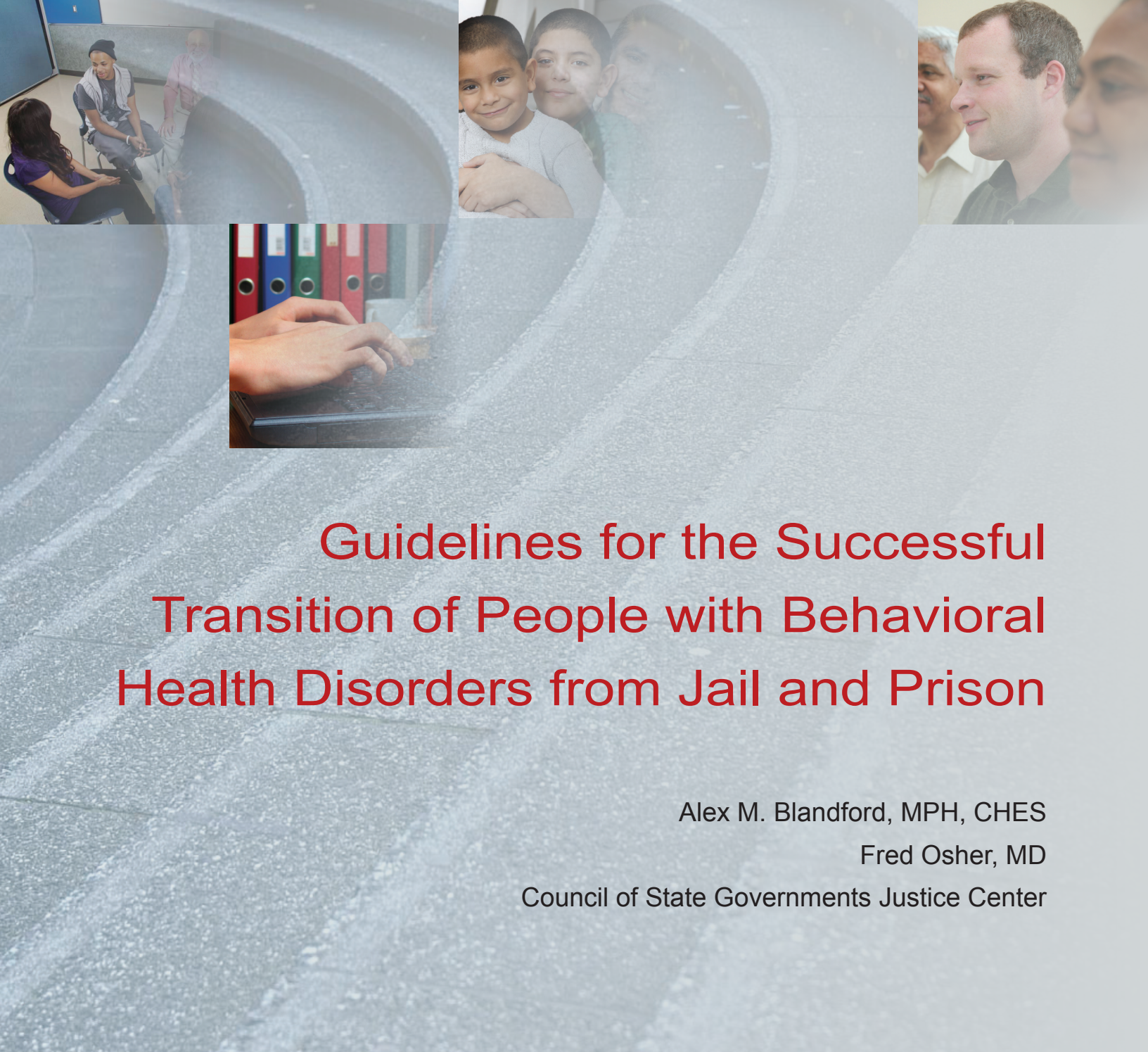




# Guidelines for the Successful Transition of People with Behavioral Health Disorders from Jail and Prison

Alex M. Blandford, MPH, CHES

Fred Osher, MD

Council of State Governments Justice Center

[Assess Plan Identify Coordinate]

SAMHSA's GAINS Center for Behavioral Health and Justice Transformation

The Council of State Governments Justice Center

# Guidelines for the Successful Transition of People with Behavioral Health Disorders from Jail and Prison

Alex M. Blandford, MPH, CHES

Fred Osher, MD

Council of State Governments Justice Center

SAMHSA's GAINS Center for Behavioral Health and Justice Transformation  
Council of State Governments Justice Center

November 2013

This work was conducted by SAMHSA's GAINS Center for Behavioral Health and Justice Transformation (GAINS Center), operated by Policy Research Associates, Inc., in collaboration with the Council of State Governments Justice Center (CSG Justice Center), and was authored by Alex M. Blandford, MPH, CHES, and Fred C. Osher, MD. Support for this work came from U.S. Department of Health and Human Services' Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Mental Health Services (CMHS) and the Department of Justice's (DOJ) Bureau of Justice Assistance (BJA). The material contained in this publication does not necessarily represent the position of the U.S. Department of Health and Human Services or the U.S. Department of Justice.

The suggested citation for this resource is Blandford, Alex M. and Fred C. Osher. Guidelines for the Successful Transition of Individuals with Behavioral Health Disorders from Jail and Prison. Delmar, NY: SAMHSA's GAINS Center for Behavioral Health and Justice Transformation, 2013.

About SAMHSA's GAINS Center: Since 1995, SAMHSA's GAINS Center has been operated by Policy Research Associates, Inc. in Delmar, NY. The GAINS Center's primary focus is on expanding access to community based services for adults diagnosed with co-occurring mental illness and substance use disorders at all points of contact with the justice system. The Center emphasizes the provision of consultation and technical assistance to help communities achieve integrated systems of mental health and substance abuse services for individuals in contact with the justice system.



345 Delaware Avenue  
Delmar, NY 12054

<http://gainscenter.samhsa.gov/>

About the CSG Justice Center: The Council of State Governments Justice Center is a national nonprofit organization that serves policymakers at the local, state, and federal levels from all branches of government. It provides practical, nonpartisan advice and consensus-driven strategies—informed by available evidence—to increase public safety and strengthen communities.



100 Wall Street, 20<sup>th</sup> Floor  
New York, NY 10005

[www.csjusticecenter.org](http://www.csjusticecenter.org)

# Contents

|                                                                                                                                                                               |           |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------|
| <b>Acknowledgments.....</b>                                                                                                                                                   | <b>v</b>  |
| <b>Introduction.....</b>                                                                                                                                                      | <b>1</b>  |
| Table 1: Estimated Proportion of Adults with Mental Health, Substance Use, and Co-occurring Disorders in U.S. Population and under Correctional Control and Supervision ..... | 1         |
| Building Effective Partnerships Through a Shared Vision .....                                                                                                                 | 2         |
| Implications for Successful Transition and Reentry .....                                                                                                                      | 5         |
| Figure 1: Summary of Guidelines.....                                                                                                                                          | 6         |
| <b>Assess — Guidelines 1 &amp; 2 .....</b>                                                                                                                                    | <b>9</b>  |
| Table 2. “Central Eight” Risk Factors That Place a Person at Risk for Future Criminal Behavior...10                                                                           |           |
| <b>Plan — Guidelines 3 &amp; 4 .....</b>                                                                                                                                      | <b>13</b> |
| <b>Identify — Guidelines 5 &amp; 6 .....</b>                                                                                                                                  | <b>17</b> |
| <b>Coordinate — Guidelines 7–10.....</b>                                                                                                                                      | <b>21</b> |
| <b>Conclusion.....</b>                                                                                                                                                        | <b>27</b> |
| <b>Appendix A. Evidence-Based Practices and Programs for Individuals with Behavioral Health Needs in the Criminal Justice System .....</b>                                    | <b>29</b> |
| <b>Appendix B. Information Sharing in the Criminal Justice-Behavioral Health Context: HIPAA and 42 CFR.....</b>                                                               | <b>31</b> |
| <b>Endnotes .....</b>                                                                                                                                                         | <b>33</b> |



# Acknowledgments

SAMHSA's GAINS Center for Behavioral Health and Justice Transformation (GAINS) in partnership with The Council of State Governments Justice Center (Justice Center) produced this technical assistance resource with support from the U.S. Department of Health and Human Services' Substance Abuse and Mental Health Services Administration (SAMHSA) and the U.S. Department of Justice's Bureau of Justice Assistance (BJA). The project staff thanks the leaders of these agencies for their commitment to addressing the overrepresentation of people with behavioral health disorders in jails, prisons, and under probation and parole supervision. Special thanks to Danica Binkley, BJA; Dr. Larke Huang, SAMHSA; Dr. David Morrisette, SAMHSA; Ruby Qazilbash, BJA; and Kenneth Robertson, SAMHSA.

Agencies collaborating on this project included the National Association of State Mental Health Program Directors, the National Association of State Alcohol and Drug Abuse Directors, Association of State Correctional Administrators, and the American Probation and Parole Association.

In addition, project staff gratefully acknowledge the contributions of the group of practitioners who provided invaluable ideas and feedback on earlier drafts. Special thanks go to Steven Allen, Executive Director, Mental Health And Substance Abuse Treatment Services, DHS Direct Care at the State of Minnesota; Marianne Cripps, Peer/Case Manager at the 31st Judicial Drug Court in Tennessee; Laverne Miller, Senior Project Associate, SAMHSA's GAINS Center; and Dr. Merrill Rotter, Associate Clinical Professor Of Psychiatry at the Albert Einstein College Of Medicine.



