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Repository Citation

London K, Tourish J. (2019). University of Massachusetts Medical School Report to Minnesota Department of Human Services Health and Incarceration Project. Commonwealth Medicine Publications. <https://doi.org/10.13028/cq34-e351>. Retrieved from https://escholarship.umassmed.edu/commed_pubs/233

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Commonwealth Medicine

University of Massachusetts Medical School Report to Minnesota Department of Human Services Health and Incarceration Project

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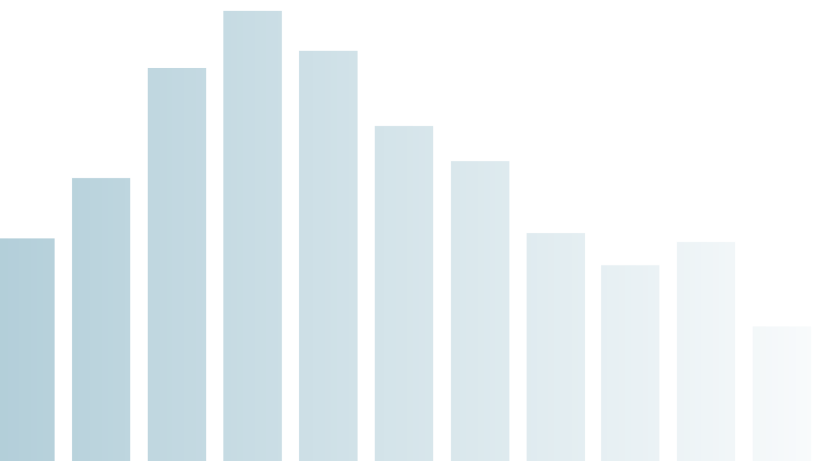
University of Massachusetts
Medical School

June 2019

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Recommendation



In 2015, the Minnesota Legislature directed the Minnesota Department of Human Services (DHS) to develop a methodology for paying higher rates to healthcare providers who provide services to high cost and high complexity groups such as individuals who were previously incarcerated.¹ The goal is to ensure that populations experiencing the greatest health disparities achieve the same health and quality outcomes seen by other populations in Minnesota. On behalf of DHS, the University of Massachusetts Medical School conducted (1) a literature search of successful interventions across the country that improve the health of previously incarcerated individuals and (2) five focus groups to gain feedback from experienced professionals who work directly with previously incarcerated individuals regarding interventions likely to improve the health of these individuals.

The focus groups and literature review highlighted that each intervention possesses its own intricacies, however, there are common themes across them, which determine their ultimate success or failure. Based on the information we gathered, we recommend DHS create an intervention(s) that incorporates each of these key elements.

- Developing the intervention(s) in collaboration with correctional authorities, county and state agencies, community partners, and any other relevant stakeholders;
- Ensuring the intervention's service and support provider organization is one that is community-based, so it is free of any inherent conflict of interests that could arise if it were based in a correctional, county, or state agency (the staff could be based at any location - e.g. probation, correctional facility, county office, community office - or could travel among them);
- Establishing formal channels for clear and frequent communication between all partner organizations;
- Providing highly individualized, culturally competent services, including the services of a case manager or similar professional and a discharge or care plan that transitions from incarceration to the community;
- Providing housing and employment support, along with behavioral health or substance abuse treatment to previously incarcerated individuals;
- Developing a trusting relationship with a previously incarcerated individual behind the wall that translates to the community;
- Hiring of highly experienced staff, with knowledge of the criminal justice system, who are given small caseloads to work with;
- Ensuring the intervention's base of operations is in a location that is accessible to both enrollees and staff and gives staff the ability to provide services behind the wall in correctional facilities;
AND
- Providing ongoing funding, training, and managerial support for intervention staff.

Evidence shows that programs that incorporate these elements are effective, save money, and can positively affect the lives of those that participate.

¹ Laws of Minnesota 2015, chapter 71, article 11, section 63

Review of Interventions that Improve the Health of Previously Incarcerated Medicaid Enrollees

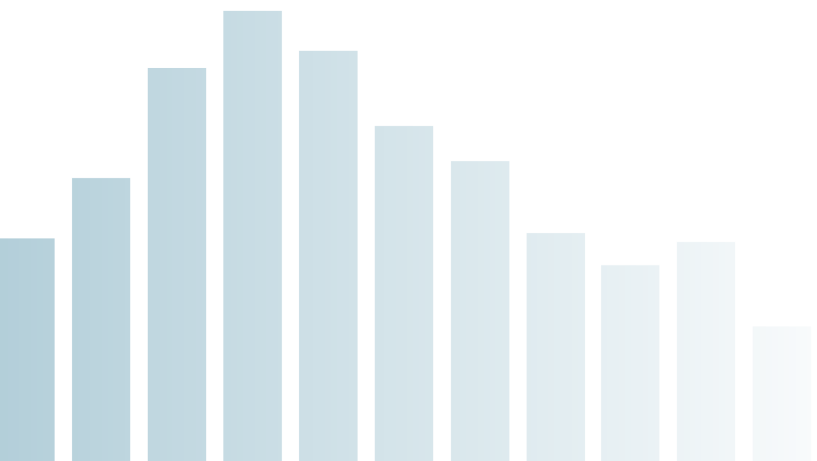


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I. Introduction

America's prisons and county jails have become de facto healthcare facilities treating inmates for physical and mental health, substance abuse, and other health related issues. In 2011-2012, an estimated 40% of state and federal prisoners and jail inmates reported having a current chronic medical condition.¹ In addition, in comparison to the non-incarcerated population, jail and prison inmates had a higher prevalence of hypertension, diabetes, myocardial infarction, asthma, arthritis, cervical cancer, and hepatitis.² A 2010 study concluded that prisons and jails contain more than three times as many people with severe mental illness (SMI) when compared with hospitals and another study estimated that about two-thirds of prison and jail inmates (1.5 million) in the U.S. met the formal medical criteria for a substance use disorder (SUD).^{3,4} These health issues, and their related costs, do not stop once an inmate is released. A study in Washington State found the risk of death from other causes – including cardiovascular disease, cancer, hepatitis, HIV, and opioid overdose – to be 3.5 times higher among former inmates compared with the general population, and 12.7 times higher in the first two weeks after release.⁵

Providing healthcare to this large and complicated population, that is prone to cycle between jails, emergency rooms, and shelters, puts significant strain on correctional budgets and Medicaid, as many justice-involved individuals have low incomes and are more likely to be unemployed upon release.⁶ In fact, in fiscal year 2011, the fifty states spent a total of \$7.7 billion on correctional healthcare and Minnesota spent almost \$70 million.⁷ Despite the current spending levels, inmates do not always receive the care they need, either in jail or prison, or after release. There are a number of contributing factors as to why this occurs including barriers to care or gaps in care, an uncoordinated healthcare system, and the unavailability of services, personnel, or resources. Moreover, treatment programs often will not accept justice-involved individuals upon their release who are disruptive, argumentative, or violent because of the belief that they might put staff and other patients at risk.

In 2015, the Minnesota Legislature directed the Department of Human Services (DHS) to develop a methodology for paying higher rates to healthcare providers who provide services to high cost and high complexity groups such as the justice-involved population.⁸ The goal is to ensure that populations experiencing the greatest health disparities achieve the same health and quality outcomes seen by other patients and populations in Minnesota. This report summarizes research the University of Massachusetts Medical School, under contract by DHS, undertook to inform policy development in the area of community support programs for recently release justice-involved Medicaid enrollees in Minnesota. The report is divided into three sections in an effort to summarize three distinct program types (community reentry programs, forensic care coordination programs, and supportive housing programs) and their current use across the country. It concludes with identifying common themes across all three-program types.

II. Community Reentry Programs

Community reentry programs provide individualized assessments, treatment planning, and care coordination for individuals with physical and mental health conditions leaving incarceration. The risk of death is 12.7 times higher for ex-inmates during the first two weeks after release compared to the general population,⁹ with the leading causes of death being drug overdose, cardiovascular disease, homicide, and suicide.¹⁰ Community reentry programs aim to improve outcomes by connecting at risk individuals with needed services. Because of the high incidence of substance use disorder and mental illness among inmates, together with the elevated risk of death upon release from overdose and suicide, many programs focus on reentry needs of individuals with mental health and substance use issues.

The Substance Abuse and Mental Health Services Administration (SAMHSA) provides general principles for reentry coordination for individuals with mental health or substance abuse issues:¹¹

- Assess clinical and social needs, as well as public safety risk; match intervention intensity with individual's risk level

- Plan required treatments and services

- Identify required community and correctional programs

- Coordinate transition plan to avoid gaps in community-based care provision

The National Institute on Drug Abuse (NIDA) recommends coordination between treatment providers and courts or parole/probation officers for individuals with a SUD. In addition, NIDA suggests that discharge planning address other needs such as housing, childcare, social support services, and employment assistance.¹² In general, treatment initiated during incarceration and continued in the community is most effective in preventing recidivism and drug use relapse.¹³ For the longer-term incarcerated, reentry planning is important because a lack of psychological preparation for reentering a community can contribute to recidivism, criminal behavior, and a relapse of behavioral health (BH) conditions.¹⁴

Many community reentry programs do not receive rigorous evaluation, or their evidence is merely 'suggestive' of effectiveness.¹⁵ However, a handful of programs conducted concurrent randomized controlled trials or quasi-experimental studies, and some received awards and grants based on strong outcomes.

The majority of community reentry programs reported here focus on individuals at high risk of recidivating and/or those with the highest need for community support(s). These programs typically begin release planning multiple months before an inmate's release date, and many partner with state and local corrections agencies and health departments.^{16,17,18,19,20,21} Some programs feature Forensic Peer Support Specialists or Community Health Workers (CHW) as part of larger Reentry Support Networks or Peer Support Networks.^{22,23,24,25} Below we describe several approaches to reentry, grouped into the following three categories: (1) primary care based, (2) general care coordination based, and (3) a modified therapeutic community (MTC).

A. Primary care based

Generally, primary care based approaches are partnerships between correctional facilities and community health centers that focus on optimizing care continuity and fostering provider relationships with inmates. They target inmates with chronic health conditions who are in need of follow-up care after their release.

i. Transitions Clinic

The Transitions Clinic (TC) program provides medical care and coordinated social services for individuals released from prison with chronic conditions, including BH conditions. It is perhaps the most widely known, cited, and replicated primary care based community reentry program in the country. The Agency for Healthcare Research and Quality profiled the TC model as a service delivery innovation, and several studies document its effectiveness.^{26,27,28,29} Data reported here is from the original program in San Francisco.

Pre-Release Services: TC staff provide education to inmates on available services. On a weekly basis, a TC clinical staff member conducts a clinic to outline to inmates how to access care at a partner clinic upon their release. In addition, TC staff attend weekly parole meetings where they introduce the program and offer inmates their services, including a clinical transitional healthcare appointment within two weeks of their release.

Post release Services: Upon release, staff help participants access the following services: drug treatment (if needed), employment, education, housing/food, and a referral to San Francisco General Hospital and Trauma Center for health related issues not treatable in the community clinic setting. Additionally, TC staff will provide case management to address social needs that influence an inmates' health, often by linking them to community agencies and sometimes accompanying them to appointments.

Eligible Population: A participant must meet the following criteria: (1) speaks English, (2) has at least one chronic physical or BH condition or is over the age of 50, (3) does not have a standing relationship with a primary care provider, and (4) was previously incarcerated.

Partners: TC partners include a city department of public health, the State corrections agency, a county sheriff's department, a legal services network, and an institution of higher learning.

Service Providers: TC collaborates with six area healthcare providers, primarily community health centers.

Funding Source(s): The San Francisco Department of Public Health provided initial program funding. Private and Center for Medicare and Medicaid Innovation grants provide additional funding.

Program Cost(s): The program costs approximately \$200,000 per year. A partner community health center pays for the below referenced nurse practitioner's salary.

Staffing: A team consisting of two part time primary care practitioners (PCP) with previous experience with criminal justice involved individuals, a social worker, a nurse practitioner, two CHWs (who were previously incarcerated themselves), and an administrative assistant provide services to participants.

Caseload per Staff Member: The staff to participant ratio is 1:30.

Program Utilization: From 2007-2009, 98 people participated.

Health Outcomes: Program data highlighted a 51% decrease in the emergency department (ED) usage rate by participants. In addition, program participants had higher attendance rates for initial (55%) and follow-up (77%) clinic appointments than similar patients seen at the large health center in which the clinic operates (40% and 46%, respectively).

