Principles of Community-based Behavioral Health Services for Justice-involved Individuals: **A Research-based Guide**

A bridge to **the possible**

SAMHSA
Substance Abuse and Mental Health Services Administration

Acknowledgments

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Introduction

SAMHSA's Vision and Values for Serving Justice-involved Individuals

Community-based behavioral health providers and systems have an essential role in serving individuals with mental and substance use disorders who are currently or formerly involved with the criminal justice system. These individuals are a part of every community, and as for all community members with behavioral health needs, individualized, integrated, comprehensive, coordinated, and continuous service is the standard of care.

Individuals with behavioral health issues are overrepresented in jails and prisons across the United States.[1] Most of these individuals return to their communities, families, and social networks and subsequently require community-based behavioral and physical health care services. Research has shown that mental and substance use disorders affect people from all walks of life, with or without justice involvement, and, with the services and supports of behavioral health providers, many people recover. Community-based behavioral health providers play a key role in ensuring that **every individual** they serve has the treatment, support, skills, and opportunity for recovery and lives productively with dignity and respect.

Unfortunately, people who need access to quality community-based care may be arrested instead. In many communities, people with behavioral health disorders cannot access adequate community-based services and find themselves channeled into the justice system. This may happen when a person is arrested for behaviors or actions related to his or her untreated mental illness. Additionally, some law enforcement officers use discretion to arrest when they believe a person needs health care services that are provided in the jail.

Arrest and incarceration often destabilize an individual's life, including their housing, health care, employment, and social connectedness. Researchers have found that even brief incarceration leads to adverse consequences, including loss of employment and future employment opportunities, poorer physical and behavioral health due to breaks in health care services and treatment, loss of housing and future housing opportunities, and disruptions in family life and social connections.[2] Once in the criminal justice system, individuals with mental and substance use disorders stay in jails longer, have an increased risk for self-harm, and receive more frequent punitive responses to infractions.[3] Due to funding and staffing limitations, many people with mental illnesses do not receive the services they need and their conditions often worsen inside jail settings.[4] For individuals already receiving medications and treatment in the community, these services may be interrupted during incarceration, creating lapses in treatment and difficulties in resuming treatment upon release and reentry to the community. Without continuous coordinated care throughout and following incarceration, these individuals are at risk for re-incarceration,[5] emergency department use,[6,7] and hospitalization.[8]

Clinical and case management skills of community providers are the foundation of effective treatment and services for justice-involved individuals. Additional training, knowledge, and skills may be needed, but the goals of community-based treatment—improving behavioral and physical health through treatment and services, promoting social wellbeing, and preventing or reducing the likelihood of contact with the criminal justice system—remain the same. The *Principles* elevate essential components to achieving the goals of community-based treatment and quality care for justice-involved individuals.

Purpose and Scope

This document is intended to assist community-based behavioral health providers in their clinical and case management practice with people with mental and substance use disorders who are currently involved with or have a history of involvement in the adult criminal justice system. The focus of this document is on services provided in the community rather than in institutional settings (i.e., jail, prison, or hospital). The information provided is intended to be used in practice, and is therefore appropriate for any staff providing direct services in community settings. However, to practice these principles, organizations may need to reconsider staff training, evidence-based practices, and other programmatic elements to ensure that staff providing direct services have the information, policy support, and resources needed. This document is also intended for agency leaders and program developers who are responsible for shaping how their organizations deliver community-based services. The *Principles* provide a foundation for realizing a quality, community-based behavioral health treatment system that is responsive to **all** individuals with mental and substance use disorders and skilled in serving those with histories of justice involvement.

The eight principles and accompanying frequently asked questions (FAQs) in this document are based on the most current and relevant research. Resources are also included that provide additional information and tools to achieve quality practice.

The content for this document was developed through a collaborative process. An expert panel was convened in August 2017, and additional review was solicited through a peer-review process and public comment.

The Substance Abuse and Mental Health Services Administration (SAMHSA) is committed to supporting the shared goals and responsibilities for achieving public health and public safety with our criminal justice colleagues. SAMHSA encourages behavioral health providers and criminal justice professionals to work together and across systems to improve the lives of individuals with mental and substance use disorders, their family members' lives, and their communities.

> "The *Principles* provide a foundation for realizing a quality, community-based behavioral health treatment system."

The Eight Principles

PRINCIPLE **1**

Community providers are knowledgeable about the criminal justice system. This includes the sequence of events, terminology, and processes of the criminal justice system, as well as the practices of criminal justice professionals.

The criminal justice process starts at the point of contact with a law enforcement officer. Such contact may result in an arrest and entry into the criminal justice system, including prosecution and pretrial services, adjudication, sentencing and sanctions, and corrections, the last of which may involve jail, prison, or community supervision. Understanding the criminal justice system can help community providers facilitate continuous and coordinated treatment and services for justice-involved individuals with mental and substance use disorders. This understanding also helps providers know where in the criminal justice system and with what criminal justice personnel their client is currently involved. Understanding the system also helps community providers recognize where opportunities exist to divert clients into treatment and services, both before and after entry into the criminal justice system.

PRINCIPLE **2**

Community providers collaborate with criminal justice professionals to improve public health, public safety, and individual behavioral health outcomes.

Collaboration between community providers and criminal justice professionals is essential for ensuring continuity of care and care coordination during transitions to and from incarceration and sustaining treatment and supports both in correctional settings and in the community. This includes sharing information, responsibility, and accountability. Clarifying roles and responsibilities, ensuring treatment and supervision efforts are complementary, and working collaboratively with individuals to identify and meet their treatment and supervision goals are the cornerstones of effective partnerships. For individuals under the supervision of community corrections, partnering with parole and probation professionals can facilitate coordinated care and adherence to supervision requirements.

The Eight Principles

PRINCIPLE **3**

Evidence-based and promising programs and practices in behavioral health treatment services are used to provide high quality clinical care for justice-involved individuals.

Evidence-based programs and practices for mental and substance use disorders should be used for all individuals, with adaptations specific to justice involvement when appropriate. Adaptations include practices that specifically address criminal thinking through cognitive-skills training focused on judgment and criminal behaviors. Treatment should be tailored to the individual and address motivation; problem solving; skill building to improve cognitive, social, emotional, and coping skills; and assist in building prosocial supports and activities. Where needed, integrated treatment for co-occurring mental illness and substance use disorders should be provided to ensure coordination and continuity of care. As with all clinical care, community providers should track treatment outcomes and adjust treatment as needed.

PRINCIPLE **4**

Community providers understand and address criminogenic risk and need factors as part of a comprehensive treatment plan for justice-involved individuals.

Criminogenic risk is the likelihood that an individual will engage in future illegal behavior in the form of a new crime or failure to comply with conditions of probation or parole. Criminogenic needs are factors that increase an individual's likelihood of re-offense, such as lack of employment or livable wages, or the presence of a substance use disorder. Criminogenic risk and need factors are malleable and responsive to intervention. Research indicates that behavioral health treatment alone does not reduce recidivism, and conversely, interventions that address only criminogenic risk and need factors do not improve behavioral health outcomes.[9] Effective treatment for justice-involved individuals includes evidence-based and promising programs and practices that address an individual's mental illness, substance use, and criminogenic risk and need factors.

The Eight Principles

PRINCIPLE **5**

Integrated physical and behavioral health care is part of a comprehensive treatment plan for justice-involved individuals.

Formerly incarcerated populations are at increased risk for serious and complex chronic health conditions and may require coordinated care with other health care professionals. Rates of infectious and noncommunicable chronic diseases are high in incarcerated populations and those under community supervision. Furthermore, incarceration may exacerbate these existing medical conditions. Testing for infectious and noncommunicable diseases and coordinating medical services are part of an effective treatment plan for justice-involved populations. By integrating physical and behavioral health care, community providers can offer whole-person care that is well coordinated and convenient for an individual, thereby improving access to and engagement with services. Where needed, this should include integrated treatment for co-occurring mental and substance use disorders.

PRINCIPLE **6**

Services and workplaces are trauma-informed to support the health and safety of both justice-involved individuals and community providers.

Justice-involved populations have high rates of exposure to traumatic events.[10] Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being. While incarcerated, individuals may experience trauma specific to the jail or prison setting, including sexual violence, physical violence, intimidation, confinement, isolation, and coercion. Prior trauma may be compounded by experiences of trauma while incarcerated. Creating and promoting a trauma-informed approach to services and the workplace promotes safety and trust and can minimize risky situations in office or field-based settings for both the client and the practitioner. Trauma-informed approaches include consideration of the safety and wellbeing of all persons involved, including both clients and providers.

The Eight Principles

PRINCIPLE **7**

Case management for justice-involved individuals incorporates treatment, social services, and social supports that address prior and current involvement with the criminal justice system and reduce the likelihood of recidivism.

Individuals currently involved with the criminal justice system or reentering communities from jails and prisons face unique obstacles in finding housing, employment, and coordinating health and behavioral health care. Case managers play an important role in connecting individuals to services and addressing social factors that can contribute to low quality of life, poor health, and recidivism. These include lack of housing, employment and vocational activities, and social support (from peers or family members, or both), and untreated substance use disorders.

PRINCIPLE **8**

Community providers recognize and address issues that may contribute to disparities in both behavioral health care and the criminal justice system.

Different population groups, often based on race, ethnicity, gender, sexual orientation, and economic status, have disparate access to high-quality behavioral health treatment and experience disproportionate representation in the criminal justice system. It is important for community-based providers to understand these structural biases in order to prevent their further perpetuation and interference with positive treatment and justice outcomes.

Frequently Asked Questions

Criminal Justice

1. Why should community-based providers understand the criminal justice process?

Knowledge about criminal justice procedures, criminal justice professionals, and terminology, and the kinds of experiences people with mental and substance use disorders have with the criminal justice system is essential for serving justice-involved individuals. This knowledge can help community providers tailor treatment services and supports as well as assist clients in meeting supervision requirements and avoiding further involvement with the criminal justice system. Understanding the roles and functions of criminal justice professionals can help community providers navigate the criminal justice system with their clients.

Opportunities may exist to divert an individual from the criminal justice system prior to or after arrest and link them with treatment services. When public safety is not at risk, police-behavioral health collaborations can support diversion from the criminal justice system prior to an arrest for individuals with mental and substance use disorders.

Specialized treatment courts, including drug treatment courts and mental health courts, can also support individuals in connecting with treatment and supportive services after an arrest. Upon successful completion, charges may be dismissed by the judge. Each court may have different requirements for the individual's participation in treatment and the provider's responsibility to report to the court. Community providers partnering in these programs can be in a unique position to help inform their clients' orders to treatment and services and ensure effective delivery of treatment in accordance with the court order.

2. What is the sequence of events in the criminal justice system?

The sequence of events within local justice systems varies based on the jurisdiction and state; however, what follows is a general description of what takes place in many jurisdictions.

After an arrest, a person is taken into custody by law enforcement and taken to jail to undergo the intake and booking process. There is no determination of guilt or innocence at this point. Prior to or after booking, a magistrate or judge reviews the charge(s) and determines the person's bail. If the person is released, he or she may be released on bond, released to custody, or released on recognizance (ROR). If a person is considered at risk of failing to appear in court or being arrested for new criminal charges, they may be assigned to a pretrial services agency with supervision requirements for their release, such as regular drug testing or participation in supervision activities.