# Introduction

*Transition planning can only work if justice, mental health, and substance abuse systems have a capacity and a commitment to work together.<sup>1</sup>*

Progress has been made in recent years to reduce the number of individuals with behavioral health<sup>2</sup> disorders (mental and/or substance use disorders) who are incarcerated and to expand interventions that address the many factors that lead to their involvement in the criminal justice system. However, these individuals continue to be overrepresented in criminal justice settings. High arrest and recidivism rates still act as barriers to the recovery paths of these individuals, create stress for their families, and adversely affect public safety and government spending. As reflected in Table 1, research confirms that many individuals under correctional supervision have mental or substance use disorders, or both.

Table 1. Estimated Proportion of Adults with Mental Health, Substance Use, and Co-occurring Disorders in U.S. Population and under Correctional Control and Supervision<sup>3</sup>

|                                                                                               | General Public      | State Prisons       | Jails               | Probation and Parole |
|-----------------------------------------------------------------------------------------------|---------------------|---------------------|---------------------|----------------------|
| Serious Mental Disorders                                                                      | 5.4% <sup>4</sup>   | 16% <sup>5</sup>    | 17% <sup>6</sup>    | 7–9% <sup>7</sup>    |
| Substance Use Disorders (Alcohol and Drugs) — Abuse and/or Dependence                         | 16% <sup>8</sup>    | 53% <sup>9</sup>    | 68% <sup>10</sup>   | 35–40% <sup>11</sup> |
| A Co-occurring Substance Use Disorder When Serious Mental Disorder Is Diagnosed <sup>12</sup> | 25% <sup>13</sup>   | 59% <sup>14</sup>   | 72% <sup>15</sup>   | 49% <sup>16</sup>    |
| A Co-occurring Serious Mental Disorder When Substance Use disorder Is Diagnosed <sup>17</sup> | 14.4% <sup>18</sup> | 59.7% <sup>19</sup> | 33.3% <sup>20</sup> | 21% <sup>21</sup>    |

Despite the significant number of individuals with behavioral disorders in the criminal justice system, 2010 marked the first time in nearly 40 years that the number of state prisoners in the United States declined.<sup>22</sup> To achieve better outcomes, policymakers and researchers agree that a shift away from a reliance on incarceration to an emphasis on expanding capacity to supervise and treat individuals in the community is necessary. This shift has focused attention on the importance of cross-system approaches to providing effective criminal justice and behavioral health treatment interventions with the dual goals of reducing recidivism and promoting recovery. A critical component of cross-system work occurs at the transition from jail or prison to the community. Reentry into the community is a vulnerable time, marked by difficulties adjusting, increased drug use and a 12-fold increased risk of death in the first two weeks after release.<sup>23</sup> Effective transition planning and implementation can minimize the risk of these hazards, enhance public safety by increasing the possibility that individuals will participate in and complete supervision and treatment requirements, and improve individual outcomes.

## Health Care Reform and Opportunities for Expanded Access to Behavioral Health Services

Over the past five years, the United States has seen the passage of several laws making major changes to our health care system, including the:

- 2008 passage of the Mental Health Parity and Addiction Equity Act (MHPAEA);
- 2009 passage of the Health Information Technology for Clinical and Economic Health (HITECH) Act; and
- 2010 passage of the Patient Protection and Affordable Care Act (ACA).

Taken together, these health care reforms will require more comprehensive health care coverage, especially for mental health and substance abuse services; expand health care coverage to millions of Americans; and promote quality of care and care coordination through the electronic exchange of health information. Implementation of these laws is just now gaining full steam, and the implications for individuals under correctional and community-based supervision are yet to be realized.

As many as 90 percent of individuals involved in the criminal justice system are uninsured, but expanded eligibility under the ACA will greatly reduce these numbers. Starting on January 1, 2014, many in the criminal justice-involved population are expected to be eligible for coverage in either Medicaid or a federally subsidized health plan offered in the Marketplace. Importantly, protections on coverage required by the ACA and the MHPAEA will ensure that all plans offer comprehensive coverage of “essential health benefits,” including coverage of mental health and substance abuse services at parity, i.e., on a basis that is no more restrictive than coverage for medical/surgical coverage. In addition, payment and delivery reforms authorized by the ACA and the improved ability of health care providers to record and share health information electronically resulting from the HITECH Act will work in concert to promote care coordination and quality.

These health system changes represent an opportunity to improve access to comprehensive health care services, improve continuity of care between incarceration and reentry, and reduce state and local expenditures for individuals involved with the criminal justice system. To help realize this potential, systems should support applications and enrollment at all points in the justice system, including during incarceration. Stakeholders should also commit to the use of comprehensive, coordinated primary and behavioral health care, which studies have shown can reduce recidivism and build recovery.

## Building Effective Partnerships Through a Shared Vision

While there is overlap in the populations they serve, there is little consensus among behavioral health care, corrections, and community corrections administrators and providers on who should be prioritized for treatment, what services they should receive, and how those interventions should be coordinated with supervision conditions. Too often, corrections and community corrections administrators hear that “those aren’t my people” from behavioral health care administrators and providers. Just as often, the behavioral healthcare community feels that it is asked to assume a public safety role that is not in sync with its primary mission. Misunderstandings about each system’s capacity, abilities, and roles—as well as appropriate types of referrals—have contributed to the overrepresentation of behavioral health disorders in the criminal justice system. Renewed emphasis on efficiency and results within the criminal justice and behavioral health systems has increased the focus on effective and quality interventions designed with key outcomes in mind.

To help professionals in the corrections and behavioral health systems take a coordinated approach to reducing recidivism and advancing recovery, *Adults with Behavioral Health Needs Under Correctional Supervision: A Shared Framework for Reducing Recidivism and Promoting Recovery* (Behavioral Health Framework) was

## Prioritizing Enrollment to Facilitate Transition

*To ensure successful transition planning, states and counties must address the need for timely access to benefits.*

Health insurance coverage and Social Security benefits are key to successful transition planning so that individuals can access required services in a reliable and timely manner. Whether health insurance coverage is accessed through Medicaid or a subsidized plan offered through Health Insurance Marketplace, it is critical for ensuring access to essential treatment services (psychiatric treatment, health care, medications, etc.) upon reentry to the community.

For individuals with serious disabilities, Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) provide a monthly income benefit, which can be used for housing. In most states, qualification for SSI or SSDI also entitles an individual to enroll in Medicaid or Medicare, ensuring access to both income supports and healthcare coverage. While the application process for SSI/SSDI is lengthy and can be time consuming, this comprehensive benefit can help to meet the full range of an individual's basic needs and has been shown to be instrumental in facilitating successful reentry.

It is in everyone's best interest for jails and prisons to develop community partnerships to ensure timely access to benefits upon release. Four key areas must be addressed to ensure timely access to benefits:

- Develop MOUs or Letters of Agreement with county social services agencies and the Social Security Administration.
  - These documents clarify procedures for submission of benefit applications, response time for determinations, and enrollment procedures.
  - Some states have passed Medicaid suspension statutes that require that Medicaid can be reactivated upon release from custody.
  - Social Security Outreach, Access and Recovery (SOAR) is an approach focused on facilitating the submission of SSI/SSDI applications through training that results in approval rates of 70–90 percent. This training has been successfully implemented in jails and prisons. Each state has a SOAR team lead and training transition staff may be available. For further information: <http://www.prainc.com/SOAR>.
- Screen for benefits.
  - Screening for Veterans benefits, Medicaid, and Social Security benefits at point of intake will enable prompt processing of appropriate benefit applications.
- Designate resources to assist with preparation, submission, and follow-up of benefit applications.
  - Transition planning is resource intensive and staff resources must be identified to initiate applications, liaise with benefit agencies, and communicate with providers. Resources can be jail or prison based, or community based, and are provided through in-reach by community staff, or shared between institution staff and community staff.
- Develop jail/prison and community partnerships to assist with transition.
  - Sharing of information, timely access to treatment, collaborative transition planning, and post-release follow-up on benefits applications submitted prior to release are some of the activities that require coordination and shared responsibility. Often communities have reentry-specific task forces to address system barriers to transition planning.

\* In states that will not participate in ACA Medicaid expansion and where Medicaid benefits are restricted to people with disabilities and custodial parents, state/local or other funding may be required to obtain essential services for people who require mental health treatment but are not considered disabled.

## The Risk-Need-Responsivity (RNR) Model

The underlying principles of the RNR model are:

**Risk Principle: Match the intensity of individuals' treatment to their level of risk for reoffending.**

Research shows that prioritizing supervision resources for individuals at moderate or high criminogenic risk can lead to a significant reduction in recidivism among this group. Conversely, intensive supervision interventions alone for individuals who are at a low risk of recidivism will do little to actually change the individuals' likelihood of committing future criminal acts, and may even be harmful. High-intensity supervision for low-risk people is an ineffective use of resources to reduce reoffending. All persons with significant behavioral health needs should have access to comprehensive and effective services.

**Need Principle: Target criminogenic needs—those dynamic factors that contribute to the likelihood of reoffending.**

The need principle states that individuals have criminogenic and noncriminogenic needs and that treatment and case planning should prioritize the core criminogenic needs that can be changed through treatment, supervision, or other services and supports. Research indicates that the greater the number of criminogenic needs addressed through interventions, the greater impact the interventions will have on the likelihood of recidivism.

**Responsivity Principle: Address individuals' barriers to learning in the design of treatment interventions.**

The responsivity principle highlights the importance of reducing barriers to learning by addressing learning styles, reading abilities, cognitive impairments, and motivation when designing supervision and service strategies. Accordingly, the presence of a mental disorder may need to be addressed to accommodate individuals' level of processing so they can learn from service providers and comply with the conditions of their supervision or release.

