2017

A TOOLKIT

Planning and Implementing a Reentry Program for Clients With Co-Occurring Disorders

PROVIDED BY:

The Assisting Reentry for Co-Occurring Adults Through Collective Support (ARCCS) Program

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PURPOSE

This toolkit is intended to provide information and guidance to those planning and implementing a reentry program for individuals with co-occurring substance use and mental disorders reentering from jail or prison.

AUDIENCE

We think the toolkit will be most useful to

- Criminal justice coordinating councils
- Corrections and community corrections leaders and practitioners
- Behavioral health leaders and specialists
- Other criminal justice stakeholders

However, other audiences interested in developing reentry programs for individuals with co-occurring substance use and mental disorders may find the toolkit to be useful.

BACKGROUND

The Second Chance Act (SCA) is a federal initiative to provide assistance to state, local, and tribal governments, and nonprofit organizations in their efforts to work with people returning from prison, jail, or juvenile facilities. This effort aims to provide federal funding to jurisdictions to help improve the reentry process, improve outcomes for those returning to communities, and reduce recidivism.

Section 201 of the SCA focuses on individuals on probation, parole, or community supervision, who have been released into the community and may require treatment due to challenges with co-occurring substance abuse and mental health disorders. Section 201 aims to provide individuals with evidence-based services, which utilize reentry plans and **risk and needs assessments** to target and address a person's **criminogenic needs**. ARCCS is funded through the Second Chance Act Reentry Program for Adults with Co-occurring Substance Use and Mental Disorders.

WHAT IS A CO-OCCURRING SUBSTANCE USE AND MENTAL DISORDER? HOW COMMON IS IT IN THE REENTRY POPULATION?

A **co-occurring substance use and mental disorder**, commonly referred to as a **co-occurring disorder**, is a combination of a mental health diagnosis and one or more substance use disorders. According to the Substance Abuse and Mental Health Services Association (SAMHSA), approximately 7.9 million adults in the United States are identified as having a co-occurring disorder[1]. While this figure may be informative, diagnosing an individual with a co-occurring disorder can be difficult due to the complexity of symptoms, and estimating the true size of the population with this disorder type is a challenge.

While estimates regarding the prevalence of co-occurring disorders, specifically, among corrections populations are difficult to access, estimates for mental health conditions and substance use disorders, separately, are much more common. More than half of all prison and jail inmates (56 percent of state prisoners and 64 percent of jail inmates) are found to have a mental health diagnosis. About 74 percent of state prisoners and 76 percent of local jail inmates experience a substance use disorder or issues with drugs and/or alcohol the year before their incarceration[2].

There are many reasons why the disorders may co-occur. It is not necessarily true that one caused the other or even that one disorder appeared prior to the other. For more information about some theories regarding why these disorders co-occur, visit: https://www.drugabuse.gov/publications/drugfacts/comorbidity-addiction-other-mental-disorders.

Individuals with co-occurring disorders are more vulnerable to homelessness, suicidality, violence, and other challenges. Additionally, research suggests that prisoners with co-occurring mental health and substance use disorders are at a significantly higher risk for re-incarceration than inmates with either disorder alone, or with no disorders[3].

[1] Figure represents persons with co-occurring disorders in 2014 (Center for Behavioral Health Statistics and Quality. (2015). Behavioral health trends in the United States: Results from the 2014 National Survey on Drug Use and Health (HHS Publication No. SMA 15-4927, NSDUH Series H-50). Retrieved from http://www.samhsa.gov/data/)

[2] James, Doris J. and Glaze, Lauren E. (2006). *Mental Health Problems of Prison and Jail Inmates*. Bureau of Justice Statistics Special Report. Office of Justice Programs. U.S. Department of Justice

[3] Baillargeon, Jacques Ph.D, Williams, Brie A. M.D., Mellow, Jeff Ph.D., Harzke, Amy Jo M.P.H., Hoge, Steven K. M.D., Baillargeon, Gwen M.S., and Greifinger, Robert B. M.D. (2009). *Parole Revocation Among Prison Inmates With Psychiatric and Substance Use Disorders*. Psychiatric Services. Volume 60 (Eleventh Issue), Pp. 1516–1521.

WHAT ARE BEST PRACTICES FOR WORKING WITH REENTRY POPULATIONS WHO HAVE CO-OCCURRING DISORDERS?

More than 90 percent of incarcerated individuals will return to the community, the majority of whom will remain under some sort of supervision and require services and treatment.[4] To ensure successful reentry, it is important to prioritize assessment and planning. The foundation for what works in rehabilitating individuals is adherence to the **Principles of Effective Intervention (PEI)**.[5] These principles include the **Risk Principle**, the **Need Principle**, the **Responsivity Principle**, and the **Fidelity Principle**. The **Risk Principle** advocates for matching the level of services to the risk level of the client; intensive services should be reserved for higher-risk clients. The **Need Principle** advocates that interventions should target **criminogenic needs**; criminogenic needs are the dynamic (changeable) risk factors that are predictors of criminal behavior, such as antisocial attitudes or substance abuse. The **Responsivity Principle** advocates that the intervention should match the ability and learning style of the client. Finally, the **Fidelity Principle** tells us how to provide services correctly. Research suggests that the adherence to these principles, especially in a one-to-one supervision environments, was found to be directly related to a decrease in likelihood of reoffending.[6]

The **Principles of Effective Intervention** can guide practitioners in working with the reentry population that are challenged with co-occurring disorders. Preparation for release starts the moment an individual is identified as requiring mental health or substance abuse treatment. Assessments should be used to objectively and appropriately classify an individual's risk level, and help identify **criminogenic needs.** The next step is to use the assessment to generate a treatment plan that addresses the individual's **criminogenic needs**.

Effective and comprehensive screening and case planning procedures are essential to providing treatment to individuals reentering the community. Screening and assessment are part of the information gathering phase of providing treatment. This phase is essential for identifying risks and needs, and informing treatment or case plans. This is also an opportunity for practitioners to get to know the individual, and tailor best practices and methods to fit that individuals specific and unique needs.

With this appropriate preparation, community-based referrals can be made to link the individual with the appropriate services,

MORE THAN **90%** OF INCARCERATED INDIVIDUALS WILL RETURN TO THE COMMUNITY

THE CENTER FOR MENTAL HEALTH SERVICES (CMHS) RECOMMENDS THE FOLLOWING CONSIDERATIONS WHEN SCREENING A JUSTICE-INVOLVED CLIENT[7]:

- Engage the individual
- Collect collateral information
- Screen and detect co-occurring disorders
- Determine the severity of mental health and substance abuse issues or needs
- Determine the level of treatment services needed
- Identify a diagnosis
- Determine the level of disability and functional impairment
- Identify strengths and supports
- Identify cultural and linguistic needs and supports
- Describe key areas of psychosocial problems
- Determine individual's level of motivation and readiness for treatment

[4] James, Nathan. (2015). *Offender Reentry: Correctional Statistics, Reintegration into the Community and Recidivism.* Washington DC: Congressional Research Service.

