.

Linehan, M. M., Armstrong, H. E., Suarez, A., Allmon, D., & Heard, H. L. (1991). Cognitive-behavioral treatment of chronically parasuicidal borderline patients. *Archives of General Psychiatry, 48*, 1060–1064.

Little, G. L., & Robinson, K. D. (1988). Moral reconation therapy: A systematic step-by-step treatment system for treatment resistant clients. *Psychological Reports*, *62*, 135-151.

McMurran, M. (2009). Motivational interviewing with offenders: A systematic review. L*egal and Criminological Psychology*, 14, 83-100.

Milkman, H., & Wanberg, T. D. (2007). *Cognitive-behavioral treatment: A review and discussion for corrections professionals.* Washington, DC: U.S. Department of Justice, National Institute of Corrections.

Morrissey, J., Meyer P., & Cuddeback, G. (2007). Extending assertive community treatment to criminal justice settings: Origins, current evidence, and future directions. *Community Mental Health Journal, 43*, 527-544.

Osher, F.C., & Steadman, H. J. (2007). Adapting evidence-based practices for persons with mental illness involved with the criminal justice system. *Psychiatric Services, 58,* 1472-1478.

Porporino, F. J., & Fabiano, E. (2005). *The focusing on reentry programme (F.O.R.): Theory and conceptual overview*. Ottawa: T3 Associates, Inc.

Rosenfeld, B., Galietta, M., Ivanoff, A., Garcia-Mansilla, A., Martinez, R., Fava, J., Fineran, V., & Green, D. (2007). Dialectical behavior therapy for the treatment of stalking offenders. *International Journal of Forensic Mental Health, 6*, 95-103.

Ross, R. R., Fabiano, E. A., & Ewles, C. D. (1988). Reasoning and rehabilitation. *International Journal of Offender Therapy and Comparative Criminology*, *32*, 29-35.

Rotter, M., McQuistion, H. L., Broner, N., & Steinbacher, M. (2005). Best practices: The impact of the "incarceration culture" on reentry for adults with mental illness: A training and group treatment model. *Psychiatric Services, 56*, 265-267.

Skeem, J., Manchak, S., Vidal, S., & Hart, E. (2009, March). *Probationers with mental disorder: What (really) works?* Paper presented at the American Psychology and Law Society Annual Conference, San Antonio, TX.

Steadman, H. J. (2009, March). *TCE for jail diversion programs: Cross-site evaluation update.* Paper presented at the CMHS Targeted Capacity Expansion for Jail Diversion Programs Annual Grantee Meeting, Bethesda, MD.

Walters, G. D. (1999). Short-term outcome of inmates participating in the lifestyle change program. *Criminal Justice and Behavior*, *26*, 322-337.

Young, J. E. (1999). *Cognitive therapy for personality disorders: A schema-focused approach*. Sarasota, FL: Professional Resource Press.

Young, S. J., & Ross, R. R. (2007). *R&R2 for youths and adults with mental health problems: A prosocial competence training program*. Ottawa: Cognitive Centre of Canada.

Sequential Intercept Mapping & Taking Action for Change

Appendix T: Program Abstract: Illinois Department of Human Services/ Division of Mental Health, Mental Health Jail Data Link Project

Policy Research Associates


Policy Research Associates

BJA2008-1819/CFDA 16.745

Illinois Department of Human Services/Division of Mental Health
Mental Health Jail Data Link Project

PROGRAM ABSTRACT

The Illinois Criminal Justice Authority (applicant) in partnership with the Illinois Department of Human Services/Division of Mental Health (IDHS/DMH) is requesting $199,990.00 under Category III, Implementation and Expansion of Bureau of Justice Assistance, to expand the current Jail Mental Health Data Link project to St. Clair and Madison counties in Illinois.

The project is based on significant advances made in the current Jail Data Link Projects that 1) established a computer database that cross references the daily census in correctional facilities with mental health centers and then 2) added dedicated case managers to ensure jail detainees receiving care are linked back to community mental health agencies and other supportive services, thus helping to reduce the likelihood of their re-arrest.

Persons formerly served by Division of Mental Health agencies who are arrested and end up in St. Clair and Madison county jails will receive intensive case management services in this project. Project case managers will use a secure system of Internet database to cross-reference the daily census of the county jails with the IDHS/DMH Reporting of Community Agencies (ROCS) file. The database will allow recipients of mental health services who are arrested or detained to continue receiving care. Expansion of the Jail Data Link project to these two counties is expected to continue mental health services to a minimum of 30 detainees per month. Through these improved mental health services, the goal is to reduce re-arrest and recidivism.

PROGRAM NARRATIVE

1: STATEMENT OF THE PROBLEM:

The Illinois Department of Human Services/Division of Mental Health (IDHS/DMH) is requesting support in the amount of $199,990.00 for the expansion of the internet-based, integrated mental health cross-match system for jail detainees in Illinois, known as the Mental Health Jail Data Link Project, in response to Category III (Implementation and Expansion). Five of the largest counties in Illinois currently participate in this program, and the funds requested would expand the mental health cross-match system to two additional large counties with mixed rural and small urban environments. With the active participation of the state, along with local justice and community-based providers, this program will provide access to a comprehensive level care for a minimum of 30 mentally ill jail detainees per month. This request is made in partnership with the St. Clair County Sheriff's Office, the St. Clair County 708 Board (Mental Health Commission), Chestnut Mental Health Center ("Chestnut"), Comprehensive Mental Health Center of East St. Clair County ("Comprehensive"), and the Madison County Sheriff's Office.

The Bureau of Justice Statistics estimates that nationwide over 280,000 mentally ill offenders are incarcerated in prisons and jails. An additional 550,000 mentally ill individuals are in the probation systems. The rates of mental illness among offender populations are estimated to be two to three times that of the general U.S. population (Ditton, 1999) and arrest rates are disproportionately higher for mentally ill persons compared to the general population. An estimated 8 to 16 percent of the prison population has at least one serious mental disorder and is in need of treatment (Lurigio, 2001).

Illinois' county jails mirror this national picture; with one study concluding that between

12-16 percent of inmates in Illinois county jails are mentally ill (Bureau of Justice Statistics, 1999). Statewide, the Illinois Division of Mental Health (IDMH) is responsible for providing services to over 2,000 mentally ill jail detainees on a daily basis.

The challenge in Illinois is not only one of scope, but also one of efficient application of services. Although, jail detainees with mental illness may have had contact with state mental health services, that information is often not immediately available. Consequently, identification of mentally ill detainees becomes a cumbersome process, usually prompted by a clinician's response to an inmate's request for mental health attention, a diagnosis from a jail psychiatrist if the inmate is presenting with active symptoms, or a procedural face-to-face psychological interview. Complicating the problem is the fact that procedural evaluations rely on self-reported information, and thus have a low level of data integrity that ultimately compromises effective service delivery. The clinical services they *do* receive, such as assessment, service planning and medication management, may be duplicative of those they had been receiving through a mental health agency.