*Excerpt from Adults with Behavioral Health Needs Under Correctional Supervision: A Shared Framework for Reducing Recidivism and Promoting Recovery*

developed.<sup>24</sup> The Behavioral Health Framework provides a structure to identify subgroups within the larger group of individuals involved in the criminal justice system based on their identified behavioral health and criminogenic needs (factors associated with committing future crimes; see Table 2 on page 10). In doing so, the Behavioral Health Framework is a helpful tool to prioritize resources and allocate those resources to the most effective interventions for each subgroup. The Behavioral Health Framework was funded by the National Institute of Corrections (NIC), the Bureau of Justice Assistance (BJA), and the U.S. Department of Health and Human Services' Substance Abuse and Mental Health Services Administration (SAMHSA), and supported by the Association of State Correctional Administrators (ASCA), the American Probation and Parole Association (APPA), the National Association of State Mental Health Program Directors (NASMHPD), and the National Association of State Alcohol and Drug Abuse Directors (NASADAD).

The cross-system strategies promoted by the Behavioral Health Framework are designed to

1. advance collaboration and communication by developing a shared language associated with risk of criminal activity and public health needs and setting common priorities between criminal justice and behavioral health systems for individuals with treatment needs who are likely to commit future crimes;
2. ensure that scarce resources are used efficiently by promoting the use of validated assessment tools to gauge individuals' criminogenic risk and behavioral health needs, identify the right people for appropriate interventions, and align and develop capacity to meet those needs;

3. promote effective practices by matching individuals' risk and needs to programs and practices associated with research-based, positive outcomes and refocusing transition and other reentry efforts for individuals leaving prisons and jails, or who are on probation or parole, to equip them with the necessary skills and competencies; and
4. improve continuity of care and community integration through development of policies and practices to share information across systems.

## Implications for Successful Transition and Reentry

To effect successful transition and reentry, behavioral health, corrections, and community corrections agencies should partner on state and local levels to develop cross-system approaches based on the principles of the Behavioral Health Framework. Tools such as the APIC model<sup>25</sup> can help jurisdictions improve outcomes for people with substance use and mental disorders who are released from jail and prison. Developed by corrections and behavioral health experts to guide evidence-based transition planning, APIC stands for:

- **Assess** the individual's clinical and social needs, and public safety risks;
- **Plan** for the treatment and services required to address the individual's needs (while in custody and upon reentry);
- **Identify** required community and correctional programs responsible for post-release services; and
- **Coordinate** the transition plan to ensure implementation and avoid gaps in care with community-based services.

To actualize the principles set forth by the Behavioral Health Framework, the APIC model, and evidence-based practices (EBPs), the following guidelines were developed (see the Guidelines-at-a-Glance chart on pages 6 and 7, and detail in subsequent pages). They are intended to promote the behavioral health and criminal justice partnerships necessary to successfully identify which people need services, what services they need, and how to match these needs upon transition to community-based treatment and supervision. These guidelines build upon the APIC approach and its emphasis on “building lasting bridges” between behavioral health and criminal justice systems to achieve “coordinated and continual health care for clients in both systems.” Through applying these principles, state and local policymakers and behavioral health and criminal justice practitioners can promote the development of effective transition and reentry practices for individuals with behavioral health disorders who are involved in the criminal justice system. While the guidelines are intended to apply across the continuum of the criminal justice system, the authors recognize that there are differences between the provision of behavioral health services inside correctional facilities and in the community; missions may differ and the comprehensiveness and access to services may vary.

The guidelines rest on two key assumptions. First, each guideline depends on meaningful collaboration among leadership and staff in the criminal justice and behavioral health systems. Although achieving the requisite level of collaboration is often challenging—particularly when faced with long-standing systemic or cultural barriers—successful partnerships and a shared commitment to reducing recidivism and advancing recovery are needed to carry out the guidelines. Second, to address problems raised by the large number of people with behavioral health disorders in the criminal justice system, agents of change and staff must work together across the criminal justice continuum to develop a comprehensive community- and system-wide strategy. Adopting policies and implementing practices associated with these guidelines can seem impossibly complex, especially for agencies and departments facing shrinking budgets, increased demands for accountability, and scarce resources. Also, the process is not simple and may take years—requiring leadership and staff in both systems to remain flexible, patient, and optimistic as they build upon shared goals.

## Guidelines at-a-Glance

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

#### **Guideline 1:**

**Conduct universal screening as early in the booking/intake process as feasible and throughout the criminal justice continuum to detect substance use disorders, mental disorders, co-occurring substance use and mental disorders, and criminogenic risk.**

- Valid and reliable screening instruments for the target population should be used.

#### **Guideline 2:**

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

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

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

#### **Guideline 3:**

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

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

#### **Guideline 4:**

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

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

#### **Guideline 5:**

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

#### **Guideline 6:**

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

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

#### **Guideline 7:**

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

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

#### **Guideline 8:**

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

#### **Guideline 9:**

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

#### **Guideline 10:**

Collect and analyze data to

- evaluate program performance;
- identify gaps in performance; and
- plan for long-term sustainability.



# Assess—Guidelines 1 & 2

*Assess the individual's clinical and social needs and public safety issues.*

## Rationale

To identify individuals' needs that affect their likelihood of achieving positive criminal justice and other recovery outcomes, providers and criminal justice agencies should develop a comprehensive approach to screen and assess for criminogenic risk (the likelihood individuals will commit additional crimes or violate conditions of release); behavioral health needs; medical needs; and other factors such as housing, employment, and trauma that may have an impact on their ability to respond to treatment. All of the information obtained can then be used to identify individuals who need services, determine what services are needed (both during incarceration and upon release), and help match these needs upon transition to community-based treatment and, if applicable, supervision.

### **Major Risk/Need Factors Associated with Committing Future Crimes**

Researchers have identified the “central eight” risk factors (see Table 2, page 10) that place a person at risk for future criminal behavior and have found the first “big four” should be effectively addressed before a focus on the remaining factors will show positive outcomes.

Behavioral health care providers have historically assessed and provided services to address the bottom four risk factors. The top four—those involving antisocial attitudes and behaviors—have not typically been perceived as part of their mission. Understanding criminogenic risk, however, is an important part of identifying and responding to dangerousness and violence, so assessing individuals' risk and needs is essential to creating safe service environments.

On the other hand, criminal justice staff have traditionally assessed for and provided services to address the top four risk factors, and are increasingly identifying the bottom four as treatment priorities.

## Implications for Cross-system Planning and Practice

The screening and assessment process within jail and prison settings to determine risk and behavioral health needs should be coordinated between corrections and community staff to avoid parallel efforts and maximize benefits of scarce treatment resources. Better coordination can help minimize the duplicative or inconsistent efforts that often occur within institutions between various program and non-program staff and between institutional and community-based providers. A clearly agreed upon screening and assessment process is critical to understanding the nature and severity of an individual's behavioral health need. While screening is the first step in the process, it is not sufficient because it only determines whether or not further assessment is warranted and not what kind of problem the person might have or how serious it might be. Follow-up assessment is necessary to ensure the right care is provided. Mutually agreed upon policies and procedures should detail the steps in the screening and assessment process and the role and responsibilities of each agency. In addition, to comply with the risk principle, agencies should ensure that assessment tools accurately predict risk of recidivism and that the information from the tool is used to determine the appropriate services, supervision, and supports for each individual. While some agencies may already identify all of the dimensions of risk as part of their screening and assessment process, it is possible for those who do not to build upon existing procedures without creating an entirely new process.

Table 2. “Central Eight” Risk Factors That Place a Person at Risk for Future Criminal Behavior

| Risk Factor                    | Description                                                                                                                                                                    |
|--------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Antisocial Behavior            | Early and continuing involvement in a number and variety of antisocial acts in a variety of settings                                                                           |
| Antisocial Personality Pattern | Adventurous, pleasure-seeking, weak self-control, restlessly aggressive                                                                                                        |
| Antisocial Cognition           | Attitudes, values, beliefs, and rationalizations supportive of crime; displays of anger, resentment, and defiance; and negative attitudes toward the law and justice systems   |
| Antisocial Associates          | Close association with criminals and relative isolation from law-abiding individuals; positive and immediate reinforcement for criminal behavior                               |
| Family and/or Marital          | Poor relationship quality with little mutual caring or respect; poor nurturance and caring for children; and few expectations that family members will avoid criminal behavior |
| School and/or Work             | Poor interpersonal relationships within school or work setting; low levels of performance and satisfaction in school and/or work                                               |
| Leisure and/or Recreation      | Low levels of involvement and satisfaction in non-criminal leisure pursuits                                                                                                    |
| Substance Abuse                | Abuse of alcohol and/or other drugs (tobacco excluded)                                                                                                                         |

Table adapted from Andrews, D. A., James Bonta, and Robert D. Hoge. (1990). Classification for effective rehabilitation: Rediscovering psychology, *Criminal Justice and Behavior*. 17(1): 19-52.

## Guideline 1

**Conduct universal screening as early in the booking/intake process as feasible and throughout the criminal justice continuum to detect substance use disorders, mental disorders, co-occurring substance use and mental disorders, and criminogenic risk.**

- Valid and reliable screening instruments for the target population should be used.<sup>26</sup>

### Practice Tips for Behavioral Health

- It is not appropriate for community behavioral health providers to use formal screens for criminogenic risk on all clients; obtain information about an individual’s criminal history during the routine psychosocial evaluation process, which triggers screening and assessment as indicated for criminogenic risk.
- Many criminogenic risk tools include questions that screen for mental and substance use disorders, but do not provide full assessment of need. Integrate a standardized clinical assessment into the process for those whom the screen indicates it is warranted.