[5] Andrews, D. A., & Bonta, J. (2003). The psychology of criminal conduct. (3rd ed.). Cincinnati, OH: Anderson

[6] Robinson, Charles R., Lowenkamp, Christopher T., Holsinger, Alexander M., VanBenschoten, Scott, Alexander, Melissa and Oleson, J.C. (2012). *A Random Study of Staff Training Aimed at Reducing Re-Arrest (STARR): Using Core Correctional Practices Probation Interactions.* Journal of Crime and Justice. Volume 34 (Second Issue), Pp. 135-187.

[7] Peters, R.H., Bartoi, M.G., & Sherman, P.B. (2008). Screening and assessment of co-occurring disorders in the justice system. Delmar, NY: CMHS National GAINS Center.

based upon their **criminogenic needs**. Due to the complexity of mental health disorders, and the greater complexity of co-occurring disorders, the best approach to treatment is not a one-size-fits-all approach. Treatment plans can encompass a variety of techniques and therapeutic approaches to address individual criminogenic needs.

Cognitive Behavioral Therapy (CBT) is an approach used to manage and modify behavior, and is used in a variety of capacities, such as addressing criminal conduct and treating mental illness or substance abuse. CBT is becoming more wildly used in criminal justice settings due to the growing research that supports its effectiveness. CBTs that are used amongst criminal justice populations typically incorporate cognitive-restructuring techniques, coping-skills, or problem-solving strategies. CBT programs that are often used in criminal justice settings that service individuals struggling with mental health and substance abuse include, but are not limited to:

SSC	**Criminal Conduct and Substance Abuse Treatment: Strategies for Self-Improvement and Change**
MRT®	**Moral Reconation Therapy®**
R&R and R&R2	**Reasoning and Rehabilitation**
RPT	**Relapse Prevention Therapy**
T4C®	**Thinking for a Change®**
ART®	**Aggression Replacement Training®**
CBI/SA	**Cognitive-Behavioral Interventions for Substance Abuse**
MATRIX	**The Matrix Model**

Incorporating CBT programming into a reentry program is an effective tool in addressing the criminogenic needs of reentering into the community. However, CBT principles may also be incorporated more broadly into treatment plans as a means of utilizing cognitive behavioral techniques in various environments. For example, therapy plans that focus on criminogenic needs can assist in identifying goals for the individual, such as achieving and increasing coping skills and problem-solving skills. Research suggests that CBTs that are targeted at justice-involved individuals should focus on cognitive functioning and increasing prosocial cognition. Effective techniques for incorporating CBT into therapeutic approaches include defining the problem, selecting goals, generating new alternative prosocial solutions, and implementation of the solutions.[8]

KEY TERMS

Co-Occurring Disorder	A mental health diagnosis that coincides with one or more Substance Use Disorders. In this past this may have been referred to as dual diagnosis or dual disorders.
Cognitive Behavioral Therapy	A form of therapy that seeks to treat negative behaviors by addressing the thinking that leads to such behaviors and teaching clients to develop better responses.
Principles of Effective Intervention (PEI)	**Risk Principle** – tells us WHO to target **Need Principle** – tells us WHAT to targe **Responsivity Principle** – tells us HOW to effectively work with individuals **Fidelity Principle** – tells us HOW to do this work RIGHT
Criminogenic Needs	An individual risk factor that predicts recidivism that is also dynamic (i.e. it can be changed). Examples include antisocial attitudes, peers, personality, and substance abuse.
Risk and Needs Assessment	In corrections, an individual assessment of the client's risk of recidivism, their criminogenic needs, protective factors, and responsivity factors
Evidence-Based Practice	"Evidence-based practice (EBP) is the objective, balanced, and responsible use of current research and the best available data to guide policy and practice decisions, such that outcomes for consumers are improved."[9]

[8] Milkman, Harvey Ph.D., Wanberg, Kenneth Ph.D. (2007). Cognitive Behavioral Treatment: A Review and Discussion for Corrections Professionals. Denver, CO. National Institute of Corrections.

[9] Guevara, Meghan and Solomon, Enver. (2009) *What is Evidence-Based Practice? Implementing Evidence-Based Policy and Practice in Community Corrections.* (Second Edition), Chapter 1. Washington DC: U.S. Department of Justice, National Institute of Corrections.

ASSISTING REENTRY FOR CO-OCCURRING ADULTS THROUGH COLLECTIVE SUPPORT (ARCCS) PROGRAM

The Assisting Reentry for Co-occurring Adults through Collective Support (ARCCS) program is funded through monies awarded to the San Joaquin County Probation Department by the Office of Justice Programs, Bureau of Justice Assistance (BJA). The ARCCS program built upon the work of San Joaquin's Transition-Age Grounds for Recovery (TYGR) program, which was funded in 2011 by the Second Chance Act through a Justice and Mental Health Collaboration Program grant, to serve high-risk adult offenders with co-occurring disorders. A grant through the Second Chance Act Reentry Program for Adults with Co-Occurring Substance Use and Mental Disorders renewed funding for the program in 2013. The toolkit was drafted in collaboration with the partners and stakeholders of the ARCCS program. Information contained in the toolkit draws upon the lessons learned, challenges faced, and strategies developed by the ARCCS and TYGR programs in their implementation of a successful program model. Much of the content provided within describes general strategies for implementation, followed by specific examples from the San Joaquin experience.

Before providing recommendations regarding planning and implementing a program, it is instructive to first provide a basic outline of the ARCCS program model.

HOW ARCCS WORKS

PHASE I:

Eligibility and assessment (2 weeks)

- Probation receives an initial list of potential ARCCS candidates from the officer at the jail assigned to the ARCCS initiative. Participants must have more than 90 days left in custody after assignment to ARCCS, must be on formal probation, and be assessed as high-risk (or moderate with an override) using the STRONG (Static Risk and Offender Needs Guide).
- If eligible, individuals are screened by Behavioral Health Services (BHS) to determine whether or not they would benefit from the program and evaluate any behavioral health needs.
- If not eligible, they would continue to be housed in a standard housing unit and receive standard probation upon their release.

PHASE II (PART 1):

Intake, full assessment, case planning (3 to 4 months for Part 1 and Part 2)

- Probation and BHS complete a full assessment. Domains covered in the assessment include family, housing, education, employment, health, mental health, and substance abuse.
- Following assessment, Probation and BHS complete a case plan along with treatment plans and a transition plan.

PHASE II (PART 2):

In-custody programming (3 to 4 months for Part 1 and Part 2)

- The client receives in-custody programming through BHS. All clients participate in two program modules – Seeking Safety and Cognitive Behavioral Interventions (CBI) for Substance Abuse, best practices for the targeted population. Clients will complete up to 87 hours of evidence-based programming while in custody.
- Two weeks before release, the team reviews the client's needs and determines if they need services while in custody that would aid in their transition to the community (e.g., appointments for medication).
- The client meets with the ARCCS probation officer throughout participation.