Justice Related Outcomes: Program participation did not result in significant changes in justice related outcomes.

Cost Savings/ROI: Cost savings from program participation stemmed from a decrease in ED use post-incarceration. The approximate savings totaled \$912 per participant per year. When measured against the programs costs, this computes to a return on investment (ROI) of approximately 0.45.

Replication: The TC's success spurred replication of the model in Arkansas, Alabama, North Carolina, Maryland, New York, Connecticut, Massachusetts, and Puerto Rico.

ii. Hampden County Correctional Center Reentry Model

The Hampden County Correction Center (HCCC) Reentry Model, instituted in 1992, is a partnership between the county health department and law enforcement agency whose goal is “to provide a comprehensive spectrum of health care services beginning within the first days of incarceration and continuing into the community upon release.”³⁰

Pre-Release Services: During intake to the correction facility, jail staff conduct an initial health assessment to screen inmates for chronic health, mental health, and substance use issues; history of treatment or hospitalization for mental illness or suicide; pregnancy; and other health issues. Within 14 days of admission, a staff nurse conducts a full health assessment that includes review of the initial screening, a full physical examination, and a recommendation (if applicable) concerning housing, job assignment and/or program participation. In addition, incoming inmates receive a dental health assessment, a mental health assessment, and a suicide risk assessment. Upon integration into the corrections community, jail staff and community health care clinicians provide a full range of health care services to inmates, including health prevention and promotion related programs and services.

Program staff develop a discharge plan for each inmate that includes a referral to appropriate community resources, assistance in preparing inmates for initial health care appointments once released, and support for addressing the vocational/housing/financial needs. Staff assist with applications for government support programs such as Medicaid and Social Security, and monitoring inmates through the process of parole and probation.

Post release Services: HCCC provides After Incarceration Support Services to former inmates that focus on education, job training, employment, family support, and community reintegration. The discharge-planning nurse and case manager are available to assist with after release transitional issues, particularly for complex medical needs. Community health providers assist in reminding ex-inmates about going to their appointments and assessing how they are adjusting to post-incarceration life.

Eligible Population: There are no reported restrictions on eligibility for this program.

Partners: Partners include the county corrections department, the county Sheriff's department, the county health department, a state department of public health, non-profit community healthcare providers, community-based health education agencies, a university dental school, a non-profit mental healthcare provider, and two local optometrists.

Service Providers: HCCC contracts with three local community health centers in Hampden County, MA. In addition, because of these contracts, HCCC can access hospitals associated with these community health centers.

Funding Source(s): State department of public health funds augment the already available resources of HCCC. Additional funds came from both public and private grants.

Program Cost(s): Program costs during incarceration are included in the health care budget of the county jail. Program costs after incarceration are included in partner organizations' budgets.

Staffing: Staffing for the program includes a Case Manager, Mental Health Discharge Planner, Discharge Planning Nurse, a Utilization Review Nurse, and other applicable HCCC medical staff.

Caseload per Staff Member: We are unable to compute a caseload per staff member statistic due to a lack of specific staffing information.

Program Utilization: Program utilization data is not reported.

Health Outcomes: 88% of HIV+ inmates referred for ongoing care after their releases keep their initial medical appointment at their designated community health center. A major benefit of the model is the dramatic decrease in the use of the emergency room as the primary care provider

Justice Related Outcomes: Program participation led to a 15% lower recidivism rate over a three-year study period when compared with a similar incarcerated national study group. In fiscal year 1998, per inmate per day healthcare costs for program participants were \$7.23. This is 66 cents less per inmate per day compared to the average of the 30 largest US jails at the time.

Cost Savings/ROI: We are unable to compute an ROI due to a lack of specific cost savings information.

Replication: Programs such as the Michigan Prisoner Reentry Initiative cite the HCCC program as a basis for their own.

iii. Community Oriented Correctional Health Services

The Community Oriented Correctional Health Services' goal is to make correctional care an extension of the existing community health care system in Oakland, CA. The program, based on the model first implemented in Hampden County, MA, fosters relationships between local jails and community health centers. In this program, a community health center takes responsibility for providing appropriate, coordinated health care services throughout an inmate's incarceration and after release.³¹

Pre-Release Services: At booking, a program staff nurse conducts a health screening and documents chronic conditions, dietary needs, allergies, and signs of mental illness. The nurse crosschecks an

inmate's assessment against the community health center's electronic medical record system to determine if he/she received previous treatment or medication so that they can continue it. Program staff triages inmates for either immediate or next-day evaluation by a PCP. If necessary, the nurse can schedule an appointment with a visiting community health physician, or other provider, for an inmate. During incarceration, program staff operates a full-time, onsite, community health center where inmates can receive treatment. If an inmate needs specialty care, program staff can schedule an appointment.

Post release Services: After release, a program participant leaves with a follow-up appointment at the community health center, typically with the same primary care provider, and with appropriate medications. In addition, program staff provide participants with appropriate connections to community-based care for substance abuse or other specialty services, if applicable.

Eligible Population: There are no reported restrictions on eligibility.

Partners: The program collaborates with a number of different organizations including community health centers, local jails, and local law enforcement agencies.

Service Providers: Local community health centers provide services to participants.

Funding Source(s): The program receives funding from a number of charitable organizations and local governments.

Program Cost(s): Costs vary by program site, but additional information on specific costs is not reported.

Staffing: Total staffing was not reported. Staffing depends on the capacity of existing community health centers to assume duties from prison staff and the number of inmates served.

Caseload per Staff Member: Staffing data was not reported.

Program Utilization: Program utilization data was not reported.

Health Outcomes: Program staff set up an appointment to see a community health provider for 53% of participants prior to their release and 65% of those participants went to those appointments. Among participants with a mental health condition, program staff set up an appointment with a community based mental health care provider for 36% of participants prior to their release and 70% of those individuals kept the appointment. In addition, participants highlighted that program participation resulted in greater access to healthcare services.

Justice Related Outcomes: Anecdotal evidence highlights that program participation leads to a decline in inmate-inmate and inmate-correctional officer violence due to good medication management.

Cost Savings/ROI: Data not reported.

Replication: The program also operates in Washington, D.C. and Marion County, Florida.

B. General care coordination based

General care coordination based programs provide case management services during both the pre-release and post release periods. The goal is to enhance connections to healthcare and social services along with providing benefits such as housing, transportation, and employment assistance.

i. Worcester Initiative for Supported Reentry

The Worcester Initiative for Supported Reentry (WISR) is a private, not-for-profit, program operated by Advocates, Inc. in Worcester, Massachusetts. The program offers both pre-release and post release services that aim to stabilize an inmate as they reenter the Worcester community.³²

Pre-Release Services: Services start 30-90 days before release by identifying inmates with SMI or SUD. Staff members then assist inmates with health plan eligibility and administer a criminogenic risk needs assessment. Case managers also assist inmates in creating a treatment plan, making appointments with community providers, and obtaining housing and other services. In addition, as appropriate, case managers can assist in getting inmates access to medication-assisted treatment.

Post release Services: Program staff provide intensive care coordination that includes referring participants to a wide range of community services including: employment services, legal services, obtaining clothing and toiletries, transportation services, and housing placement.

Eligible Population: Individuals released from Massachusetts medium, minimum, pre-release state prisons, and Worcester County House of Correction, who will reenter the Worcester community are eligible.

Partners: WISR collaborates with a number of organizations including the county probation department, the county Sherriff's office and house of correction, the State department of correction, the State parole board, and a community advocate organization.

Service Providers: WISR collaborates with two healthcare service providers.

Funding Source(s): The Health Foundation of Central Massachusetts provided a total of \$1.9 million in funding for planning in 2011, piloting in 2012, and full implementation in 2013-2016.

Program Cost(s): Including the pilot (2012) and three implementation years (2013-2015), but excluding the evaluation and advocacy costs, the program costs \$961,593 or \$6,327 per participant for three years.

Staffing: WISR program staff includes a project manager, three case managers, and one clinician.

Caseload per Staff Member: Based on reported data, the computed caseload per staff member is approximately 1:38.

Program Utilization: Between 2011 and 2016, 152 people participated in the program.

Health Outcomes: Among the 152 participants, 96% obtained housing immediately and 4% obtained it within one day of release, 62% secured employment and of these 71% remained employed for 1 year or longer, 93% of participants referred to substance abuse treatment services accessed them, and 75% of participants referred to mental health services accessed them. In addition, WISR referred 70% of eligible program participants to MassHealth.

Justice Related Outcomes: Based on a three-year analysis by Brandeis University researchers, participation in WISR reduced recidivism rates by 47% during the three years post release, when compared with participants in the study's control group.

Cost Savings/ROI: Averted incarcerations produced an estimated net savings of \$375,079 (averted incarceration costs of \$1,007,779 less program costs of \$632,700) per 100 participants, which represents an ROI of approximately 0.59.

ii. The San Diego County Prisoner Reentry Program

California Senate Bill 618 established The San Diego County Prisoner Reentry Program. The goal of the program is to educate and rehabilitate incarcerated nonviolent felons in an effort to reduce recidivism.^{33,34}

Pre-Release Services: Program staff conduct an individualized needs assessment, including screening for mental illness and substance use disorders. Each participant develops a Life Plan in conjunction with program staff, designed to meet identified needs.

Post release Services: Upon release, a Community Roundtable meets regularly to address reintegration challenges. Services available to program participants include housing placement, drug treatment, and vocational training. Program staff members provide intensive case management during the first 72 hours after release with an emphasis on acquiring stable housing.

Eligible Population: A participant must be in local custody, be a legal resident of San Diego County, and sentenced for a period of 8 to 72 months.

Partners: The San Diego County Prisoner Reentry Program partners with a number of different organizations including the county Superior Court, the District Attorney's Office, the Sherriff's department, a local high school district, the county probation department, the county Public Defender's office, the State department of corrections, the State department of parole, two State prisons, a local university, and a local defense lawyers' organization.

Service Providers: Not applicable.

Funding Source(s): The California State government funds this program.

Program Cost(s): The average cost per participant totals \$123,648 over a six-year period.

Staffing: Staffing for the program consists of a Prison Case Manager, a Community Case Manager (CCM), a Parole Agent, a Reentry Employment Coordinator (REC), and a representative from the University of California, San Diego's Department of Psychiatry. In addition, the program uses a Community Roundtable, which includes the CCM, REC, Parole Agent, and other individuals identified by each participant who help ensure successful reentry.

Caseload per Staff Member: Based on reported data, the computed caseload per staff member is approximately 1:83.

Program Utilization: During the six-year program period, 1,078 people participated.

Health Outcomes: 80% of participants gained stable housing and 67% obtained employment.

Justice Related Outcomes: Participants are 9% less likely to be re-arrested for any offense, 17% less likely to return to prison, and 18% less likely to return to prison for a parole violation.

Cost Savings/ROI: The program created a savings of \$8,166 per participant, with a long term savings of approximately \$10 million. Based on reported program costs and savings, a computed ROI is .066.

iii. Mentally Ill Offender Community Transition Program

The Washington State Legislature established the Mentally Ill Offender Community Transition Program (MIO-CTP) in 1998.^{35,36}

Pre-Release: Prerelease planning includes comprehensive assessment of mental health and chemical dependency treatment needs, as well as certain Department of Corrections community supervision requirements. In addition, program staff create an individualized treatment plan that includes input from the inmate and community-based providers. Program staff assist inmates in applying for benefits (SSI, Medicaid) and coordinating start-up appointments for the day/week of release with local Community Service Offices. Ongoing coordination of prerelease activities occurs during weekly team meetings that cover topics such as housing needs, medication management, and chemical dependency treatment needs. Overall, a main goal of these services is to form a therapeutic relationship with the participant that continues after their release.

Post release: Program participants receive intensive post release case management services, which include coordinating individual and group treatment services with a multidisciplinary staff. The program includes structured programming, daily contact (if needed), bimonthly home visits, and individual crisis response planning (available 24 hours a day). Additional residential support is available, which includes a housing subsidy, onsite housing management, and monitored living for the primary initial housing option. Cross-trained staff members provide substance abuse treatment services to those with co-occurring disorders.

Eligible Population: Participants must 1) have a major mental illness that influenced previous criminal activity, 2) be judged by corrections staff as less likely to reoffend if provided ongoing mental health treatment, 3) be unlikely to obtain housing and/or treatment from other sources, 4) be 3-6 months prerelease, 5) *not* be a Level 3 sex offender, and 6) want to participate.

Partners: Program partners include the State department of corrections and the department of social and health services.