### Practice Tips for Criminal Justice

- Obtain access to criminal histories and sufficient data to identify static risk factors.
- Use a validated risk instrument to identify how likely an individual is to reoffend.
- Ensure that screening for mental disorders, substance use disorders, and co-occurring mental and substance use disorders is conducted not only at intake, but also periodically thereafter.

### **Joint Practice Tips**

- Due to the high rates of co-occurring mental and substance use disorders in criminal justice settings, screen upon detection of one disorder (i.e., either a mental disorder or substance use disorder) for the other type of disorder if that screening is already not conducted as part of the routine intake process.
- Train staff on the correct administration and scoring of the instruments.<sup>27</sup>

### **Guideline 2**

**For individuals with positive screens, follow up with comprehensive assessments<sup>28</sup> to guide appropriate program placement and service delivery. The assessment process should involve obtaining information on**

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

### **Practice Tips for Behavioral Health:**

- Determine the extent to which a clinical assessment was conducted for the individual while incarcerated—an important step for community-based providers to guide their own assessment process prior to or upon release.
- While conducting an assessment is an important part of engaging an individual in care, to the extent possible, share information between institution and community staff. (For additional detail see guideline # 8 on information sharing).

### **Practice Tips for Criminal Justice:**

- For jail:
  - For individuals in jail, the time for assessment is dependent on the time that the individual spends in jail. Develop and implement “fast track” strategies for individuals spending less than 72 hours in custody, and recurrently conduct assessments informed by continual observation and consultation for longer stay individuals.
- For prison:
  - Conduct full assessments to determine individuals’ risk levels and develop treatment plans while they are incarcerated to better prepare them for post-release transition.



# Plan — Guidelines 3 & 4

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

## Rationale

It is important to match individuals' risk and needs to programs and practices associated with research-based, positive outcomes while they are in jail or prison and in the community. Professionals in the criminal justice and behavioral health systems should use information regarding individuals' risk levels and mental health and/or substance use treatment needs to target the right people for the most appropriate interventions—those most likely to benefit from coordinated treatment and supervision strategies, and those who can do well with fewer interventions. It is important to combine thoughtful consideration of the actuarial score obtained through assessment with clinical judgment to guide the development of supervision strategies and case management plans. The intensity of interventions should be proportionate to the assessed risk levels. Using RNR principles helps refocus reentry efforts for individuals leaving jails and prisons, or who are on probation and parole, to equip them with the necessary skills and competencies to live as law abiding and healthy members of communities and families, while progressing towards their recovery.

## Implications for Cross-system Planning and Practice

Agencies should assess the extent to which they incorporate RNR practices into their supervision and service delivery, and identify areas where they can make changes to strengthen their approach. Evaluating the extent to which RNR approaches are incorporated into service planning and delivery can help agencies plan and develop different responses based on individuals' risk and need levels. A focus on implementing RNR may require an analysis of how the agencies are engaging clients with lower levels of motivation to change and participate in treatment services. Shifting programmatic focus from prioritizing services and treatment for people who volunteer or demonstrate a willingness to participate in services to those who may be less motivated or willing to participate is an important aspect of effective RNR practice.

## Guideline 3

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

- Determine the appropriate level of treatment and intensity of supervision, when applicable, for individuals with behavioral health needs.
- Identify and target individuals' multiple criminogenic needs in order to have the most impact on recidivism.
- Address the aspects of individuals' disorders that affect function to promote effectiveness of interventions.
- Develop strategies for integrating appropriate recovery support services into service delivery models.

- Acknowledge dosage of treatment as an important factor in recidivism reduction, requiring the proper planning and identification of what, where, and how intensive services provided to individuals will be.<sup>29, 30</sup>

### ***Practice Tips for Behavioral Health***

- Integrate information about criminogenic needs that is collected as part of the criminogenic risk assessment into individuals' treatment plans.
- When working with those under community supervision, make certain to address basic practical concerns and needs within treatment plans — housing, food, clothing, transportation, and childcare; optimal medication regimens; integrated treatment for individuals with co-occurring mental and substance use disorders; and benefits applications/reinstatements for Supplemental Security Income (SSI), Social Security Disability Insurance (SSDI), Medicaid, and other entitlements.
- Implement training approaches and policies to motivate and incentivize the 'harder to engage' clients in programming during incarceration.

### ***Practice Tips for Criminal Justice***

- Develop case plans using this information to address risk and inform decisions regarding appropriate behavioral health treatment services while the individual is in jail or prison, in accordance with length of time in the institution.
- Use risk and need assessment results, and information from any programming individuals participated in while incarcerated, to formulate plans to transition them to continuing services in the community once they are released from jail or prison.
- Share information about services received while incarcerated with community supervision staff to incorporate into supervision strategies and conditions of release.
- Begin the application and enrollment process for people in jail and prison who are eligible for income supports and benefits.

### ***Joint Practice Tips:***

- Identify and target individuals' multiple criminogenic needs in order to have the most impact on recidivism. Research indicates that targeting as many needs as possible, as opposed to just one or two, has more impact on recidivism.<sup>31</sup>
- For providers working to provide services in jail or prison settings, prioritize individuals with high to moderate risk and behavioral health needs and refrain from only selecting voluntary clients.
- Determine the roles for criminal justice staff and behavioral health providers based on a person's risk and need profile.
- Align dosage of treatment with current research.<sup>32</sup>
  - The greater the risk for recidivism, the greater the need for significant hours of treatment.
  - In addition to treatment intensity, the treatment duration should be long enough to allow for learning practice and behavioral change.

## **Guideline 4**

**Develop collaborative responses between behavioral health and criminal justice that match individuals' levels of risk and behavioral health needs with the appropriate levels of supervision and treatment.**

**Joint Practice Tips:**

- The degree of collaboration required will vary based on individuals' levels of risk and needs:
  - **Individuals with high criminogenic risk and high behavioral health needs** may require specialized, targeted, and integrated interventions and intensive supervision.<sup>33</sup> While in jail or prison, they may require special programming, including enrollment in interventions targeting criminogenic risk and need (e.g., cognitive behavioral therapy (CBT)). On probation or on their return to the community, the relatively limited treatment options (including CBT) and housing funds controlled by corrections systems (e.g., transitional housing) should be prioritized for this population to reduce their chances for recidivism. These individuals will require intensive community supervision, which can be used in lieu of incarceration or as a condition of release from jail or prison.
    - **Example:** frequent check-ins with community supervision agent, including curfew checks and drug testing, and access to integrated treatment options with multiple group and individual treatment sessions per week and ongoing pharmacotherapy.
  - **Individuals with high criminogenic risk and without significant behavioral health disorders** will likely need intensive monitoring and supervision, and minimal to no formalized treatment intervention. While in jail or prison, they should be prioritized for enrollment in interventions targeting criminogenic needs, such as those that address antisocial attitudes and thinking; lower prioritization is appropriate for behavioral health treatment resources. On their return to the community, they may participate in community-based programming that provides cognitive restructuring and skill building to address criminogenic needs. Corrections staff should make referrals to community service providers on reentry to address targeted low-level mental health/substance use treatment needs.
    - **Example:** frequent check-ins with community supervision officer and visits to outpatient treatment clinic to assess and address symptoms associated with mental disorders.
  - **Individuals with low criminogenic risk and high behavioral health needs** will likely require less intensive supervision, monitoring, and access to integrated treatment interventions. While in jail and prison, they must be provided health care for acute and chronic health conditions and linked with appropriate community service providers upon release to ensure continuity of treatment. Outside the corrections facility, the level of care and types of treatment provided will conform to existing eligibility criteria and payment sources. Probation officers can spend less time with these individuals and promote case management and services over revocations for technical violations and/or behavioral health-related issues.
    - **Example:** monthly supervision meetings, attendance at mutual support groups, and linkages with peer support programs may be appropriate.
  - **Individuals with low criminogenic risk and without significant behavioral health disorders** will likely require low levels of supervision and minimal to no formalized treatment intervention. When possible, they should be separated from high-risk populations in correctional facility programming and/or when under community supervision programming. Referrals to behavioral health providers should take place as the need arises to meet targeted treatment needs.
    - **Example:** less frequent face-to-face contact with the community corrections officer and access to integrated treatment options with individual and group interventions, pharmacotherapy, and participation in independent self-help groups.



# Identify—Guidelines 5 & 6

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

### **Rationale**

Individuals with mental and/or substance use disorders in jails and prisons or in the community have multifaceted needs and require specialized, comprehensive, and coordinated treatment and supervision interventions. Behavioral health professionals often express concern that criminal justice agencies refer types of individuals for which service providers have developed few effective interventions (such as those for individuals who have personality disorders), and have expectations that treatment alone is sufficient to change their criminal behavior. At the same time, criminal justice professionals are frustrated by the lack of community-based treatment services and alternatives to incarceration and the revolving door nature of this population. Deep budget cuts to all systems have led to staff reductions and a diminished capacity to offer services. In this context, limited resources are most wisely spent on interventions that—if properly implemented—have demonstrated positive outcomes for these clients as well as for the system. In addition, clients with behavioral health disorders have the best outcomes when mental health and substance use systems use evidence-based practices that include effective strategies to address the criminogenic needs of their clients with criminal histories to promote recovery goals. Many treatment providers already address certain criminogenic needs (e.g., substance use, lack of employment) of clients with criminal histories through evidence-based treatment components they routinely offer. Still, interventions addressing other criminogenic needs (e.g., antisocial thinking) should be added to have the greatest impact on public safety and recovery. A correctional institution or community corrections agency that has well-designed programs in place—including substance use treatment, mental health services, educational and vocational programs, cognitive behavioral skills programs, special needs services, and balanced supervision strategies—still needs to target the right individuals to improve the likelihood of success.