PHASE III:

Release and transition plan (3 to 4 months)

- After release, a home visit is scheduled or the individual is directed to report to Probation to follow up on the transition plan, case plan, and treatment plan.
- Programming with BHS – Seeking Safety and CBI for Substance Abuse – continues in the community if it was not completed in custody.
- The client and probation officer focus efforts on the client's top three criminogenic needs.
- Routine home visits by BHS and Probation take place.
- The client receives monthly evaluation of progress with the ARCCS Probation Officer.
- The time on the program in the community ranges from 3 to 9 months post-release.

PHASE IV:

Aftercare (3 to 4 months)

- Client reports to the ARCCS Probation Officer on a monthly basis, but has bi-weekly contact with their officer.
- Continued participation in evidence-based programming.
- Enrolled in Advanced Practice – which supports primary needs and addresses secondary needs including prosocial support, relapse prevention, and education and employment assistance.
- Alcohol and drug testing continues.
- Relapse triggers a review of the case plan and an appropriate intervention.

PHASE V:

Completion

- Clients are eligible to reduce their level of supervision or for early termination of probation.
- Clients have met the goals of their case plan and treatment plans.
- After completion of the program, clients will continue to receive support such as continued aftercare services and access to medications.

RECOMMENDATIONS FOR PROGRAM IMPLEMENTATION

ASSESSING THE SIZE AND SCOPE OF YOUR CO-OCCURRING REENTRY POPULATION

Among the first steps any program must take is determining the need for the program in the first place. Without a demonstrated need for a program, leaders will encounter numerous difficulties in implementation. Under-enrollment, lack of staff buy-in, and low morale, not to mention the misuse or misapplication of grant funds, are all potential problems faced by programs trying to provide a solution to a problem that doesn't exist.

Determining the need for a reentry program to address the needs of individuals with co-occurring disorders relies on a combination of data and institutional knowledge. Risk and need assessment data, if available, is vital to determining the total population of persons that could benefit from a program targeting co-occurring disorders. Additional sources of data could include enrollment in or referral to jail or prison-based substance abuse and/or mental health treatment programming. If such data is not accessible, program leaders may consult data regarding community-level substance abuse and mental health, including data regarding the prevalence of serious mental illness, treatment need, access to mental health and substance abuse providers, and other measures that indicate a need for services for individuals with co-occurring disorders. While it is best to rely on quantitative data to communicate the need for a program, institutional knowledge can play a significant part in the early stages of determining program need. Public safety and behavioral health staff and leadership have a good sense, in many cases, of the problems faced by their community and the most pressing needs in terms of programming.

San Joaquin: *According to data analyzed by the California Health Care Foundation (CHCF), 4.7 percent of adults in San Joaquin County have a serious mental illness.[10] 18.2 percent of adults in San Joaquin County report a need for treatment for a mental health issue or alcohol and drug use, compared to 15.9 percent for the state as a whole. Simultaneously, access to mental health care is an issue faced by many individuals with mental health concerns in San Joaquin County – the rate of mental health providers per 100,000 population is 42 percent lower than the rate for California as a whole. Substance abuse and the associated social costs are also an issue in San Joaquin County. The rate of drug-induced deaths is 56 percent higher than the average rate for all of California.*

Institutional knowledge can supplement and confirm findings obtained through data. Correctional staff and agencies leaders know their populations well. In the case of San Joaquin County, the Jail identified that they were struggling to respond to high numbers of individuals with co-occurring disorders, a challenge that was exacerbated by California's Public Safety Realignment implemented in 2011 through Assembly Bill 109 (AB109). In addition to increasing the jail population, corrections leaders observed increases in the number of suicide attempts and inmates requiring psychiatric medications, indicating there are more inmates with serious mental illnesses.

In the last application for funding through the Second Chance Act, the members of TYGR made a decision to change the criteria for inclusion in the program, broadening the age range, which had been limited to individuals aged 18 to 25. This had an impact on the number of inmates eligible for the program and their needs. Permitting more people to join the program was, on the whole, a positive development as the program had at times struggled to find enough clients that fit the narrow eligibility criteria.

4.7%
OF ADULTS IN SAN JOAQUIN COUNTY HAVE A SERIOUS MENTAL ILLNESS.

18.2%
OF ADULTS IN SAN JOAQUIN COUNTY REPORT A NEED FOR TREATMENT FOR A MENTAL HEALTH ISSUE OR ALCOHOL AND DRUG USE.

[10] Holzer, Charles. (2000). *California Mental Health Prevalence Estimates.* California Department of Health Care Services. http://www.dhcs.ca.gov/provgovpart/Documents/CaliforniaPrevalenceEstimates.pdf

PARTNERS NECESSARY TO ADDRESS THE TRANSITION FROM INCARCERATION TO THE COMMUNITY – THE JAIL OR PRISON, A PROVIDER OF EVIDENCE-BASED PROGRAMMING, AND SUPERVISION IN THE COMMUNITY.

IDENTIFYING AND ENGAGING PARTNERS

All multi-agency programs need to begin by deciding who should be at the table. In some cases, identifying partners that need to be involved may be quite easy. For most reentry programs, at least three partners are necessary to address the transition from incarceration to the community – the jail or prison, a provider of evidence-based programming, and an agency to act as case manager/supervision in the community. For a prison-based reentry program, the other partners need to be added based on the needs of the target population. Depending on the client type and the needs of the population, housing, family services, health-care providers, education, and employment may all need to be engaged in the initiative in order to achieve maximum impact.

In some cases, the initiative may need to reach out to and engage new partners with whom there is no prior working relationship. Such partners may need more assistance in working with a recently incarcerated population. It could also be the case that the partners initially invited to participate in the initiative do not meet all of the needs of the population that is released, or that the needs of the population change over time. If that is the case, the leaders of the reentry program may want to invite new partners to the table.

San Joaquin: *The primary partners – San Joaquin County Probation, San Joaquin County Sheriff's Office (Jail), and San Joaquin County Behavioral Health Services were easily identified based on the basic structure of the reentry program. At about the same time the program was being planned, AB109 passed the California Legislature. The law shifted responsibility for many lower-level inmates from the state prison system to jails. This changed some expectations regarding who the program would serve, which had potential implications on who would need to be a partner in the reentry program. One concern was around exposing lower-risk jail inmates to higher-risk prison inmates with lengthier offending histories.*

Eventually the program began to identify other needs, primarily in the community and other partners, were added. For example, housing was identified as a major need for many clients, which led directly to Friends Outside becoming involved in the initiative as a provider of housing for individuals returning from incarceration.