The fact remains that these individuals must be treated. Untreated offenders with mental illness are more likely to return to the criminal justice system as a result of repeated arrests and incarcerations. They are also more likely to be admitted and readmitted to psychiatric hospitals. Without effective treatment, these individuals pose significant threats to public safety, especially when they have histories of co-morbid substance abuse or dependence disorders (Lurigio & Swartz, 2000). With the statewide justice and mental health systems already overburdened, communication and comprehensive service delivery are critical to providing services that improve mental health and thus have the potential to reduce re-arrest and recidivism.

The Mental Health Jail Data Link Program

In response to the lack of coordinated service delivery between the Illinois Department of Human Services and county jails, leadership in the Cook County (Chicago) criminal justice system, the Illinois Division of Mental Health (IDMH) and local mental health treatment providers launched the Mental Health Jail Data Link Program (Data Link) in 1999. Data Link is an internet-based application that performs a cross-match between the daily jail census and IDHS/DMH open case records, thereby immediately identifying mentally ill detainees eligible for - and at some point receiving - state funded mental health services. The result of this cross-match is an identification of individuals that may be eligible for diversion from the jail setting into justice-monitored community-based treatment, whether supervised by a mental health court, specially trained mental health probation or otherwise. For this project, mentally ill detainees will be identified in the same manner through a cross-match between the daily jail census and the IDHS/DMH open case records.

The Data Link system has evolved from a database cross-match to a full-fledged client management tool, providing jail-based case managers with up-to-date case information, including diagnosis, planning, medications and services received by the detainee, and allowing the case managers to coordinate continuing care services, provide input, and update information. Authorized users from the courts and jail can access this information, and community based provider agencies. An immediate result is continuity of care supported by real-time critical information that allows jail-based staff to immediately address the mental health needs of detainees without reliance on requests from inmates or self-reporting.

Since its initial implementation in 1999, Data Link has expanded increasing the number of service providers with access to the system and increasing the number of counties that

participate in the project. The Cook County version of the program, which operates in conjunction with the county mental health court, now has the active participation of fourteen treatment agencies. Statewide, Data Link has been expanded to include Will County (4th largest in Illinois), Peoria County (11th largest), Jefferson County (34th largest) and Marion County (33rd largest). The significance of this expansion is the inclusion of suburban and rural environments, and their community-based treatment systems, as part of the integrated network created by Data Link.

In 2005, the Illinois General Assembly supported the Data Link model by amending the Mental Health and Developmental Disabilities Confidentiality Act to authorize the following: "For the purposes of continuity of care, the Department of Human Services, … community agencies funded by the Department of Human Services in that capacity, prisons operated by the Department of Corrections, mental health facilities operated by a county, and jails operated by any county of this State may disclose a recipient's record or communications, without consent, to each other, but only for the purpose of admission, treatment, planning, or discharge (740 ILCS 110/9.2)."

The most recent addition to the project is the Proviso Township Mental Health Commission ("708 Board"). The 708 Board provides - resources that support a single case manager working with a single agency alongside the Division of Mental Health and the Cook County Sheriff's Office. The Proviso model evolved from the lessons learned from the other counties, which consistently identified substance abuse treatment, housing and other social and familial supportive services as barriers to participants' recovery. With the additional resources from the Township 708 Board, the Proviso model incorporates a holistic approach by not only re-engaging individuals in mental health treatment, but by also identifying their other recovery

support needs and providing linkages to these services and systems. The dedicated case manager in Proviso Township also performs additional duties and responsibilities including sharing information with Public Defenders and State's Attorneys and testifying about clients' progress at court hearings. The Proviso model is the model upon which this proposal is based.

Evolution of Data Link Technology Infrastructure

The Jail Data Link Project was initially established in 1999 on a Microsoft Access platform. It was in distributed structure and difficult to synchronize the databases. Since that time, with additional funding provided by the Illinois Criminal Justice Information Authority (ICJIA), the Jail Data Link Project has evolved into an Secure Socket Layer (SSL) Internet-based web application and all the information is encrypted during communication that complies with the HIPPA requirement. On the back end, it utilizes SAS (Statistical Analysis Software) as the database engine which provides powerful data analysis and reporting capacities. Any Internet connection can be utilized to access the system with the authentication credentials. Based on the user's authorization level, only the appropriate information will be displayed.

Programmatic Additions

Not all mentally ill individuals discharged from a State Operated Psychiatric Hospital, although given an appointment to secure follow-up services, indeed participate in that appointment. As a result, Data Link has added a component whereby these individuals are identified as "INPATIENT ONLY", indicating a hospitalization without a record of follow-up care. This discovery alerts case managers to the needs of this individual in jail and may prompt a more intensive level of case management services to ensure their appearance at community-based services.

Public Policy Influence

The success of the current Jail Data Link Project has also contributed to public policy development in Illinois. The Illinois General Assembly recently introduced legislation that represents a collaborative effort between IDMH and the Illinois Department of Health Care and Family Services (the Medicaid Authority) to allow for continuation of Medicaid benefits to detainees that are released within 120 days of arrest from any county jail. This non-suspension of benefits is critical for individuals seeking medications, treatment and other medical services that may be needed immediately upon release, and that would otherwise require re-application – a time-consuming and cumbersome process, particularly for those suffering from mental illness.

Project Outcomes

The Data Link programs operating in Will, Peoria, and Jefferson counties – those counties most similar to St. Clair and Madison in terms of size and demographics, and those counties with active case management as a part -- have provided services for a total of 542. Aggregate data from Jefferson, Will and Cook counties has shown a marked decrease in several key indicators:

	Pre Project 1/1/05 to12/31/05	**Post Project 1/1/07 to 12/31/07**
Total # of individuals booked at the respective jails	11,137	9,330
# of individuals booked and identified as mentally ill	936	893
Unduplicated hospital events of mentally ill population	195	155
Hospital bed days	4064	2568

Data on total numbers of individuals booked and individuals booked and identified as mentally ill are provided to demonstrate that the percentages of individuals in these jails identified as

mentally ill are consistent with the national estimates (8.4 - 9.7 percent). The significant data from a programmatic perspective are the overall reduction in hospital events, a drop of 20.5 percent and even more significantly a drop of 36.8 percent in the number of hospital bed days. This drop indicates not only a significant saving of public resources, but also an elevated level of stability among program participants.

Limits of the Current Funding Environment

Case management services in all of the current Data Link counties and Proviso Township are sustained with limited grant funding from IDMH. However there are currently no resources available to allocate funds to expand Data Link into other counties or municipalities.

Expansion of Data Link to St. Clair and Madison Counties

This proposal seeks to implement the Data Link information-sharing system and case management service delivery in two of the largest counties in Illinois—St. Clair and Madison. Both of these counties present a need for Data Link participation, as evidenced by the prevalence of mental illness and the high percentage of need for State-funded mental health treatment. Both counties are predominantly rural, border St. Louis, Missouri, and the city of East. St. Louis, Illinois is the major population center for both counties. These counties are significant as they represent smaller urban environments as well as rural environment in which services are to be delivered.

St. Clair County is the 9th largest in Illinois; with an estimated population of 260,919 and Madison County is the 8th largest in Illinois, with an estimated population of 265,303 (Census Bureau est. 2006). Together, the rural downstate counties have an estimated population of 260,919 (Census Bureau est. 2006) and median household income of $39,148.00. Both counties also have a significant number of households living in poverty. Approximately 14% of families

living in St Clair County are below the poverty line. Madison County has an estimated population of 265,303 and a median household income of 42,541.00 with 9.80% of families below the poverty line.