Service Providers: Program service providers include a social enterprise organization and a transitional housing facility.

Funding Source(s): The Washington State Mental Health Division funds the MIO-CTP program through a federal block grant.

Program Cost(s): Program costs per participant are approximately \$18,000-\$20,000 per year, with a minimum of \$6,600 per participant dedicated to housing.

Staffing: The MIO-CTP program includes a mental health case manager, psychiatrist, a nurse practitioner, a registered nurse, a substance abuse counselor, a community corrections officer, and a residential house manager. Most of these staff members are devoted only part-time to the

program, and the total staffing represents approximately five and one-half full-time equivalents (FTEs).

Caseload per Staff Member: Based on data that total staffing represents five FTEs, the computed caseload per staff member is 1:17.

Program Utilization: As of 2008, 92 people participated in the program.

Health Outcomes: Data on health outcomes of program participants was not reported.

Justice Related Outcomes: The program reported a 22% reduction in rate of committing any new offense, a 19% reduction in the rate of new felonies, and a 13% lower recidivism rate for program participants both 1 and 18 months after release.

Cost Savings/ROI: Data not reported.

iv. Muskegon Community Health Project

The Muskegon Community Health Project (MCHP) seeks to help participants successfully re-integrate into their communities after their release from incarceration through access to both primary care and specialty care services. It is an offshoot of a statewide initiative called the Michigan Prisoner Reentry Initiative.^{37, 38}

Pre-Release: Six months prior to their release, the Michigan Department of Corrections sends MCHP staff a listing of potential participants for their review. Program staff then provide in reach sessions, twice a week during the six months prior to release, to applicable qualifying participants to educate them about the services they can expect upon reentering the community. Each team consists of one medical navigator and three community health workers with specific expertise in housing, job training/employment, and transportation services. Medical navigators conduct health screenings for chronic conditions, infectious diseases, or other health needs. The medical navigator also assesses whether the prisoner may be eligible for certain benefits (Medicaid, SSI, FSP, etc.) and determines what medications the prisoner is or needs to be taking. Medical navigators and other program staff also assist in scheduling a primary care visit within two weeks of release, transferring a participant's medical records, arranging prescription drug coverage (if needed), linking participants to needed medical services to address chronic health issues, and assistance with copayments for initial visits at health centers or community clinics.

Post release: While on parole, a medical navigator meets with each participant to complete enrollment applications, review the participant's medical needs assessment and complete it if necessary, assist the participant in accessing and using the pharmaceutical assistance program, and reconfirm medical appointments plus additional medically necessary services. The navigators also assists participants in ensuring they can attend each appointment and if they cannot, the navigator will assist in rescheduling.

Eligible Population: The Michigan Department of Corrections determines which participants are eligible for this program.

Partners: The MCHP program collaborates with a number of different organizations including a charitable organization, the State department of human services, the State department of

corrections and parole, a community mental health services organization, a victim's services organization, a State prison, local police agencies, and a number of faith-based organizations.

Service Providers: MCHP collaborates with a number of different service providers including West Michigan Therapy, Michigan Rehabilitation Services, and Orchard View Community Education.

Funding Source(s): The Michigan Department of Corrections is the primary funding source for the program, though funding also comes from Mercy Health Partner's community benefit program and an AMERICORP grant.

Program Cost(s): Program costs since inception total \$436,750 or approximately \$174 per participant.

Staffing: Staff includes one full-time and one-half time medical navigator, one 15%-time pharmaceutical health worker, one full-time member assisting the program's pharmaceutical assistance program, and seven full-time CHWs.

Caseload per Staff Member: Based on reported data, the computed caseload per staff member is 1:250.

Program Utilization: More than 2,500 people participated in the program.

Health Outcomes: Data on changes in health status of program participants was not reported.

Justice Related Outcomes: The overall recidivism rate fell from 46% at the program's inception in 2007 to 21.8% in 2012 for two-year parolees.

Cost Savings/ROI: Based on reported data, a computed ROI for this program is approximately 1.55 though this calculation only applies to the value of the prescription drug benefit. Data on cost savings from decreased recidivism rates was not reported.

C. Modified therapeutic community

A MTC consists of a flexible, individualized approach that builds coping and self-management skills and addresses psychiatric symptoms and cognitive impairments among individuals with co-occurring disorders (COD). It is a prosocial model that uses peers as role models and derives from the therapeutic community approach.

i. Oklahoma Collaborative Mental Health Reentry Program

The Oklahoma Collaborative Mental Health Reentry Program (CMHRP) is a prisoner reentry program geared towards providing a constant stream of services to the mentally ill from incarceration, to release, and beyond.^{39, 40, 41}

Pre-Release: Within 12 months of inmates' release, staff assess potential participants' need for community based mental health services and eligibility for Federal (SSI, SSDI), State (Medicaid), Veteran's Administration and Tribal benefits. Two months prior to release, staff assist participants in filing Medicaid applications. CMHRP staff assess participants' job/life skills, educational and housing needs/assets, post release supervision requirements, and criminogenic risk factors. Finally, staff develop a mental health reentry plan for each participant.

Post release: Case management services, provided by Reentry Intensive Care Coordinating Teams (RICCT), are available 24/7 upon release. Each RICCT ensures the offender connects with a community based mental health provider, follows up with various benefits applications, and follows up with the goals and referrals made in each participant's reentry plan. Program staff can provide transportation to court appointments, probation offices, the Social Security Administration, the Department of Transportation, or other community-based resources. Other post release services include housing assistance, food assistance, which includes assisting participants in obtaining food stamps, clothing, and hygiene-related items.

Eligible Population: A participant must be an adult aged 18 or older with a diagnosis of major depression, bipolar disorder, or psychoses, and released from Joseph Harp Correctional Center, Mabel Bassett Correctional Center, or the Oklahoma State Penitentiary.

Partners: CMHRP partners include a State department of mental health and substance abuse services and a department of corrections.

Service Providers: Service providers include two community BH service providers and a county government mental health center.

Funding Source(s): The Oklahoma Department of Mental Health & Substance Abuse Services (ODMHSAS) funds this program.

Program Cost(s): The program costs an average of \$2,700 per participant per year.

Staffing: The CMHRP program includes seven full-time/co-trained ODMHSAS staff and three discharge managers (one at each participating facility). The RICCT teams consist of a Peer Recovery Support Specialist and a Certified Case Manager. The PRSSs are specialists that offer peer support services based on their own experience with mental illness or substance abuse.

Caseload per Staff Member: Based on reported data, the computed caseload per staff member is 1:89.

Program Utilization: As of February 2014, 626 people participated.

Health Outcomes: Program participants increased their use of community-based outpatient services by 34%, increased Medicaid enrollment within 90 days of release by 41%, and increased their social security benefit enrollment by 53%.

Justice Related Outcomes: Recidivism rates for participants decreased from 43% to 25%.

Cost Savings/ROI: A 6% decline in inpatient hospitalizations caused an estimated savings of \$776,000 per year. Based on reported utilization and yearly costs savings data, a computed ROI for the program is 0.45.

D. Common Themes across Community Reentry Programs

The interventions summarized here share a number of common components. These commonalities may suggest that these components contribute to the success of these interventions.

Structure: Each intervention includes a formal collaboration between correctional facilities and community partners who provide services to offenders. These partnerships recognize that no one

entity can meet all of an individual's needs. Working together, with clear and frequent communication among stakeholders, is essential.

Services: In each of these interventions, preparation for reentry begins well in advance of release. In some cases, preparation for reentry begins at intake. Each intervention attempts to continue care begun during incarceration after release. In many cases, the case manager or even the provider develop a relationship with the offender during incarceration that continues in the community. Finally, all of these interventions focus on arranging stable housing and employment after release to support successful reentry.

Staffing: All of these interventions emphasized the need for consistent staffing with small caseloads. The interventions provided ongoing training and support for their staffs.

III. Forensic Care Coordination Programs

Forensic Assertive Community Treatment (FACT) and Forensic Intensive Case Management (FICM) are relatively intensive mental health treatment models that were adapted from established models to meet the needs of the justice involved population. FACT and FICM programs target individuals with SMI who have a high degree of functional disability and significant difficulty living independently, high service needs, and repeated psychiatric hospitalizations. SAMHSA rates the Assertive Community Treatment model (ACT) and FACT as evidence-based practices, and FICM as a promising practice for treating individuals with mental illness. ^{42, 43, 44}

Practitioners developed FACT and FICM as a response to the growing recognition that persons with SMI did not only cycle through repeated hospitalizations, but also through repeated jail stays. Both models expand ACT and Intensive Case Management (ICM) models by adding the explicit goal of preventing further recidivism. FACT and FICM interventions are long term, often with no end date. ⁴⁵ Practitioners may use FACT and FICM either independently or in conjunction with diversion programs, courts, probation/parole, and reentry/transition programs. ⁴⁶ Proponents argue that FACT is the most widely researched psychosocial treatment

This section describes examples of FACT and FICM programs in various locations across the country.

A. Forensic Assertive Community Treatment

FACT programs aim to divert individuals from future criminal justice involvement through high frequency of contact, low patient-to-staff ratio, and around-the-clock service availability. A mobile team that typically includes a psychiatrist, a nurse, a peer specialist, and an addiction counselor/substance use specialist provide services. The treatment team may also include a probation officer or other official from the justice system. Some programs accept referrals from correctional facilities, probation/parole staff, courts, and law enforcement, while others collaborate only with one of these.

Most FACT programs target individuals with SMI who have prior arrests and who cycle repeatedly between criminal justice involvement, emergency health care services, and homelessness. Some programs have residential treatment units for clients with CODs, and some programs accept violent offenders. ^{47, 48}

i. King County FACT Program

In 2006, the King County Mental Health, Chemical Abuse, and Dependency Services Division, in Washington State, instituted a FACT-based program with these objectives: to bring stability to participants, to promote their recovery, and to reduce their involvement with the criminal justice system. The program includes both the provision of certain healthcare services and care coordination for participants. ^{49,50,51}

Services Offered: The King County FACT team provides services to program participants seven days a week, 24 hours a day, 365 days a year. These services include medication management, case management, chemical dependency treatment, mental health treatment, 24-hour crisis services, vocational training, and housing assistance (through inclusion of a “permanent” housing voucher). In addition, the FACT team is mobile and can travel to meet clients to provide services within a community setting.

Eligible Population: Eligibility for the program included SMI and frequent use of the King County Jail within the last 33 months.

Partners: Partners for the program include two county government agencies.

Service Providers: A local mental health and addiction treatment services provider offers services to program participants.

Funding Source(s): The program receives primary funding from the state Homeless Grant Assistance Program and additional funding from the King County Veterans and Human Services Levy.

Program Cost(s): Not reported.

Staffing: Staffing for the program includes a Team Lead Mental Health Professional (1.0 FTE), two Registered Nurses (1.0 FTE), a Mental Health Professional (1.0 FTE), a Bachelor level Mental Health Case Manager (1.0 FTE), a Bachelor or Master level Chemical Dependency Specialist (1.0 FTE), a Vocational Specialist (1.0 FTE), a Forensic Peer Specialist (1.0 FTE), a Psychiatric Prescriber (Psychiatrist or Advanced Registered Nurse Practitioner) (0.4 FTE), a Program Assistant (1.0 FTE), and a Boundary Spanner (0.5 FTE).

Caseload per Staff Member: The computed caseload per staff member is ~1:6.

Program Utilization: 51 people participated in the program during the evaluation period.

Health Outcomes: Program participation contributed to a 25% decrease in psychiatric hospital admissions and a 44% decrease in psychiatric hospital days. At the end of the three-year evaluation period, 23 of 51 participants had been stably housed for a year or more and 16 had been continuously stably housed.

Justice Related Outcomes: In the first year, participants had 45% fewer jail and prison bookings, which is an average of 2.3 fewer bookings per participant. Also, in the first program year, participants experienced a 38% reduction in their total days spent in jail or prison, which is an average of 45 fewer incarcerated days per participant.

Evaluation Design: Randomized controlled trial. The number of eligible individuals exceeded the number of slots available. Researchers randomly assigned eligible individuals to participation or control.

Cost Savings/ROI: Not reported.

ii. **Project Link**

Project Link is a university-led consortium of five community agencies in Monroe County, New York that spans the healthcare, social service, and criminal justice systems. Its primary goals are to prevent jail and hospital recidivism and to promote community reintegration among adults with SMI and histories of criminal justice involvement. Key features of the program include a mobile treatment team with a forensic psychiatrist, a dual diagnosis treatment residence, and culturally competent staff. ^{52, 53, 54}

Services Offered: For those patients needing intensive treatment, Project Link refers them to their 24/7 mobile treatment team where participants can receive in vivo treatment and have access to a

dual diagnosis supervised residence treatment facility. Project Link uses a four-level system of care where participants learn about mental illness/substance abuse, receive treatment, and develop future life skills.