ESTABLISHING AND MAINTAINING A STRONG COLLABORATIVE GROUP

Despite best efforts, many programs struggle with establishing a strong collaborative group. There are a great deal of ways that a collaborative group may stumble. Partners may have different visions of the program, compete over funding, or experience individual personality conflicts. On the other hand, it is often difficult to point to a single reason why a group develops successful collaboration, although there are a few useful guidelines and tips.

Develop good group meeting habits. Establishing a regular meeting schedule for group communication is important. Developing meeting agendas and structuring the meeting so that meeting time is used in the most effective way is also key. Identifying a person in the lead agency who is comfortable facilitating a group meeting is also a good idea.

Find common ground. As much as possible, the group should seek to establish a common vision for what the program or initiative hopes to accomplish. This might be through a structured process to develop a vision/mission/values statement or less formally through a group conversation about the aims of the program/what group members consider to be success. While this may seem like an obvious step, many collaborative groups have fallen apart because of different ideas of what the purpose of the group is.

Establish roles. In order to function healthily, the collaborative must clearly establish the responsibilities of each partner agency. Developing an operations guide or policy manual, reviewing it with the group, and approving it together are good measures to ensure that all partners have a common understanding of their role in the program. Through that process, partners will have the opportunity to explain their capabilities and intra-organizational responsibilities to one another, so that all may have a consistent understanding of the broader process. In any new collaborative, developing a working relationship with partners is challenging. Part of this relationship is understanding each other's roles and limitations. This can be clarified through informal discussion, but should be included in more formalized meetings at the inception of the program to establish clear boundaries and expectations for all those involved.

Reinforce communication. We are all busy in our own professional roles. Many times, important information needs to be reiterated or presented in multiple methods or venues to have maximum impact. If possible, circulate minutes or notes from collaborative group meetings, or follow-up on important action items with emails or phone calls. At the operational level, communication is key to collaboration. Holding regular meetings to review individual cases and ensuring that operational staff are in constant communication is necessary to coordinate care. In the case of a reentry program, staff working with clients in custody should begin communication with post-release staff well before the client reaches the community.

San Joaquin: *Prior to beginning the reentry program with TYGR in 2011, the partners now involved in ARCCS did not have any experience working together in a similar collaborative capacity. However, they all agreed on the need for a program like this and, organizationally, shared very similar visions regarding the intent of the program. Throughout the planning process, the group established a strong foundation for their collaboration, including regular meetings, an operations guide, and robust communication at the operational level. Probation was the natural selection for a lead agency because of its principle role in the program and role in planning and organizing the proposal. Over time the relationship between the organizations has developed into a strong one.*

In terms of regular collaborative meetings, the group has established a schedule to meet together on a monthly basis. There is a rolling agenda, with some items discussed at every meeting. Other items are added to the agenda upon request or if a situation arises that requires a group decision. Occasionally, specific cases are discussed during the meeting – especially if they can impact how they run the program or present unique challenges. Communication between partners outside of meetings is regular, particularly at the operational level where the ARCCS clinician, ARCCS probation officer, and jail staff talk on a regular basis.

How to establish and maintain group strong collaboration?

1. Develop good meeting habits
2. Find common ground
3. Establish roles
4. Reinforce communication

[11] Peters, R.H., Bartoi, M.G., & Sherman, P.B. (2008). Screening and assessment of co-occurring disorders in the justice system. Delmar, NY: CMHS National GAINS Center.

THE BEST APPROACH TO TREATMENT IS NOT A ONE-SIZE-FITS-ALL APPROACH. TREATMENT PLANS SHOULD BE TAILORED TO THE INDIVIDUAL AS MUCH AS POSSIBLE.

ASSESSING THE NEEDS OF THE CLIENT POPULATION

An important part of the program development process is assessing the needs of the program and to identify the participants. In some cases the grant will determine which participants are eligible. In other cases, it may be helpful to identify which parts of a population are lacking services. For example, are current services mostly geared towards youth as opposed to adult clients? It is valuable to create a set of concrete criteria, such as this example, for eligibility and disqualification.

Once the population has been identified, programming can be selected based upon the needs of the population. The best case scenario for assessing the needs of the program is to review existing risk and needs assessment data for the corrections population, generally, or the target population, specifically, should such data exist. Risk and needs assessment data can be used to link individuals with the appropriate services, based upon their criminogenic needs. Additionally, due to the complexity of mental health disorders, and the greater complexity of co-occurring disorders, the best approach to treatment is not a one-size-fits-all approach. Treatment plans should be tailored to the individual as much as possible, and can encompass a variety of techniques and therapeutic approaches to address individual criminogenic needs. While services should address individual needs, these needs can be met through group programming, such as Thinking for a Change® or Aggression Replacement Training®. While assessing risk and need, it is important to keep in mind that mental health issues in and of themselves are not a criminogenic need. Mental health issues can effect successful participation in programming and thus need to be addressed, but as a responsivity factor, they are not a criminogenic need.

If risk and needs assessment data is not available, estimates will need to be made or other data sources reviewed until such information becomes available. The Center for Mental Health Services (CMHS) recommends that practitioners consider various factors when screening justice-involved clients[11], including (but not limited to) the range in severity of mental health and substance abuse problems, various levels of treatment services needed, disability and functional impairment challenges, and possible cultural and linguistic needs and supports. Understanding the scope of a program's population and how these factors may play a role in the population, or estimating what needs may exist among the program population, can be useful in the absence of risk and needs data.

During program selection, client needs, such as specific drug treatment, should be taken into consideration. The applicable setting of programming (e.g. in-facility or in-community) should also be taken into consideration. When working with reentry populations, programs should be as consistent as possible both before and after release; a client's treatment plan should start before release and continue after release. Similarly, those involved with client programming should be aware of community resources, as well as how to access these resources or how to make referrals.

San Joaquin: *Before beginning TYGR/ARCCS, partners had some sense of what the needs of the population were from working with them in various capacities over time as well as the risk and need assessment that was in use. Additionally, the grant provided some guidance regarding the parameters of the target population. Given these facts, the ARCCS group (formerly TYGR) felt like they had a solid understanding of the needs of the population they intended to serve.*

With respect to assessing the needs of those participating in ARCCS, the program relies upon a number of assessments. After the clients have completed an initial screening and orientation (incarceration time, formal probation supervision status and risk level), a pre-assessment interview is set up with the potential clients while they are in custody." At this time, the potential client is given an overview of the program, including all EBP programing BHS assessments and expectations. At the end of the program overview, the clients are informed that the program is voluntary and if they wish to receive services, additional assessments will be needed we will continue the assessment process. Program leadership feel that it is important to ensure that the program is voluntary, because participation is indicative of the fact that the client is in the contemplation stage of change. Once the client agrees to participate, a full psychosocial analysis is completed to determine if the client has a DSM IV diagnosis and is now fully eligible for the program.