Both counties also demonstrate a significant need for the project based on current mental health services data. In 2007, Chestnut Mental Health Center, a St. Clair County mental health service provider, documented 1,376 *new* mental health cases and a total of 3,975 *active* cases. Comprehensive Mental Health Center, another local provider, documented 501 *new* cases and a total of 1,485 *active* cases. In 2007, two Illinois State Psychiatric Hospitals (Alton and Choate) which serve both of these counties documented combined new admissions of 656 individuals.

St. Clair County Jail has an estimated daily jail population of 434. Madison County Jail has an estimated daily jail population of 306. The expansion of Data Link to these counties would provide services to a minimum of 30 detainees per month. This number is based on current client flow of the Jail Data Link Project in Jefferson/Marion Counties. Between July 2005 and June 2007, the Project in these counties served 146 individuals out of the 150 identified for Jefferson (from a bed capacity of 249) and 46 individuals served out of the 52 identified for Marion (from a bed capacity of 120).

2: PROJECT DESIGN AND IMPLEMENTATION:

Purpose and Goals

The purpose of this project is to continue the expansion of the Jail Data Link Project across Illinois, building upon lessons learned from the counties and townships already participating in the program. The goals of the proposed project are twofold. The first goal is the implementation of the Jail Data Link System as part of the detainee intake process at both the St. Clair County Jail and the Madison County Jail. The second goal is the use of the Data Link

system and dedicated case management services to identify mentally ill individuals in the two jails and link them with diversion options where applicable and the necessary clinical services to achieve stability. The project will assist these two counties in addressing the detainee needing mental health services and will bolster relationships between local justice systems, mental health, treatment, and community based providers. Project Partners

The proposed expansion of the Jail Data Link Project includes new partnerships between the Illinois Division of Mental Health (IDMH), St. Clair County, Chestnut Mental Health Center, St. Clair County Mental Health Commission (708 Board), Marion County Jail, Comprehensive Services Center and the Madison County Mental Health Commission. Madison County currently operates a mental health court. St. Clair county mental health court is currently in the early stages of implementation and there are plans for it to utilize the Data Link system. The Data Link services provided in these areas would include case management with the case managers provided by the local service providers.

Key project staff include: Anderson Freeman, Ph.D., Director of Forensic Services for IDHS/DMH as Project Administrator (5% of time); and Kathleen Nee, Director of the Jail Data Link Project for the IDMH, will serve as Project Director (25% of time). Chestnut Mental Health Center, Comprehensive Mental Health Center, as well as the St. Clair County 708 Board will be responsible for one 0.5 FTE case manager each to provide the case management services. Additional information on the roles and responsibilities of each of these individuals and the agencies they represent is provided in Section 3, below. The project is requesting funds to hire a technical consultant to support the expansion of the information system to two new jails; the integration with the IDMH database; and the training of staff.

Project Design

The Jail Data Link Project is premised on the sequential intercept model *[Psychiatric Services, April 2006, Vol 57, #4].* Under this model, the justice system intervenes with the clinical needs of a detainee at the earliest possible point of contact for the purpose of prohibiting further deterioration of the detainees' mental health and further progression into the criminal justice system. Data Link follows this model by conducting a daily cross-match of the local jail census and the database of open IDMH cases. In doing so, it automatically identifies individuals with documented mental illness within hours of their intake at the jail and provides critical data to jail officials and community providers about the detainees' documented history of services by state-funded mental health agencies.

Once identified, these individuals are enrolled in a case management process whereby they will have access to the necessary care, either within the institution or as part of a diversion program such as a mental health court. Case management is the critical service component of the Data Link model, and includes comprehensive assessments, service planning, and service linkages. Participants are assessed and service plans developed within 24 hours after identification. The initial point of contact between the case manager and the detainee can be initiated within 24 hours on weekdays and within 48 hours on weekends. The case manager conducts an in-depth assessment of the detainees' criminal justice history, treatment history, the nature and extent of addiction and mental health issues, readiness for treatment, and likelihood of treatment success. This process is bolstered by the availability of service history via the Data Link system. Case managers work with clients to develop individualized service plans that include linkages to the appropriate level of care in community-based mental health and substance abuse treatment programs. The majority of program participants are also faced with additional

barriers to health and productivity. Service planning therefore also includes referrals and linkages to social supports, including housing, employment, childcare, transportation, and family reintegration services. Case managers meet with clients several times per week to help clients navigate the systems and services in which they are involved. This supports retention in services and helps improve the detainees' mental health status.

The Data Link system will serve as the ongoing repository for information about clinical service delivery, allowing authorized users to input and document individual behavior and treatment notes that can be simultaneously shared with authorized personnel. The database also records exclusionary criteria that may result in ineligibility for the program, such as refusal of services, charges beyond the scope of the project, and pending transfer to another correctional facility. Data Link also alerts case managers to critical dates *post*-discharge, such as a 30-day follow-up flag which prompts case managers to contact the participant and ensure they are engaged in community services per their service plan. This transitional involvement is critical to maintaining continuity of care and ensuring that individuals don't fall through the gaps that often exist in the transition from supervised care to non-supervised care.

Numbers to be Served

Applying national estimates of 8-16 percent prevalence of mental illness among jail populations, between 60 and 120 individuals in the combined jail populations of the two target counties may be mentally ill on a daily basis. However, since some of these individuals may not have received state-funded services, they would not appear in the Data Link system. The proposed expansion provides for three part-time case managers. The average caseload, based on experiences in similar counties is projected to be 25. It is projected that the minimum number of individuals served with this staffing is 30 detainees per month.

Project Logic Model

The logic model below identifies resources to be implemented with grant funding, and the immediate and extended outcomes the project currently has accomplished and plans to reach within the twenty-four month grant period.

BJA GRANT RESOURCES	***ACTIVITIES***	***INTERMEDIATE OUTCOMES***	***LONG-TERM OUTCOMES***
Part Time case manager Chestnut Mental Health Center Part time case manager Comprehensive Services Center of St. Clair County Part time case manager St Clair County 708 Board (Mental Health Commission)	-Case manager checks cross match daily -Case manager visits jail to make assessment/ensure medication continuation -Case manager enters data in database - Case manager develops discharge/link/aftercare plan and appointments -Case manager seeks additional services (substance abuse, housing, vocational, education) -Case manager determines mental health court eligibility with judge and states attorney -Case manager conference weekly with DMH/Project Director	-100% of MI detainees identified - 80% identified reviewed - 100% database entry as to eligibility/status - 100% of mentally ill detainees w/hospital records identified -Establish mental health court St. Clair county. - 50% of substance abuse clients engaged in services	-80% of eligible detainees linked to services - 80% compliance with 30 day linkage follow up - Reduce hospital bed day by 20% - Reduce booking events (not days) by 20%.
Part time technical consultant	-Oversee equipment and software expansion and integration. Maintenance, edits, security, data collection and reporting	100% compliance	- Expansion to Madison, St. Clair counties

Timeline

It is anticipated that services under the Project will commence January 1, 2009. Steering

Committee meetings will begin March 2009 and will be scheduled quarterly for the duration of the project. A detailed Project Time and Task Plan is provided in Attachment 3.