For those participants not needing intensive services, Project Link refers patients to community treatment facilities (if applicable) and other services. In addition, program staff coordinate with both justice and healthcare agencies to ensure program participants receive the care and services they need. Staff assist participants during court appearances and identify judges, prosecutors, and other criminal justice related officials who are particularly keen on assisting program participants.

Eligible Population: To be eligible for this program, participants must be 18 years or older, have a diagnosis of SMI, a history of previous involvement with the criminal justice system, and a history of non-adherence with outpatient treatment. In addition, though not an eligibility criterion, a large majority of participants also have a diagnosis of substance abuse or dependency.

Partners: Project Link partners include a university-based community support program, three community support organizations, and a county socio-legal services clinic.

Service Providers: Project Link provides treatment through its own mobile treatment vehicle for those participants who need intensive treatment. For those not needing intensive treatment, Project Link can refer patients to available community services.

Funding Source(s): The program received grant funding from the Robert Wood Johnson Foundation, in partnership with state and county government, and a non-profit human services company.

Program Cost(s): A preliminary cost analysis showed that Project Link cost \$34,360 per participant per year.

Staffing: Staff members for Project Link include a project coordinator (who is a nurse with chemical dependency treatment experience), five bachelor-level case advocates, a three-fifths time forensic psychiatrist, and a nurse practitioner.

Caseload per Staff Member: The goal is for each case advocate to have a caseload of 20 patients.

Program Utilization: Sixty people participated in the program during the four-year study period.

Evaluation design: Pre-post study of individuals with long term high utilization. A subsequent randomized control trial reported similar outcomes but did not report cost data.⁵⁵

Health Outcomes: Mean yearly hospital days per participant dropped from 115.9 in the year prior to participation to 7.4 the year after.

Justice Related Outcomes: Mean jails days per participant dropped from 107.7 in the year prior to program participation to 46.4 the year after program participation. In addition, there were no assaults, suicide attempts, or other reportable incidents among a sample of participants studied over four years.

Cost Savings/ROI: A preliminary cost analysis showed that Project Link cost \$34,360 per participant per year. When compared to a pre-enrollment per year cost of \$73,878 per enrollee, that is a reduction of \$39,518 per year.

A computed ROI for this savings is ~0.53.

iii. **Arkansas Partnership Program**

The Arkansas Partnership program is a unique public-private partnership creating a continuum of care that bridges the gap between inpatient treatment and community aftercare for insanity acquittees with chronic mental illness and substance use disorders. Its goal is to create a less restrictive and secure residential treatment program where participants receive access to case management services, crisis stabilization beds, and clinical assessments. ⁵⁶

Services Offered: After release from an inpatient facility, participants receive services in a secure residential treatment facility. They participate in a five-step program that prepares them for reintegration into the community once they graduate. Participants learn basic social skills and coping techniques, how to adjust to a therapeutic community, as well as to understand the addictive disease model and recovery, and mental illness and medication management. Team members encourage participants to engage and actively take charge of their own progression through the five-step program. Participants receive case management services from a dedicated case manager both during their time in the program and as they reintegrate into the community. Case managers provide up to 30 hours of direct contact per week and offer a variety of services including supportive counseling, housing assistance, direct financial assistance, supportive employment, medication management assistance, community and family support, transportation assistance, and day treatment services.

Eligible Population: Participants must meet the following criteria: (1) be acquitted of a crime by reason of mental disease, (2) have a major diagnosis of serious and persistent mental illness, (3) be psychiatrically stable at the time of application, (4) present no immediate risk of harm to themselves or others, (4) be capable of responding to cognitive-behavioral treatment, and (5) have needs that cannot be met in a less restrictive treatment environment.

Partners: Program partners include state government, a private non-profit agency, a private for-profit company, and the community at large.

Service Providers: Participants receive services from a health and human services management company.

Funding Source(s): The Arkansas State government funds this program.

Program Cost(s): Not reported.

Staffing: Exact staffing numbers are not reported. Treatment teams consist of a lead psychiatrist, psychologists, social workers, substance abuse counselors, recreation therapists, nurses, counseling assistants, and case managers. Many staff members are dually trained in mental health and addiction treatment, and all staff must participate in 80 hours of cross training.

Caseload per Staff Member: The literature states that caseloads are small, but exact caseload per staff member figures are not reported.

Program Utilization: 18 people participated in the program during the study period.

Health Outcomes: All but one participant made a successful transition to the community and no participants suffered a relapse into criminal behavior or substance abuse. At the time of the study, successful participants had been living and working in the community for an average of 508 days.

Justice Related Outcomes: Not reported.

Cost Savings/ROI: Not reported.

iv. Other Notable Programs

Other FACT-based programs currently providing services to the justice involved population include:

- The Thresholds State-County Collaborative Jail Linkage Project (quasi-experimental study design/matched controls) ^{57, 58, 59}
- The California Mentally Ill Offender Crime Reduction Grant FACT Program (randomized controlled trial) ⁶⁰
- Places for People Initiative (pre-post study design) ⁶¹

B. Forensic Intensive Case Management

FICM programs facilitate access to psychiatric treatment in the community to sustain recovery and prevent further justice involvement, as opposed to FACT teams that provide treatment directly. FICM case managers are specially trained in forensics, typically carry an individual caseload, and do not have 24/7 availability. FICM is also a less resource-intensive intervention than FACT. Very little research has been published on the effectiveness of FICM. ^{62, 63, 64}

i. Philadelphia Suburban Jail FICM Study

Researchers designed the Philadelphia Suburban Jail FICM study to evaluate whether participation in ACT or FICM programs produces better outcomes for program participants. Participants in the FICM group were provided with both in reach and outreach services once they were released from jail. This study, conducted in the early 1990s, did not detect a statistical difference in outcomes produced by various case management approaches. ^{65, 66}

Services Offered: Case managers connect program participants to an array of services in community mental health centers, including psychosocial services, vocational rehabilitation, or social rehabilitation. Participants receive access to a case manager 24 hours a day. Services are available to participants for greater than one year.

Eligible Population: Participants are eligible if they are expected to be released in 4-6 weeks; had a major mental illness; have a Global Assessment of Functioning score of < 40 if over age 35 and <60 if age 35 or younger; have a history of treatment for serious mental disability as indicated by extended community hospitalization, outpatient treatment, or state hospitalization; or is homeless.

Partners: City department of mental health.

Service Providers: Community mental health clinics provided services to program participants.

Funding Source(s): Not reported.

Program Cost(s): Not reported.

Staffing: Staff for the program consisted of three case managers, and a housing specialist.

Caseload per Staff Member: Not reported.

Program Utilization: 60 people participated in the study.

Evaluation design: Randomized controlled trial. Participants were randomly assigned to FACT, FICM or another case management model.

Health Outcomes: No significant difference in inpatient hospitalization rates.

Justice Related Outcomes: Re-arrest rate was lower among the FICM participants relative to the FACT participants, but the difference was not significant.

Cost Savings/ROI: Not reported.

C. Common Themes Across Forensic Care Coordination Programs

Each of the FACT or FICM interventions summarized above share a number of common components. These commonalities may suggest that these components contribute to the success of these interventions.⁶⁷

Structure: Each intervention stresses the importance of the collaboration between the criminal justice system and community partners providing treatment. Those treating this group recognize that no one entity can meet all of an individual's needs. Working together, with clear and frequent communication among stakeholders, is essential to address the heterogeneous and changing needs of the population.

Services: Each intervention provides highly individualized services directly to participants. Common services include addiction treatment, medication management, vocational rehabilitation, housing support, and assisting participants in navigating the criminal justice process.

Staffing: Each intervention emphasizes the need for a multidisciplinary mobile treatment team that is available 24/7. Team members are trained in psychiatry, nursing, addiction counseling, social work, and vocational rehabilitation. Participants are served by the entire team, and consumer to staff ratios are ideally no more than 10 to 1.

IV. Supportive Housing Programs

Housing instability increases the risk of incarceration, which in turn increases the risk for homelessness upon release. Supportive housing programs target individuals who cycle in and out of correctional facilities, hospitals, and shelters. Coupling permanent supportive housing with individualized services, these programs aim to break this cycle.⁶⁸ Supportive housing combines lease-based, permanent affordable housing in the community with voluntary, flexible, and individualized services.⁶⁹ Services offered may include availability of 24/7 crisis services, integrated dual disorder treatment, intensive case management, forensic peer support, and education and employment assistance.^{70,71} The goal is to support individuals in their recovery from mental illness by providing a system of professional and peer supports that allow a person to live independently in the community.

After incarceration and upon integration into the community, supportive housing is particularly helpful for individuals with BH conditions. These individuals require ongoing community support to avoid cycling between emergency health services, jail stays, and homelessness. Breaking this cycle is especially a challenge for individuals with serious mental illness or co-occurring disorders. SAMHSA recognizes supportive housing as an evidence-based practice that has the greatest potential to impact health and criminal justice outcomes for individuals with mental illness.^{72,73}

Key features of successful programs include the following.⁷⁴

- Participants have a choice of housing, including type, location, and who individuals live with
- Housing is safe and affordable (i.e., tenants pay no more than 30% of their income in rent and utilities)⁷⁵
- Housing is integrated into the community (i.e. not segregated/institutionalized; allows residents to interact with other residents in the greater community)
- Individuals receive full tenancy rights in accordance with a standard lease or occupancy agreement
- Housing is accessible to individuals without having to demonstrate housing "readiness"

Participants receive a range of flexible, consumer-driven services to transition to and successfully maintain housing.

Medicaid can cover key supportive housing services; however, requesting Medicaid reimbursement for these services may require a state plan amendment or waiver. The services Medicaid can cover include the following:^{76, 77}

1. Existing best practice community-based services (typically long term), including a case manager or housing specialist on an ACT team
2. Services to promote the implementation, and use, of community-based services as opposed to institutional services including personal care, home health, specialized care for chronic health conditions, supported employment, crisis prevention/stabilization, housing transition and sustaining services
3. Ongoing supports provided by community or housing support staff, peers, and Alcoholics Anonymous or recovery support groups, community-based organizations such as neighborhood wellness or drop-in centers, etc.

This section describes examples of Frequent User Service Enhancement (FUSE), Justice involved Supportive Housing (JISH), and Forensic Intensive Supported Housing (FISH) programs in certain locations across the country.

A. Frequent User Service Enhancement

The FUSE program is a partnership between a city health department and non-profit housing providers. FUSE locates individuals based on jail and shelter rosters and then provides housing units to participants in a neighborhood of their choosing. Once housed, clients receive in-home visits from their case managers. The United States Interagency Council on Homelessness includes the FUSE model in its “solutions” database as a promising practice. ^{78,79,80, 81, 82}

i. FUSE/FUSE II Initiatives

The FUSE program in New York City, NY (NYC) was one of the first programs in the country to use a data linkage approach to target high-cost, high-use individuals who persistently cycle among jails, shelters, and hospitals. The successful evaluation of the first FUSE program in 2002 led to the expansion of the program through FUSE II. ^{83, 84, 85, 86, 87, 88, 89}

Services Offered: Participants receive permanent supportive housing in either scattered-site housing with services provided through mobile case management teams and other staff, or single site, mixed-tenancy buildings operated by non-profits as special needs housing with onsite services. The housing units are subsidized, such that tenants pay no more than 30% of their income or housing allowance.

Each housing provider receives a one-time payment of \$6,500 per participant for the funding of flexible services, including recruitment, engagement, and linkage to comprehensive medical, mental health, and other services. The housing service providers’ use of this enhancement varied, and included providing funding for clinical supervision, client recruitment and engagement, intensive case management, and the hiring of special FUSE staff to provide intensive support during the first year of program participation.

Eligible Population: To be eligible for the program, tenants must have a diagnosis of SMI and have had four jail or shelter stays in the past five years. Specific providers also may require additional criteria such as having gone through substance abuse treatment in the past twelve months.

Partners: The city department of corrections, department of homelessness services, housing authority, and a non-profit housing services organization.

Service Providers: Ten non-profit housing services providers offer housing to participants.

Funding Source(s): Funding comes from city, state, and federal funds along with grants from multiple foundations.