Before an individual begins any programming, the individual receives a screening by BHS and the Sheriff's department at booking to identify any health, behavioral health, or trauma-related issues. An additional screening is completed by BHS to update and complete the health and behavioral health information following booking. After an individual has been identified as a potential client and accepted into the program, they receive four additional assessments:

Static Risk Offenders Need Guide (STRONG) 2.0 *assesses the individual's criminogenic risk and needs. The STRONG 2.0 is a 55-item tool with 10 domains: Education, Community Employment, Friends/Associates, Residential, Family, Alcohol/Drug Use, Mental Health, Aggression, Attitudes/Behaviors, and Coping Skills. The STRONG tool is administered by the intake officer as part of starting a new term of probation. Addiction Severity Index (ASI) 5th Edition– "is a semi-structured interview designed to address seven potential problem areas in substance-abusing patients: medical status, employment and support, drug use, alcohol use, legal status, family/social status, and psychiatric status." The assessment is completed after the individual is flagged by the Sheriff's Department as needing an assessment.*

A level of care tool based the American Society of Addiction Medicine (ASAM) criteria for level of care *(formerly known as the ASAM patient placement criteria) was developed by a committee formed by San Joaquin County Behavioral Health Services. It contains 10 items covering the 6 dimensions for the ASAM criteria: acute intoxication and/or withdrawal potential, biomedical conditions and complications, emotional/behavioral/cognitive conditions and complications, readiness to change, relapse/continued use/ continued problem potential, and recovery environment. The assessment is completed after the individual is flagged by the Sheriff's Department as needing an assessment.*

Texas Christian University Mental Trauma and PTSD Screen *is a 17 item tool intended to identify the severity of symptoms representing post-traumatic stress disorder. The assessment is completed after the individual is flagged by the Sheriff's Department as needing an assessment.*

Bio Psycho-Social Assessment *is a tool that was created by a Behavioral Health Services Committee. The tool captures information including the client's current status, illness, strengths, treatment and treatment history, family history, education and work history, medications, substance use and abuse history, medical history, and mental health diagnosis. The assessment is completed after the individual is flagged by the Sheriff's Department as needing an assessment.*

PLANNING A REENTRY PROGRAM FOR THE CO-OCCURRING POPULATION

First and foremost, a successful reentry program benefits from a structured and well-thought-out planning process. To some extent, this process is built into receiving Second Chance Act funding. Perhaps because of early challenges faced by programs beginning a new program with Second Chance Act funds, BJA has made the completion of a Planning and Implementation Guide, done in partnership with the assigned technical assistance provider, an eligibility requirement for receiving funds to being implementation of the grant. The Planning and Implementation Guide requires the program stakeholders to memorialize many important decisions about their program – including the target population, data to be used, programming to be offered, transition planning processes, supervision strategies, and plan for sustainability.

While the planning process for a reentry program to address the needs of persons with co-occurring disorders may not follow the format of the Planning and Implementation Guide required by BJA (https://csgjusticecenter.org/wp-content/uploads/2016/02/SCA_Co-Occurring_Disorders_PI_Guide.pdf), it is a good idea to commit some things to writing before engaging in implementation. For example, if your grant does not require a formal planning process, consider creating a document that briefly covers the basic elements of the program.

San Joaquin: *In 2010, San Joaquin received a Justice and Mental Health Collaboration Program grant, which the county leveraged to plan for its Second Chance Act implementation. The planning process was the first time that the individual organizations had assembled collaboratively around a program idea. When the TYGR grant transitioned to the ARCCS program (essentially expanding eligibility criteria), the group went through the exercise of completing the required Second Chance Act Planning and Implementation Guide.*

The guide requires grantees to identify (among other things): their target population, estimated number of people they expect to serve, criminogenic risk and needs instrument to be used, services provided, and collaborating agencies. In addition to providing suggested readings, the group must complete exercises intended to guide them through a planning process, and establishment of a working collaborative group, provision of evidence-based programming, data collection, and sustainability.

GUIDELINES FOR PLANNING A REENTRY INITIATIVE FROM THE PLANNING & IMPLEMENTATION GUIDE FOR THE SECOND CHANCE ACT - REENTRY PROGRAM FOR ADULT OFFENDERS WITH CO-OCCURRING SUBSTANCE ABUSE AND MENTAL DISORDERS

- Defining the target population as specifically as possible so that all partners understand who the program is for.
- Defining partners and their roles within the program, including identifying the lead agency.
- Establishing the outline of a collaborative group to guide the program, troubleshoot, and hold each other accountable.
- Deciding what programming and services the program will provide versus what it will refer out to.
- Determining how to make the handoff from in custody to the community.
- Identifying a risk-need assessment tool.

PRE-IMPLEMENTATION PREPARATION

Pre-implementation preparation is the period in time when the organizations involved with a program assemble the resources and supports necessary to facilitate implementation. This includes gathering the needed resources (e.g., identifying space, hiring staff), preparing the organizations involved for changes associated with the new program, bolstering support for implementation, and readying staff for implementation. For a collaborative group implementing a reentry program like ARCCS, this could include interviewing and hiring staff for new positions and transfers, establishing a space within the correctional facility for the subpopulation that is being targeted, educating and training staff that will be working on the grant, and drafting necessary policies and rules that will guide changes following implementation.

San Joaquin: *One factor identified by ARCCS program leadership as contributing to the success of the initiative is identifying the right staff during pre-implementation. While easy to overlook, ensuring that the program is staffed with "someone that has a commitment to the work" rather than just someone interested in the position for the wrong reasons, is an important component to success. One of the ways that San Joaquin addressed this was through the interview process for positions within the ARCCS initiative. During the interview process, leadership sought to better understand the motivations and commitment of candidates to working with the targeted population, implementing evidence-based practices, and collaborating with other organizations to solve a problem.*

San Joaquin prioritized training for individuals working with the ARCCS initiative. For example, the correctional officers working with the target population were among the first to receive motivational interviewing training. Similarly, training and professional development opportunities were offered to the clinician charged with delivering program, to ensure that ARCCS was delivering programming that best met the needs of the target population.

The ARCCS program wanted to utilize programming that could be delivered in custody as well as in the community. After reviewing their population and capacity, BHS chose two programs to deliver to ARCCS clients: Seeking Safety and the Matrix Model. Eventually Matrix was replaced with Cognitive-Behavioral Interventions for Substance Abuse (CBI-SA). While those two programs form the backbone of ARCCS programming, other programming is available including Thinking for a Change (T4C) and Aggression Replacement Training (ART). They have also used Moral Reconation Therapy (MRT).

WHILE EASY TO OVERLOOK, ENSURING THAT THE PROGRAM IS STAFFED WITH "SOMEONE THAT HAS A COMMITMENT TO THE WORK" RATHER THAN JUST SOMEONE INTERESTED IN THE POSITION FOR THE WRONG REASONS, IS AN IMPORTANT COMPONENT TO SUCCESS.