3: CAPABILITIES/COMPETENCIES:

Steering Committee

Prior experience has demonstrated that establishing a steering committee, as the vehicle through which project partners collaborate is effective. This Steering Committee supports buy-in for the program goals, objectives, and project design. Even more importantly, the Steering Committee creates a forum to address and resolve challenges/issues/concerns.

Steering Committee members will include: senior staff from the Illinois Criminal Justice Information Authority; the Illinois Division of Mental Health (IDMH); St. Clair and Madison County Sheriffs Departments; the executive directors of Chestnut Mental Health Center, Comprehensive Mental Heath Center of St Clair County, the St. Clair and Madison County 708 Boards; and senior-level staff representatives for the court systems and jails from each county. The Steering Committee will also include the participation of Mary Jensen, the Statewide Consumer Specialist for IDMH. Under the Jail Data Link Project, the partners will sign a Memorandum of Understanding (see attachment) to become Steering Committee Members and undertake several distinct programmatic responsibilities. Upon notification of an award, community mental health agencies will be recruiting their respective case managers for the project with an anticipated starting date of January 1, 2009. Review of the Jail Data Link structure, data input criterion and other necessary technological issues will be addressed and resolved by the end of January 1, 2009. For the duration of the project, the Steering Committee will guide the project to ensure successful project implementation and that all project goals and objectives are met.

Specific Partner Roles and Responsibilities

Illinois Division of Mental Health (IDMH). Anderson Freeman, Ph.D., Director of Forensic Services for the Division of Mental Health will serve as Project Administrator (5% of time) and Kathleen Nee, Director of the Jail Data Link Project, will serve as Project Director (25% of time). Within the first two months of the project, IDHS/DMH leadership staff will travel to St Clair/Madison counties to conduct the initial meeting with participation by project partners, along with the Madison County Sheriff, St Clair County Sheriff, and other technological liaisons. For the duration of the project, in addition to convening and providing staff to the Steering Committee meetings, Dr. Freeman and Ms. Nee will be responsible for the following: programmatic and fiscal oversight and coordination, completion and submission of all required federal reports, oversight for the expansion and enhancement of technology related items vis-a-vis Internet database and Sheriff's Office of each county jail. Additionally, Dr. Freeman and Ms. Nee will serve as a single point of contact for each county jail, Sheriff's Office, community mental health agency, Mental Heath Commission. Ms. Nee will facilitate a weekly conference call with site case managers to discuss and monitor the planning and delivery of services to to support the continuation of care for detainees.

Mental Health Treatment Agencies. Chestnut Mental Health Center, Comprehensive Services Center, as well as the St. Clair County Mental Health Commission will be responsible for hiring and maintaining one part-time case manager each to provide the case management services to the detainees. The case managers will be responsible for: identifying and meeting with mentally ill detainees identified through the Jail Data Link database, completing a needs assessment, developing service and aftercare/discharge plans, and collecting mental health court data. Case managers will be required to participate in a weekly conference call facilitated by the

Project Director (Ms. Nee); attend Steering Committee meetings; and collaborate with staff in the Mental Health Court. Research supports and our experience with the Jail Data Link project reveals that detainees with mental illness are often charged with trespassing due to a lack of permanent/transitional housing and unemployment. Therefore, the proposed project incorporates The Illinois CHAMP Services (Community Homeless Assistance Management Program) a well-established housing, vocational service, and recovery support providers. This provider's services include: supervised living beds; skills training, medication management, group counseling, recovery-oriented development, and substance abuse treatment; short term transitional housing providing daily living skill services; vocational services in job application and job coaching and on-site job assistance. Additionally, this provider does outreach to schools, families, faith-based organizations, and other community providers to assist their clients.

Justice System Partners include local sheriffs, judges and other court staff, and local jail administration. They will: provide access/clearance to the respective community mental health center case management staff, give authorization to interview detainee and speak with additional appropriate jail personnel staff (nurse, physician, therapist, psychiatrist); provide access to demographic and statistical data for project evaluations; provide additional detainee information needed to develop and implement a comprehensive discharge/aftercare linkage plan; participate in Project Steering Committee meetings; provide the Division of Mental Health and the Illinois Criminal Justice Authority staff with a single point of contact for technology related items.

Consumers and advocates. Initially, Mary Jensen, Statewide Consumer Specialist for IDMH will represent consumers and advocates on the Steering along with the case managers who will maintain frequent contact with the participants in their communities. A goal of the Steering Committee is to add two consumers from the Jail Data Link Project before the end of

the first year of the project.

Key Milestones

Key milestones for the project are as follows. By the end of Month 2, ICJIA and DMH will have completed meetings with all key participants, and convened the first meeting of the Steering Committee. Also, the Memoranda Understanding between all project partners will have been signed. By the end of Month 4, the technical infrastructure will have been expanded to and be operational in Madison and St. Clair counties. By the end of Month 6, new case management staff will have been trained and Data Link services have begun.

Potential Barriers

Although new challenges will evolve, past experience with the project has demonstrated that the existence of a Steering Committee provides an effective vehicle for addressing and resolving issues/concerns/challenges immediately. The Steering Committee facilitated by staff support communicates frequently through e-mails, conference calls, and meetings to identify barriers/challenges and resolve them expeditiously. The benefit of the weekly conference calls with the case management staff has proven to be most beneficial in resolving program issues, answering questions and implementing changes needed instantaneously. The Steering Committee meetings have proven to be useful for project guidance, strategic planning, and training. Even more importantly, the Steering Committee will be utilized to review evaluation data and make adjustments necessary to support the achievement of goals, objectives, and project outcomes.

4: BUDGET:

IDMH is requesting $199,990 for this project. The budget will be used to support the work required by six key staff, the purchase and upgrading required for the technology expansion to Madison and St. Clair counties, and project operations (i.e. travel to grantee

meetings). A detailed budget and budget narrative is included as Attachment 2 to this proposal.

5: IMPACT/OUTCOMES, EVALUATION, AND SUSTAINMENT:

The Data Link project partners are committed to ongoing review of evaluation data to monitor the project as it evolves and insure that goals, objectives and outcomes are met. Monthly steering committee meetings of project participants provide the venue for discussion about project operations and addressing/resolving issues.

Measuring Program Progress

Program implementation progress reports will be provided quarterly by each partner to Dr. Freeman, the Project Administrator. Problem solving will take place at the Steering Committee Meeting. The use of the Data Link system as a tool for input and tracking of client data via the case mangers will be the process by which performance and outcome data will be collected to measure project effectiveness. The Steering Committee which includes senior level staff representatives from project partner agencies will regularly review performance data and reports submitted to BJA on the following four objectives:

1. Reduce recidivism of offenders with mental illness in the criminal justice system.

Using the Data Link system, as well as census and court records, data will be collected on a.) number of participants who successfully complete the program, b.) number of participants who are rearrested or excluded from the program due to severity of charges, c.) number of jail days experienced. Each quarter, Steering Committee members review the information on clients that are re-arrested to determine if any changes in services are needed to prevent re-arrests.

