# THE COURAGE TO CHANGE:

## A Guide for Communities to Create Integrated Services for People with Co-Occurring Disorders in the Justice System

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# "KNOWLEDGE PLUS COMMITMENT PLUS COURAGE EQUALS POSITIVE CHANGE."

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# PREFACE

T his publication is the result of a yearlong collaborative effort of the Open Society Institute's Center on Crime, Communities & Culture and the National GAINS Center for People with Co-Occurring Disorders in the Justice System. It is based on a four-part critical issues series that focused on helping communities to identify more appropriate, effective, and humane methods to create treatment services for people with co-occurring mental health and substance abuse disorders in the justice system.

The paramount goal of the series was to identify how successful programs had been designed, implemented and operated in communities across the United States and what could be learned from these successes to guide other communities who wished to gain the knowledge they needed to mix with the commitment and courage they had to forge new solutions for old problems.

A small, diverse core group of experts were convened for the series. The core group included judges, psychiatrists, attorney's, sociologists, policymakers, administrators, caseworkers, consumers and members of the Center for Crime, Communities & Culture, the GAINS Center and representatives from the Center for Substance Abuse Treatment, Center for Mental Health Services and the National Institute of Corrections.

In addition to the core group, special topic members were assembled for each meeting in order to further discuss each topic issue. Special topic members consisted of people who are experts in their fields and/or people who have been integral parts of programs and initiatives that are recognized as effective in addressing the needs of people with co-occurring disorders in the justice system. (A complete list of meeting participants is included in Appendix B).

# THE EMERGING LANDSCAPE

A bout 10,000,000 adults each year are booked into U.S. jails.[1] In 1997, about two-thirds of these people belonged to racial or ethnic minorities, most of them poor.[2] Approximately 700,000 of these 10 million people each year enter the justice system with serious mental disorders and 75 percent of these 700,000 people have co-occurring substance abuse disorders.[3] Likewise, a majority are persons of color, who are poor and have higher risks of physical and sexual abuse.

Each year, over two million youth under the age of 18 are arrested. A million of them will have formal contact with the juvenile justice system, and over 100,000 will eventually be removed from their homes and placed in juvenile detention and correctional facilities. Available research indicates that at least 20 percent of all youths who enter the juvenile justice system experience serious mental disorders, with a much higher percentage experiencing some level of mental health problems.[4] There is also a growing recognition that many of these youths, nearly 50 to 75 percent, have serious substance abuse problems. Further, the service needs of minority populations with co-occurring disorders, such as adolescent girls and youth of color, are frequently overlooked or misunderstood within the current juvenile justice system.

In the past, little attention has been paid to these youth. Much like adults with co-occurring disorders, youth with co-occurring disorders have wandered through service systems and communities unrecognized and misunderstood. Youth with co-occurring disorders often have problems at home, at school and in their neighborhoods. Neglect, physical and sexual abuse, violence, crime, lack of health care and poverty are just a few of the difficulties that many of these young people face. Unlike adults who enter the justice system through a criminal arrest, a youth can be brought into the system for status offenses, which are behaviors that would not be considered crimes if committed by someone 16 years of age or older, such as truancy and running away from home.

While the primary focus of this meeting series was on adults with co-occurring disorders in contact with the justice system, it was determined that given the importance of the issues facing youth with mental health and substance abuse disorders involved with the juvenile justice system, one meeting in the series needed to focus exclusively on children and youth. As a result, the last meeting in the series was entirely devoted to a discussion of the issues and concerns affecting children and youth with co-occurring disorders in contact with the ju-

venile justice system. A select group of national experts and children's advocates were convened to identify and discuss the issue of youth with co-occurring disorders and to highlight some of the major issues affecting this population. The critical issues emerging from the discussion include the following:

• Historically, the mental health and substance abuse service needs of youth involved with the juvenile justice system have largely been ignored. Up until recently, relatively few studies have been conducted on how services to youth are organized or delivered, and data on treatment impact and effectiveness has been lacking. As Randy K. Otto, of the Department of Law and Mental Health, Florida Mental Health Institute states, "A review of the literature addressing the issues of youths with mental disorders in the juvenile justice system suggests that little more attention has been paid to this population in the past 15 years than was paid in the 15 years before that."