FINDING A LOCAL RESEARCH PARTNER RATHER THAN ONE HUNDREDS OF MILES AWAY, IF POSSIBLE, IS A GOOD IDEA.

FINDING A RESEARCH AND EVALUATION PARTNER

While it may not immediately appear to be an important part of beginning a reentry initiative, identifying and establishing a relationship with a qualified, local research and evaluation partner is a valuable early decision that can impact success and sustainability. A good local research and evaluation partner will help to ensure that the program is tracking participant progress in a way that enables measurement of success during their participation and prepares for measurement of recidivism upon completion. Demonstrating success and recidivism reduction is vital to establishing a sustainable program model – with the growing emphasis on evidence-based practices, funders, local decision makers, and legislators are more likely to support a program that demonstrates success quantitatively as well as qualitatively.

Finding a local research partner rather than one hundreds of miles away, if possible, is a good idea. While it may be tempting to engage a large well-known evaluator, that is probably not necessary for most programs. Establishing a level of comfort and personal rapport with an evaluator is an overlooked benefit. Further, being able to meet in person to review data, preliminary findings, and receive recommendations is an added benefit to having a good local evaluator. If your program is fortunate enough to be located close to a university, you may be able to find a suitable evaluator there. If that is not an option, there may be other data analysis and social science research groups or non-profits that can fill that role.

The right research and evaluation partner can provide more than process or outcome evaluation reports. They may be able to help you better understand your clients, their circumstances, and what makes them succeed or fail in the program. A research partner can offer to assist with satisfaction surveys, interviews with clients, interviews with program staff, reentry mapping, and community engagement. Having a trusting relationship with the research partner and understanding their capabilities can greatly enhance a program.

San Joaquin: *The County was fortunate to find a local research partner capable of providing evaluation services, the San Joaquin County Data Co-Op (a non-profit applied social research and evaluation organization). The Data Co-op provides the initiative with a dashboard of statistics (see Appendix A) that is regularly reviewed during the monthly ARCCS Collaborative Meeting. In addition to analysis of data collected regularly by partner programs, the Data Co-Op has provided support with required reporting, conducted customer satisfaction surveys, facilitated focus groups, calculated program recidivism, and interviewed ARCCS participants to learn about the participant experience. Research activities and products like these are valuable tools that partners can use to better understand their population and improve their program model.*

IMPLEMENTATION

Initial implementation is sometimes referred to as the "awkward stage". The idealism of proposing and planning a new initiative meets the reality of creating new processes and policies in implementation. It is vital during this stage that program leaders closely monitor progress to ensure that the program is being implemented as planned. It is also important to realize that it may take time to achieve anticipated results. Patience and diligence are necessary.

Program leaders may wish to use time during collaborative group meetings to review the operations guide or policy manuals developed during the planning stages. After beginning enrollment, program staff may find that elements of the operations manual did not fit with the practical realities of implementation.

Any programming offered to clients should be periodically assessed to ensure that it maintains fidelity to the program model. Evidence-based programs can be expected to have a positive impact when they are implemented according to the model provided. Modifying curriculums, changing durations, adding additional exercises may all alter a program model in a way that reduces potential positive effects.

Finally, as much as possible, leaders should demonstrate commitment to the new program. This can be achieved in a number of ways – announcing and celebrating the start of the program, heralding early successes, incentivizing staff leadership in the program, or simply showing a personal interest in the program itself.

San Joaquin: *San Joaquin addressed fidelity by hiring a clinician with a background in delivering evidence-based curricula and providing with the training and coaching needed to deliver the program models with fidelity. When there was a turnover of clinical staff, the new clinician was provided with the same training and coaching opportunities. ARCCS leaders demonstrated a commitment to the program in their actions. For example, the jail offered a 5 percent stipend for correctional officers working in facilities where TYGR (the ARCCS predecessor) was implemented. Unfortunately, due to the end of ARCCS funding and a desire to sustain the program within existing budgets, the 5 percent stipend will be eliminated when SCA funding runs out.*

Finally, ARCCS staff acknowledge that it took a long time for the program to be established in a way that had been envisioned. One partner told us that "Progress can be slow. It took one year to really get the program running."

MAKING ADJUSTMENTS TO THE PROGRAM

Programs need space to grow and adapt as they are implemented. What worked on paper does not always work in the real world. Program modules that were selected may not engage clients or have the outcomes that were expected.

Many programs find that the pool of eligible participants is different than they initially expected. Projections may have been overly rosy or some change in policy may impact the program in an unforeseen way. If enrollment is lower than expected, leaders may need to think about how to get the word out about their program, find untapped pools of potential participants, or adjust eligibility criteria.

Collaborative group meetings are a good place to raise issues and think about how to respond to challenges or make adjustments to the program. The group can aid in strategic thinking and problem-solving. It may be that one of the partners has experience dealing with a similar situation in a different setting or grant program.

RAISE ISSUES AND THINK ABOUT HOW TO RESPOND TO CHALLENGES OR MAKE ADJUSTMENTS TO THE PROGRAM.

San Joaquin: *Implementation of TYGR/ARCCS was not without its challenges and stumbles. The program initially experienced lower than expected enrollment numbers, although this became less of an issue when ARCCS changed their eligibility criteria to allow a larger age range. Throughout implementation, the grant has tried to create opportunities for female-only groups, but has struggled with identifying enough female participants to make this feasible. Finally, as previously mentioned, housing was found to be a larger issue for participants than the grant had anticipated. This presented a significant challenge as the grant attempted to find a workable solution. A new partner was engaged to address this need, although issues with engaging clients in housing persisted, despite best efforts.*

REQUESTING AND RECEIVING TECHNICAL ASSISTANCE

In any new program, partners and staff may be pushed into roles that test the boundaries of their knowledge, skills, and abilities. When this is the case, it may be a good idea to seek outside expertise and assistance, which can take many forms. In the case of reentry, in general, and the Second Chance Act, specifically, there are a great deal of resources available to programs and grantees to assist them during implementation. The National Reentry Resource Center, operated by the Council of State Governments Justice Center in partnership with BJA, collects research, news, and materials that can assist programs with any questions, obstacles, or issues that may arise. Additionally, all Second Chance Act grantees are assigned a technical assistance provider with whom they have regular communication and who can help them work through issues that arise or connect them to additional expertise as needed.

San Joaquin: *The ARCCS initiative has regular monthly phone calls with their Second Chance Act technical assistance provider, who works for the Council of State Governments. A site visit was conducted in November 2016 to provide more in-depth assistance and identify any technical assistance needs. As the ARCCS program is, at this point, an established reentry program, needs have been fairly low. The focus of most TA efforts has been on data collection, reporting, and sustainability following the end of SCA funding.*

REPORTING PROGRESS

As a grantee, you may be tasked with submitting regular progress reports, including specific quantitative measures of program performance as well as narrative descriptions. For many grantees, progress reporting can be a challenge. Data systems currently in use by partner organizations may not support or facilitate reporting into the required format. Some partners may be perpetually tardy with reporting. Finally, the intention and importance of regular reporting may never be communicated in a way that emphasizes its true significance.