2. Increase the number of criminal justice personnel trained in diversion strategies.

The participating jails and court systems will track, a.) number of staff trained under this project, b.) number of training sessions.

3. *Increase the number of court based diversion program/alternative jail diversion strategies.*

Since the Jail Data Link project is both an alternative jail diversion strategy and a court based diversion program, the successful implementation of the program in the two counties will represent the establishment of such program. The Data Link system, using information input by case mangers will track a.) number of individuals screened/assessed for mental illness and participation, b.) number of individuals accepted not/accepted into mental health court case management, c.) number of individual who declined participation, d.) number of individuals enrolled and participating.

4. Increase mental health and other services available to offenders with mental illness.

The Data Link system, using information input by case managers will track a.) number of service Referrals to mental health, substance abuse and co-occurring disorders, housing needs, employment, vocational education and other services, b.) number of individuals released into the community with written discharge plan and shared with community providers and c.) number of individuals who are discharged from jail not eligible for follow up services (i.e., sentenced to prisons, moving out of state).

5. Increase and Maintain Stakeholder and Partner Support.

Dr. Freeman will continue to host quarterly stakeholder meetings to discuss progress and gather feedback on successes and challenges at programmatic and systemic levels. Additionally, all recommendations will be reviewed by the steering committee, and determinations will be made whether they can be adopted. Recommendations and timeline for implementation will be submitted to BJA in the annual report. Program partners are committed to continue these efforts after the federal support ends. Partners will also leverage existing resources for this project, including mental health and substance abuse treatment funded through other Illinois agencies.

Sustainability Plan

Extended system-of-care funding will be aggressively pursued. Expansion to and implementation of the Data Link project in these two counties will be the catalyst for improved mental health for the target population. Long-term systemic change will occur because detainees with mental health issues will have immediate access to continue their care. Furthermore, change is supported because the partners are committed to developing a formal plan to support sustainability and work with key state staff to implement the plan. Additionally, funding to support continuing services under this project could be obtained through the Illinois Department of Human Services state agencies of the Division of Mental Health and the Department of Alcoholism and Substance Abuse. The Illinois Department of Human Services/Division of Mental Health and ICJIA have a history of securing funding to continue projects as evidenced by the expansion of the Jail Data Link project to five Illinois counties.

Sequential Intercept Mapping & Taking Action for Change

Appendix U: Providing Jail Diversion for People with Mental Illness

Policy Research Associates


Policy Research Associates

Providing Jail Diversion for People With Mental Illness

Bexar County Jail Diversion Program, The Center for Health Care Services, San Antonio, Texas

The 2006 Achievement Award Winners

The American Psychiatric Association will honor four outstanding mental health programs in an awards presentation on October 5 at the opening session of the Institute on Psychiatric Services in New York City. The Bexar County Jail Diversion Program of the Center for Health Care Services in San Antonio, Texas, has won the Gold Achievement Award in the category of community-based programs because of its development of an innovative system of jail diversion involving community partnerships and collaborations, which has improved services, enhanced access to and continuity of care for persons with mental illness, and resulted in financial savings. In the category of academically or institutionally sponsored programs, the Perfect Depression Care program of the Henry Ford Health System Department of Psychiatry in Detroit has won the Gold Achievement Award for its exemplary success in implementing evidenced-based treatment for depression in a large health care system, ensuring consumer involvement in care redesign, and achieving dramatic reductions in suicide. Both of these programs will receive a $10,000 prize made possible by a grant from Pfizer, Inc.

In addition, a Silver Award will be presented to Community Support Services of Wyandot Center for Community Behavioral Healthcare, Kansas City, Kansas, and a Bronze Award will be presented to the Missouri Mental Health Medicaid Pharmacy Partnership Project, Jefferson City, Missouri. Both award winners will be presented with plaques during the awards ceremony.

The winning programs were selected from among 53 applicants by the 2006 Achievement Awards Committee, chaired by Jacqueline Maus Feldman, M.D., of Birmingham, Alabama. The awards have been presented annually since 1949.

Persons with mental illness are often jailed for nonviolent, victimless crimes. According to the National Alliance on Mental Illness, up to 40 percent of adults with mental illness will come into contact with law enforcement. And nationally, 16 percent of the jail population is incarcerated for offenses related to mental illness, mental retardation, or substance abuse. Of these, 60 percent to 75 percent were jailed for nonviolent offenses.

In response to the significant number of detainees and prisoners presenting with symptoms of severe mental illness, the Center for Health Care Services created the Bexar (pronounced "bear") County Jail Diversion Program. Since its inception in 2002, the program has sought to streamline the process of jail diversion to reduce the number of people who end up in jail as a result of behavioral problems caused in part by mental illness. The program has also sought to reduce the inappropriate use of emergency departments by this population. Today, the jail diversion program involves a dynamic community collaborative, increased access to care, continuity of care, and cost savings to the community.

Initial results show that from September 2003 to February 2006, 3,674 persons were diverted from jail, resulting in an estimated $3.8 million to $5.0 million in avoided costs within the county's criminal justice system.

In recognition of its innovative Bexar County Jail Diversion Program for persons with severe mental illness and substance use disorders, the Center for Health Care Services was selected as winner of the 2006 Gold Achievement Award in the category of community-based programs. The winner in the category of academically or institutionally sponsored programs is described on page 1524. The awards will be presented on October 5 during the opening session of the Institute on Psychiatric Services in New York City. Each Gold Award winner will receive a plaque and a $10,000 prize made possible by a grant from Pfizer, Inc.

Intervention phases

In order to effectively divert offenders from jail and direct them into appropriate community services, the Bexar County Jail Diversion Program has identified and operationalized 46 separate and distinct intervention points in the current arrest-detention process in the criminal justice system. These intervention points were then divided into three phases. The first phase focuses on diverting persons with mental illness from the legal system, before they are arrested or booked into the county jail. This is accomplished by identifying and screening for mental illness, making recommendations to magistrates or judges, and providing options for treatment. The second phase of the diversion program focuses on identifying persons with mental illness who

are already in the criminal justice system and recommending alternate dispositions, such as a mental health bond or release to a treatment facility. The third phase focuses on providing appropriate mental health and support services upon release from jail or prison.

Phase one

The first phase of the program involves prebooking diversions, and a crisis hotline is used to route calls for assistance and serve a point of coordination for all crisis and jail diversion services. All calls are recorded and tracked for follow-up.

Calls can be routed to the deputy mobile outreach team (DMOT). This team—consisting of a mental health professional and a law enforcement officer trained in working with persons with mental illness—responds to calls from the community for assistance with persons with mental illness or mental retardation. The team is available at all times to respond to calls and is able to make on-site mental health assessments, consultations, and referrals. The actions of the DMOT often minimize the need for on-site arrests.

As another prebooking tactic, the program uses crisis intervention teams (CIT), which consist of police officers who have been specifically trained in working with persons with mental illness. These teams respond to calls in the field that may involve mentally ill consumers. By training officers to recognize and deal with people acting inappropriately as a result of mental illness, the Bexar County Jail Diversion Program hopes to direct consumers to the most appropriate treatment options, rather than automatically directing them to jail or the psychiatric unit of an emergency department.