The case will be assigned to a judge, and the first court hearing is an arraignment. At the arraignment, the formal charges are read, the individual is told of their right to an attorney, and a plea may be entered. If an individual is unable to afford an attorney, a public defender is assigned. Some jurisdictions review and make changes to the bail at this hearing.

The court then decides on one of several next steps. If diversion to a specialty court is appropriate, the person may be diverted. If the person is ROR, they may remain at this status as the court case begins. A person who is

detained or released on bond may stay on bond as the court case begins. A person meeting criteria in state statutes for being a risk to public safety may return to jail. If there is insufficient evidence, the charges are dismissed. If the individual pleads not guilty, a trial date is set. A plea bargain may also occur, in which the individual pleads guilty to a same or lesser charge and forgoes the right to a trial by jury.

If a person is assigned to a specialty court, such as a drug treatment court, mental health court, or veterans court, their charge may be dropped, contingent upon successful completion of the requirements of the court.

If a person is not diverted to a specialty court, after the arraignment a trial is held to determine the individual's guilt or innocence. The individual may have a trial by jury or opt for a bench trial, where guilt or innocence is determined by the judge. If found innocent, the individual will be released. If found guilty or a guilty plea has been entered, the individual is sentenced to jail (generally, for less than a year), prison (for sentences longer than a year), or community supervision.

If an individual is sentenced to community supervision, they will be assigned to a probation officer and must meet supervision requirements, such as regular drug testing and meetings with the probation officer.

If a person is sentenced to jail, they will be transferred to the custody of a local sheriff or jail administrator to serve their sentence. If a person is sentenced to prison, they will be transferred to the custody of the state Department of Corrections to serve their prison sentence.

If an individual becomes eligible for and receives parole, they will be assigned to a parole officer and must meet the supervision requirements. For individuals with mental and substance use disorders, treatment-oriented specialty probation or parole may be available in some jurisdictions.

3. What is diversion?

Diversion is the process by which individuals with mental and substance use disorders are diverted from the criminal justice system into treatment or alternatives to incarceration. There are multiple points at which a person with mental illness may be intercepted and diverted into treatment or services (see the Sequential Intercept Model under FAQ #7).

Diversion prior to arrest may include different models of police-behavioral health collaborations, such as Crisis Intervention Teams (CIT),[11,12] Law Enforcement Assisted Diversion (LEAD),[13,14] co-response by police and behavioral health, and diversion to treatment for individuals with substance use disorders.

After arrest, initial detention and initial court hearings provide the opportunity for formal assessment and diversion from standard prosecution, if appropriate. Diversion may entail coordination between criminal justice professionals involved with the initial detention, including local law enforcement (the police department or sheriff's office), local jail staff, prosecutor's office, public defender's office, probation department, pretrial services, and district judges.

Treatment courts divert individuals from standard criminal prosecution. These courts have a separate docket and a dedicated judge, prosecution, and defense counsel. Participation is voluntary and defendants agree to a course of treatment. If an individual successfully complies with treatment, charges may be dismissed or reduced. Some jurisdictions partner with their local probation departments to provide community supervision of individuals participating in the treatment court programs; other jurisdictions rely on program case managers to provide oversight.

Drug treatment courts are the most common treatment court and show positive outcomes among participants completing the programs.[15,16] This model has been adapted by other problem-solving courts, including

mental health courts, tribal wellness courts, veterans courts, and domestic violence courts. The focus of these courts is to address the underlying mental health and substance use issues and related needs of individuals by using the judicial leverage of the court to connect them with treatment and other alternatives to incarceration.

For those individuals who meet the stringent criteria of being at risk of harm to self or others, as well as other requirements in accordance to state statutes, opportunities may exist to divert them to a community-based civil commitment process through Assisted Outpatient Treatment programs.

4. What are reentry services?

Reentry is a general term that includes both prerelease institutional coordination and community-based programming following release from jails or prisons. The transition from incarceration in jail or prison to the community is a critical period for ensuring continuity of care, reducing the likelihood of overdose or death after release, and linking individuals to needed social services and supports. Research has shown that, for individuals with substance use disorders, the likelihood of death by overdose increases 12-fold the 2 weeks post-incarceration.[17] For individuals with opioid use disorders, this risk is 40 times that of the general population.[18] Individuals reentering communities are also at an increased risk for suicide.[19] If treatment is started in jail or prison, a process of therapeutic change can commence; continuing treatment upon reentry into the community can sustain these gains.

To best support individuals currently incarcerated, collaboration with correctional staff and correctional health providers will ensure continuous and coordinated care for physical and behavioral health needs, reduce the likelihood of overdose death when an individual returns to the community from incarceration, and decrease the likelihood of recidivism. Collaboration improves when correctional staff, correctional health providers, and community providers understand their respective roles in facilitating coordinated transitions into and out of jails and prisons. Strategies to initiate or improve collaboration and coordination include establishing regular contact with correctional staff and correctional health providers and developing policies and procedures for communication and visits (if allowed). Increasingly, peer-support staff (staff with lived experience) have played a role in reentry, helping with the coordination from incarceration into the community. It is believed that peer support enhances engagement and buy-in to the planning process, given peer staff's unique expertise from having been through the experience themselves. See FAQ #21 for information on peer support specialists and the role they play in providing services.

Providers may be able to facilitate collaboration with correctional staff by first establishing relationships with the local jail administrator—most likely the county sheriff's office—by way of the local government agency responsible for behavioral health services. For state and local prisons, providers can directly initiate contact with the correctional facilities' reentry services.

Coordinating with jail and prison reentry service personnel and community reentry providers can improve the likelihood that an individual's full range of physical health, behavioral health, and human service needs are met upon entering or exiting jail or prison. Due to the high risk of homelessness, morbidity, and mortality among people released from incarceration, housing support, employment support, transportation, and linkage to identification and benefits are critical service components. See FAQ #15 for information on Medicaid coverage for individuals involved with the criminal justice system.

5. What are community corrections programs?

Individuals under current criminal justice supervision may be monitored and supervised by community corrections after release from jail or prison. Community corrections programs oversee individuals released from jails or prisons who receive probation or parole. They are administered by agencies or courts with the legal authority to enforce sanctions.

Probation is correctional supervision within the community, rather than a jail or prison sentence; parole is a period of conditional, supervised release from prison. Coordination among community treatment providers and community corrections professionals can facilitate successful completion of correctional supervision requirements.

Where a separate pretrial services agency does not exist, probation and parole agencies may also provide pretrial community supervision to individuals released from jail while awaiting their court date. In some areas, community corrections also provides oversight to individuals participating in treatment court programs.

Collaboration

6. Should community case managers coordinate with law enforcement, jail, prison, probation, parole, and other criminal justice professionals?

Yes. Collaboration with criminal justice professionals improves the health and social outcomes of justice-involved individuals. It enables continuity of care, coordinated reentry into the community, and complementary supervision and treatment plans for individuals under community supervision. It can also enable opportunities for shared training between community provider organizations and criminal justice agencies.

For individuals who may be diverted from arrest or prosecution through pre- or post-arrest diversion programs or treatment courts, coordination is an essential element in ensuring connection with treatment and services or continuing care. Case managers may be contacted and connected with a client in the field during a police encounter, or they may be linked with a client through a court or jail program. Effective relationships and communication with criminal justice partners at these points of diversion are critical to ensure the person in need of services is effectively engaged in needed treatment and support.

For individuals in jails or prisons, case management should ideally begin before release and continue throughout the transition to the community. In many jurisdictions, this may be complicated by unknown release dates, releases after scheduled court appearances, or lack of jail reentry services. However, there are organizational strategies that can help facilitate coordination. Provider agencies can establish relationships, policies and procedures, interagency agreements, or memorandums of understanding in collaboration with jail or prison reentry staff. This can assist in coordinating services through strategies such as jail visits by community providers to individuals prior to release (in-reach services) and sharing of assessments and case plans completed by jail or prison staff with a signed release of information by the shared client. The more consistent and standardized the process, the more likely coordination and collaboration will occur.

For individuals under community supervision, parole and probation officers are important partners in reducing recidivism because they can encourage adherence to treatment and case management plans and connect individuals to programs and services, such as inpatient

substance use treatment. As with jail or prison reentry staff, provider agencies can use the same mechanisms—policies and procedures, interagency agreements, memorandums of understanding, and releases of information—to better coordinate with community corrections staff. Coordination should occur within the parameters of applicable record privacy and confidentiality laws (see FAQ #8 for more information). Specific supervision, monitoring, or substance use testing may be required, which case managers should take into consideration when developing case management plans. Collaboratively identifying individuals with medium- or high-risk criminogenic needs and medium or high treatment needs will help providers to prioritize and efficiently use services.

7. What strategies exist for behavioral health and criminal justice collaboration?

Research spanning 40-plus years has documented how behavioral health providers and criminal justice professionals—particularly law enforcement—have collaborated to divert individuals with mental illness from the criminal justice system.[20,21,22] Over the last 10 years, increased focus by federal, state, and local governments; researchers; and practitioners have identified best and promising practices in mental health and criminal justice collaborations.[23] More recently, criminal justice professionals and behavioral health providers have created collaborative models specific to individuals with substance use disorders.

Community providers and criminal justice professionals have both shared and distinct goals. For criminal justice professionals, the goal of public safety includes successfully managing transitions to and from jails and prisons, effectively supervising individuals on probation and parole, and reducing the likelihood of re-offense, or recidivism. Community providers focus on supporting their clients in achieving health and wellness through treatment and supports. Ideally, both community providers and criminal justice professionals share the goal of reducing an individual's likelihood of returning to the criminal justice system. In working together, community providers and criminal justice professionals should identify common goals in collaboration with their shared client.

The Sequential Intercept Model identifies six key points for "intercepting" individuals with behavioral health issues, linking them to services, and preventing further penetration into the criminal justice system.[24] This model builds on collaboration between the criminal justice and behavioral health systems, highlights where to intercept individuals as they move through the criminal justice system, and identifies critical decision-makers with the authority to divert individuals from the criminal justice system and into treatment. Importantly, it delineates essential personnel at each intercept, including mental health, substance use, law enforcement, pretrial services, court, jail, community corrections, and social services staff, indicating the potential for partnerships.[25]

8. What information and data can be shared with a criminal justice professional?

Information sharing often becomes a barrier to collaboration between community providers and criminal justice professionals. Interpretations of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) may not be clear or understood by community providers and criminal justice professionals, causing delays or disruptions in care. It is helpful to remember that the original intent of the legislation was to facilitate insurance coverage through the development of an information system for electronic health records that ensured appropriate privacy and IT security. HIPAA was not designed or intended to impede the provision of necessary health services.

Behavioral health providers, including those based in correctional facilities, are "covered entities,"

and HIPAA permits a covered health care provider to disclose protected health information (PHI) for treatment purposes to other providers without having to first obtain an authorization from the individuals.