### **Implications for Cross-system Planning and Practice**

It is important that agencies, departments, and organizations work together across systems, prompting the need for cross-system leadership to meet and establish partnerships. This collaboration should extend beyond informal handshakes and instead involve more formalized mechanisms to ensure that it lasts beyond leadership changes and staff turnover. Memoranda of understanding or other policy and procedure agreements can be useful tools to articulate different phases and aspects of a jurisdiction's transition process. These agreements can also help agencies reach consensus about the roles and responsibilities of each agency and key staff in the transition process. Defining “who does what, when, and how” is a critical planning component and essential cornerstone of effective cross-system partnerships.

One initial step agencies can take is to inventory the services that are provided prior to release and what is available in the community post-release. Conducting this activity early on will provide a helpful framework to guide discussions about gaps in resources that may exist in the community and how they can be addressed as part of the transition planning process. Differences across communities, particularly between urban and rural communities, will exist with regard to the availability and accessibility of quality care and services to address the needs of people with behavioral health needs; rural communities face a number of challenges and barriers to implementing EBPs—such as workforce issues and lack of transportation—that threaten the quality of care for behavioral health disorders.<sup>34</sup>

## Guideline 5

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

### ***Practice Tips for Behavioral Health:***

- Prior to release,
  - develop specific plans to map out the time period immediately following release, including needed supports and resources such as housing, transportation, identification of likely interaction with family and peers, and scheduled appointments with supervision agents and community provider(s); and
  - identify and access treatment resources for military veterans to ensure that they are connected to specialized service for which they are entitled.
- When appropriate, include family members in transition planning and help prepare them for a family member's release and possible return to the residence.
- Consider involving peer support and recovery specialists (trained peer specialists with personal "lived" experience with mental disorders and involvement in the criminal justice system) in transition planning as they can play a role in motivating an individual to engage in care; linking an individual to essential services, including housing, educational and vocational opportunities; and directly providing a wide array of recovery support services.<sup>35</sup>

### ***Practice Tips for Criminal Justice:***

- Prior to release, establish or secure
  - appointments for necessary and appropriate services and supports (e.g., behavioral health, medical care);
  - a housing plan;
  - a supply of medication to last two to four weeks or until his/her appointment for service;
  - a state approved identification card (for Medicaid and other purposes); and
  - adequate clothing.
- When appropriate, identify family members who can assist in transition planning.
  - Remove certain barriers (e.g., housing individuals closer to their communities and reducing the cost of phone calls) or offer programming specifically designed to strengthen positive relationships.<sup>36</sup>
- Establish procedures to ensure access, such as
  - expediting the process to reduce wait time to see individuals;
  - extending hours for visits; and
  - streamlining the search process upon entering jail (to extent possible while ensuring safety)
- Train community providers on facility security policies and procedures to facilitate adherence to them and expedite entry.
- Consider developing specialized caseloads to help ensure that individuals with particular needs, such as behavioral health-related issues, can be given the attention they need by a community supervision officer with experience and expertise in those areas.<sup>37</sup>

**Joint Practice Tip:**

- Jointly establish a process to submit applications to reinstate or enroll individuals in Medicaid, SSI/SSDI, and other benefits at least several months in advance of release. Community providers can pick up on the application process so that assistance is available once the individual is released.
- Develop protocols on access to jail or prison for community providers to conduct in-reach to initiate the engagement process (preferably through in-person contact) so that a connection is made with the community-based agency accepting responsibility for treatment and care.
- Work towards a model for the reentry of individuals with mental disorders consistent with principles of Critical Time Intervention (CTI)—an intensive, time-limited case management model that uses three phases to support transitions from institutional settings into community settings. CTI combines several evidence-based tools, including cognitive behavioral therapy, illness management, supported housing, integrated dual disorder treatment, and motivational enhancement. The intervention suits the transitional nature of the reentry process, the complexity of service and treatment needs, and the demand for individualized services.<sup>38</sup>

**Guideline 6**

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

**Practice Tips for Behavioral Health:**

- If no pre-release access is available, identify whether there is a pre-release/reentry coordinator or other staff person whose role it is to develop transition or reentry plans to coordinate release plans and access to post-release services.
- Behavioral health professionals can be trained along with criminal justice professionals to assess and respond to individuals' criminogenic risk, or at a minimum understand its role in recidivism reduction to successfully address criminogenic needs as part of treatment.
  - Use an integrated approach consistent with effective practice to provide services that address individuals' behavioral health and criminogenic needs, and targets those needs that are most likely leading to criminal justice involvement (e.g., cognitive behavioral treatment, or CBT, targeted to criminogenic risks, such as Reasoning and Rehabilitation and Thinking for a Change).<sup>39</sup>
- Use EBPs associated with serving clients who are involved in the criminal justice system to maximize recovery and recidivism outcomes (see Appendix A).<sup>40, 41, 42, 43</sup>
  - Although not correlated with recidivism reduction, trauma-informed and trauma-specific strategies and interventions have been adapted and implemented for use with individuals with behavioral health disorders involved in the criminal justice system who have experienced trauma to enhance coping skills and support recovery.<sup>44</sup>

**Practice Tips for Criminal Justice:**

- Identify an array of services that address criminogenic needs, including treatment options available in the community, provided either through community corrections agencies or through partnerships with behavioral health and other community-based organizations, to facilitate direct referrals of people upon release from prison or jail.
  - Recognize that the types of services that benefit individuals most are based on level of risk and need.

- Communicate the expectation to contracted providers that they provide specialized and effective community-based services, directly or through referral.
- Use referrals to CBT programs that may be led by providers or specialized probation or parole staff to address anti-social risks in addition to other criminogenic needs like family, education, and employment (e.g., Motivational Interviewing ).<sup>45</sup>
- Prior to release, gather information provided by jail and prison staff to determine what funding may be available to fund services for the individual.
  - Does the individual meet Medicaid eligibility criteria, either based on disability or income as defined in the ACA (if a Medicaid expansion state)?
  - Is the individual eligible for SSI or SSDI benefits based on a disability?
  - Is the individual eligible for any other publicly funded treatment services (such as the Ryan White Care Act)?<sup>46</sup>

### **Joint Practice Tips**

Identify collaborative strategies (particularly those that are reimbursable) to engage individuals prior to and following release to enhance continuity of care. Ideally, interventions should begin in jail or prison and continue with a community-based provider following an individual's release, and include:

- Using case management so that an individual has a single case manager before and after release
  - Use of “boundary spanners” (e.g., an employee of the local mental health authority who works in a jail mental health unit) to oversee transition planning process
- Involving certified peer specialists in process to provide support and mentoring services
- Using technology to
  - connect individuals in jails and prisons with community-based organizations and support networks, including family members, prior to release (e.g., through video conferencing); and
  - provide mental health treatment through telemedicine following release, particularly in rural areas.

# Coordinate—Guidelines 7–10

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

## Rationale

Individuals with mental, substance use, or co-occurring mental and substance use disorders on probation or returning from prisons and jails to the community often have complex problems. The reality is that public health care professionals already serve them — a significant number of individuals who receive services through the publicly funded mental health and substance use systems are involved in the criminal justice system. As such, corrections and behavioral health care systems have considerable overlap in the populations they serve, so building truly collaborative responses to address the needs of these individuals is certainly warranted. Although these systems vary among jurisdictions in terms of how their work is financed, how providers and staff are regulated, and how services are evaluated, there are opportunities to work collaboratively and determine how existing resources can be used more efficiently. For example, criminal justice and behavioral health care professionals can jointly determine how scarce treatment slots and intensive supervision services should be allocated to have the greatest impact. It is important that they also develop mechanisms to support this collaboration and communication, such as ways to share data and information.

## Implications for Cross-system Planning and Practice

The planning and development of policies and procedures regarding the transition process should include discussion and identification of essential information agencies should collect regarding how systems share information about clients, supervision and treatment outcomes, and the treatment referral process. Coordination strategies can be bolstered by: (1) gaining endorsement of leadership within the criminal justice, substance use, and mental health systems; and (2) establishing goals to link the systems that are specific and attainable. In addition, cross-system coordination efforts should include the adoption of a unifying goal that encompasses the needs of both the behavioral health treatment and criminal justice systems. The goals of each system should also be identified to clarify and resolve any differences that may exist among group members. Ideally, the goals should be accompanied by objectives and a work plan that will help identify roles and responsibilities within the group.

## Guideline 7

### Support adherence to treatment plans and supervision conditions through coordinated strategies.

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

### *Practice Tips for Behavioral Health:*

- Include supervision agents as part of the treatment team to strengthen cross-system approaches.
- Convene regular meetings with supervision agents as necessary to discuss client progress in meeting treatment and supervision goals as a useful mechanism to coordinate service delivery and messaging regarding expectations for clients.
- In community correction settings, work in “case staffings” to modify treatment plans, monitor adherence of the terms of release, and make changes to the conditions when appropriate.
- Train staff how to handle the “treater-turned-monitor dilemma” in which they may be tempted to engage in so-called “benevolent coercion” and use return to jail or prison as a threat to get individuals to comply with treatment.
- Train behavioral health providers to use Motivational Interviewing and other approaches to enhance individuals’ engagement in treatment.