Still, while the task itself may be frustrating, hopefully that does not discourage you from reviewing the progress reporting to see how the program is doing. There may be certain measures that you keep an eye on or you may want to track how you are doing compared to expectations over time. So, while the progress reporting process may not be fun, try to find some elements of it that can be used to your advantage.

San Joaquin: *ARCCS reports certain information to BJA as part of the conditions of its grant. Most of the data collection tools have been established with reporting in mind. Still, reporting can be a challenging process, even for an established grant. As much as it can, ARCCS tries to use the progress reporting to track how they are doing with respect to expectations. However, program staff acknowledge that some measures required for progress reporting have little practical significance to the business of running the program.*

TRACKING PERFORMANCE

While completing necessary progress reporting can be a frustrating process, leaders of the reentry program, along with the research and evaluation partner, should be continuously thinking about how to track and report performance of the initiative back to partners and the collaborative group. This can take many forms and is largely dependent on partner's data systems, comfort with data, and the capacity of the research and evaluation partner. The group may want to focus on a few significant measures to monitor the performance of the program as a whole – for example, number of new admissions, number of persons enrolled in the program, number/percent completing the program successfully, number/percent unsuccessfully completing the program, etc. Alternatively or in conjunction with general measures, partners may wish to create individual performance measures to be tracked. Partners may wish to focus on, for example, number of supervision contacts, average number of hours of programming received, number completing CBT programming, number of risk assessments completed, average risk score of participants, etc.

The collaborative group should establish good habits around collectively reviewing performance measures. Depending on the quality of data and the capacity of the research partner, performance measures can be reviewed on a monthly or quarterly basis. Establishing a format for review, whether it be a PowerPoint or data dashboard, and then maintaining consistency with the format is helpful in focusing partners on the data rather than the presentation method itself.

In addition to quantitative data, partners may wish to share individual performance successes, which help to ground the program and drive home the reality of its mission. Anecdotes don't replace data, but they can supplement it and are an important part of celebrating success.

San Joaquin: *ARCCS Research and Evaluation Partner, San Joaquin Data Co-op, has worked with partners to track and report performance, using a data dashboard, on a quarterly basis. The dashboard (see Appendix A) provides basic information – like number assessed, housing, employment, demographic information, custody (in/out of custody), and programming participation – for partners to review in the monthly meeting.*

In addition to the data dashboard, the Data Co-op collected preliminary information on recidivism of program participants, finding that just 16% had an arrest in the six months following program enrollment. The Data Co-op did note that there were increases in revocations and violations, perhaps as a result of a combination of the ARCCS program model, which utilizes graduated sanctions, and being supervised on a smaller specialized caseload (leading to closer monitoring by probation).

Through a client satisfaction survey and key informant interview, the Data Co-op was able to provide ARCCS leadership with important data regarding how the program was received by participants. The results of the key informant interview, for example, found that the participant interviewed held the probation officer in high esteem. The client saw the value in multiple program components, including the required programming provided by BHS.

ARCCS partners feel that having some early performance data and anecdotes about how the program was helping clients was important to creating a good collaborative approach. Once partners began to see the successes, buy-in increased and group cohesion strengthened.

PREPARING FOR EVALUATION

Ultimately, most successful programs should work toward participating in an evaluation. Process and outcome evaluations are vital to understanding if your program is achieving the desired outcomes. Working with your research partner to ensure that the required data and documentation are being generated at each step in the process, programs can set themselves up for an objective evaluation in the not-so-distant future.

Outcome evaluation should be reserved for programs with established program models and good model fidelity. Many of the elements described above – operations manuals, fidelity monitoring, planning guides – provide the necessary groundwork for an evaluation.

San Joaquin: *Through its relationship with the San Joaquin Data Co-op, ARCCS has laid the necessary groundwork for an outcome evaluation. The San Joaquin County Probation Department has committed to finding funding to continue with the Data Co-Op's evaluation work. Evaluation is built into sustainability planning.*

SUSTAINABILITY

For programs implemented with the aid of grant funding, it is important to begin considering how the program could be sustained well in advance of the grant end-date. This may seem premature, but if the program is successful and achieving the desired goal, the program partners should consider how to continue the work in the absence of the current funding mechanism. For some grants and programs, positions funded through the grant may be absorbed into organizational budgets. Alternatively, other sources of funding, through foundations or other grants, may be applied for to support the program. Regardless of the method of sustaining the program, leadership must be ready to adapt to changing circumstances.

San Joaquin: *At the request of the technical assistance provider, ARCCS began to consider the options for sustainability months in advance of the grant end-date. Many of the positions are being funded internally. The Probation Department will also continue to fund the program evaluation activities after grant funding ends. The Sheriff's Office will continue to dedicate a housing unit to the ARCCS program. The program will continue, largely unchanged, with probation funding a probation officer to work with the ARCCS population and a BHS clinician continuing to work with the jail. A few elements of the initiatives won't be sustained when grant funding ends, including the stipend for the corrections officers working in the unit housing the ARCCS program participants and the housing voucher for ARCCS participants.*

CHECKLIST

- [ ] Assess the size and scope of your population
- [ ] Identify and engage necessary partners
- [ ] Establish the foundation for a strong collaborative body
- [ ] Assess the needs of the client population
- [ ] Formally plan the program
- [ ] Preparation for implementation
- [ ] Find a research and evaluation partner
- [ ] Implement the program
- [ ] Review quantitative data
- [ ] Make adjustments to the program
- [ ] Request and receive technical assistance as needed
- [ ] Report progress
- [ ] Track performance and review as a group
- [ ] Make necessary preparations for evaluation
- [ ] Plan for sustainability

ADDITIONAL RESOURCES

- **Effective Prison Mental Health Services: Guidelines to Expand and Improve Treatment. 2004 ed.** https://nicic.gov/library/018604

- **Peters, R.H., Bartoi, M.G., & Sherman, P.B. (2008). Screening and assessment of co-occurring disorders in the justice system. Delmar, NY: CMHS National GAINS Center.** http://www.pacenterofexcellence.pitt.edu/documents/ScreeningAndAssessment.pdf

- **Milkman, Harvey Ph.D., Wanberg, Kenneth Ph.D. (2007). Cognitive Behavioral Treatment: A Review and Discussion for Corrections Professionals. Denver, CO. National Institute of Corrections.** https://nicic.gov/library/021657

- **A Best Practice Approach to Community Reentry From Jails for Inmates With Co-Occurring Disorders: The Apic Model** http://journals.sagepub.com/doi/abs/10.1177/0011128702239237

- **National Reentry Resource Center** https://csgjusticecenter.org/nrrc

- **What Works in Reentry Clearinghouse** https://whatworks.csgjusticecenter.org/

- **Cushman, Robert C. Guidelines for Developing a Criminal Justice Coordinating Committee. Washington, DC: National Institute of Corrections, 2002.** https://s3.amazonaws.com/static.nicic.gov/Library/017232.pdf.