Criminal justice professionals are not covered entities, but HIPAA does allow for information sharing in some situations. In 2016, the Office of Civil Rights, U.S. Department of Health and Human Services issued clarifying guidance on whether a covered entity can collect, use, and disclose criminal justice data under HIPAA. This can be found on the Office of Civil Rights, U.S. Department of Health and Human Services website. In the guidance, the Office of Civil Rights clarified that, "A covered entity is permitted to disclose PHI in response to a request by a law enforcement official having lawful custody of an individual if the official represents that such PHI is needed to provide health care to the individual or for the health and safety of the individual."

There are also tools that can be used to exchange information between provider agencies and criminal justice entities. These include partnerships formed through "business associate agreements" and "qualified service organization agreements." These agreements can help clarify and standardize the information sharing between partners. For individuals showing patterns of recurrent criminal justice involvement, providers could obtain signed releases of information for the clients' files to ensure that PHI is able to be shared appropriately with other treatment and service partners to ensure continuity of care. For more information on HIPAA, go to the U.S. Department of Health and Human Service's website. In addition to HIPAA, the Confidentiality of Substance Use Disorder Patient Records regulation, 42 CFR Part 2 ("Part 2") governs confidentiality for people seeking treatment for substance use disorders from federally assisted programs. Part 2 protects the confidentiality of records relating to the identity, diagnosis, prognosis, or treatment of any patient whose records are maintained in connection with the performance of any federally assisted program or activity relating to substance use disorder education, prevention, training, treatment, rehabilitation, or research. Under this regulation, a federally assisted substance use disorder program may only release a patient's identifying information with the individual's written consent, pursuant to a court order, or under a few limited exceptions, such as situations where there is an immediate threat to a person's health. For more information and fact sheets on 42 CFR Part 2, visit the SAMHSA website.

Providing Optimal Health Services

9. What are the implications of a person having a serious mental illness and being justice involved?

People with serious mental illness have a "mental, behavioral, or emotional disorder resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities."[26] While treatment and services are important for people with any type of mental illness, people with serious mental illness tend to experience longer and more punitive criminal justice involvement. The experience of incarceration is stressful and services provided often lack the therapeutic environment needed to foster recovery. Due to funding and staffing limitations, many jails and prisons are not able to support continuity of care from and back into the community and many do not have adequate resources to treat serious mental illness. This may result in longer incarcerations; solitary confinement; re-arrest or re-

incarceration; and worsened physical health, behavioral health, criminal justice, and social outcomes.[27]

10. What evidence-based and promising programs and practices to treat mental and substance use disorders can be used for justice-involved populations?

The most common definition of evidence-based practice (EBP), appropriated from evidence-based medicine, is "the conscientious, explicit and judicious use of current best evidence in making decisions about the care of the individual patient. It means integrating individual clinical expertise with the best available external clinical evidence from systematic research."[28] Promising practices do not currently have the strength and validity established by rigorous research to be evidence based; however, emerging research suggests future and possible strength and validity of results.

As a general practice, all behavioral health providers should assess and evaluate criminal justice history and risks in all individuals seeking care. The programs and practices indicated in Tables 1-7 have been found to be evidence based or promising when used with justice-involved individuals.

Table 1. Evidence-based Programs in Mental Health Treatment for Justice-involved Individuals

Domains	Description
Assertive Community Treatment (ACT)	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.
Critical Time Intervention	Nine-month, three-stage intervention that develops individualized linkages in the community and facilitates engagement with treatment, supports, and housing through building problem-solving skills, motivational coaching, and connections with community agencies.
Integrated Mental Health and Substance Use Services	Treatment and service provision to support recovery from co-occurring mental and substance use disorders through a single agency or entity.
Supported Employment	Matches and trains people with severe developmental, mental, and physical disabilities where their specific skills and abilities make them valuable assets to employers.
Permanent Supportive Housing (PSH)	PSH combines permanent housing with a system of professional or peer supports or both 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 or other services to prevent relapse, such as those focusing on mental health, substance use, and employment.
Pharmacotherapy	Treatment that uses one or more medications as part of a comprehensive plan of psychosocial and behavioral interventions to reduce symptoms associated with mental illness or mental health issues.

Table 2. Evidence-based Practices in Mental Health Treatment for Justice-involved Individuals

Domains	Description
Cognitive Behavioral Therapy (CBT)	A therapeutic approach that attempts to solve problems resulting from dysfunctional thoughts, moods, or behavior through brief, direct, and time-limited structured counseling. CBT for substance use disorders adds a component of coping strategies to stop substance use and address other co-occurring issues.
Motivational Interviewing	A "person-centered counseling style for addressing the common problem of ambivalence about change."[29]

Table 3. Promising Programs in Mental Health Treatment for Justice-involved Individuals

Domains	Description
Forensic ACT (FACT)	Forensic ACT is an adaptation of ACT for individuals involved in the criminal justice system. FACT provides the same level and type of treatment services of ACT, but also includes interventions targeted to criminogenic risk and need factors.
Forensic Intensive Case Management (FICM)	Like FACT, FICM involves the coordination of services to help individuals sustain recovery in the community and prevent further involvement with the criminal justice system. Unlike FACT, FICM uses case managers with individual caseloads as opposed to a self-contained team.
Assisted Outpatient Treatment (AOT)	AOT, also known as conditional release, outpatient commitment, involuntary outpatient commitment, or mandated outpatient treatment, is intended to facilitate the delivery of community-based outpatient mental health treatment services to individuals with SMI who have refused psychiatric treatment in the past, are at risk for deterioration or harming themselves or others, and for whom hospitalization is unnecessarily restrictive.

Table 4. Promising Practices in Mental Health Treatment for Justice-involved Individuals

Domains	Description
Cognitive Behavioral Treatment Targeted to Criminogenic Risks	CBT interventions (e.g., Reasoning and Rehabilitation or Thinking for a Change) that are designed to address criminogenic risks and may focus on anger management, problem solving, and assuming personal responsibility for behavior.
Case Management	Case management is a coordinated approach to the delivery of physical health, substance use, mental health, and social services, linking individuals with appropriate services to address specific needs and achieve stated goals in a case management plan.
Forensic Peer Specialists	Formerly justice-involved individuals who are in recovery provide support to other individuals who are also involved, or at risk of becoming involved, in the criminal justice system.

Table 5. Evidence-based Programs for Treatment of Substance Use Disorders for Justice-involved Individuals

Domains	Description
Modified Therapeutic Community (MTC)	MTCs alter the traditional Therapeutic Community 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.

Table 6. Promising Programs for Treatment of Substance Use Disorders for Justice-involved Individuals

Domains	Description
12-step or Other Mutual Aid Groups	Groups of nonprofessionals who share a problem and support one another through the recovery process.
Peer-based Recovery Support Programs	Formerly justice-involved individuals who are in recovery provide support to other individuals who are also involved, or at risk of becoming involved, in the criminal justice system.

Table 7. Evidence-based Practices for Treatment of Substance Use Disorders for Justice-involved Individuals

Domains	Description
Cognitive Behavioral Therapy (CBT)	A therapeutic approach that attempts to solve problems resulting from dysfunctional thoughts, moods, or behaviors through brief, direct, and time-limited structured counseling. CBT for substance use disorders helps individuals address problematic behaviors and develop effective coping strategies to stop substance use and address other co-occurring issues.
Motivational Interviewing	A "person-centered counseling style for addressing the common problem of ambivalence about change."[30]
Contingency Management Interventions	Interventions that reinforce an individual's commitment to abstinence and to reduce their drug use using positive incentives (e.g., vouchers) and negative consequences (e.g., increased supervision) in response to desired and undesired behaviors.
Pharmacotherapy (i.e., Medication-assisted Treatment)	Treatment that uses one or more medications as part of a comprehensive plan of psychosocial and behavioral interventions to reduce symptoms associated with substance or alcohol use disorders.
Relapse Prevention Therapy	A systematic treatment method of teaching recovering clients to recognize and manage relapse warning signs.
Behavioral Couples Therapy (BCT)	A family treatment approach for couples that uses a "recovery contract" and behavioral principles to engage both people in treatment, achieve abstinence, enhance communication, and improve the relationship.

Table 8. Promising Practices for Treatment of Substance Use Disorders for Justice-involved Individuals

Domains	Description
Case Management	A coordinated approach to the delivery of physical health, substance use, mental health, and social services, linking individuals with appropriate services to address specific needs and achieve stated goals in a case management plan.

11. What is medication-assisted treatment (MAT), and why is it effective for criminal justice-involved populations?

Medication-assisted treatment is the use of medications, usually in combination with counseling and behavioral therapies, to treat substance use disorders, especially opioid use disorder (OUD). Abundant evidence shows that the opioid agonist methadone and the opioid partial agonist buprenorphine can reduce opioid use and symptoms related to OUD, risk of infectious disease transmission, and criminal behavior associated with drug use.[31] These medications, which work by controlling withdrawal symptoms and cravings for the drug, also increase treatment retention, which itself is associated with lower risk of overdose mortality, reduced risk of HIV and hepatitis C transmission, reduced criminal justice involvement, and greater likelihood of employment.[32] The extended-release formulation of the opioid antagonist naltrexone, which works by blocking the effects of other opioids, is also effective for relapse prevention in patients who have been stably detoxified from opioids.[33] However, due to persistent anti-medication biases inherited from a previous era that saw medication use as a "crutch," as well as concerns regarding diversion of drugs, MAT remains underutilized both in the wider health care system and especially in criminal justice settings.[34]

About 60 percent of state and federal prisoners have a substance use disorder, in many cases OUD. OUD typically goes untreated during incarceration, putting inmates at high risk of relapse upon release; due to lost opioid tolerance, relapse to opioid use often results in overdose.[35] Research suggests formerly incarcerated people have a nearly 12-fold higher mortality rate during the 2 weeks following release from prison than the general population, and fatal overdoses are a leading contributor to this statistic.[36] Several studies have shown benefits of incorporating methadone or buprenorphine into criminal justice treatment programs, such as reducing post-release opioid use,[37,38] hastening treatment engagement, increasing duration of treatment after release,[39] and reducing all-cause and overdose mortality rates after release.[40]

12. What is the prevalence of chronic diseases among justice-involved populations?

Research in correctional and community settings has found that incarcerated and formerly incarcerated populations have a higher prevalence of HIV and AIDS, hepatitis C, tuberculosis, and other infectious diseases.[41,42] Approximately 40 percent of incarcerated individuals have at least one chronic health condition, such as diabetes or hypertension.[43] Twenty-one percent of people in prison and 14 percent of people in jail reported ever having an infectious disease, including tuberculosis, hepatitis B and C, and other sexually transmitted diseases, compared with 4.8 percent of the general population.[44]

The prevalence of HIV and AIDS in correctional settings is three and four times higher, respectively, than in the general population. Additionally, rates of active and latent tuberculosis in correctional institutions remain considerably higher than those in the general population, in part due to close living conditions, poor ventilation, and overcrowding. Injection drug use carries the risk of hepatitis C infection, which has a prevalence of approximately 30 percent in most correctional settings; for people with HIV/hepatitis C co-infection, liver disease is a leading cause of morbidity and mortality.[45] In addition to HIV/AIDS, incarcerated populations are at risk of sexually transmitted infections, including the human papillomavirus (HPV), gonorrhea, and syphilis.[46]

Research has found that women incarcerated in U.S. jails have a higher prevalence of chronic medical and psychiatric disorders compared to men incarcerated in U.S. jails.[47] Some women may also experience exacerbation of existing reproductive and

gynecological health issues during incarceration and should be connected with reproductive and gynecological care upon reentry to the community.