The Bexar County's CIT training program consists of a 40-hour, weeklong training course for law enforcement officers (state requirements are less than ten hours) and involves a broad range of community stakeholders and financial support from public and private organizations. Throughout the week, mental health professionals develop and act in role-play scenarios that must be successfully completed by officers. Participation of consumers, families, and members of the National Alliance on Mental Illness is an integral feature of this training.

Also, a mental health docket that combined data from ten criminal courts was reengineered. With the reengineering, the Center for Health Care Services became an integral part of the process by identifying and screening candidates before they arrived at the docket and by making recommendations as to appropriate placement and need for treatment. These changes have resulted in a significant reduction in the rearrest rate of misdemeanor offenders.

Phase two

The second phase of the diversion program focuses on identifying persons with mental illness who are already in the criminal justice system. To this end, the entire jail population is screened daily against a statewide database to determine which persons have accessed the mental health system in the past. This screening process identifies persons who are in potential need of intervention and assistance from mental health services.

In the second phase alternatives to jail for persons who are already in the system are explored. Persons with mental illness make up a significant proportion of the jailed population partly because inmates with mental illness serve an average of 15 months longer than those without mental illness for committing the same crime. Once incarcerated, these persons do not have access to adequate treatment and remain in the system simply because there is nowhere for them to go.

To help direct offenders to treatment, the program has established a residential step-down program, allowing judges a sentencing option that ensures that individuals go directly into treatment programs. The only one of its kind in Texas, the program consists of a 100-bed alcohol and substance abuse treatment facility and a 60-bed mental health facility, which allow persons to step down directly from jail into treatment.

Also, an involuntary outpatient commitment program was established within the civil probate court. Through a court-assigned mental health care professional, this program provides case management and continuity of care to persons who have been repeatedly incarcerated for minor crimes or who have come to the attention of law enforcement for health and safety reasons as a result of mental illness. This group of persons generally has their charges escalated because of the increasing number of offenses, and the intervention serves as a diversion from both jail and emergency departments, as it offers judges a sentencing option (commitment for 90 days, which can be renewed upon a physician's recommendation). When data were compared for the year before and the year after the first 14 participants entered the program, results showed that participants had a 79 percent reduction in the number of hospital bed-days (131 to 27 bed-days).

Phase three

The third phase focuses on preventing recidivism and arrests. For this phase, the program provides cognitive adaptive training (CAT) to consumers in their homes. For example, once patients with schizophrenia are discharged from detention or the hospital, CAT is provided to help them to resume daily activities in a community setting. The CAT program also employs persons with schizophrenia to help gain the trust and participation of persons with mental illness.

The Genesis Special Needs Offenders Program was created as another way to prevent recidivism. The program provides intensive case management, psychiatric services, and rehabilitation training for offenders who are on probation and parole. These services are provided in collaboration with local and state probation and parole departments.

Crisis Care Center

To provide law enforcement personnel enhanced access to services, the Crisis Care Center was opened in 2005. The center is open 24 hours a day and offers a more structured system of care by housing medical, psychiatric, and social work resources in one place. The center provides an

average of 700 medical and mental health screenings per month. Not only has the center streamlined the screening process, but it also simplifies processes for evaluation, emergency treatment, disposition, and follow-up.

Before the Crisis Care Center was opened, law enforcement personnel had to deal with wait times of up to 12 hours when persons suspected of having minor legal infractions were evaluated by the hospital's emergency department. Now, wait times for screenings are just over an hour, thus saving the time of law enforcement.

Program staffing and funding

The jail diversion model is an integrated system of emergency departments, the court system, the mental health system, and probate courts. In addition to staff of partner agencies working in these systems, the Bexar County Jail Diversion Program employs 146 multidisciplinary staff, including physicians, nurses, licensed mental health professionals, benefit specialists, caseworkers, rehabilitation specialists, vocational and housing specialists, and records management personnel.

Funding for the Bexar County Jail Diversion Program—approximately $8.4 million annually—is provided through federal, state, and local support, Medicaid and Medicare, the University Health System, and CareLink.

Obstacles overcome

In many cases, the shortage of available funds and fractured and scattered resources are difficult problems for programs to overcome. Key to the success and leadership of the Bexar County Jail Diversion Program is the Medical Directors Roundtable, which meets monthly. The organizers of the roundtable brought representation from 22 city, county, and state law enforcement, judicial, and health care entities. Hospitals were also brought on board from the beginning, because of the high emergency department costs from recidivism. These representatives highlighted the mutual problems and frustrations that they faced and worked to find a common solution for all. The roundtable was also instrumental in finding and combining funding sources from all available resources.

In 2003 Texas faced a severe budget deficit resulting in an $8 million funding cut to the Center for Health Care Services. Despite this loss, the jail diversion program was successful in obtaining funds to enable it to continue, in part because it was clear how effective the program was. Small and major contributions were received from the federal government (three-year grant in the amount of $900,000), the state, local commissioners court, law enforcement agencies (dedication of $100,000 from drug seizure assets), and a host of provider entities, such as the National Alliance on Mental Illness, private hospitals, and an unrestricted grant from AstraZeneca Pharmaceuticals ($1.5 million).

Program effectiveness and quality assurance

The Bexar County Jail Diversion Program is outcome driven. As such, gathering and monitoring program data is a priority. The program documents all services and interventions. The Bexar County Jail Diversion Program follows the Texas Administrative Code in its procedures and program compliances. Best practices are in operation, such as Projects for Assistance in Transition From Homelessness (PATH), assertive community treatment, and crisis services. The Crisis Care Center maintains an active utilization review and utilization management process.

As part of the review process, the model employs a psychiatrist who is involved in the daily review of emergent cases and all activities of the crisis hotline, DMOT, and the Crisis Care Center. Also the DMOT calls the psychiatrist about every research case, directly from the scene. Staff also ensure quality improvement measures by tracking cases to completion and reviewing all state hospitalizations from the program.

Accomplishments

The program has been successful in providing humane and confidential care for persons with serious mental illness who are involved in the criminal justice system.

The accomplishments of the program have been acknowledged in many ways. The Substance Abuse and Mental Health Services Administration has featured the Bexar County Jail Diversion Program in its list of national model programs. Also, the program was adopted by the State of Texas Department of Health Services as the model for implementation of jail diversion programs throughout the state. Furthermore, mandatory state contract performance measures were adopted by the state and pulled directly from the standards of the Bexar County Jail Diversion Program.

Because of the success of the program, in 2003 it was a recipient of one of seven Target Capacity National Jail Diversion Program Grants. And in 2006 the Bexar County Program was the recipient of the National Council for Community Behavioral Healthcare award for service excellence.

Also, the favorable outcomes of the program led to legislation in 2005 by the 78th Texas Legislative session requiring the provision of state-approved jail diversion plans for all community mental heath centers.