Program Cost(s): Annual costs per program participant are reported as payor only costs (\$23,290) and overall societal costs (\$27,210). The payor costs for the program include the services provided, operating the supportive housing units, a \$6,500 service enhancement, and the value of any federally funded affordable housing voucher secured for a scattered site unit. The overall societal costs include the payor costs and resident-incurred costs including out-of-pocket rent payments

from a participant's income, public assistance benefits in the form of rental subsidies, security deposit payments, and a one-time furniture allowance.

Staffing: FUSE program personnel include direct service staff (counselors, case managers, nurses, etc.) and supervisory staff (direct supervisors, program directors, administrative staff, executive director, financial manager, etc.). Information on exact numbers of each not reported.

Caseload per Staff Member: Caseloads per staff member are initially low (1:10 or 1:15). However, they can increase as participants stabilize and increase their independence.

Program Utilization: The program housed 72 individuals over a two-year study period, though only 60 participants completed the intervention.

Housing Outcomes: At twelve months, 91% of participants remained in their housing units, and after 24 months, 86% remained in their housing units. In contrast, at the end of the first year, only 28% of the comparison group had permanent housing, and at the end of the second year, 42% of the comparison group had permanent housing. Program participants spent 140 fewer days in homeless shelters than the comparison group and participants saw an overall average reduction of 70% in their shelter use.

Health Outcomes: Fifty percent fewer program participants used hard drugs recently than the comparison group and participants scored significantly lower on measures of stress and higher on measures of current family and social support. In addition, program participants spent half as many days hospitalized for psychiatric reasons than the comparison group. Finally, participants had no residential treatment days, while the comparison group spent an average of 10 days per person in a residential treatment facility.

Justice Related Outcomes: Program participants spent 19 (40%) fewer days in jail over the two-year study period than the comparison group.

Evaluation Design: The program evaluation design is a two-group pre-post evaluation with a comparison group of FUSE-eligible individuals that strongly matches the participants receiving services.

Cost Savings/ROI: Mean jail/shelter related costs decreased from \$38,443 per participant in the two years prior to the study period to \$9,145 in the two years following program participation. This is a savings of \$29,298 or a 76% reduction in costs. The comparison group's costs decreased \$12,639 over the same two-year period. The net savings in shelter and jail costs of the intervention relative to the comparison group was \$16,659 (43%) per participant over the two-year study period. In addition, the participants' health care costs for inpatient crisis medical and BH services over the two-year study period were \$7,308 (45%) lower than the comparison groups. Combined, savings from fewer jail/shelter days and decreased use of inpatient medical and BH services results in savings of \$23,967 per participant over the two-year study period relative to the comparison group, or \$11,983 per participant per year.

Based on program cost and savings data, the payor perspective receives an ROI of \$1.03 on each of dollar of investment while the societal perspective receives an ROI of \$0.88.

Replicability: More than thirty-five communities, including Los Angeles and Chicago, have developed programs based on the original FUSE model used in NYC.

B. Justice Involved Supportive Housing

Similar to the FUSE program, JISH programs target individuals who continuously cycle through shelters, jails, and emergency rooms. Most clients also have low-level misdemeanor charges, have significant BH and extensive substance use issues, and are older than the average jail population (47 years old on average).⁹⁰

i. JISH Program, NYC

The NYC Mayor's Task Force on Behavioral Health in Criminal Justice recommended development of the NYC JISH program with a goal of breaking the cycle of recidivism and homelessness. JISH will build 267 new supportive housing units in NYC, and as of 2017, 120 (45%) housing slots had already been added. NYC designed the program to support a full evaluation of the program.^{91, 92, 93, 94, 95}

Services Offered: The NYC Department of Health and Mental Hygiene assigns program participants to one of three non-profit organizations. Participants receive the services of both a case manager and a recovery peer specialist to help them through the intake process. In addition, they receive support services including mental health treatment, substance use treatment, and a referral to a primary care provider, vocational training, educational opportunities, medication management, and a range of other services for daily living skills. Participants receive housing in an apartment (either single or shared) and are responsible for paying 30% of their income towards rent.

Eligible Population: Eligible individuals have had at least five jail and five shelter admissions over a four-year period.

Partners: Program partners include the city departments of mental health and hygiene, correctional health, and homeless services, as well as the city district attorney's office, two non-profit housing services organization, a non-profit prisoner reentry services provider, and a non-profit social services provider organization.

Service Providers: Three non-profit housing service provider organizations provide services to participants.

Funding Source(s): NYC provides funding for the program.

Program Cost(s): Not reported.

Staffing: Each program participant receives a case manager and a recovery peer specialist. Other staff not reported.

Caseload per Staff Member: Not reported.

Program Utilization: The program identified 400 eligible individuals. Two hundred received program services and 200 received placement in a control group.

Health Outcomes: Not reported.

Justice Related Outcomes: Not reported.

Evaluation Design: Evaluators randomly assign participants to either a control or an intervention group.

Cost Savings/ROI: Not reported.

C. Forensic Intensive Supported Housing

FISH is an integrated mental health and substance abuse treatment program based on evidence-based integrated dual disorder treatment. The FISH team model incorporates a mobile multi-disciplinary team of professionals who work to provide the majority of treatment, rehabilitation, and support services participants need to achieve their goals. Typically, the program provides housing with support services, assertive engagement to recovery-based treatment, intensive case management, integrated co-occurring disorder treatment, medication management, 24-hour crisis services, forensic peer support, and education and employment assistance.⁹⁶

i. King County FISH Program

The FISH program in King County, WA, is a Housing First program targeting homeless adults who are unable to participate in a Mental Health Court (because they were found to be not legally competent to stand trial, with charges subsequently dropped), or homeless veterans with mental illness in a county or municipal jail. Participants receive permanent housing without a requirement to participate in BH treatment, although a participant can partake in these services. The program started in 2009 to fill a gap in housing and mental health services for a specific population of homeless adults who are involved in the criminal justice system.^{97, 98, 99, 100}

Services Offered: The program offers vocational training and placement services, housing support and stability services, medication management, benefits assistance, intensive case management and assertive engagement, integrated mental health and substance abuse treatment, and 24-hour crisis services. Services are time-unlimited and provided from a recovery and resiliency perspective.

Eligible Population: The eligible population for this program includes homeless adults who are unable to participate in a Mental Health Court (because they were found to be not legally competent to stand trial, with charges subsequently dropped), or homeless military veterans with mental illness in a county or municipal jail.

Partners: The Mental Health, Chemical Abuse, and Dependency Services Division of the King County Department of Community and Human Services administer this program and a local non-profit organization implements it.

Service Providers: Participants receive services from a local non-profit BH services provider.

Funding Source: The King County Veterans and Human Services Levy fund the program.

Program Cost(s): Not reported.

Staffing: Staff for this program includes a forensic boundary spanner (serves as the liaison with the criminal justice system), mental health professionals, case managers with mental health and substance use disorder treatment training, a vocational specialist, a forensic peer specialist, and a psychiatric prescriber. A total of 10 staff work on this program, however, staff makeup is not reported.

Caseload per Staff Member: A computed caseload per staff member is ~1:7.

Program Utilization: 73 individuals participated in the program over a two-year evaluation period.

Health Outcomes: Program participation led to a number of positive health outcomes including a ninety-five percent reduction in Sobering Center episodes (average per person decline from 17.0 to 0.9), a permanent housing rate of 92%, and a roughly 50% decrease in psychiatric hospital days for those participants who have been in the program for one year.

Justice Related Outcomes: Program participation led to a number of positive justice related outcomes including a 56% reduction in jail bookings (average per person decline from 4.4 to 1.9), and a 59% reduction in jail days (average per person decline from 82.9 to 34.2) for a total of 2,922 jail days saved.

Evaluation Design: Pre-post study design. Study evaluators took baseline measures in the year prior to participant participation to compare against the same measures after one and two years of participation. Evaluators split participants into two cohorts. Cohort One consisted of those with between one and two years in the program. Cohort Two consisted of those with two or more years in the program.

Cost Savings/ROI: A formal evaluation for cost savings is not available; however, cost savings may accrue from: (1) significant declines in institutionalized days (jail and hospital), (2) increase in days in the community, and (3) significant declines in use of sobering support services and crisis services.

D. Other Notable Supportive Housing Programs

Other supportive housing programs currently providing services to the justice involved population include:

- Frequent Users of Jail and Mental Health Services Program in Chicago, IL ¹⁰¹
- Just In Reach, Los Angeles, CA ¹⁰²
- Project 50, Los Angeles, CA ¹⁰³
- Returning Home Ohio ¹⁰⁴
- 10th Decile Project, Los Angeles, CA ¹⁰⁵
- Community Support Program for People Experiencing Chronic Homelessness, MA ¹⁰⁶

E. Common Themes Across Supportive Housing Programs

Each of the FUSE, JISH, or FISH programs summarized above share a number of common components. These commonalities may suggest that these components contribute to their success.

Structure: Each program relies on a multi-group collaboration among correctional agencies, city and/or state government, and community partners who provide services. Working together, with clear and frequent communication among stakeholders, is essential to ensure that each program participant receives the services they need.

Services: In each of these programs, participants receive permanent supportive housing with support services. Onsite services offered include vocational training, mental health, and substance abuse treatment, assistance in signing up for other related benefits, and crisis management services. In addition, support services are generally time-unlimited.

Staffing: All of these programs emphasize the need for consistent diversified staffing with small caseloads. Some interventions also provide ongoing training and support for their staffs.

F. States' Use of Medicaid Funds for Supportive Housing Programs

A handful of states successfully have leveraged the Medicaid program to provide services that support individuals with mental illness in obtaining and keeping housing, although Medicaid cannot pay for rent.

The New Jersey Division of Mental Health and Addiction Services has developed public supportive housing options through a state subsidy program, delivered by Medicaid ACT, and targeted case management providers. The state has added Community Support Services to its Medicaid state plan through a state plan amendment using the Rehabilitation Services Option, which allows it to provide community-based services by a broader range of professionals, such as peers, with a focus on recovery-based illness management, crisis support, coordination, and management. ^{107, 108}

In Pennsylvania, individuals with mental illness and Medicaid have benefited from supportive housing opportunities developed within the state using targeted reinvestment funds. Savings generated through BH service contracts with counties ('reinvestment funds') may be used to develop supportive housing and services for people with mental illness. ¹⁰⁹

V. Conclusion

Recent statistics highlight that nearly 700,000 people were released from prison into their communities in 2015, while another 9 million are released from jail each year.¹¹⁰ Lack of education, physical health and behavioral health issues, and a need for permanent housing all contribute to the high recidivism rate for this population. High rates of recidivism put more pressure on an already overburdened criminal justice and healthcare systems. However, as outlined in this report, proven programs exist that can help these individuals curtail this cycle of incarceration and successfully transition to being reintegrated into the community.

Programs reviewed possess their own intricacies. However, there are common themes across them all, which include:

- Collaboration and clear and frequent communication between correctional authorities, local or State agencies, and community partners.
- The need for highly individualized services and oftentimes enrollees are provided with the services of a case manager or similar professional. In addition, many programs helped provide housing and employment support, along with behavioral health or substance abuse treatment.
- The importance of consistent staffing with small caseloads. In addition, there is a need for ongoing training and support for program staff.

Our research and analysis outline the importance of incorporating community support programs for recently released individuals on Medicaid into any reintegration planning. Evidence shows that these programs work, save money, and can positively affect the lives of those that participate.

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Report on Health and Incarceration Focus Groups

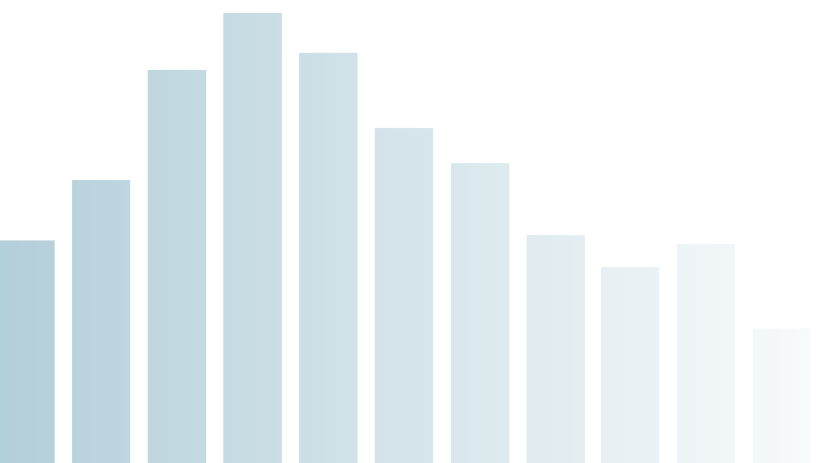


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1. Executive Summary

University of Massachusetts Medical School (UMass) staff conducted five focus groups on behalf of the Minnesota Department of Human Services (DHS) and Minnesota Department of Corrections (DoC) to gain feedback from those working directly with previously incarcerated individuals on interventions likely to improve the health of these individuals.