13. What strategies can providers use to link individuals with primary and preventive care?

Federally Qualified Health Centers (FQHCs) are a resource available to provide health care services to people upon release. FQHCs are community-based health care providers funded by the Health Resources and Services Administration (HRSA) to provide primary and preventive health care, dental care, and behavioral health services to persons of all ages on a sliding scale basis. FQHCs are located in underserved areas and can provide a partnership for linking individuals with primary and preventative care. Providers can find FQHCs using HRSA's Health Center Locator.

14. What barriers to access of physical and behavioral health care do justice-involved populations experience?

Upon returning to their communities from jails or prisons, individuals may be uninsured due to suspension of Medicaid, ineligible for health insurance through Medicaid or Medicare, or unable to afford private insurance and physical and behavioral health care. In a study of unmet psychiatric needs,[48] researchers found that individuals with mental illness who had involvement with the criminal justice system in the last 12 months were more likely to have a perceived unmet need for mental health treatment. Affordability and stigma were the primary reasons for perceived unmet need.

Individuals may need extensive education on self-care and disease and health management, particularly as many health conditions may have progressed during incarceration. Establishing or re-establishing eligibility for public health services prior to release and reentry into the community will assist individuals in receiving comprehensive physical health treatment and services and coordinated behavioral health care.

15. What happens to Medicaid coverage when an individual is incarcerated or returns to the community after incarceration?

Depending on a state's legislation, an individual enrolled in Medicaid will either have their coverage suspended during a period of detention in a jail or incarceration, which can be resumed once the appropriate paperwork is filed upon release, or their coverage will be terminated, requiring them to re-enroll after release. Community service providers should familiarize themselves with the rules in their state.

In 2016, the Centers for Medicare and Medicaid Services (CMS) issued the guidance "To Facilitate Successful Re-entry for Individuals Transitioning from Incarceration to their Communities." This guidance reiterated CMS policy that incarceration does not make an individual ineligible for Medicaid and restated its encouragement for states to suspend, rather than terminate, Medicaid coverage during incarceration. It also stated that, for eligible applicants, "the state must enroll or renew the enrollment of the individual effective before, during, and after the period of time spent in the correctional facility."

The guidance clarified that Medicaid coverage is allowed for individuals on parole, probation, or released to the community pending trial; living in a halfway house (unless an individual does not have "freedom of movement and association"); living in a public institution voluntarily; and on home confinement. Medicaid coverage is not available to individuals in state or federal prisons, local jails, or detention facilities; federal residential re-entry centers; or residential mental and substance use disorder

treatment facilities for inmates. This guidance can be found on the CMS website.

In communities where the state may not adhere to the CMS guidance, community-based providers can still take steps to explore whether clients are eligible for coverage and link them with enrollment services. To identify local agencies or individuals providing enrollment services, providers may conduct a quick search at Healthcare.gov. Community-based providers with staff trained in Supplemental Security Income (SSI)/Social Security Disability Insurance (SSDI) Outreach, Access, and Recovery (SOAR) may have increased capacity to link individuals with Medicaid coverage. In 32 states, individuals who are approved for SSI automatically receive Medicaid benefits. More information about SOAR and Medicaid benefits may be found at Medicaid and Medicare: An Overview.

16. Do some justice-involved individuals have higher rates of trauma?

Community providers should be aware that some populations have higher rates of trauma that precede their justice involvement. All persons with current or historical involvement in any aspect of the criminal justice system should be screened for trauma and provided treatment accordingly. Women and lesbian, gay, bisexual, and transgender individuals are at an increased risk of re-traumatization due to higher rates of intimate partner violence, sexual assault, and hate violence. In a study supported by the Bureau of Justice Assistance of women in jails, researchers found that, when compared to women without a serious mental illness (SMI), women with an SMI reported more childhood physical abuse (53 percent vs. 32 percent), childhood sexual abuse (60 percent vs. 37 percent), witnessing violence as children (77 percent vs. 60 percent), adult partner violence (75 percent vs. 60 percent), and adult sexual assaults (56 percent vs. 37 percent).[49] The Targeted Capacity Expansion for Jail Diversion study of people with mental illness also found that more women (96 percent) reported experience of trauma across the lifetime than men (89 percent). However, more men (86 percent) than women (74 percent) reported a traumatic experience in the past 12 months.[50] The MacArthur Mental Health Court Study confirmed these data among participants in 3 mental health courts across the country, with 70 percent of the women reporting sexual abuse or rape before age 20 and 22 percent reporting being injured by parents enough to need medical attention.[51] Among lesbian and bisexual women, approximately 1 in 2 bisexual women and 2 in 5 lesbian women experience intimate partner violence (compared to 1 in 3 heterosexual women).[52]

Veterans are also at an increased risk for re-traumatization due to combat exposure and military sexual assault. Studies of rates of post-traumatic stress disorder (PTSD) among veterans found prevalence rates higher than in the general population. Among a sample of Operation Enduring Freedom/Operation Iraqi Freedom veterans, the prevalence of current PTSD was 13.8 percent.[53] One study indicated that, among women veterans of the conflicts in Iraq and Afghanistan, 21 percent have been diagnosed with PTSD.[54]

It should be noted that the experience of incarceration in a jail or prison may also traumatize or re-traumatize people. The Bureau of Justice Statistics estimates that in 2011-2012, rates of sexual victimization were 4 percent among state and federal prison inmates and 3.2 percent among jail detainees. Sexual victimization by other inmates as well as by facility staff was reported.[55] Researchers have also found that people with mental illness incarcerated in prisons experience about 1.6 times greater inmate-on-inmate and 1.2 times greater staff-on-inmate physical violence compared to people with no mental illness.[56] Women with mental illness report high rates of sexual victimization (23.4 percent), but the rate of sexual victimization among men with mental illness is also disproportionate (8.3 percent)

when compared to victimization of people without mental illness.[57]

17. How is trauma assessed and treated?

SAMHSA defines a trauma-informed approach as the following: "A program, organization, or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatization."[58]

To best serve people who have experienced trauma, agencies should ensure that all criminal justice and behavioral health staff receive training on trauma-informed approaches. The first two steps in screening are to determine whether the person has a history of trauma and whether he or she has trauma-related symptoms. Screening mainly obtains answers to "yes" or "no" questions, including "Has this client experienced a traumatic event in the past?" and "Does this client at this time warrant further assessment regarding trauma-related symptoms?" If someone acknowledges a trauma history, then further screening is necessary to determine whether trauma-related symptoms are present.[59]

When a client screens positive for trauma-related symptoms, the community provider should follow up with a more comprehensive trauma assessment that determines whether trauma-specific treatments are indicated.

18. What is a trauma-informed approach?

Six key principles are fundamental to a trauma-informed approach:[60]

- **Safety**—Throughout the organization, staff and clients should feel physically and psychologically safe.
- **Trustworthiness and transparency**—Organizational operations and decisions are conducted with transparency and the goal of building and maintaining trust among staff, clients, and family members.
- **Peer support and mutual self-help**—Both are seen as integral to the organizational and service delivery approach and are understood as key vehicles for building trust, establishing safety, and empowerment.
- **Collaboration and mutuality**—There is true partnering between staff and clients and among organizational staff, from direct care staff to administrators.
- **Empowerment, voice, and choice**—Throughout the organization and among the clients served, individuals' strengths are recognized, built on, and validated, and new skills developed as necessary.
- **Cultural, historical, and gender issues**—The organization actively moves past cultural stereotypes and biases, considers language and cultural considerations in providing support, offers gender-responsive services, leverages the healing value of traditional cultural and peer connections, and recognizes and addresses historical trauma.

19. How does a trauma-informed approach assist with the safety of behavioral health professionals?

A trauma-informed workplace is one of safety; trust; collaboration; mutual self-help; empowerment; and recognition of cultural, gender, and historical issues. A welcoming and safe office environment that includes safe spaces and safe procedures can minimize risky situations.

Awareness and realistic assessment of one's skills, capabilities and professional experience, as well as universal safety precautions, are key pieces for creating a safe, therapeutic encounter in an office or field-based location. Additionally, observing professional boundaries increases physical and psychological safety and trust in a therapeutic environment. Strategies for working with individuals with a known history of violence or violent offense include partnerships with law enforcement wellness officers or probation/parole officers trained for specialized mental health caseloads, co-located services near agencies that can provide additional safety or support measures, and ensuring all partners implement a trauma-informed approach.

Self-care and mutual self-help are important to achieving safe working environments. Researchers have found that the quality of care provided and the health of clinicians working with individuals with histories of trauma are related to the clinicians' personal ability to manage stress.[61,62] Being mindful of and addressing stress and burnout improves a provider's capacity for thriving in often strenuous and challenging environments. Where clinicians may be working with individuals with a known history of violence or violent offense, training in de-escalation and opportunities for critical incident debriefings may be necessary to ensure staff receive optimal support and maintain their capacity to provide effective services.

20. Are case management services different for individuals who are justice involved?

SAMHSA describes case management as a coordinated approach to the delivery of social, physical health, substance use, and mental health services, linking individuals with appropriate services to address specific needs and achieve stated goals in a case management plan. Research suggests case management is effective as an adjunct to treatment.[63]

Some elements of case management services are different for justice-involved individuals. Continuous and coordinated services should be a primary goal for all transitions into and out of the criminal justice system. Understanding criminogenic risks and needs and the Risk-Need-Responsivity model (Principle Four) can assist case managers in tailoring their case management and treatment plans. Additionally, the collateral consequences of incarceration and a criminal history are barriers that case managers should be prepared to address. In some states or local jurisdictions, a criminal history may make someone ineligible for public benefits, such as Temporary Assistance for Needy Families (TANF), Supplemental Nutrition Assistance Program (SNAP), public housing, or other government-funded supports. Background checks and gaps in work history due to incarceration can significantly impact a person's job search. A person's identification may expire during incarceration, which impacts his or her ability to access employment, vocational, and educational resources.

> "Social determinants impact health, behavioral health, and criminal justice involvement."

Case management should begin with an assessment, and reassessments should be done after any transition between the community and criminal justice system. Additionally, case management should increase in intensity as individuals move from one setting to another, since they are most vulnerable at these times. Basic services and supports in case management plans should address the following:[64,65]

- Housing
- Treatment services for mental and substance use disorders, including medication and evidence-based behavioral treatments
- Basic necessities (food, clothing, and transportation)
- Benefits applications/reinstatements for Supplemental Security Income (SSI), Social Security Disability Insurance (SSDI), Medicaid, and other entitlements, if appropriate
- Supervision requirements and other criminal justice obligations, if applicable
- Maintaining contact with pretrial, probation, parole, or other criminal justice professionals
- Employment, vocational, or educational resources

The length and intensity of case management and required skills and experience of a case manager should vary according to needs of the individual. For individuals at higher risk of recidivism, case managers may need specialized skills and more in-depth knowledge of criminogenic risks and needs and the criminal justice system.