### *Practice Tips for Criminal Justice:*

- Share release dates from prison or jail, to the extent possible, with provider agencies to strengthen their ability to provide a direct and immediate link to post-release continuing care.
- Participate in regular joint meetings with treatment staff to discuss treatment and supervision progress.
- For jail and prison:
  - Train corrections staff to use Motivational Interviewing and other engagement approaches to encourage individuals to participate in treatment in the community.
- For community corrections:
  - Include expectations regarding participation in and completion of treatment in supervision plans to emphasize its importance.
  - Ensure that staff communicate to the individuals that they have sustained access to these treatments and other supports when supervision ends.
  - Train community corrections staff to utilize Motivational Interviewing and other approaches to encourage individuals to participate and engage in treatment while under supervision.
  - Avoid sanctions that separate individuals from essential treatment and services.

### *Joint Practice Tip:*

- Determine if any evidence-based collaborative interventions are appropriate, such as:
  - Specialized community supervision caseloads<sup>47</sup>

- Forensic Assertive Community Treatment (FACT)<sup>48</sup>
- Forensic Intensive Case Management (FICM)<sup>49</sup>

## Guideline 8

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

### *Practice Tips for Behavioral Health:*

- Develop an information sharing protocol with criminal justice to clearly establish what information will be shared and under what circumstances.
- Whenever possible, have individuals sign releases to allow for sharing of appropriate information related to their criminogenic risks, needs, and treatment progress.

### *Practice Tips for Criminal Justice:*

- Provide behavioral health providers with appropriate access to information relating to a person's criminal history and pre-sentence report.
- When services are provided prior to release, develop an approach to ensure that information can flow to community-based providers.

### *Joint Practice Tips:*

- Establish mechanisms for sharing information, such as screening and assessment information, which comply with all legal privacy and confidentiality mandates and promote efficiency (see Appendix B for more information on HIPAA and 42 CFR).<sup>50</sup> In order to facilitate the transition from jail and prison to the community, mechanisms should focus in particular on sharing information between jail/prison and community providers prior to release and, for people under supervision, between probation/parole and community providers. Information-sharing tools and strategies could include
  - developing interagency guidelines (e.g., memorandum of understanding, or MOU) among agencies that have contact with individuals so information can be shared;
  - obtaining permission from the individual to release his/her health information by getting an authorization or consent form; and
  - employing manual processes or management information systems (e.g., shared database) to support cross-system information sharing.

## Guideline 9

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

### *Practice Tips for Behavioral Health:*

- Train all staff to be more informed about fundamental practices in the criminal justice system, such as understanding
  - the varied pathways that individuals with mental and co-occurring substance use disorders may take into the criminal justice system;
  - relevant terms of conditions of supervision, how and when and to whom to report violations of supervision conditions, their roles and responsibilities when warrants are issued, and how to convey information during court hearings; and

- how to use problem-solving strategies in response to noncompliance.

### ***Practice Tips for Criminal Justice:***

- Train all staff to be more informed about fundamental practices in community behavioral health, such as understanding
  - the signs and symptoms, and basic terminology of mental and co-occurring substance use disorders;
  - how mental disorders and co-occurring disorders impact psychosocial functioning and are associated with diverse service needs such as housing, social services and supports, and vocational skills;
  - the principles of effective treatment and programming for mental disorders and co-occurring substance use disorders and setting realistic expectations for recovery;
  - the methods to improve interactions with individuals with mental and co-occurring substance use disorders (e.g., minimizing the use of jargon, making eye contact, using the principles of Motivational Interviewing); and
  - how to use problem-solving strategies, RNR principles, and graduated sanctions in response to noncompliance.

### ***Joint Practice Tip***

- Recognize and acknowledge that criminal justice and behavioral health systems have traditionally different missions. While cross-training is necessary, it is not sufficient for reconciling these differences and achieved shared goals and outcomes. Structural supports, policies, agency leadership are crucial for training to be absorbed and implemented.
- Ensure that staff understand the “culture of incarceration” so as to engage and support individuals under correctional supervision, both while incarcerated and in the community. Sensitizing Providers to the Effects of Correctional Incarceration on Treatment and Risk Management (SPECTRM) is one model to improve interactions with individuals who are involved in the criminal justice system.<sup>51</sup>
- Staff from each system should serve as boundary spanners to actively coordinate treatments and services with supervision.

## **Guideline 10**

### **Collect and analyze data to**

- evaluate program performance;
- identify gaps in performance; and
- plan for long-term sustainability.

### ***Practice Tips for Behavioral Health:***

- Collect data elements related to criminal justice involvement like violations and arrests to help measure the impact of treatment on the criminal justice system.
- Consider using a strong independent evaluation approach to help agencies collect, analyze, and use data to improve program performance. Universities are often used as unaffiliated partners with the state or local agency.

## ***Practice Tips for Criminal Justice:***

- Use performance measures to help agencies improve access to and quality of treatment.
- Collect data elements to measure the number of successful referrals to community-based mental health and substance abuse treatment or reduced revocations among probation or parole officers to help assess impact.

## ***Joint Practice Tips:***

- Where possible, include program evaluators in the initial planning and design processes to ensure that cross-systems work can be evaluated for effectiveness and to determine long-term sustainability.
- Establish a system of quality assurance at each respective agency/provider in order to denote strengths and weaknesses of newly implemented cross-system approach.
- Create user-friendly reports to educate staff on how to use the data to inform and improve their work.
- Provide ongoing training and professional development to provide support to staff whose roles and assessment processes may have been altered.
- Incentivize positive staff performance to create and acknowledge agents of change.



# Conclusion

*Ultimately it is collaboration between the behavioral health and criminal justice systems that will ensure available resources are used efficiently and effectively to improve outcomes for individuals, and to make our communities safer.*

Although the overrepresentation of people with behavioral health disorders in criminal justice settings persists, recent research suggests that with appropriate evidence-based interventions, treatment providers can have a significant impact on recovery and recidivism. These guidelines are intended to assist behavioral health and corrections and community corrections administrators in their ability to develop effective transition plans and to drive cross-system reentry approaches between behavioral health and criminal justice agencies. The guidelines can be used as a tool within behavioral health agencies on the state and local levels to ensure that community-based approaches respond to the multi-dimensional needs of clients who are involved in the criminal justice system and the agencies that supervise them. While each guideline is important and necessary, ultimately it is collaboration between the behavioral health and criminal justice systems that will ensure available resources are used efficiently and effectively to improve outcomes for individuals, and to make our communities safer.



# Appendix A

## Evidence-Based Practices and Programs for Individuals with Behavioral Health Needs in the Criminal Justice System\*

| Evidence-Based Practice or Program†                                                                                                                                                                                                                                                                                                                                                                 | Mental Health (MH) Treatment | Substance Abuse (SA) Treatment | Co-occurring MH and SA Treatment |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|--------------------------------|----------------------------------|
| <b>Forensic Assertive Community Treatment (FACT)</b><br>ACT-like programs that have been adapted for people involved in the criminal justice system and focus on preventing arrest and incarceration; ACT involves treatment coordinated by a multidisciplinary team with high staff-to-client ratios that assumes around-the-clock responsibility for clients' case management and treatment needs | +                            |                                | +                                |
| <b>Illness Management and Recovery (IMR)</b><br>An approach that involves teaching clients skills and techniques to minimize the interference of psychiatric symptoms in their daily lives                                                                                                                                                                                                          | +                            |                                |                                  |
| <b>Integrated Mental Health and Substance Abuse Services</b><br>Treatment and service provision to support recovery from co-occurring mental and substance use disorder through a single agency or entity                                                                                                                                                                                           | +                            | +                              | +                                |
| <b>Supported Employment</b><br>An EBP for people with severe developmental, mental, and physical disabilities that matches them with and trains them for jobs where their specific skills and abilities make them valuable assets to employers                                                                                                                                                      | +                            |                                |                                  |
| <b>Psychopharmacology</b><br>Treatment that uses one or more medications (e.g., antidepressants) to reduce depression, psychosis, or anxiety by acting on the chemistry of the brain                                                                                                                                                                                                                | +                            | +                              |                                  |

\* Please note that the following list is not exhaustive.