Focus group members described their view of systemic gaps and issues that should be addressed, such as a Medical Assistance (MA) enrollment process with multiple barriers for those soon to be leaving prison, previously incarcerated individuals' lack of health literacy, and a lack of resources dedicated to providing care coordination and community resources to previously incarcerated individuals. Focus group members offered solutions to address these issues, such as developing care plans while an individual is incarcerated for use in the community and dedicating greater funding to the provision of community resources, such as stable housing and employment training. Focus group members were convinced these steps would improve the health and well-being of previously incarcerated individuals and promote their community tenure.

Focus group members also provided feedback on two interventions gleaned from the research literature. The first intervention would add a social worker, trained to be the point person working with individuals being released from prison, to work with teams of supervision agents and/or county case managers. The second would provide transitional support staff who would work with incarcerated individuals before and after their release to help meet their needs. Focus group members stressed the need for intervention staff to have many years' experience working with previously incarcerated individuals. Staff should also have ample knowledge of the criminal justice system and county/state level policies related to the care of previously incarcerated individuals and their reintegration into the community. Focus group members indicated the need for a discharge/community care plan with a dedicated case manager and community case management team. Funding, training, and managerial support were presented as key supports needed by staff to be successful in their work with this population.

On the potential impact of the proposed interventions, focus group members generally agreed that implementing any of the interventions would positively impact the behavioral and physical health and well-being of previously incarcerated individuals. Most focus groups indicated that implementing interventions such as the ones proposed would decrease costs to either, or both, the criminal justice or health care systems. However, members expressed concerns regarding implementation issues that could reduce the effectiveness of these interventions including that they would not be properly funded, staff would not be provided with adequate training, and that the interventions would not be properly messaged to previously incarcerated individuals or corrections and supervision staff. Further, some members expressed concerns that these interventions do not prevent criminal justice involvement, an especially important issue for minority populations.

2. Introduction

In 2015, the Minnesota Legislature directed DHS to develop a methodology for paying higher rates to health care providers who provide services to high cost and high complexity groups such as previously incarcerated individuals.¹ The goal is to ensure that populations experiencing the greatest health disparities achieve the same health and quality outcomes seen by other populations in Minnesota.

This report offers a summary of the findings gathered from a series of focus groups conducted by UMass staff on behalf of DHS and DoC. UMass conducted these focus groups to gain feedback from experienced professionals who work directly with previously incarcerated individuals regarding interventions likely to improve the health of these individuals. The report is organized by the topics outlined in the interview guide provided to the focus groups and each section details the response(s) from each and any overlap, or differences, between them. The interview guide is included as an appendix to this report.

This report summarizes views, opinions and recommendations expressed by focus group participants to help state decision-makers consider the effects of potential policy choices. The opinions described here do not represent the views of the authors, and they have not been endorsed by DHS or DoC.

3. Background on Previously Incarcerated Individuals

America's correctional institutions are de facto health care facilities treating inmates for their physical health, mental health, and substance abuse issues. Between 2011 and 2012, an estimated 40 percent of state, federal, and jail inmates reported a current chronic medical condition.² Correctional facilities contain more than three times as many people with severe mental illness (SMI) than inpatient health facilities, and about two-thirds of prison and jail inmates meet the medical criteria for a substance use disorder (SUD).^{3,4} These health issues, and their related costs, do not stop with an inmate's release from incarceration. The risk of death from all causes – including cardiovascular disease, cancer, hepatitis, HIV, and opioid overdose – is 3.5 times higher among previously

In fiscal year 2011, the fifty states spent a total of \$7.7 billion on correctional healthcare, of which Minnesota accounted for almost \$70 million.

¹ Laws of Minnesota 2015, chapter 71, article 11, section 63

² United States Department of Justice, Office of Justice Programs, Bureau of Justice Statistics: Medical Problems Of state And Federal Prisoners And Jail Inmates, 2011-12; Available at <https://www.bjs.gov/index.cfm?ty=pbdetail&iid=5219>. Accessed on March 29, 2018.

³ E. Fuller Torrey, Aaron D. Kennard, Don Eslinger, Richard Lamb and James Pavle, "More Mentally Ill Persons Are in Jails and Prisons Than Hospitals: A Survey of the States." Treatment Advocacy Center and National Sheriff's Association, May 2010. The study uses 2004-2005 data.

⁴ National Center on Addiction and Substance Abuse, "Behind Bars II: Substance Abuse and America's Prison Population". February 2010.

incarcerated individuals than the general population and 12.7 times higher in the first two weeks after release.⁵

Previously incarcerated individuals cycle between incarceration and the community, and while in the community, they frequently seek health care in emergency departments. The provision of health care services to previously incarcerated individuals strains both correctional and state Medicaid budgets. In fiscal year 2011, the fifty states spent a total of \$7.7 billion on correctional health care, of which Minnesota accounted for almost \$70 million.⁶ Despite current spending levels, U.S. inmates do not always receive needed care during their incarceration or in the community. Several factors contribute to these barriers and gaps in care including an uncoordinated health care system, a lack of sufficient services, a lack of personnel, and a lack of community-based resources. Additionally, community-based treatment programs may bar ex-offenders from participating because they can be disruptive, argumentative, or violent.

4. Focus Groups and Participants

The UMass team conducted five focus groups to gain insight from stakeholders who work closely with previously incarcerated individuals. Listed below is the name of each focus group and the expertise of its participants. We thank them for taking the time to offer their expertise and feedback on the interventions.

1. Clinical Expertise:
 - One care coordinator in a large medical center from the southern region of Minnesota, one re-entry staff person in a behavioral health center in a rural community, and two staff specializing in brain injuries
2. County Case Management Expertise
 - One staff person in a county re-entry program, one FACT team member, one county case manager who works with clients with serious and persistent mental illness re-entering the community, and one staff person from a community center specializing in working with clients who identify as American Indian
3. Mental Health Treatment Expertise
 - One behavioral health manager for a large health and wellness campus in an urban community, and two mental health providers in a mental health center with expertise in serving those involved in the criminal justice system.
4. Substance Use Disorder Treatment Expertise

⁵ Ingrid A. Binswanger, MD, MPH, Patrick J. Blatchford, PhD, Shane R. Mueller, MSW, and Marc F. Stern, MD. "Mortality After Prison Release: Opioid Overdose and Other Causes of Death, Risk Factors, and Time Trends From 1999 to 2009." *Ann Intern Med*. 2013 November 05; 159(9): 592–600.

⁶ The Pew Charitable Trusts and the John D. and Catherine T. MacArthur Foundation: State Prison Healthcare Spending, An Examination; Available at <http://www.pewtrusts.org/~media/assets/2014/07/stateprisonhealthcarespendingreport.pdf>. Accessed on March 29, 2018.

- Two managers in SUD treatment centers, each specializing in clients involved in the criminal justice system.
5. Supervision Expertise
- Three supervision agents and one probation officer representing different regions of the state (southern, urban, rural), as well as a variety of supervision levels.

5. Stakeholder Feedback on Current System

DHS’s analysis found that previously incarcerated individuals have worse health outcomes and higher MA expenditures than other MA enrollees, even when the analysis accounts for their demographic characteristics, medical and behavioral health diagnoses, and other social determinants of health.

The following section summarizes opinions offered by focus group members on topics including (1) systemic gaps or issues that contribute to the disparity in health outcomes for individuals who were previously incarcerated, (2) solutions DHS and DoC could adopt to address or mitigate the disparity, and (3) other suggestions on how the MA enrollment process could be improved.

A. Systemic Gaps and Issues

Focus group members described several systemic gaps or issues that contribute to the disparity in health outcomes for previously incarcerated individuals. These gaps or issues are grouped into four categories (1) the MA eligibility and enrollment process, (2) care for chronic health conditions and a lack of health literacy, (3) care coordination during the transition from incarceration to the community, and (4) a lack of community resources to assist this population. Members of the Clinical and County Case Management focus groups noted that racial and ethnic minorities have higher rates of incarceration and chronic health conditions and that special consideration should be given to these groups when implementing any solutions.

“People get released with no services and they are on their own.”

Focus Group Participant

MA eligibility and enrollment process. Members of all focus groups described the difficulty previously incarcerated individuals have in obtaining MA coverage upon release, and more broadly, expressed the view that the MA enrollment process takes too long and is too complicated. Each focus group highlighted that previously incarcerated individuals typically do not have MA coverage, or their MA coverage is inactive, upon release and once they are released, the enrollment process can take up to 90 days.⁷ In addition, variation amongst counties as to how each administers MA coverage can

⁷ DHS staff note that there are policies and procedures that allow individuals to have coverage upon release, but these may not be consistently applied by all workers. Additionally, incarcerated individuals may not be aware that

contribute to confusion. All focus groups agreed that a lack of MA coverage results in previously incarcerated individuals receiving care more frequently in the emergency room.

Care for chronic health conditions and lack of health literacy. Focus group members described several issues related to chronic health conditions and lack of health literacy, summarized as follows. Clinical focus group members suggested that chronic health conditions, such as a traumatic brain injury (TBI), could make it virtually impossible for previously incarcerated individuals to navigate their post-release landscape. In addition, members of the Mental Health focus group said that individuals typically receive less comprehensive care while incarcerated than they could receive in the community. Therefore, once they are released, previously incarcerated individuals must “catch up with” the care they should have received for chronic conditions. However, obtaining this care can be difficult because this population generally lacks health literacy. According to the Mental Health focus group, previously incarcerated individuals often do not understand the importance of self-care or gaining access to needed mental health or chemical dependency treatment because they are more concerned with their next meal or where they would sleep that night. They need assistance in coordinating their care upon release.

Care coordination during the transition from incarceration to the community. Members of all focus groups stated that many individuals awaiting release do not receive care coordination and discharge planning because (1) MA does not pay for care coordination while an individual is incarcerated and (2) DOC has rigid eligibility requirements to qualify for these services. Care coordination and discharge planning are critical to the development of the relationship between community supervision staff, providers, and previously incarcerated individuals. As noted by a member of the County Case Management focus group, some providers struggle with their relationship(s) with certain members of law enforcement who could be less focused on the rehabilitation process. This distrust could hinder the level of communication needed for care coordination and discharge planning for previously incarcerated individuals. A good relationship and level of trust is vital to ensuring this population accesses the assistance, services, and supports provided by community-based resources.

“Medications and a place to put their head at night ... Nothing else matter[s].”

Focus Group Participant

Lack of community resources. All focus groups stated that there is an insufficient level of community resources available for previously incarcerated individuals upon release. There is insufficient availability of stable housing and transportation to needed appointments, especially for those living in rural areas. In addition, there are not enough community-based mental health or chemical dependency treatment resources. All focus groups agreed the lack of community resources could contribute to higher recidivism rates and emergency medical costs.

they can apply for Medical Assistance in advance of their release, or they may not receive enough assistance to do so successfully.

B. Solutions to Address or Mitigate Disparities

Focus group members provided several solutions to address or mitigate systemic disparities that adversely affect previously incarcerated individuals. These solutions are grouped into four categories (1) increasing the availability of stable housing, (2) developing care plans behind the wall through in-reach sessions, (3) improving access to clinical resources, and (4) providing greater levels of community supports to address social determinants of health.

Provide additional stable housing. All focus groups recommended that stable housing should be made available for this population when they are released. A lack of stable housing could lead to chronic homelessness, which could adversely affect care for chronic health conditions and ultimately lead to costly emergency room visits. There could be a high risk of exacerbating chronic health conditions during winter months, especially during periods of extreme cold. In addition, stable housing should be made available to those previously incarcerated individuals who have difficulty securing housing because of certain offenses they committed.

Ensure development of a care/release plan. Members of all focus groups agreed on the importance of developing care or release plans for previously incarcerated individuals. They also agreed that community-based resources could assist previously incarcerated individuals with discharge planning through in-reach sessions. These sessions could include assistance with filing benefit (including MA) applications and completing any medical forms, in addition to assistance with getting a form of identification for after release. In-reach staff could then coordinate a warm handoff of these individuals to community-based staff. Once the handoff is complete, a community-based care coordinator could assist previously incarcerated individuals in obtaining care and support.