Case managers and community providers should discuss with their clients what will happen if they are arrested. If clients sign appropriate paperwork (e.g., pre-consent and consent forms, health proxy), the case manager or community providers can represent and advocate for the individual as they move through the criminal justice system.

21. Who are peer support specialists and what role do they play in providing services?

Peer support staff offer unique expertise in treatment settings by providing information and a perspective shaped by their own lived experience with mental illness, substance use disorders, or incarceration, or a combination of the three. A growing evidence base indicates that peer support may increase clients' sense of empowerment and satisfaction with services received. Peer staff may also increase stability, reduce alcohol and drug use, and enhance community engagement and social functioning among clients.[66] Peers are also believed to help clients overcome stereotypes and barriers that society imposes on people with mental illness (i.e., perceived inability to maintain employment, lack of competitive employment opportunities, etc.) and to increase clients' sense of their treatment being responsive and inclusive of non-treatment issues.[67]

The research will continue to develop, so it is important that community-based providers employ and integrate peer staff into their services. Peer staff are commonly employed under the title of "Peer Support Specialist;" however, peer staff should be integrated to provide a number of different services, including case management, transitional support (from incarceration or inpatient hospital stays), clinical treatment, clinic administration, and other positions based on their education and skill set. Having people with lived experience involved in every aspect of the agency and its programming can ensure delivery of relevant, compassionate services that move clients toward recovery.

22. What is criminogenic risk?

Criminogenic risk is the likelihood that an individual will engage in future illegal behavior in the form of a new crime or failure to comply with probation or parole conditions.

23. What are criminogenic factors?

Criminogenic factors are risks and needs that research has demonstrated increase an individual's likelihood of re-offense. The most current research has identified eight major risk and need factors (the "Central Eight") associated with committing future crimes, which include:

- History of antisocial behavior
- Antisocial personality pattern
- Antisocial cognition
- Antisocial associates
- Family/marital problems
- Work/school problems
- Lack of healthy leisure/recreational pursuits
- Substance use

Each factor is associated with both a static risk and changeable need that should be assessed and addressed through treatment and services. For example, "antisocial personality pattern" poses a static risk of the client lacking self-control or becoming aggressive but also indicates a changeable need in the client for enhancing personal problem-solving skills, increasing self-management skills, or learning coping skills.[68]

24. How can providers address criminogenic risk and needs?

Individuals who are involved with the criminal justice system have a diverse range of behavioral health, criminogenic, case management, and social support needs. Some individuals may have higher behavioral health needs and low or no criminogenic risks, while some may have higher needs related to their criminogenic risk and low behavioral health needs. No two individuals are the same, and while many individuals with mental and substance use disorders may be incarcerated for low-level, nonviolent crimes, some individuals may have moderate or high criminogenic risk. All individuals should have access to behavioral health treatment, regardless of their criminogenic risks and needs.

Addressing criminogenic risk and need factors includes programming to address criminal thinking and behaviors, comprehensive case management, prosocial engagement and activities, and vocational and educational supports. Research suggests that addressing three or more of the criminogenic factors reduces recidivism.[69]

For community providers, clinical assessment is the first step in treatment and is used to establish the behavioral health needs and services to be addressed in an individual's treatment plan. Similarly, standardized and validated criminogenic risk and needs assessments can be used to direct resources and supports that reduce an individual's likelihood of recidivism or risk of re-offense.

The Risk-Needs-Responsivity (RNR) model can assist clinicians, case managers, and corrections professionals in identifying and prioritizing individuals for the appropriate treatments to reduce their likelihood of re-offense. Although the RNR model focuses on criminogenic risk and needs rather than behavioral health risks, it can be instructive in connecting behavioral health treatment and services to improve health outcomes while also reducing future justice involvement.[70] The three principles that underlie the RNR model—risk, needs, and responsivity—guide the assessment and treatment of individuals with criminal justice involvement. The **risk** principle matches

the intensity of individuals' treatment to their level of risk for re-offending; the **need** principle targets criminogenic needs; and the **responsivity** principle addresses individuals' barriers to learning (learning styles, reading abilities, cognitive impairments, and motivation) in the design of treatment interventions.[71] Responsivity is addressed through two routes: general and specific. General responsivity involves addressing pro-criminal attitudes and use of cognitive behavioral intervention strategies,[72] while specific responsivity involves "use of styles and modes of treatment that are matched with the client need and learning styles."[73] Both approaches to responsivity have been found effective.[74]

Community providers and criminal justice professionals may address the same Central Eight risk and need factors in their interventions, treatment, and supervision plans, which is why the RNR model is effective across both systems. For example, both community providers and criminal justice professionals may address antisocial cognition through cognitive behavioral interventions. These include Thinking for a Change[75] and other models that address criminogenic risk. Research has also documented the positive impact that results from strengths-based assessments and interventions.[76,77]

25. How does mental illness interact with criminogenic risk, needs, and responsivity factors?

Mental illness is not a criminogenic risk factor; however, justice-involved individuals with mental illness may have more identified criminogenic risk factors than those without a mental illness.[78] Each person should be considered on an individual basis to discern where and how the presentation of a serious mental illness may seem similar to or overlap with criminal thinking.[79] For individuals with co-occurring substance use disorders, substance use is one of the Central Eight risk factors that increase the likelihood of future criminal justice involvement. As standard practice for substance use disorders, providers should use evidence-based interventions to reduce substance use.

Individuals with mental illness may have functional or cognitive impairments that impact their responsivity to treatment, and co-occurring substance use may also interfere with responsivity. Behavioral health providers can address responsivity in the delivery of interventions, using interventions that are responsive to functional or cognitive impairments.

Disparate Outcomes

26. What disparities exist in the criminal justice system?

Disparities in incarceration rates exist based on an individual's racial, ethnic, sexual, and gender identities. People of color and sexual and gender minorities are disproportionately represented in the criminal justice system. Data from the U.S. Federal Bureau of Prisons and the Prison Policy Initiative[80] indicate that African Americans comprise 37.7 percent of all inmates but make up only 13.3 percent of the U.S. population; Latinos comprise 19 percent of all inmates but make up only 16 percent of the U.S. population; and the White population comprises 39 percent of all inmates and 64 percent of the U.S. population. Based on these figures, African Americans are incarcerated at five times the rate that Whites are, and Latinos are nearly twice as likely to be incarcerated as White individuals. Additionally, data from the U.S. Bureau of Justice Assistance analyzed by the Prison Policy Initiative show that, prior to incarceration, individuals in prisons had incomes 41 percent lower than non-incarcerated individuals of similar age. Women are also disproportionately entering the criminal justice system. A 2016 report found that women are the fastest

growing correctional population, with the number of women in jails increasing 14-fold since 1970.[81]

Sexual minorities (individuals who self-identify as lesbian, gay, bisexual, and transgender) also experience disproportionate rates of incarceration. Based on the National Inmate Survey from 2011–2012, one study found that sexual minorities were disproportionately incarcerated: 9.3 percent of men in prison, 6.2 percent of men in jail, 42.1 percent of women in prison, and 35.7 percent of women in jail were sexual minorities. The incarceration rate of self-identified lesbian, gay, or bisexual persons was 1,882 per 100,000, more than 3 times that of the U.S. adult population.[82]

27. What health and behavioral health disparities do criminal justice populations face?

Incarceration has a disproportionate health impact on all individuals; the impact is even greater for women, sexual and gender minorities, and people of color.[83] When compared to individuals without a history of incarceration, incarcerated and formerly incarcerated individuals have a higher prevalence of chronic medical conditions,[84,85] premature mortality,[86] and reduced access to health care services.[87] Disparities also exist in access to and use of physical health, behavioral health, and social services for women, sexual and gender minorities, and people of color.[88] This may occur for reasons related to the individual, including access to services, perceptions, preferences, and stigma related to treatment. It may also occur due to provider preference, knowledge, skills, and abilities in working with diverse populations, as well as system-level factors, such as parity in insurance coverage and the proximity of treatment services.[89] Community providers can help reduce disparities by welcoming opportunities to serve justice-involved individuals in their organizations.

People who face disparities in the criminal justice system often also face disparities in health and behavioral health due to their race and ethnicity, gender, sexual orientation, stigma associated with their illness and/or criminal justice involvement, perceived social status, and social determinants of health. Research shows that both explicit and implicit biases held by clinicians can impact moral judgments or the treatment and care they provide to clients, or both.[90] Treatment may be influenced by the patient's perceived social status;[91] the patient's economic status;[92] the type of mental disorder;[93,94] and the behavior displayed due to symptoms, such as attempted suicide.[95] Social determinants of health are the conditions in which people are born, grow, work, live, and age, as well as the wider set of forces and systems shaping the conditions of daily life.[96] These social determinants of health impact the availability and accessibility of mental and substance use treatment in the community. For example, people who live in disadvantaged neighborhoods may have less access to mental health treatment in their community if behavioral health agencies or community clinics are not located there. Criminal justice involvement is also impacted by where people are born, grow, work, live, and age and the forces and systems that shape these conditions.[97] Together, social determinants impact health, behavioral health, and criminal justice involvement and, often, lead to disparate outcomes among people of color and people with social and economic disadvantage.

Resources

Collaboration

Adults with Behavioral Health Needs under Correctional Supervision: A Shared Framework for Reducing Recidivism and Promoting Recovery, Council of State Governments (CSG) Justice Center

Bridging the Gap: Improving the Health of Justice Involved People through Information Technology, Vera Institute of Justice

Building Effective Correctional Facility-Community Provider Partnerships for the Benefit of Justice Involved Women: Lessons Learned, National Resource Center on Justice-involved Women

Information Sharing in Criminal Justice and Mental Health Collaborations, Bureau of Justice Assistance and CSG Justice Center

Police-Mental Health Collaboration Toolkit, Bureau of Justice Assistance

Police-Mental Health Collaboration Program Checklists, Bureau of Justice Assistance

Report of the Consensus Project, CSG Justice Center

The Stepping Up Initiative Toolkit, CSG Justice Center, National Association of Counties, and American Psychiatric Association Foundation

Health Care Coverage

Critical Connections: Getting People Leaving Prison and Jail the Mental Health Care and Substance Use Treatment They Need—What Policymakers Need to Know about Health Care Coverage, Bureau of Justice Assistance and CSG Justice Center

Health Coverage & County Jails: Suspension vs. Termination, National Association of Counties

State-by-State Healthcare Profile Map, Legal Action Center (funded by Bureau of Justice Assistance)

Reentry

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

Medicaid and CHIP MAC Learning Collaboratives: The Coverage Learning Collaborative

Reentry MythBusters, National Reentry Resource Center

Reentry Resources, Office of Minority Health, U.S. Department of Health and Human Services

Rural Care Coordination Toolkit

Transitions Clinic Network

Transition from Jail to Community, National Institute of Corrections and Urban Institute