- **Risk/Needs Assessment 101: Science Reveals New Tools to Manage Offenders** http://www.pewtrusts.org/~/media/legacy/uploadedfiles/pcs_assets/2011/pewriskassessmentbriefpdf.pdf

- **Peters, Roger, Marla G. Bartoi, and Pattie B. Sherman. Screening and Assessment of Co-Occurring Disorders in the Justice System. Delmar, NY: CMHS National GAINS Center, 2008.** http://store.samhsa.gov/shin/content//SMA15-4930/SMA15-4930.pdf

- **Blandford, Alex and Fred Osher. Guidelines for the Successful Transition of People with Behavioral Health Disorders from Jail and Prison. New York: Council of State Governments Justice Center, 2013.** http://csgjusticecenter.org/wp-content/uploads/2013/12/Guidelines-for-Successful-Transition.pdf

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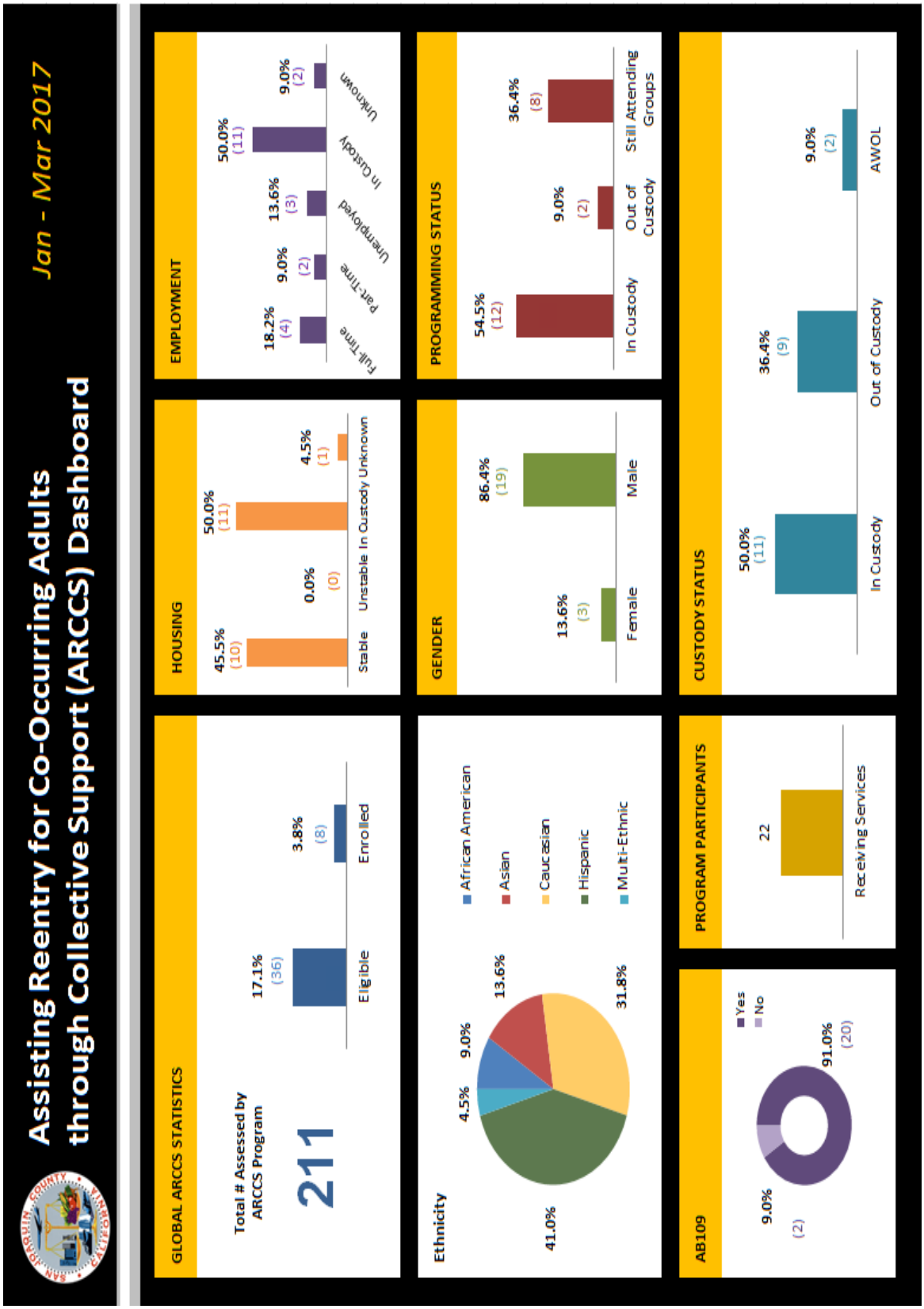
APPENDIX A


Assisting Reentry for Co-Occurring Adults through Collective Support (ARCCS) Dashboard
Jan - Mar 2017
GLOBAL ARCCS STATISTICS
Total # Assessed by ARCCS Program
211
17.1% (36)
3.8% (8)
Eligible
Enrolled
HOUSING
45.5% (10)
0.0% (0)
50.0% (11)
4.5% (1)
Stable
Unstable
In Custody
Unknown
EMPLOYMENT
18.2% (4)
9.0% (2)
13.6% (3)
50.0% (11)
9.0% (2)
Full-Time
Part-Time
Unemployed
In Custody
Unknown
Ethnicity
African American
Asian
Caucasian
Hispanic
Multi-Ethnic
4.5%
9.0%
13.6%
31.8%
41.0%
GENDER
13.6% (3)
86.4% (19)
Female
Male
PROGRAMMING STATUS
54.5% (12)
9.0% (2)
36.4% (8)
In Custody
Out of Custody
Still Attending Groups
CUSTODY STATUS
50.0% (11)
36.4% (9)
9.0% (2)
In Custody
Out of Custody
AWOL
AB109
Yes
No
9.0% (2)
91.0% (20)
PROGRAM PARTICIPANTS
22
Receiving Services

The Crime and Justice Institute (CJI) at Community Resources for Justice strives to make criminal and juvenile justice systems more efficient and cost effective, and to promote accountability for outcomes.

We take pride in our ability to improve evidence based practices in public safety agencies; to gain organizational acceptance in difficult work environments; to create realistic implementation plans; to put these plans into practice; to evaluate their effectiveness; and to enhance the sustainability of corrections policies, practices and interventions.

CJI provides nonpartisan policy analysis and practice assessment, capacity and sustainability building technical assistance, research and program evaluation, and educational activities throughout the country

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