Improve Access to Clinical Services. Members of all focus groups agreed that improving access to clinical services would increase community tenure. Providing a connection to a primary care physician and completing a mental health assessment prior to release could allow for more effective care coordination once an individual is in the community. To assist in the care coordination and treatment process, the County Case Management, SUD, and Supervision focus groups, respectively, provided additional ideas regarding how to better support the treatment needs of this population. First, the County Case Management group suggested the state should create universal medical records for previously incarcerated individuals that can be shared between medical professionals behind the wall and those in the community. Sharing these records would prevent duplicate assessments and lost patient information. Second, the SUD group suggested the state should create a 'health care hub' where previously incarcerated individuals could learn about self-care and receive clinical treatment. Third, the Supervision group suggested the state should have a list of pre-

“A lot of people come out of prison and they don’t get the services they need, and then they end up in the [correctional] system.”

Focus Group Participant

approved providers, who are experienced in treating this population, as a reference for previously incarcerated individuals to consult.

Provide greater levels of and ease access to community-based supports. Members of all focus groups agreed on the need to provide greater levels of community-based supports and to make those supports easier to access for previously incarcerated individuals. Examples of these supports could include coordinating chemical dependency or mental health treatment options, and transportation to and from those treatments. These supports promote the community tenure of this population; however, previously incarcerated individuals may not be able to access them if they are homeless or unemployed. For example, a participant noted that a previously incarcerated individual could not access a food pantry because the individual did not have a form of identification or a permanent address.

C. Suggestions to Improve the MA Enrollment Process

Focus group members provided several solutions that DHS and DoC could adopt to address or mitigate the disparity in health outcomes for previously incarcerated individuals. The solutions are grouped into three categories (1) improving and streamlining the MA application process, (2) improving the infrastructure regarding the provision of reentry services to applicable individuals, and (3) improving access to educational opportunities to eligible enrollees prior to, and after release.

Improve and streamline the MA application process. A clear message from all the focus groups was that the MA application process is too complicated, slow, and oftentimes burdensome, especially, as noted by the Mental Health focus group, if an individual must submit paperwork in person at a county office.⁸ To ensure previously incarcerated individuals receive needed treatment and services as soon as possible after their release, members of the County Case Management focus group suggested establishing an MA eligibility grace period after release, during which individuals would be temporarily eligible for MA while the state processed their paperwork. A solution noted by the Supervision focus group was to enable incarcerated individuals to apply for MA online prior to release. These focus group members said that electronic applications are processed much more quickly than paper applications, and that individuals could be approved for MA much more quickly if they could apply online. Members of the Supervision focus group noted that each time a previously incarcerated individual recidivates, a new MA application must be started. The focus group suggested developing a process whereby individuals applying for MA coverage would not need to restart the enrollment process each time they recidivate.⁹

⁸DHS staff note that incarcerated individuals apply for MA using a paper application because they do not have access to the Internet to apply online, however, DHS never requires an in-person interview in conjunction with an MA application.

⁹DHS staff note that regulations require a review of a person's eligibility when they are released from prison, as there has been a change in their circumstances.

Improve the infrastructure for providing reentry services. Members of the SUD focus group felt strongly that the infrastructure surrounding the provision of reentry services should be improved. Connecting a previously incarcerated individual to a discharge planner prior to release is key, and to do that, additional discharge planners should be hired. County Case Management focus group members suggested decreasing supervision agent caseloads and increasing the use of Forensic Assertive Community Treatment (FACT) teams would improve the infrastructure of reentry services. Using FACT teams could help ensure previously incarcerated individuals receive the level of service and support they need. In addition, one member of the County Case Management focus group noted the need for better coordination with Native American tribal resources and governments when providing services to Native Americans. Finally, members of the SUD focus group noted the need to improve the availability of county level treatment centers and their connection to county level corrections agencies. Strengthening this relationship would help previously incarcerated individuals access substance use or mental health treatment.

“When you’re in prison, there is no consistent enrollment process or practice.”

Focus Group Participant

Improve the health literacy of eligible enrollees. Members of the Mental Health focus group noted the need to better educate previously incarcerated individuals on how to access health care services, including obtaining MA eligibility. In addition, Mental Health focus group members stressed the importance of educating previously incarcerated individuals on self-care after release.

6. Feedback on Proposed Interventions

A. Proposed Interventions

UMass reviewed published studies of interventions intended to improve the health and well-being of individuals who were previously incarcerated. One successful strategy identified from the literature was community reentry support programs that aim to improve outcomes by connecting at-risk individuals with needed services. Community reentry programs provide individualized assessments, treatment planning, and care coordination for individuals with physical and mental health conditions leaving incarceration. Because of the high incidence of SUD and mental illness among inmates, together with the elevated risk of death upon release from overdose and suicide, many community reentry programs focus on the needs of individuals with mental health and substance use issues.

Common components of successful interventions included the following:

- ***Structure:*** Each intervention included a formal collaboration between correctional facilities and community partners who provide services to previously incarcerated individuals.

- *Services:* In each of the interventions, preparation for reentry began well in advance of release. In some cases, preparation for reentry began at intake. Each intervention attempted to continue care that began during incarceration after release. In many cases, the case manager or the provider developed a relationship with the previously incarcerated individual during incarceration that continued into the community. Each intervention aimed to arrange stable housing and employment after release to support successful reentry.
- *Staffing:* Each intervention emphasized the need for consistent staffing with small caseloads. The interventions provided ongoing training and support for their staffs.

Informed by UMass’s review, DHS and DoC proposed two community re-entry support interventions intended to improve the health and well-being of individuals who were previously incarcerated. The first included either (1) having a justice entity employ and train a social worker to team up with supervision agents, or (2) designate and train one social worker, per county, to be the point person for working with individuals leaving incarceration. The second proposed intervention included hiring Transitional Support (TS) staff, employed by a non-justice entity, to work with people who are in prison for a few months before their release to develop a support plan and continue working with them after release to implement the support plan.

The following section describes feedback received from focus group members on design components that would make this intervention most effective, including: (1) the skills and experience intervention staff must have, (2) the services and supports the intervention must provide to enrollees, (3) the supports staff members would need, and (4) the location where intervention staff should be based.

B. Intervention Design

i. Experience and Skills Needed by Staff

Members of all focus groups agreed on the level of experience and skills program staff would need to work successfully with previously incarcerated individuals.

Appropriate experience level for staff. Members of all focus groups agreed that intervention staff should have many years of experience working with previously incarcerated individuals. Intervention staff should also have extensive knowledge of the policies and processes of the criminal justice system and of county and state level organizations. Each staff member should be knowledgeable about available and effective services and supports for previously incarcerated individuals and be able to identify which services and supports an enrollee would benefit from. Experience and good relationships with providers and county organization employees in the area(s) staff work would also be very helpful.

Staff skills needed to promote enrollee success. All focus group members agreed staff should be mission-driven and creative in addressing common issues among previously incarcerated individuals. Staff should have strong advocacy, communication, coordination, and writing skills, which would enable

them to navigate reintroducing previously incarcerated individuals into the community. In addition, staff should have the ability to educate family members, the community, and medical professionals regarding the criminal justice system, related trauma, and how each relates to treatment. Finally, staff members should be skilled in establishing clear boundaries while assisting enrollees in their continued community tenure.

Working with Native American and Other Minority Populations.

One member of the County Case Management focus group stated that intervention staff should be aware of any cultural differences between subpopulations, especially the Native American population. Intervention staff should take these differences into account when communicating and coordinating service provision among subpopulations. Additionally, staff members should be aware of programs specifically geared toward the Native American population and understand how the proposed interventions would integrate with tribal governments. Currently, previously incarcerated individuals who are members of a Native American tribe are not consistently referred to available tribal resources.

“[An intervention staff member] better be creative and be able to come up with solutions for a spectrum of problems.”

Focus Group Participant

ii. Services and Supports to Promote Enrollee Success

Across focus groups, there was consensus as to the services and supports that an intervention should provide to promote enrollee success.

Prior to exiting jail or prison, an enrollee should have a comprehensive discharge or release plan that facilitates a warm handoff from corrections to community-based support staff. The plan should include a readily available case manager who is the primary point of contact for an enrollee and is also a part of the greater care team. The case manager and care team should focus first on connecting each enrollee to (1) stable housing, (2) chemical dependency and/or mental health treatment resources, (3) transportation to medical appointments, and (4) assistance in completing, and keeping up-to-date, MA paperwork. Additionally, an enrollee should receive (1) employment assistance and job training, (2) a cellphone or other method by which an enrollee can be contacted, (3) access to proper nutrition, and (4) clothing and hygienic items. Provision of these services and supports would promote the community tenure of previously incarcerated individuals.

iii. Staff Supports

Focus groups members noted several supports imperative to a staff member’s success in working with previously incarcerated individuals.

Members of all focus groups noted the importance of consistent funding for the intervention. In addition, focus group members noted the need for training new and existing staff on topics such as the relationships between correctional agencies and other governmental bodies and proper safety protocols when meeting with an enrollee. Focus group members also noted the need for intervention staff to have weekly case consultations with managerial staff, team meetings, individual supervision, and access to a support network. Intervention staff should also have access to an enrollee’s health records and have standing contacts at different community-based organizations so that they can provide effective support to an enrollee in a timely manner. Employers should provide intervention staff with a phone to enable staff to communicate with an enrollee, a computer to document their visit(s), and a panic button to call for help in the event a difficult or dangerous situation arises. While focus group members generally agreed that intervention office space should be in an easily accessible urban area, they felt that staff should have access to a vehicle so that staff can meet with an enrollee offsite.

*“It needs to be a team
[approach].”*

Focus Group Participant

iv. Program Staff Location

Participants generally agreed within their own focus group as to the best location for program staff, however, there was not agreement across focus groups.

Members of the Clinical focus group indicated that intervention staff should be based with a non-justice related entity in an urban location to promote ease of access for enrollees. Being in a centrally located urban area could allow staff to be based near other resources that enrollees may rely on such as homeless shelters, treatment facilities, and public transportation. The focus group suggested that the organization could be clinic-based with culturally sensitive advocates.

Members of the County Case Management focus group stated that intervention staff should be employed by the county they work in as opposed to a justice entity. Staff could then have access to county-based databases, so they would not need additional release forms to access needed health care data and local corrections staff would also have a community-based contact. One member of the County Case Management noted the Native American community in her county does not have a good relationship with local government. This focus group member stressed that if DHS and DoC base the proposed interventions at the county level, the interventions should hire staff that are Native American or who have strong ties to that community.

Members of the Mental Health Treatment focus group stated that staff should be employed by an outside community agency but physically sit at correctional facilities. This arrangement would allow intervention staff to develop a level of trust with enrollees behind the wall that can continue when an enrollee is in the community.

Members of the SUD focus group expressed that intervention staff should be co-located with probation because the highest concentration of applicable potential enrollees visits those offices.

Members of the Supervision focus group did not reach consensus on where program staff should be based. However, two members of the focus group indicated a regional approach could work best.

C. Impact on Behavioral Health, Physical Health and Well-Being

Most participants agreed that these proposed interventions would have a positive impact on the behavioral and physical health and well-being of program enrollees.

Members of the Clinical focus group indicated this intervention would lead to a decrease in emergency rooms visits because previously incarcerated individuals would now get access to employment, food, housing assistance, and warm handoffs to medical professionals.

Members of the Mental Health focus group noted that this intervention would prevent previously incarcerated individuals from recidivating, which in turn would lead to better health outcomes as enrollees gain access to better health care services in the community.

Members of the Supervision focus group noted that the benefits of this intervention stem from allowing a neutral party to assist these individuals in getting the assistance and services they need. Successful provision of services and supports would in turn increase the likelihood of community tenure for enrollees.

Members of the County Case Management focus group provided varying responses as to whether implementation would improve the behavioral health, physical health and well-being of MA enrollees who were previously incarcerated. One focus group member stated that the program would positively impact a previously incarcerated individual. Another focus group member pointed out that the success of the program would depend on how one defines “success” in this context.

Members of the SUD focus group offered that any impact this intervention would have on the behavioral and physical health and well-being of program enrollees would depend on how the program is marketed to probation officers. Probation officers should not feel that this intervention increases their workload. Focus group members also indicated the need for intervention staff to have a roadmap with information on how to navigate key topics such as probation’s rules and regulations. Staff would also need to know the level of offense committed by the individual with whom they are working and would need to understand the importance of establishing boundaries when working with previously incarcerated individuals.

“You need to have a justice entity open to having a social worker or community health worker on a team.”