Transition from Jail to Community Initiative Phase Two Site Reports

Clinical Care and Case Management

Adults with Behavioral Health Needs under Correctional Supervision, CSG Justice Center

Case Management for Justice-Involved Populations: Colorado, Urban Institute

Screening and Assessment of Co-Occurring Disorders in the Justice System, SAMHSA

Collaborative Comprehensive Case Plans, CSG Justice Center

Correctional Health, Centers for Disease Control

Effective Clinical Practices in Treating Clients in the Criminal Justice System, National Institute of Corrections

SAMHSA-HRSA Center for Integrated Health Solutions

Services Integration: Strengthening Offenders and Families, While Promoting Community Health and Safety, Office of the Assistant Secretary for Planning and Evaluation

TIP 27: Comprehensive Case Management for Substance Abuse Treatment, SAMHSA

TIP 30: Continuity of Offender Treatment for Substance Use Disorders from Institution to Community, SAMHSA

Criminogenic Risk and Recidivism

Adults with Behavioral Health Needs under Correctional Supervision: A Shared Framework for Reducing Recidivism and Promoting Recovery, CSG Justice Center

Thinking for a Change 4.0, National Institute of Corrections

Trauma

SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach

TIP 57: Trauma-Informed Care in Behavioral Health Services, SAMHSA

Provider Wellness Self-Care for Providers, SAMHSA

Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers, Occupation Safety and Health Administration

Special Populations

Increasing Cultural Competence to Reduce Behavioral Health Disparities, SAMHSA

National Standards for Culturally and Linguistically Appropriate Services

Top Health Issues for LGBT Populations, SAMHSA

National PREA Resource Center

Glossary of Terms

42 CFR Part 2: The Confidentiality of Substance Use Disorder Patient Records regulation, 42 CFR Part 2 ("Part 2"), governs confidentiality for people seeking treatment for substance use disorders from federally assisted programs. Part 2 protects the confidentiality of records relating to the identity, diagnosis, prognosis, or treatment of any patient records that are maintained in connection with the performance of any federally assisted program or activity relating to substance use disorder education, prevention, training, treatment, rehabilitation, or research.

Adjudication: The action or process of resolving a court case, which in many jurisdictions results in a decision, finding, or verdict on the charge or matter at hand.

Appeal: A request made after a trial, asking another court (usually the court of appeals) to decide whether the trial was conducted properly. To make such a request is "to appeal" or "to take an appeal."

Arrest warrant: A written order directing the arrest of a party. Arrest warrants are issued by a judge after a showing of probable cause.

Bail: Security given for the release of a criminal defendant or witness from legal custody (usually in the form of money) to secure his/her appearance on the day and time appointed.

Behavioral health: "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."[98]

Booking: Procedure in which a jail records information about a person taken into custody by law enforcement and placed in the jail's custody.

Charge: The law that the police believe the defendant has broken.

Community-based provider: An agency or individual that delivers services in a community setting versus an institution, such as a hospital, jail, or prison.

Community corrections: Correctional services, often called probation and/or parole, which are delivered in the community rather than prison or jail. People under the oversight of community corrections may be serving the remainder of a sentence or may be required by state statute to remain under oversight for a set period of time following release from a jail or prison. In some areas, probation agencies also provide oversight to post-adjudication treatment court program participants during their participation in the treatment court program.

Community supervision: The activities involved in providing oversight to people who are under community corrections. In some areas, probation agencies also provide community supervision to post-adjudication treatment court program participants during their participation in the treatment court program.

Co-morbid disorders: The presence of two chronic diseases or conditions in a patient.

Co-occurring disorders: The coexistence of both mental illness and substance use disorder(s); may include polysubstance use disorders, which are substance use disorders involving more than one type of drug.

Criminogenic factors: Criminogenic factors are risks and needs that research has demonstrated increase an individual's likelihood of re-offense.

Criminogenic needs: Dynamic or changeable factors that increase an individual's likelihood of re-offense but can be remedied or lessened through appropriate interventions or services.

Criminogenic risk: The likelihood that an individual will engage in future illegal behavior in the form of a new crime or because of failure to comply with probation or parole conditions.

Crisis Intervention Teams (CIT): An evidence-based program for first responders that provides training, resources, and partnerships to support the diversion of people with mental illness or co-occurring mental and substance use disorders from arrest or a jail stay into treatment or services.

Diversion: The process of channeling a person away from the justice system and placement into services or treatment to address symptoms and underlying causes leading to justice involvement.

Federally Qualified Health Centers (FQHC): Community-based health care providers funded by the Health Resources and Services Administration (HRSA) to provide primary and preventive health care, dental care, and behavioral health services to persons of all ages on a sliding scale basis. FQHCs are located in underserved areas and can provide a partnership for linking individuals with primary and preventative care.

Felony: A crime regarded more serious than a misdemeanor and usually carrying a penalty of more than a year in prison.

Evidence-based practice (EBP): "The conscientious, explicit, and judicious use of current best evidence in making decisions about the care of the individual patient. It means integrating individual clinical expertise with the best available external clinical evidence from systematic research."[99]

Evidence-based program: A program providing an intervention that is supported by a robust research base indicating its effectiveness on populations receiving the intervention.

Health Insurance Portability and Accountability Act (HIPAA): United States legislation that provides data privacy and security provisions for safeguarding medical information.

Initial hearing: Court proceeding in which the defendant learns of his or her rights and the charges against him or her and the judge decides bail.

Jail: Short-term facilities that are usually administered by a local law enforcement agency and that are intended for adults but sometimes hold juveniles before or after adjudication. Jail inmates usually have a sentence of less than 1 year or are being held pending a trial, awaiting sentencing, or awaiting transfer to other facilities after a conviction.

Justice-involved: This descriptor indicates past or current involvement in the criminal justice system, typically indicating the person has experienced one or more of the following: an arrest, prosecution, incarceration in a jail or prison, and/or community supervision.

Medicaid: A federal health care program that provides coverage of certain health services to families or individuals that meet income eligibility requirements. The eligibility requirements and services covered vary by state. Funding is largely provided by the federal government; however, states may supplement the funds and direct the way Medicaid is delivered on the state level.

Medication-assisted treatment: The use of medications, usually in combination with counseling and behavioral therapies, to treat substance use disorders; often used to treat opioid use disorders.

Mental health: The "state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community."[100]

Mental illness: "Any mental illness (AMI) is defined as a mental, behavioral, or emotional disorder. AMI can vary in impact, ranging from no impairment to mild, moderate, and even severe impairment . . ."[101]

Misdemeanor: A crime considered less serious than a felony, usually punishable by less than a year of confinement. Depending on the jurisdictions, misdemeanors may or may not include infractions, which are even less serious offenses, such as exceeding the speed limit, illegal parking, and others.

Parole: The conditional release of an offender from prison to serve the remainder of his/her sentence under supervision in the community.

Plea: In a criminal case, the defendant's statement pleading "guilty" or "not guilty" in answer to the charges.

Pretrial services: Monitoring and services provided by a designated agency to defendants awaiting the adjudication of their court case. Typically, defendants must be court ordered to pretrial supervision. The research indicates that people at high to medium-high risk of failure to appear in court and/or criminal activity during the pretrial phase are most appropriate for pretrial services.

Prison: Compared to jail facilities, prisons are longer-term facilities owned by a state or by the federal government. Prisons typically hold felons and persons with sentences of more than a year; however, the sentence length may vary by state. Six states (Connecticut, Rhode Island, Vermont, Delaware, Alaska, and Hawaii) have an integrated correctional system that combines jails and prisons. There are a small number of private prisons, facilities that are run by private prison corporations whose services and beds are contracted out by state or the federal government.

Probation: A sentencing alternative to imprisonment in which the court releases convicted defendants under supervision as long as certain conditions are observed.

Probation officers: Monitor convicted offenders released under court supervision; in some jurisdictions, may provide community supervision for offenders under the oversight of a treatment court program.

Promising practice: A specific activity or process used that has an emerging or limited research base supporting its effectiveness. Promising practices are not considered "evidence based" until additional evaluation research is completed to clarify its short- and long-term outcomes and impact on groups going through the activity or process.

Promising program: An intervention program that has an emerging or limited research base supporting its effectiveness. Promising programs are not considered "evidence based" until additional evaluation research is completed to clarify its short- and long-term outcomes and impact on groups receiving the intervention.

Prosecution: The process of legal proceedings to resolve a criminal case (with one or more charges) against a defendant.

Protected health information: Any identifiable information about an individual's health condition, receipt of health care services, or payment for such services that is gathered by a Covered Entity (or Business Associate of a Covered Entity) according to HIPAA.

Public Defender: An attorney that is assigned to an individual unable to afford a private attorney.

Recovery: The process through which people with mental illness or co-occurring disorders improve their health and wellness.

Risk-Need-Responsivity (RNR) model: A correctional treatment model that supports clinicians, case managers and corrections professionals in identifying and prioritizing individuals for the appropriate treatments to reduce their likelihood of re-offense. Although the RNR model focuses on the risk of re-offense, it can be instructive in connecting behavioral health needs to criminogenic risk.

Sentence: The punishment ordered by a court for a defendant convicted of a crime.

Sentencing: The process by which a person convicted of a crime is ordered to a specified punishment.

Sequential Intercept Model: A conceptual model to inform community-based responses to the involvement of people with mental and substance use disorders in the criminal justice system.

Specialty or problem-solving courts: These courts differ from traditional courts in that they are specially designed court calendars or dockets dedicated to addressing one type of offense or offender. These court-based interventions may focus on substance use, mental health, and other criminogenic issues. Typically, the judge plays a key supervisory role, and other criminal justice components (such as probation) and social services agencies (such as substance use treatment) collaborate on case management.

Substance use disorder (SUD): A medical condition involving a physical and/or psychological dependence on one or more substances, such as a drug or alcohol. "Polysubstance use" is often used to describe use of more than one type of drug by a person with SUD.

Trauma-informed: The use of information, precautions, and sensitive approaches by community-based providers that considers real or potential experiences of trauma among people served.

Treatment court: Also called "problem-solving courts" or "specialty courts," these courts have a specialized docket where programming is provided to people meeting eligibility criteria under court order and oversight. Common treatment courts include drug treatment court, mental health court, veterans court, and Driving While Impaired (DWI) court, among others. Treatment courts are voluntary and may be a pre-plea (charge is dismissed upon program completion) or a post-plea (conviction is removed from record upon program completion) type of court.

Trial: A hearing that takes place when the defendant pleads "not guilty," and the parties are required to come to court to present evidence.

Endnotes

1 See Bronson, J., Stroop, J., Zimmer, S., & Berzofsky, M. (2017). *Drug use, dependence, and use among state prisoners and jail inmates, 2007-2009*. U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics. 1-27; Bronson, J., & Berzofsky, M. (2017). *Indicators of mental health problems reported by prisoners and jail inmates, 2011-12*. U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics. 1-17; and Steadman, H. J., Osher, F. C., Robbins, P. C., Case, B., & Samuels, S. (2009). Prevalence of serious mental illness among jail inmates. *Psychiatric Services, 60*(6), 761-765.