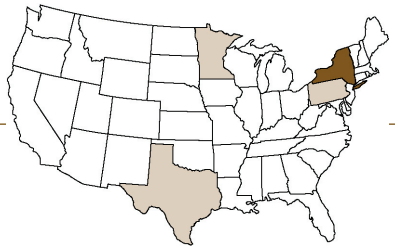
The Bexar County Jail Diversion Program has been successful in integrating health care, law enforcement, and the judicial system to transform the way mental health services are delivered to offenders with mental illness with low-level offenses. In doing so, the program has reduced the recidivism of persons with mental illness by providing access to appropriate treatment. Giving persons with mental illness the opportunity to stay out of jail has enhanced public safety by freeing up jail beds for violent offenders and has provided humane and confidential care for persons with serious mental illness who are involved in the criminal justice system.

For more information contact Leon Evans, president and chief executive officer, the Center for Healthcare Services, 3031 IH 10 West, San Antonio, TX 78201; e-mail: levans@chcs.hhscn.org.

Sequential Intercept Mapping & Taking Action for Change

Appendix V: Ensuring Timely Access To Medicaid and SSI/SSDI for People with Mental Illness Released from Prison: New York

Policy Research Associates



Ensuring Timely Access to Medicaid and SSI/SSDI for People with Mental Illness Released from Prison:

New York

I. BACKGROUND INFORMATION

In New York State Medicaid expenses are generally shared between the federal government (50%), the state (25%) and each county (25%). This is unlike the majority of other states where the federal government and the states share the costs and there is no local financial participation. Assuring uniformity in the implementation of a statewide initiative involving Medicaid, which typically requires agreement by 57 separate counties and the city of New York, is therefore an ongoing challenge. Many programs have a local option, and as such are subject to variation.

II. STRATEGIES TO ENSURE PROMPT REINSTATEMENT OF BENEFITS

A. Overview of Programs

The primary mechanism employed in New York State to connect eligible individuals with mental illnesses to federal benefits after release from prisons and jails is the Medication Grant Program (MGP). Additionally, the Central New York Psychiatric Center (CNYPC) of the New York State (NYS) Office of Mental Health (OMH) administers a formal discharge planning initiative, called "Pre-Release Coordination," for inmates who received prison mental health services and are about to be released.

MGP was initiated under "Kendra's Law" (1999 Laws of New York, Chapter 408), which also established involuntary outpatient commitment in New York State, and became active in September 2000. The NYS OMH, which is responsible for providing mental health care within all NYS correctional facilities, monitors its functioning. The program is grant-funded, and counties can choose not to participate. Since its inception the MGP program has enrolled 9,600 individuals. As of March 2004, close to 1,800 enrollees were active in the program.

MGP seeks to connect people to Medicaid and other benefits such as food stamps and cash assistance as well as to provide access to psychiatric medications in the community. To be eligible for the program the offender must have a serious mental illness, be currently taking prescribed psychiatric medications, and appear to be eligible for Medicaid after release (though ultimate Medicaid eligibility can only be decided by the local department of social services). To be enrolled in MGP an individual must file an application for Medicaid benefits; the individual can then participate in MGP while his or her Medicaid application is being processed and until an eligibility determination is made on that application.

Under the MGP, an application for Medicaid benefits can be submitted up to 45 days prior to release from incarceration or within seven days after release. In discussions between OMH, the NYS Office of Temporary Disability Assistance (OTDA), and the NYS Department of Health (DOH) it was decided that a combined Medicaid/Cash Assistance/Food Stamp application would be used as it offers access to additional services (e.g., food stamps, public assistance), for which the participant may potentially be qualified. However, because each of these additional benefits programs require the applicant to submit distinct supporting information, submitting the joint application alone is typically insufficient for the individual to gain access to those benefits. Applying for Social Security Disability Insurance (SSDI) benefits or Supplemental Security Income (SSI) is not required as part of the MGP but may be required (depending on the county) as part of the Medicaid application process. Most counties participating in the MGP file and process applications for Medicaid only.

An implementation manual was developed as part of the MGP program. It contains administrative directives from DOH and OTDA and model agreements between the

Support for this project is provided by the US Department of Health and Human Services' Substance Abuse and Mental Health Services Administration (SAMHSA), the MacArthur Foundation, and the New York Community Trust.

county mental health and the county social service offices that manage the Medicaid, Food Stamps, and Cash Assistance programs locally. Medications are provided as part of the program through an OMH contract with a "benefits manager." This benefits manager (First Health) sub-contracts with a network of 3,700 pharmacies statewide. MGP participants receive MGP cards, which can be used like insurance cards to pay for medication at any pharmacy in the network. Once Medicaid eligibility is established for a participant, OMH retroactively bills Medicaid for the medications dispensed while the person was in the community. The statewide average of MGP enrollees who are found to be Medicaid-eligible is 69 percent.

Under MGP if a participant is found ineligible for Medicaid benefits, his or her eligibility for MGP ends and the locality is expected to assist that person to obtain medications under some other auspice (e.g., drug company indigent programs, local mental health funds, etc.). Funds expended for medications and services for participants later found ineligible for Medicaid come from an ongoing legislative appropriation that is allocated by OMH on a county to county basis.

Some county administrators see inherent dangers in implementing a program that may not be re-appropriated in subsequent state budgets. Some counties which did not participate in MGP, such as Duchess and Orange, came up with their own programs in which they were permitted to utilize their county allocation of MGP funds. Jefferson County worked out an arrangement with their county social service office to have social service staff go into the county jail and complete Medicaid applications for offenders with mental illnesses about to re-enter the community.

The MGP also separately funds "transition management" positions in correctional facilities. Staff hired with these funds assist in the Medicaid application process, register eligible persons with First Health via fax and dispense MGP cards to the person when he or she is released to the community. According to participating state agencies these positions have been critical to the success of the MGP program. In jails these positions (approximately 80 statewide) are generally referred to as "transition managers" or "discharge planners," while in prison they are called "pre-release coordinators" and administered as part of OMH's previously-established Pre-Release Coordination program.

Pre-Release Coordination was established in 1995 by the New York State Office of Mental Health, which provides mental health services for persons in New York State prisons via its Central New York Psychiatric Center (CNYPC) and its satellite/mental health units located in state correctional facilities. Through the Pre-Release Coordination program, CNYPC and its satellite/mental health units supervise a network of pre-release coordinators in prisons. These coordinators assist with filing benefit applications and make referrals to service providers for those inmates who received prison mental health services and are about to be released. In 2003, CNYPC provided community referrals and service linkages for 1,600 inmates with mental illnesses being released from prison to the community. More information on pre-release coordination can be found at: http://www.omh.state.ny.us/omhweb/forensic/manual/html/chapter4.htm.

B. Medicaid

With the implementation of the Medication Grant Program CNYPC received seven additional pre-release coordinators, raising the total number of coordinators to 24 across the prison system. Since the MGP program is considered a county-based program, the prison pre-release coordinators complete the combined Medicaid/Public Assistance/Food Stamp for eligible inmates and forward these applications to the local MGP Coordinator. The local MGP Co-ordinator logs in the application and forwards it to the county social services agency for eligibility determination. Pre-release coordinators experience certain challenges related to the inconsistent implementation of the programs in certain counties. Once the Medicaid application is completed, the pre-release coordinator faxes a MGP enrollment form to First Health and issues a MGP card to the inmate upon release.