Focus Group Participant

D. Impact on Cost to Criminal Justice and Health Care Systems

Participants generally agreed that interventions such as the ones proposed would decrease costs. However, there was not consensus as to whether the savings would be to the criminal justice system, health care system, or overall to society.

Members of the Clinical focus group agreed that this program would decrease community medical spending, incarceration related costs, and homelessness related costs. Focus group members stated that these cost savings would come from fewer ER visits, decreases in recidivism rates, and greater rates of community tenure.

Members of the County Case Management focus group agreed that overall costs to society for care of previously incarcerated individuals would decrease. However, costs to the justice system would increase due to the need hire additional staff.

Members of the Mental Health focus group agreed that over the long-term this type of intervention would decrease costs to the health care and criminal justice systems by decreasing recidivism and hospitalizations. However, more of an investment should be made in (1) preventing youth from being incarcerated and changing their life trajectory, and (2) resources available to previously incarcerated individuals.

Members of the SUD focus group agreed interventions such as these would save money because there would be a reduction of criminal behavior in the community. In addition, it would give previously incarcerated individuals the opportunity to take better care of themselves, which could hopefully lead to a reduction in ED visits. A model to follow may be the “Opportunity for Change” program, which exists in a subset of correctional facilities across Minnesota.

Members of the Supervision focus group agreed these interventions would reduce costs to the criminal justice system. The costs stemming from hiring program staff would be less than those associated with the continued presence of enrollees cycling in and out of the criminal justice system.

E. Stakeholder Concerns on the Effectiveness of Proposed Interventions

Members of each focus group expressed concerns about the effectiveness of the proposed interventions. Members of most groups agreed with each other, but each group highlighted different concerns.

Members of the Clinical focus group shared several concerns regarding the proposed interventions. Members noted the need for proper staffing levels to ensure that enrollees get the level of service they need to ensure their community tenure. Focus group participants relayed concerns that a program such as this would not be properly funded and that a realistic implementation timeline might not be followed. Participants voiced concerns regarding the provision of culturally appropriate, and sensitive,

training for programmatic staff. Finally, focus group participants noted their concern that all appropriate stakeholders would not be involved in the process of promoting the community tenure of this population. Having a community champion in each community where services are provided could be one way to promote follow-through and ultimate success of this program.

Members of the County Case Management focus group expressed multiple concerns regarding the development, and effectiveness of these interventions. First, a justice entity needs to be open to the idea of including a social worker as part of their team, which, according to some focus group members, could not be a given. At times there is a level of mistrust between case management and supervision staff, especially between case management and supervision staff in the Native American community. Second, caseloads for programmatic staff should be commensurate to the level of work needed with previously incarcerated individuals. Third, staff should receive training regarding working with previously incarcerated individuals that includes information specific to the county each staff member would be working in. Fourth, developing this intervention requires a life-span approach. One focus group member noted that the challenges of incarceration, especially for minority populations such as Native Americans, start long before incarceration. Native Americans are institutionalized starting at a young age and, according to this focus group member, many Native American children believe they will end up incarcerated. Therefore, preventing individuals from being incarcerated in the first place should be as important as providing services to previously incarcerated individuals.

“I think this is a great idea. Implementing it is a different story, but it is a good idea.”

Focus Group Participant

Members of the Mental Health focus group noted their concern that this intervention would not be consistently messaged to previously incarcerated individuals. In addition, the focus group expressed concerns that once implemented, these interventions would not provide sufficient service capacity to more rural, and southern counties in the state.

Members of the SUD focus group relayed multiple concerns about this intervention. First, the culture of probation and case management could conflict with this intervention because the criminal justice system can be resistant to new ideas. Second, focus group members expressed concern regarding the possibility that currently available state and local services would overlap with those provided by these interventions and would take funding away from other available programs. Focus group members stated that some stakeholders could be less supportive of the proposed interventions because of these concerns. To gain stakeholder support, proponents should effectively message the proposed interventions to convince staff working in the field that the proposed interventions could both make their jobs easier and provide the level of services and support that previously incarcerated individuals need.

Members of the Supervision focus group noted several concerns mainly revolving around staff for the interventions. These include staff burnout, accountability between staff and enrollees, potential confusion between correctional and intervention staff, safety issues that may arise when intervention

staff transport enrollees to appointments, the manipulation of staff by enrollees, and enrollees not taking intervention staff seriously.

F. Funding for Current Similar Services and Supports

Focus group members identified several different current funding streams for services like the ones in the two proposed interventions. One focus group did not offer any detail.

Members of the Clinical focus group stated they receive funding for providing similar services from DHS, Drug and Alcohol Division grants, direct billing for peer support services, and DWI reinstatement fees.

Members of the County Case Management focus group noted they are aware of one current program that received funding through a justice entity.

Members of the Mental Health focus group offered they receive funding from MA and PMAP, other forms of insurance besides MA, federal funding, subsidies from property tax revenues, and grants.

Members of the SUD focus group highlighted they receive funding for current reentry services from consolidated chemical dependency treatment funding provided through Minnesota Chapter 245G.

Members of the Supervision focus group did not provide information on funding for current services and supports.

7. Other Suggestions from Focus Group Participants

Focus group members provided several additional suggestions as to how DHS and DoC could further improve the development of the proposed interventions or better use currently available resources.

Members of the Clinical focus group proposed several suggestions to promote the community tenure of previously incarcerated individuals. First, improve access to sober housing for those recovering from addiction, especially upon release from detox. One current underused resource is housing provided by faith-based organizations. Second, corrections agencies should screen previously incarcerated individuals for brain injuries, and this intervention should help people with TBI access mental health treatment. Overall, the Clinical group agreed that more funding should be made available for the provision of services to previously incarcerated individuals.

Members of the County Case Management focus group indicated it would be of vital importance to have leadership who are responsible and held accountable for the success of the intervention.

Members of the Mental Health Treatment focus group offered additional suggestions. First, the state should encourage innovation in this space through the provision of grants for different pilot programs. Second, there should be greater use of peer support services in this type of work. Third, the state should provide greater funding for ARMHS-like programs. Finally, the state, in conjunction with other relevant organizations, should develop a competitive reimbursement rate for reentry services.

Members of the SUD Treatment focus group noted the need for involving the community in the development of the intervention through a transparent process. It is imperative to involve all stakeholders in the implementation process in a coordinated way. A member of the focus group also pointed out that intervention staff should be aware that staff working within the hierarchical structure of a criminal justice organization could give the intervention staff's work lower priority than their own.

Members of the Supervision group did not provide any additional suggestions regarding the proposed interventions.

8. Conclusion

Members of the focus groups provided detailed feedback on current issues that lead to previously incarcerated enrollees having worse health outcomes than those not previously incarcerated, solutions to tackle these issues, and input on two proposed interventions.

Focus group members discussed several systemic gaps or issues that should be addressed, such as the Medical Assistance (MA) enrollment process, which seems long and complicated due to multiple barriers for those enrolling while incarcerated, previously incarcerated individuals' lack of health literacy, and a lack of resources dedicated to providing care coordination and community resources to previously incarcerated individuals. Focus group members offered solutions to address these issues, such as developing care plans while an individual is incarcerated for use in the community and dedicating greater funding to the provision of community resources, such as stable housing and employment training. Focus group members were convinced these steps would improve the health and well-being of previously incarcerated individuals and promote their community tenure.

Focus group members also provided feedback on a few proposed interventions. They stressed the need for intervention staff to have many years' experience working with previously incarcerated individuals. Staff should also have ample knowledge of the criminal justice system and county/state level policies related to the care of previously incarcerated individuals and their reintegration into the community. Focus group members indicated the need for a discharge/community care plan with a dedicated case manager and community case management team. Funding, training, and managerial support were presented as key supports needed by staff to be successful in their work with this population.

On the potential impact of the proposed interventions, focus group members generally agreed that implementing any of the interventions would positively impact the behavioral and physical health and well-being of previously incarcerated individuals. Most focus groups indicated that implementing interventions such as the ones proposed would decrease costs to either, or both, the criminal justice or health care systems. However, members expressed concerns regarding implementation issues that could reduce the effectiveness of these interventions including that they would not be properly funded, staff would not be provided with adequate training, and that the interventions would not be properly messaged to previously incarcerated individuals or corrections and supervision staff. Further, some

members expressed concerns that these interventions do not prevent criminal justice involvement, an especially important issue for minority populations.

Appendix: Interview Guide

Welcome and Background

Thank you for agreeing to participate in this focus group. The Minnesota Department of Human Services (DHS) contracted with our center, the Center for Health Law and Economics at the University of Massachusetts Medical School (UMass). Our tasks are to identify interventions which published studies have indicated may improve health outcomes among individuals who were previously incarcerated, and to obtain feedback on these potential interventions from individuals such as yourselves. Once we have completed this and other focus groups with service providers, we plan to solicit feedback from people who have a personal history of prison incarceration.

We are interested in each person's individual input, and we also would like to understand whether there is a consensus among the group or whether there are differences of opinion. Our report would describe the consensus, as well as any divergence. We would not identify the individuals who expressed specific opinions, though we would indicate which sector they represent. Please do not share comments from other participants outside of this setting.

1. Introductions

Please tell us your name, title, organization, and how you work with people enrolled in Medical Assistance, also called MA (Minnesota's public health insurance program) who were previously incarcerated in prison.

2. Gaps/Issues

DHS's analysis found that individuals who were previously incarcerated in a state prison have worse health outcomes than other MA enrollees. They also have higher MA expenditures, even when their demographic characteristics, medical and behavioral health diagnoses, and other social determinants of health are accounted for.

- a. Are there systemic issues that contribute to these disparities? What are they?
- b. What could the state do to address or mitigate these issues?

3. Suggestions for Improvement

What ideas do you have regarding interventions to improve the health and well-being of MA enrollees who were previously incarcerated? These can include interventions that are based in the health care system, the justice system, community organizations, or other places. What do you think would make these interventions effective? Why?

Research Findings

UMass staff reviewed published studies of interventions intended to improve the health and well-being of individuals who were previously incarcerated. One strategy we identified from the literature was community reentry support that aims to improve outcomes by connecting at risk individuals with needed services. Community reentry programs provide individualized assessments, treatment planning, and care coordination for individuals with physical and mental health conditions leaving incarceration. Because of the high incidence of substance use disorder and mental illness among inmates, together with the elevated risk of death upon release from overdose and suicide, many community reentry programs focus on the needs of individuals with mental health and substance use issues.

UMass staff identified several common themes among the interventions we reviewed, including the following:

- *Structure*: Each intervention included a formal collaboration between correctional facilities and community partners who provide services to offenders.
- *Services*: In each of these interventions, preparation for reentry begins well in advance of release. In some cases, preparation for reentry begins at intake. Each intervention attempts to continue care begun during incarceration after release. In many cases, the case manager or the provider develop a relationship with the offender during incarceration that continues in the community. Each intervention aims to arrange stable housing and employment after release to support successful reentry.
- *Staffing*: Each intervention emphasized the need for consistent staffing with small caseloads. The interventions provided ongoing training and support for their staffs.

4. Potential Interventions (40 minutes)

Please consider two potential approaches to community reentry. These proposals both incorporate key components of effective interventions, as documented in the research literature.

Proposal 1: Designated Social Worker for Re-entry Support

Option A: Add a social worker, employed by a justice entity, to teams of supervision agents

Option B: Designate and train one social worker in a county to be the point person for working with people getting out of prison

Proposal 2: Transitional Support for Continuity of Care:

Transitional Support (TS) staff, employed by a non-justice entity, would work with people who are in prison for a few months before their release to develop a support plan and continue working with them after release to implement the support plan.

If the state implemented this model:

- i. What skills and experience must the staff have?
 - ii. What services and supports must they provide (at minimum)? These could include health care and community services and supports.
 - iii. What supports would these staff need in order to be successful?
 - iv. Where should such staff be based?
- b. Would this intervention improve the physical health, behavioral health, and well-being of Medicaid enrollees who were previously incarcerated? How and why?
 - c. Would this intervention reduce or increase costs in the system you work in?
 - d. Do you have concerns about the effectiveness of this approach in Minnesota? What factors need to be considered or addressed? Systemic issues? Logistics? Training?
 - e. If you currently provide this service to this population, how is it funded?
 - f. If you currently provide this service to this population, how is it funded?
 - g. If you don't currently use this model, what resources (staff and/or money) would it take to provide them?

5. Other Suggestions (10 minutes)

Are there any other thoughts, suggestions or concerns that you would like to share with us?