† These EBPs may be used across multiple domains, and an "X" in a particular column indicates that a significant research base exists for the application of that EBP in that particular domain. However, the EBP may also be used in the other listed domains when appropriate.

| Evidence-Based Practice or Program                                                                                                                                                                                                                                                                                                                                      | Mental Health (MH) Treatment | Substance Abuse (SA) Treatment | Co-occurring MH and SA Treatment |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|--------------------------------|----------------------------------|
| <b>Supported Housing</b><br>A system of professional and/or peer supports that allows a person with mental illness to live independently in the community; Supports may include regular staff contact and the availability of crisis services and other services to prevent relapse, such as those focusing on mental health, substance abuse, and employment           | +                            |                                |                                  |
| <b>Cognitive-behavioral Therapy (CBT) Targeting Criminogenic Needs</b><br>CBT interventions (e.g., Thinking for a Change or Reasoning and Rehabilitation) that are designed to address criminogenic needs and may focus on anger management, problem solving, and assuming personal responsibility for behavior                                                         | +                            | +                              |                                  |
| <b>Motivational Enhancement Therapies</b> (e.g., Motivational Interviewing)<br>A consumer-centered, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence                                                                                                                                                                |                              | +                              |                                  |
| <b>Contingency Management (CM) Interventions</b><br>The objective of CM interventions is to reinforce a client's commitment to abstinence and to reduce his/her drug use using positive (e.g., vouchers) and negative (e.g., increased supervision) reinforcers in response to desired and undesired behaviors                                                          |                              | +                              |                                  |
| <b>Modified Therapeutic Community (MTC)</b><br>MTCs alter the traditional TC approach in response to the psychiatric symptoms, cognitive impairments, and other impairments commonly found among individuals with co-occurring disorders. These modified programs typically have (1) increased flexibility, (2) decreased intensity, and (3) greater individualization. |                              |                                | +                                |

# APPENDIX B

## Information Sharing in the Criminal Justice-Behavioral Health Context: HIPAA and 42 CFR

### Health Information Portability and Accountability Act

HIPAA, together with regulations promulgated by the U.S. Department of Health and Human Services (HHS), establish federal standards for the privacy and security of Personal Health Information (PHI), including mental health information. HIPAA's restrictions on sharing health information are often misunderstood, which has resulted in practitioners' misapplying the law to be far more restrictive than the actual regulatory language requires. Practitioners should keep in mind the original intent of the legislation, which was to facilitate insurance coverage through the development of an information system for electronic health records that ensured appropriate privacy and IT security. 42 CFR Part 2

### 42 CFR Part 2

42 CFR Part 2 is the part of the Code of Federal Regulations under the Public Health chapter that deals with the confidentiality of alcohol concerns abuse patient records. These regulations apply to all "programs" that are "federally assisted."<sup>52</sup>

### Jails and Prisons

The information-sharing issues concerning medical and behavioral health that involve correctional staff who must administer a range of services in prisons and jails cause particular confusion. These laws were not designed or intended to impede the provision of necessary health services. Correctional facilities can be central locations for information collection and sharing: families and community treatment providers may be eager to share health information about those in custody; medical or corrections staff seek to identify individuals with behavioral health issues as quickly as possible and stabilize them; and successful reentry planners require the coordinated transfer of health information from treatment providers in the facility to those in the community. Incarcerated individuals generally have fewer protections for individual information privacy than individuals "outside the walls."

Correctional institutions are generally not "covered entities" under HIPAA unless they declare themselves as such. Clinical staff who work for a correctional facility meet the definition of "health provider" under HIPAA, whether employed directly by the correctional facility or under contract. If a correctional facility contracts for healthcare services, the provider of those services will determine independently whether it is a covered entity (and in most cases will consider itself such). Many correctional facilities, as well as state departments of corrections, define themselves as covered entities. HIPAA permits PHI to be made available to a correctional or other custodial facility for several purposes, including, generally, providing healthcare and protecting the health and safety of inmates, officers, or other employees of the correctional institution, or people involved in transporting incarcerated individuals, or other activities necessary for the maintenance of safety, security, and good order or the institution. This provision in HIPAA permits very broad disclosure of PHI without the person's authorization. As always, state law should be consulted to determine whether it is more protective of individual privacy.

Once a person is discharged from the facility, HIPAA rules apply to the sharing of a person's health information. However, in some circumstances, HIPAA permits sharing information without authorization/consent, although state law may not. For example, if a correctional facility is asked to provide health information to another covered entity, such as a psychiatrist, about an individual who has been released from custody, HIPAA does not require the person's permission for the disclosure because it is for the allowable purpose of care, including aftercare. However, state law may require the person's permission in such situations.

Because 42 CFR Part 2 does not contain provisions specifically addressing correctional institutions, the general rules about consent will apply.

## **Community Corrections**

With an increased emphasis on finding alternatives to incarceration for individuals with mental health and substance abuse disorders, PHI becomes a part of the work of all community corrections officers, not just those with specialized caseloads.<sup>54</sup>

Federal laws limit what information probation and parole officers can receive in monitoring compliance with treatment conditions that are part of the person's supervision. For the supervising officer to receive PHI, the person must have given permission under either authorization sections of HIPAA or the consent provisions in 42 CFR Part 2. Alternatively, the court can order that the person must waive confidentiality as a condition of probation, or the court can issue an order directing disclosure consistent with the terms of HIPAA and/or 42 CFR Part 2 if protected health or substance abuse treatment information is requested.

HIPAA and 42 CFR Part 2 do not limit what community correctional officers can disclose. For example, if an individual discloses PHI to his probation officer, that officer may share or redisclose that information without being affected because the probation officer is not a covered entity or "program." The probation officer may, however, be subject to state law prohibitions on redisclosure.

\*adapted from Petrila, John, and Hallie Fader-Towe. *Information Sharing in Criminal Justice-Mental Health Collaborations: Working with HIPAA and Other Privacy Laws*. New York, NY: Council of State Governments Justice Center, 2010.

# Endnotes

1. Osher, F., Steadman, H. B., and Barr, H. *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, 2002. <http://gainscenter.samhsa.gov/pdfs/reentry/apic.pdf>
2. The term “behavioral health” in this document refers to a state of mental/emotional being and/or choices and actions that affect wellness. Behavioral health problems include substance abuse or misuse, alcohol and drug addiction, serious psychological distress, suicide, and mental and substance use disorders. This includes a range of problems from unhealthy stress to diagnosable and treatable diseases like serious mental illnesses and substance use disorders, which are often chronic in nature but that people can and do recover from. The term is also used to describe the service systems encompassing the promotion of emotional health, the prevention of mental and substance use disorders, substance use, and related problems, treatments, and services for mental and substance use disorders, and recovery support. Source: <http://store.samhsa.gov/shin/content/SMA11-4629/01-FullDocument.pdf>
3. The numbers used in this table are estimates that come from a variety of sources. The studies cited are from different years, use different methodologies and definitions, and combine different data sets. The table is intended to give the reader a general sense of the prevalence rates of behavioral disorders in corrections populations and is not intended to be the definitive epidemiologic dataset.
4. Kessler, R. C., Nelson, C. B. McGonagle, K. A., Edlund, M. J., Frank, R. G., and Leaf, P. J. (1996). The epidemiology of co-occurring addictive and mental disorders: Implications for prevention and service utilization. *American Journal of Orthopsychiatry*, 66(1): 17–31.
5. Ditton, P. M. (1999). *Mental health and treatment of inmates and probationers*. Washington, DC: U.S. Department of Justice, Office of Justice Programs. <http://www.bjs.gov/content/pub/pdf/mhtip.pdf>; see also Metzner, J. L. (1997). An introduction to correctional psychiatry: Part I. *Journal of the American Academy of Psychiatry and the Law*, 25(3): 375–381. (Based on a review of pertinent studies, Metzner estimates that from 8–19 percent of incarcerated offenders in the United States have a psychiatric disorder that results in functional disability, and another 15–20 percent will need some form of psychiatric intervention.)
6. Steadman, H. J., Osher, F. C. Robbins, P. C., Case, B., and Samuels, S. (2009). Prevalence of serious mental illness among jail inmates. *Psychiatric Services*, 60(6): 761–765. <http://ps.psychiatryonline.org/article.aspx?articleid=100482>
7. Feucht, T. E., and Gfroerer, J. (2011). *Mental and substance use disorders among adult men on probation or parole: Some success against a persistent challenge*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. <http://www.samhsa.gov/data/2k11/MentalDisorders/MentalDisorders.pdf>
8. Ibid.
9. Mumola, C. J., and Karberg, J. C. (2004). Drug use and dependence, state and federal prisoners. Washington, DC: U.S. Department of Justice, Office of Justice Programs. <http://www.bjs.gov/content/pub/pdf/dudsfp04.pdf>

10. Karberg, J. C., and James, D. J. (2005.) Substance dependence, abuse, and treatment of jail inmates, 2002. Washington, DC: U.S. Department of Justice, Office of Justice Programs, <http://www.csdp.org/research/sdatji02.pdf>
11. Ibid. 7. (The 35–40 percent range represents both a probation and parole population. According to Feucht and Gfroerer in this SAMHSA and NIJ report, combined data from 2006–2009 reveal that 35 percent of parolees and 40 percent of probationers had “illicit drug or alcohol dependence or abuse in the past year.”)
12. Note that of those adults with serious mental disorders, the percentages in this row reflect how many also have co-occurring substance use disorders.
13. Substance Abuse and Mental Health Services Administration. (2009). *Results from the 2008 National Survey on Drug Use and Health: National findings*. Rockville, MD: Substance Abuse and Mental Health Services Administration, Office of Applied Studies, (Among adults ages 18 or older with SMI, 25.2 percent [2.5 million] were dependent on or abused illicit drugs or alcohol.)
14. Ditton, P. M. (1999). *Mental health and treatment of inmates and probationers*. Washington, DC: U.S. Department of Justice, Office of Justice Programs. <http://www.bjs.gov/content/pub/pdf/mhtip.pdf>
15. Adapted from Abram, K. M., and Teplin, L. A. (1991). Co-occurring disorders among mentally ill jail detainees. Implications for public policy. *American Psychologist*, 46(10): 1036–1045. <http://psycnet.apa.org/journals/amp/46/10/1036/>
16. Ibid. 14.
17. Note that of those adults with substance use disorders, the percentages in this row reflect how many also have co-occurring mental disorders.
18. U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. *Results from the 2011 National Survey on Drug Use and Health: Summary of national findings and detailed tables*. Accessed November 6, 2013. <http://www.samhsa.gov/data/NSDUH/2011SummNatFindDetTables/>
19. Baillargeon, J., Penn, J.V., Knight, K., Harzke, A. J., Baillargeon, G., and Becker, E. A. (2010). Risk of reincarceration among prisoners with co-occurring severe mental illness and substance use disorders. *Administration and policy in mental health*, 37(4): 367-374. <http://www.ncbi.nlm.nih.gov/pubmed/19847638> (The authors used a cohort from Texas; the findings may not be representative across other states.)
20. Wilson, A. B., Draine, J. Hadley, T., Metraux, S., and Evans, A. (2011). Examining the impact of mental illness and substance use on recidivism in a county jail. *International Journal of Law and Psychiatry*, 34(4): 264-268. <http://www.ncbi.nlm.nih.gov/pubmed/21839518>
21. Ibid. 7.
22. Pew Center on the States. *Prison count 2010: State population declines for the first time in 38 years*. Philadelphia: Pew Charitable Trusts, 2010. [http://www.pewtrusts.org/our\\_work\\_report\\_detail.aspx?id=57797](http://www.pewtrusts.org/our_work_report_detail.aspx?id=57797)
23. Binswanger, I. A, Stern, M. F., Deyo, R. A., Heagerty, P. J., Cheadle, A., Elmore, J. G., and Koepsell, T. D. (2007). Release from prison—a high risk of death for former inmates. *The New England Journal of Medicine*, 356(2): 157–165. <http://www.ncbi.nlm.nih.gov/pubmed/17215533>
24. Osher, F. C., D'Amora, D. A., Plotkin, M., Jarrett, N., and Eggleston, A. (2012). *Adults with behavioral health needs under correctional supervision: A shared framework for reducing recidivism and promoting recovery*. New York: Council of State Governments Justice Center. [http://csgjusticecenter.org/wp-content/uploads/2013/05/9-24-12\\_Behavioral-Health-Framework-final.pdf](http://csgjusticecenter.org/wp-content/uploads/2013/05/9-24-12_Behavioral-Health-Framework-final.pdf)
25. Ibid. 1.