C. SSI and SSDI

As mentioned above, the MGP does not include processes for the reinstatement of SSI/SSDI benefits. To address this issue, the New York State Division of Parole and the Social Security Administration (SSA) have entered into a memorandum of understanding (MOU) regarding procedures for submitting pre-release application for SSI and SSDI benefits. The MOU provides that OMH (CNYPC) staff will submit the applications on behalf of offenders with mental illnesses, while parole officers will submit them on behalf of offenders with other disabilities.

In order to identify individuals with mental illnesses who may require transition planning prior to release from prison, OMH (CNYPC) staff receive corrections and parole data regarding inmates anticipating release and matches this data with the OMH active caseload.

The Division of Parole has prison-based staff who generally meet with the inmate three months before his

or her scheduled release. At that time the OMH (CNYPC) pre-release coordinator submits applications for SSI and SSDI to the Social Security office closest to the prison on behalf of the individual, if he or she may be eligible. Both parole and OMH staff try to submit the application and medical evidence of disability as one package as authorized by the revised MOU with SSA (August 2003). The OMH (CNYPC) pre-release coordinators try to submit the applications three months prior to the inmate's expected release.

In New York State the Office of Temporary and Disability Assistance (OTDA) reviews and rules on the medical evidence of disability that is submitted to support the claim of disability through its Division of Disability Determinations (DDD). This division handles all disability eligibility determinations for persons applying to Social Security benefit programs whether they are in the community, in hospitals, or in correctional facilities. Applications for disability from persons in New York State prisons are therefore within a much larger pool of applications being considered by OTDA's medical examiners. Two recent developments represent an attempt at improving the response to this population. New York State has established a transitional correctional unit for persons with mental illnesses, and OTDA agreed to channel all applications from this unit to a previously determined group of only five medical examiners. These changes have resulted in increased communication and problem identification, as well as some successful eligibility determinations prior to release from prison.

While coordination between OTDA's DDD and local SSA offices has not been consistent or uniform, to date 500 of the 1,600 persons receiving OMH (CNYPC) pre-release coordination services in 2003 received assistance filing SSI and/or SSDI applications.

Multiple factors affect the ability of OMH-CNYPC to assist inmates to file SSA benefit applications within the three-month window as recommended in the pre-release policies and procedures. Situations involving unexpected releases by the parole board and persons returning to prison on a parole violation or after extended jail stays create some specific challenge areas. Also, people who have not been identified as having a mental illness during their incarceration are often identified by parole staff during the development of a post-release supervision plan. This results in insufficient notice to OMH about an inmate's transition planning needs. When this occurs the priority for OMH is to find the individual housing in the community, to enroll him or her in the MGP program for medications, and to identify a provider for mental health services. As such, a disability application may not be completed before release.

According to state officials it is difficult to determine the outcome of applications filed prior to release (i.e., whether the application was approved and the applicant received benefits) because there is no effective way to follow up with people post-release. Although in theory a pre-release eligibility determination (Notice of Medical Allowance) from OTDA-DDD can be obtained and the applicants can begin receiving benefits immediately post-release, in reality applicants seldom have a determination on their SSI/SSDI application before they are released. Some former inmates can go up to a year without a final determination on their application. A variety of reasons for this are noted including: incomplete applications, lack of treatment information from prior providers, and/or lack of follow-up by the applicant and/or the current mental health provider.

To begin to address the timelines issue, the MOU with SSA has been modified to allow applications to be filed up to six months prior to release. The inherent problem with this approach is that there is a six-month limit on completion of the application process. When an application remains incomplete due to insufficient medical evidence, inability to secure past medical records or documents such as birth certificates, an inmate's use of an alias and/or multiple Social Security numbers, it is denied and the applicant must start the process anew.

Some prisons in the state are testing new approaches to expedite the process. For example, Arthurkill prison's pre-release staff are working with local SSA staff to complete and file SSI/SSDI applications. Staff from the local SSA office meet personally with inmates previously identified as potentially eligible for SSI/SSDI at CNYPC's Arthurkill Mental Health Unit. The SSA staff explain the program rules and help the inmates complete their applications for SSI/SSDI. With the consent of the applicant, the pre-release coordinator provides the medical evidence from the OMH record and, when necessary, obtains information from the Department of Correctional Services Health Services records as part of this process. This is the only CNYPC unit to have such an arrangement.

III. ISSUES REQUIRING FOLLOW-UP

A. Medicaid

Some of the problems with MGP relate to co-ordination of the various different agencies involved (prison, parole, prison mental health, local mental health, local social

services and a benefits manager). State officials have attributed these coordination issues to "growing pains" and expect the program to become "institutionalized" and operate smoothly. However, several obstacles persist:

Achieving uniform working relationships in the 43 participating counties is an ongoing challenge for OMH, DOH, and OTDA. While the MGP program is voluntary, counties agreeing to implement the program are expected to follow the basic model. On the local level there are still some variances under review by the state agencies involved. For example, while some participating counties require social service staff to go into the county jails to meet with potential participants and complete Medicaid applications, other counties wait for an individual's release before filing an application.

Some issue is taken with instruction in a letter from Secretary of Health and Human Services Tommy Thompson which stated that Medicaid need not be terminated during incarceration and in all cases should be immediately available to individuals released from a correctional facility. The concept of suspension of Medicaid status is seen as running counter to federal regulations requiring annual re-certifications and updates of social service records when a person's status changes. Also, reinstating Medicaid immediately upon release presumes that the person is still otherwise eligible, even though the person's residential or other supports that may affect his or her Medicaid eligibility may have changed. DOH has requested specific direction from the regional office of the Center for Medicaid Services regarding implementation of Mr. Thompson's letter. Pending such direction, DOH does not feel it can impose the letter's suggestions on county departments of social services in New York State.

B. SSI/SSDI

The issue of determining what is appropriate medical evidence to support SSI/SSDI applications vexes both the CNYPC Pre-Release Coordinators and prison medical staff. A simplified booklet describing appropriate medical evidence of disability and information on the SSA criteria would be helpful.

OMH would like to replicate in all other prisons the joint SSI/SSDI application process in place at Arthurkill Correctional Facility and expand the process to include cross-training for SSA disability examiners and OMH prison staff.

Several people interviewed would like to see a reciprocal information-sharing process between SSA and the pre-release coordination services. In such an arrangement, SSA would provide OMH with names of people identified as receiving SSI/SSDI upon admission to jail and/or prison. This information is already being collected by SSA via a data match from county jails and state prisons for use in suspending or terminating benefits. Providing this information to OMH would enable OMH staff to identify inmates with mental illnesses in need of pre-release services, who otherwise might not be identified.

It is universally reported that, except in the most extreme cases, all initial applications by persons who are in prison for SSI/SSDI based on mental illness disability are denied and, if appealed, are subsequently approved. Appeals of denials of eligibility can take months and even years. As such, efforts by prison staff towards smooth transition to the community are often frustrated by the complexities of the appeals process.

There is no single mental health database of persons receiving mental health services in the community. As such, OMH (CNYPC) must rely on notification by prison mental health services of a person's need for mental health services; inmates who refuse treatment in prison may not be identified by prison mental health services staff.