2 Lowencamp, C., VanNostrand, M., & Holsinger, A. (2013). *The hidden costs of pre-trial detention*. Retrieved from http://www.arnoldfoundation.org/research-report-hidden-costs-pretrial-detention

3 Lurigio, A. J. (2011). People with serious mental illness in the criminal justice system: Causes, consequences, and correctives. *The Prison Journal, 91*(3), 66S-86S.

4 Ibid.

5 Langan, P. A., & Levin, D. J. (2002). *Bureau of Justice Statistics Special Report: Recidivism of prisoners released in 1994* (Publication No. NCJ 193427). Washington, DC: Bureau of Justice Statistics.

6 Frank, J. W., Linder, J. A., Becker, W. C., Fiellin, D. A., & Wang, E. A. (2014). Increased hospital and emergency department utilization by individuals with recent criminal justice involvement: Results of a national survey. *Journal of General Internal Medicine*, *29*(9), 1226-1233.

7 Mallik-Kane, K., & Visher, C. A. (2008). *Health and prisoner reentry: How physical, mental, and substance abuse conditions shape the process of reintegration*. Washington, DC: The Urban Institute.

8 Wang, E. A., Wang, Y., & Krumholz, H. M. (2013). A high risk of hospitalization following release from correctional facilities in Medicare beneficiaries: A retrospective matched cohort study, 2002 to 2010. *JAMA Internal Medicine*, *173*(17), 1621-1628.

9 Skeem, J. L., Winter, E., Kennealy, P. J., Louden, J. E., & Tatar II, J. R. (2014). Offenders with mental illness have criminogenic needs, too: Toward recidivism reduction. *Law and Human Behavior*, *38*(3), 212.

10 Wallace, B. C., Conner, L. C., & Dass-Brailsford, P. (2011). Integrated trauma treatment in correctional healthcare and community-based treatment upon reentry. *Journal of Correctional Health Care*, *17*(4), 329-343.

11 Teller, J. L., Munetz, M. R., Gil, K. M., & Ritter, C. (2006). Crisis intervention team training for police officers responding to mental disturbance calls. *Psychiatric Services*, *57*(2), 232-237.

12 Watson, A. C., & Fulambarker, A. J. (2012). The crisis intervention team model of police response to mental health crises: A primer for mental health practitioners. *Best Practices in Mental Health, 8*(2), 71.

13 Clifasefi, S. L., Lonczak, H. S., & Collins, S. E. (2017). Seattle's Law Enforcement Diversion (LEAD) Program: Within-subjects changes on housing, employment, and income-benefits outcomes and associations with recidivism. *Crime & Delinquency*, *63*(4), 429-445.

14 Collins, S. E., Lonczak, H. S., & Clifasefi, S. L. (2017). Seattle's Law Enforcement Assisted Diversion (LEAD): Program effects on recidivism outcomes. *Evaluation and Program Planning, 64*, 49-56.

15 Lowenkamp, C. T., Holsinger, A. M., & Latessa, E. J. (2005). Are drug courts effective: A meta-analytic review. *Journal of Community Corrections*, *15*(1), 5-11.

16 Mitchell, O., Wilson, D. B., Eggers, A., & MacKenzie, D. L. (2012). Assessing the effectiveness of drug courts on recidivism: A meta-analytic review of traditional and non-traditional drug courts. *Journal of Criminal Justice, 40*(1), 60-71.

17 Binswanger, I. A., Stern, M. F., Deyo, R. A., Heagerty, P. J., Cheadle, A., Elmore, J. G., & Koepsell, T. D. (2007). Release from prison–A high risk of death for former inmates. *New England Journal of Medicine, 356*(2), 157-165.

18 Ranapurwala, S. I., Shanahan, M. E., Alexandridis, A. A., Proescholdbell, S. K., Naumann, R. B., Edwards, E., Jr., & Marshall, S. W. (2018). Opioid overdose mortality among former North Carolina inmates: 2000-2015. *American Journal of Public Health*, *108*(9)*,* 1207-1213.

19 Binswanger, I. A., Stern, M. F., Deyo, R. A., Heagerty, P. J., Cheadle, A., Elmore, J. G., & Koepsell, T. D. (2007). Release from prison–A high risk of death for former inmates. *New England Journal of Medicine, 356*(2), 157-165.

20 Bard, M. (1971). The role of law enforcement in the helping system. *Community Mental Health Journal*, *7*(2), 151-160.

21 Zealberg, J. J., Christie, S. D., Puckett, J. A., McAlhany, D., & Durban, M. (1992). A mobile crisis program: Collaboration between emergency psychiatric services and police. *Psychiatric Services*, *43*(6), 612-615.

22 Deane, M. W., Steadman, H. J., Borum, R., Veysey, B. M., & Morrissey, J. P. (1999). Emerging partnerships between mental health and law enforcement. *Psychiatric Services*, *50*(1), 99-101.

23 See Reuland, M., Draper, L., & Norton, B. (2010). *Improving responses to people with mental illness: Tailoring law enforcement initiatives to individual jurisdictions*. Retrieved from https://csgjusticecenter.org/law-enforcement/publications/improving-responses-to-people-with-mental-illnesses-tailoring-law-enforcement-initiatives-to-individual-jusrisdictions/

24 Munetz, M. R., & Griffin, P. A. (2006). Use of the sequential intercept model as an approach to decriminalization of people with serious mental illness. *Psychiatric Services, 57*(4), 544-549.

25 See Griffin, P., Heilbrun, K., Mulvey, E.P., DeMatteo, D., & Schubert, C.A. (2015). *The Sequential Intercept Model and Criminal Justice: Promoting Community Alternatives for Individuals with Serious Mental Illness*. New York, NY: Oxford University Press.

26 Mental illness. (2017, November). Retrieved from https://www.nimh.nih.gov/health/statistics/mental-illness.shtml

27 Peterson, J., & Heinz, K. (2016). Understanding offenders with serious mental illness in the criminal justice system. *Mitchell Hamline Law Review*, *42*(2), 537-563.

28 Sackett, D. L., Rosenberg, W. M., Gray, J. M., Haynes, R. B., & Richardson, W. S. (1996). Evidence based medicine: What it is and what it isn't. *The British Medical Journal*, *312*, 71-72.

29 Miller, W. R., & Rollnick, S. (2013). *Motivational Interviewing: Helping People Change* (3rd ed.). New York, NY: Guilford.

30 Ibid.

31 Medications to treat opioid use disorder. (2018, June). Retrieved from https://www.drugabuse.gov/publications/research-reports/medications-to-treat-opioid-addiction/efficacy-medications-opioid-use-disorder

32 The American Society of Addiction Medicine. (2013). *Advancing access to addiction medications: Implications for opioid addiction treatment*. Retrieved from https://www.asam.org/docs/default-source/advocacy/aaam_implications-for-opioid-addiction-treatment_final

33 Lee, J. D., Nunes, E. V., Jr., Novo, P., Bachrach, K., Bailey, G. L., Bhatt, S., . . . Rotrosen, J. (2018). Comparative effectiveness of extended-release naltrexone versus buprenorphine-naloxone for opioid relapse prevention (X:BOT): A multicentre, open-label, randomised controlled trial. *Lancet*, *391*(10118), 309-318.

34 Medications to treat opioid use disorder. (2018, June). Retrieved from https://www.drugabuse.gov/publications/medications-to-treat-opioid-addiction/how-opioid-use-disorder-treated-in-criminal-justice-system

35 Bronson, J., Stroop, J., Zimmer, S., & Berzofsky, M. (2017). *Drug use, dependence, and abuse among state prisoners and jail inmates, 2007-2009: Special report* (Publication No. NCJ 250546). Washington, DC: Bureau of Justice Statistics

36 Binswanger, I. A., Stern, M. F., Deyo, R. A., Heagerty, P. J., Cheadle, A., Elmore, J. G., & Koepsell, T. D. (2007). Release from prison–A high risk of death for former inmates. *New England Journal of Medicine*, *356*(2), 157-165.

37 Kinlock, T. W., Gordon, M. S., Schwartz, R. P., O'Grady, K., Fitzgerald, T. T., & Wilson, M. (2007). A randomized clinical trial of methadone maintenance for prisoners: Results at 1-month post-release. *Drug and Alcohol Dependence*, *91*(2-3), 220-227.

38 Zaller, N., McKenzie, M., Friedmann, P. D., Green, T. C., McGowan, S., & Rich, J. D. (2013). Initiation of buprenorphine during incarceration and retention in treatment upon release. *Journal of Substance Abuse Treatment*, *45*(2), 222-226.

39 Gordon, M. S., Kinlock, T. W., Schwartz, R. P., Fitzgerald, T. T., O'Grady, K. E., & Vocci, F. J. (2014). A randomized controlled trial of prison-initiated buprenorphine: Prison outcomes and community treatment entry. *Drug and Alcohol Dependence*, *142*, 33-40.

40 Marsden, J., Stillwell, G., Jones, H., Cooper, A., Eastwood, B., Farrell, M., . . . Hickman, M. (2017). Does exposure to opioid substitution treatment in prison reduce the risk of death after release? A national prospective observational study in England. *Addiction*, *112*(8), 1408-1418.

41 Dumont, D. M., Brockmann, B., Dickman, S., Alexander, N., & Rich, J. D. (2012). Public health and the epidemic of incarceration. *Annual Review of Public Health*, *33*, 325-339.

42 Jürgens, R., Nowak, M., & Day, M. (2011). HIV and incarceration: Prisons and detention. *Journal of the International AIDS Society*, *14*(1), 26.

43 Binswanger, I. A., Krueger, P. M., & Steiner, J. F. (2009). Prevalence of chronic medical conditions among jail and prison inmates in the USA compared with the general population. *Journal of Epidemiology and Community Health*, *63*(11), 912-919.

44 Maruschak, L., Bersofsky, M., & Unangst, J. (2015). *Medical problems of state and federal prisoners and jail inmates: Bureau of Justice Statistics special report* (Publication No. NCJ 248491). Washington, DC: Bureau of Justice Statistics.

45 Rich, J. D., Wohl, D. A., Beckwith, C. G., Spaulding, A. C., Lepp, N. E., Baillargeon, J., & Springer, S. (2011). HIV-related research in correctional populations: Now is the time. *Current HIV/AIDS Reports*, *8*(4), 288-296.

46 Hammett, T. M. (2009). Sexually transmitted diseases and incarceration. *Current Opinion in Infectious Diseases*, *22*(1), 77-81.

47 Binswanger, I. A., Merrill, J. O., Krueger, P. M., White, M. C., Booth, R. E., & Elmore, J. G. (2010). Gender differences in chronic medical, psychiatric, and substance-dependence disorders among jail inmates. *American Journal of Public Health*, *100*(3), 476-482.

48 Ali, M., Teich, J., & Mutter, R. (2018). Perceived unmet mental health treatment need among adults with a criminal justice involvement. *Journal of Health Care for the Poor and Underserved, 29*(1), 214-227.

49 Lynch, S. M., DeHart, D. D., Belknap, J., & Green, B. L. (2013). *Women's pathways to jail: Examining mental health, trauma, and substance use* (Publication No. NCJ 241045). Retrieved from https://www.bja.gov/publications/womenspathwaystojail.pdf

50 Policy Research Associates. (2011). *Evaluation of the CMHS targeted capacity expansion for jail diversion programs: Final report*. Delmar, NY: Author.