26. For examples of screening tools for mental disorders and substance use disorders, please see: Peters, R. H., Bartoi, M. G., and Sherman, P. B. (2008). *Screening and assessment of co-occurring disorders in the justice System*. Delmar, NY: CMHS National GAINS Center, <http://gainscenter.samhsa.gov/pdfs/disorders/ScreeningAndAssessment.pdf>
27. Ibid.
28. Ibid. 26.
29. Bourgon, G., and Armstrong B. (2006). Transferring the principles of effective treatment into a “real world” setting. *Criminal justice and Behavior*, 32(1): 3-25. <http://cjb.sagepub.com/content/32/1/3.abstract>
30. “[...] practitioners and policymakers should resist the urge to translate these findings into concrete, narrowly defined standards for dosage. It is unlikely that there is a one-size-fits-all protocol for dosage, even for high-risk offenders. The evidence we currently have merely provides the field with evidence-based parameters or guidelines for making decisions about optimal dosage ranges for offender groups in the aggregate.” For more information, please see Sperber, K. G., Latessa, E. J. and Makarios, M. D. (2013). Establishing a risk-dosage research agenda: Implications for policy and practice. *Justice Research and Policy*, 15 (1): 123-141.
31. Gendreau, P., French, S. A., and Taylor, A. (2002). *What Works (What doesn't Work)* Revised 2002. Invited Submission to the International Community Corrections Association Monograph Series Project.
32. Ibid. 29.
33. Prins, S. J., and Draper, Laura. Improving outcomes for people with mental illnesses under community corrections supervision. New York: Council of State Governments Justice Center. (2009). <http://csgjusticecenter.org/wp-content/uploads/2012/12/Community-Corrections-Research-Guide.pdf>
34. For more information on how rural communities have adapted EBPs given barriers they face, please see: Office of Rural Health Policy, Health Resources and Services Administration. *Rural behavioral health programs and promising practices*. (2011). Washington, DC: U.S. Department of Health and Human Services, <http://www.hrsa.gov/ruralhealth/pdf/ruralbehavioralmanual05312011.pdf>
35. Davidson, L., and Rowe, M. *Peer Support within criminal justice Settings: The role of forensic peer specialists*. (2008). Delmar, NY: CMHS National GAINS Center. [http://gainscenter.samhsa.gov/peer\\_resources/pdfs/Davidson\\_Rowe\\_Peersupport.pdf](http://gainscenter.samhsa.gov/peer_resources/pdfs/Davidson_Rowe_Peersupport.pdf)
36. Naser, R. L., and Visser, C. A. (2006). Family members' experiences with incarceration and reentry. *Western Criminology Review*, 7(2) : 20-31.
37. For more information on specialized caseloads, please see: Prins, S. J., and Osher, F. C. (2009). *Improving responses to people with mental illnesses: The essential elements of specialized probation initiatives*. New York: Council of State Governments Justice Center, <http://bit.ly/10MKuoe>
38. For more information on CTI, please see: Draine, J., and Herman, D. B. Critical Time Intervention for reentry from prison for persons with mental illness. (2007). *Psychiatric Services*, 58(12) : 1577-1581. <http://ps.psychiatryonline.org/data/Journals/PSS/3829/07ps1577.pdf>
39. For more information on CBT targeted to criminogenic risks, please see: U.S. Department of Justice, National Institute of Corrections. (2007). *Cognitive-behavioral treatment: A review and discussion for corrections professionals*, by Milkman, H., and Wanberg, K. Washington, D.C.: U.S. Department of Justice, National Institute of Corrections, <http://static.nicic.gov/Library/021657.pdf>
40. For more information, please see: Blandford, A. M., and Osher, F. C. (2012). *A checklist for implementing evidence-based practices and programs for justice-involved adults with behavioral health disorders*. Delmar, NY: SAMHSA's GAINS Center for Behavioral Health and Justice Transformation, <http://ainscenter.samhsa.gov/cms-assets/documents/73659-994452.ebpchecklistfinal.pdf>
41. Scott, W. (2008). *Effective clinical practices in treating clients in the criminal justice system*. Washington, DC: U.S. Department of Justice, National Institute of Corrections,

42. For more information, please see: SAMHSA's GAINS Center for Behavioral Health and Justice Transformation. *Evidence-based practices (EBPs)*. Accessed November 6, 2013. [http://gainscenter.samhsa.gov/topical\\_resources/ebps.asp](http://gainscenter.samhsa.gov/topical_resources/ebps.asp)
43. Friedmann, P. D., Taxman, F. S., and Henderson, C. E. (2007). Evidence-based treatment practices for drug-involved adults in the criminal justice system. *Journal of Substance Abuse Treatment*, 32(3): 267-277.
44. For more information on trauma-specific interventions for justice-involved individuals, please see: <http://gainscenter.samhsa.gov/pdfs/ebp/TraumaSpecificInterventions.pdf>
45. For more information on Motivational Interviewing, please see: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. *Training: Motivational interviewing*. Accessed November 6, 2013. <http://www.samhsa.gov/co-occurring/topics/training/motivational.aspx>
46. For more information on the Ryan White HIV/AIDS programs funded through the Ryan White Care Act, please see: U.S. Department of Health and Human Services, Health Resources and Services Administration. *HIV/AIDS programs: Technical assistance*. Accessed November 6, 2013. <http://hab.hrsa.gov>
47. For more information on specialized community supervision caseloads and other approaches, please see Prins, S. J., and Osher, F. C. (2009). *Improving responses to people with mental illnesses: The essential elements of specialized probation initiatives*. New York: Council of State Governments Justice Center. <http://bit.ly/10MKuoe>.
48. For more information on FACT, please see: Lamberti, J. S., Weisman R., and Faden D. I. (2004). Forensic assertive community treatment: Preventing incarceration of adults with severe mental illness. *Psychiatric Services*, (55):1285-1293. <http://bit.ly/16gXquL>; and Cusak, K. J., Morrissey, J. P., Cuddeback, G. S., Prins, A., and Williams D. M. (2010). Criminal justice involvement, behavioral health service use, and costs of forensic assertive community treatment: A randomized trial. *Community Mental Health Journal*, 46:356-363. <http://1.usa.gov/1d4BleR>
49. For more information on FICM, please see: Morrissey, J. P., Myers, P. S., and Cuddeback, G. S. (2007). Extending assertive community treatment to criminal justice settings: Origins, current evidence, and future directions. *Community Mental Health Journal*, 43: 527-544.
50. For more information on information sharing in criminal justice-behavioral health collaborations, please see: Petrila, J., and Fader-Towe, H. (2010). *Information sharing in criminal justice-mental health collaborations: Working with HIPAA and other privacy laws*. New York: Council of State Governments Justice Center. Accessed November 6, 2013. [https://www.bja.gov/Publications/CSG\\_CJMH\\_Info\\_Sharing.pdf](https://www.bja.gov/Publications/CSG_CJMH_Info_Sharing.pdf)
51. For more information on SPECTRM, please see: SAMHSA's GAINS Center for Behavioral Health and Justice Transformation. (2007). *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*. Delmar, NY: GAINS Center. <http://gainscenter.samhsa.gov/pdfs/reentry/Spectrum.pdf>
52. For definitions of "programs" and "federally assisted," please see pages 29-30 in Petrila, J., and Fader-Towe, H. *Information sharing in criminal justice-mental health collaborations: Working with HIPAA and other privacy laws*. New York, NY: Council of State Governments Justice Center, 2010. Accessed November 6, 2013. [https://www.bja.gov/Publications/CSG\\_CJMH\\_Info\\_Sharing.pdf](https://www.bja.gov/Publications/CSG_CJMH_Info_Sharing.pdf)
53. For more information to assist corrections entities with establishing privacy policies and practices for sharing and receiving protected health information (PHI), please see: Association of State Correctional Administrators, American Probation and Parole Association, and Global Justice Information Sharing Initiative. *Corrections and reentry: Protected health information privacy policy template for information sharing* (forthcoming).