51 Policy Research Associates, Steadman, H. J., & Redlich, A. (2017). *MacArthur Mental Health Court study*. Ann Arbor, MI: Inter-university Consortium for Political and Social Research [distributor].

52 Brown, T. N. T., & Herman, J. L. (2015). *Intimate partner violence and sexual abuse among LGBT people: A review of existing research*. Retrieved from https://williamsinstitute.law.ucla.edu/research/violence-crime/intimate-partner-violence-and-sexual-abuse-among-lgbt-people/

53 Dursa, E. K., Reinhard, M. J., Barth, S. K., & Schneiderman, A. I. (2014). Prevalence of a positive screen for PTSD among OEF/OIF and OEF/OIF-era veterans in a large population-based cohort. *Journal of Traumatic Stress, 27*, 542-549.

54 Haskell, S. G., Gordon, K. S., Mattocks, K., Duggal, M., Erdos, J., Justice, A., & Brandt, C. A. (2010). Gender differences in rates of depression, PTSD, pain, obesity, and military sexual trauma among Connecticut war veterans of Iraq and Afghanistan. *Journal of Women's Health, 19*(2), 267-271.

55 Beck, A. J., Berzofsky, M., Caspar, R., & Krebs, C. (2013). *Sexual victimization in prisons and jails reported by inmates, 2011-12: National inmate survey, 2011-12* (Publication No. NCJ 241399). Washington, DC: Bureau of Justice Statistics

56 Blitz, C. L., Wolff, N., & Shi, J. (2008). Physical victimization in prison: The role of mental illness. *International Journal of Law and Psychiatry*, *31*(5), 385-393.

57 Wolff, N., Blitz, C. L., & Shi, J. (2007). Rates of sexual victimization in prison for inmates with and without mental disorders. *Psychiatric Services*, *58*(8), 1087-1094.

58 Substance Abuse and Mental Health Services Administration. (2014). *SAMHSA's concept of trauma and guidance for a trauma-informed approach* (Publication No. SMA14-4884). Retrieved from http://store.samhsa.gov/shin/content//SMA14-4884/SMA14-4884.pdf

59 Substance Abuse and Mental Health Services Administration. (2014). *TIP 57: Trauma-informed care in behavioral health services* (Publication No. SMA14-4816). Retrieved from https://store.samhsa.gov/product/TIP-57-Trauma-Informed-Care-in-Behavioral-Health- Services/SMA14-4816

60 Substance Abuse and Mental Health Services Administration. (2014). *SAMHSA's Concept of trauma and guidance for a trauma-informed approach* (Publication No. SMA14-4884). Rockville, MD: Author.

61 Killian, K. D. (2008). Helping till it hurts? A multimethod study of compassion fatigue, burnout, and self-care in clinicians working with trauma survivors. *Traumatology*, *14*(2), 32-44.

62 Ray, S. L., Wong, C., White, D., & Heaslip, K. (2013). Compassion satisfaction, compassion fatigue, work life conditions, and burnout among frontline mental health care professionals. *Traumatology*, *19*(4), 255-267.

63 Substance Abuse and Mental Health Services Administration. (2015, rev.). *TIP 27: Comprehensive case management for substance abuse treatment*. Retrieved from https://store.samhsa.gov/product/TIP-27-Comprehensive-Case-Management-for-Substance-Abuse-Treatment/SMA15-4215

64 Ibid.

65 Blandford, A. M., & Osher, F. C. (2013). *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.

66 Trachtenberg, M., Parsonage, M., Shepherd, G., & Boardman, J. (2013). *Peer support in mental health care: Is it good value for money?* London, Great Britain: Centre for Mental Health.

67 Davidson, L., Bellamy, C., Guy, K., & Miller, R. (2012). Peer support among persons with severe mental illnesses: A review of evidence and experience. *World Psychiatry*, *11*, 123-128.

68 Andrews, D. A., Bonta, J., & Wormith, J. S. (2006). The recent past and near future of risk and/or need assessment. *Crime & Delinquency*, *52*(7), 7-27.

69 French, S. A., & Gendreau, P. (2006). Reducing prison misconducts: What works! *Criminal Justice and Behavior*, *33*(2), 185-218.

70 Osher, F., D'Amora, D., Plotkin, M., Jarrett, N., & Eggleston, A. (2012). *Adults with behavioral health needs under correctional supervision: A shared framework for reducing recidivism and promoting recovery*. Retrieved from https://www.bja.gov/Publications/CSG_Behavioral_Framework.pdf

71 Ibid.

72 Bourgon, G., & Gutierrez, L. (2012). The general responsivity principle in community supervision: The importance of probation officers using cognitive intervention techniques and its influence on recidivism. *Journal of Crime and Justice*, *35*(2), 149-166.

73 Andrews, D. A., Zinger, I., Hoge, R. D., Bonta, J., Gendreau, P., & Cullen, F. T. (1990). Does correctional treatment work? A clinically relevant and psychologically informed meta-analysis. *Criminology*, *28*(30), 369-404.

74 Ibid.

75 Bush, J., Glick, B., & Taymans, J. (2016). *Thinking for a change 4.0*. Retrieved from https://nicic.gov/thinking-change-40. See also Golden, L. (2002). *Evaluation of the efficacy of a cognitive behavioral program for offenders on probation: Thinking for a change*. Washington, DC: National Institute of Corrections.

76 Tse, S., Tsoi, E. W., Hamilton, B., O'Hagan, M., Shepherd, G., Slade, M., . . . Petrakis, M. (2016). Uses of strength-based interventions for people with serious mental illness: A critical review. *International Journal of Social Psychiatry*, *62*(3), 281-291.

77 Xie, H. (2013). Strengths-based approach for mental health recovery. *Iranian Journal of Psychiatry and Behavioral Sciences*, *7*(2), 5-10.

78 Skeem, J. L., Winter, E., Kennealy, P. J., Eno Louden, J., & Tatar, J. R. (2014). Offenders with mental illness have criminogenic needs, too: Toward recidivism reduction. *Law and Human Behavior*, *38*, 212-224.

79 Morgan, R. D., Fisher, W. H., Duan, N., Mandracchia, J. T., & Murray, D. (2010). Prevalence of criminal thinking among state prison inmates with serious mental illness. *Law and Human Behavior*, *34*(4), 324-336.

80 Sakala, L. (2014). *Breaking down mass incarceration in the 2010 census: State-by-state incarceration rates by race/ethnicity.* Retrieved from https://www.prisonpolicy.org/reports/rates.html

81 Swavola, E., Riley, K., & Subramanian, R. (2016). *Overlooked: Women and jails in an era of reform*. Retrieved from http://www.safetyandjusticechallenge.org/wp-content/uploads/2016/08/overlooked-women-in-jails-report-web.pdf

82 Meyer, I. H., Flores, A. R., Stemple, L., Romero, A. P., Wilson, B. D., & Herman, J. L. (2017). Incarceration rates and traits of sexual minorities in the United States: National inmate survey, 2011-2012. *American Journal of Public Health*, *107*(2), 267-273.

83 Binswanger, I. A., Redmond, N., Steiner, J. F., & Hicks, L. S. (2012). Health disparities and the criminal justice system: An agenda for further research and action. *Journal of Urban Health: Bulletin of the New York Academy of Medicine, 89*(1), 98-107.

84 Binswanger, I. A., Krueger, P. M., & Steiner, J. F. (2009). Prevalence of chronic medical conditions among jail and prison inmates in the USA compared with the general population. *Journal of Epidemiology and Community Health*, *63*(11), 912-19

85 Borysova, M. E., Mitchell, O., Sultan, D. H., & Williams, A. R. (2012). Racial and ethnic health disparities in incarcerated populations. *Journal of Health Disparities Research and Practice*, *5*(2), 92-100.

86 Massoglia, M., Pare, P. P., Schnittker, J., & Gagnon, A. (2014). The relationship between incarceration and premature adult mortality: Gender specific evidence. *Social Sciences Research*, *46*,142-54.

87 Kulkarni, S. P., Baldwin, S., Lightstone, A. S., Gelberg, L., & Diamant, A. L. (2010). Is incarceration a contributor to health disparities? Access to care of formerly incarcerated adults. *Journal of Community Health*, *35*(3), 268-274.

88 Massoglia, M. (2008). Incarceration, health, and racial disparities in health. *Law & Society Review*, *42*(2), 275-306.

89 Kohn-Wood, L., & Hooper, L. (2014). Cultural competency, culturally tailored care, and the primary care setting: Possible solutions to reduce racial/ethnic disparities in mental health care. *Journal of Mental Health Counseling*, *36*(2), 173-188.

90 Hill, T. E. (2010). How clinicians make (or avoid) moral judgments of patients: Implications of the evidence for relationships and research. *Philosophy, Ethics, and Humanities in Medicine*, *5*(11). http://dx.doi.org/10.1186/1747-5341-5-11

91 Oldmeadow, J., & Fiske, S. T. (2007). System-justifying ideologies moderate status = competence stereotypes: Roles for belief in a just world and social dominance orientation. *European Journal of Social Psychology*, *37*(6), 1135-1148.

92 Monnickendam, M., Monnickendam, S. M., Katz, C., & Katan, J. (2007). Health care for the poor – An exploration of primary-care physicians' perceptions of poor patients and of their helping behaviors. *Social Science & Medicine*, *64*(7), 463-474.

93 Beryl, R., & Vollm, B. (2018). Attitudes to personality disorder of staff working in high-security and medium-security hospitals. *Personality and Mental Health*, *12*, 25-37.

94 Bowers, L., Carr-Walker, P., Allan, T., Callaghan, P., Nijman, H., & Paton, J. (2006). Attitude to personality disorder among prison officers working in a dangerous and severe personality disorder unit. *International Journal of Law and Psychiatry*, *29*(5), 333-342.

95 Mackay, N., & Barrowclough, C. (2005). Accident and emergency staff's perceptions of deliberate self-harm: Attributions, emotions, and willingness to help. *British Journal of Clinical Psychology*, *44*(Pt. 2), 255-267.

96 Social determinants of health. (n.d.) Retrieved from https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health?topicid=39

97 Fisher, W. H., Silver, E., & Wolff, N. (2006). Beyond criminalization: Toward a criminologically informed framework for mental health policy and services research. *Administration and Policy in Mental Health*, *33*(5), 544-557.

98 Substance Abuse and Mental Health Services Administration. (2013). *Behavioral Health, United States, 2012*. Retrieved from https://www.ncbi.nlm.nih.gov/books/NBK174678/

99 Sackett, D. L., Rosenberg, W. M., Gray, J. M., Haynes, R. B., & Richardson, W. S. (1996). Evidence based medicine: What it is and what it isn't. *The British Medical Journal*, *312*, 71-72.

100 Mental health: A state of well-being. (2014, August). Retrieved from http://www.who.int/features/factfiles/mental_health/en/

101 Mental illness. (2017, November). Retrieved from https://www.nimh.nih.gov/health/statistics/mental-illness.shtml

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