• Fortunately, a new national focus is emerging that has increased attention to the mental health and substance abuse needs among youth in the juvenile justice system. The factors leading to this national focus include a growing body of research documenting the gaps in our knowledge base regarding the screening, assessment and treatment of youth; the increased understanding of the multiple needs of these youth and their involvement in multiple systems; the development of new federal, state, and local initiatives designed to improve service delivery to youth in the justice system, and heightened advocacy efforts to increase awareness of the issues facing these youth.

• Despite increasing attention to the needs of youth in the juvenile justice system, children and youth of color with mental health and substance abuse problems continue to be over-represented in the juvenile justice system. Further, children and youth of color continue to be under-repre- sented or underserved by the mental health and substance abuse treatment systems.

Studies have consistently shown that race continues to be a major indicator of whether a child receives services or is incarcerated. For the most part, the treatment and juvenile justice systems lack the ability to recognize, understand and respond to the treatment needs of youth of color largely because they lack culturally appropriate and competent tools, staff and programs.

• Little emphasis has been given to understanding and responding to the gender-specific needs of adolescent girls with co-occurring disorders involved with the juvenile justice system. Generally speaking, adolescent girls with mental health and substance abuse service needs in contact with the juvenile justice system do not fare well in systems designed for boys. Anecdotal evidence and current research suggests that there are distinct differences between male and female youth in terms of gender socialization, development and environmental stressors, and that the needs of girls are dramatically different than those of their male counterparts. Many girls involved with the juvenile justice system present complicated clinical profiles, with extensive histories of violence, abuse and trauma. Juvenile justice management policies and protocols designed for males often re-stimulate or remobilize the trauma response in these girls.

Given the complex and multi-faceted nature of the issues facing youth with co-occurring disorders involved with the juvenile justice system, it was determined that it would do injustice to their needs to try to address this in this report given its primary focus on adults. Thus, while many of the strategies for change identified in the following sections may be equally effective for responding to the needs of youth, we do not try to directly address this population in this report other than highlight the major issues identified during the meeting on the needs of youth. The GAINS

Center will continue its efforts to target the needs of this population, and maintain and strengthen its connection to the organizations and individuals we've worked with to improve service development and delivery for these youth.

The lives of both youth and adults with co-occurring mental health and substance abuse disorders are characterized by unproductive cycles of decompensation, disturbance and arrest that cannot be altered by usual interventions. In most places in the United States, mental health, substance abuse and criminal justice systems offer only patchworked, uncoordinated responses. Because so many of these people have serious mental illnesses and substance abuse disorders simultaneously, treatment interventions that deal with only one part of their disorders are doomed to fail.

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The underlying purpose of this publication is to dispel the myth that "nothing works" for people with co-occurring disorders in the justice system.

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When treatment fails, these people often end up in the system of last resort, the justice system. This system is arguably the least effective place for these people to be. The police, courts and corrections staff often lack even basic knowledge about substance abuse and mental health. Further, they do not have the resources to appropriately respond to these conditions that, if overlooked, are life-threatening.

With jails and prisons horribly overcrowded, with court dockets' ever-expanding seams, and with taxpayers very reluctant to spend another dollar for services, the justice system offers few reasonable alternatives. People with co-occurring mental health and substance abuse disorders are often relegated to correctional institutions that exacerbate their illnesses, put corrections staff and other detainees at physical risk, and do little to ensure public safety after their inevitable return to the community.

Despite this bleak picture, there are effective solutions. The underlying purpose of this publication is to dispel the myth that "nothing works" for people with co-occurring disorders in the justice system. In fact, there are many exciting innovations around the country where communities have devised more effective ways of working with this population.

These communities have found ways to develop new linkages between mental health, substance abuse and criminal justice systems that, often for the first time, provide appropriate interventions to break the cycles of decompensation and incarceration in these people's lives that repeatedly harm them and the communities in which they live.

When these successful communities were examined,[5,6] it was found that many of their innovations reflected an investment in the concept of systems integration. The essence of this concept is that people in all three systems recognize the need for a holistic approach to treating each person and that they are willing to share information, money, and clients across the three systems. These promising innovations were not without major barriers, however.

Before systems integration can occur, personnel in the mental health, substance abuse, and criminal justice systems must be convinced of three things: (1) they must be convinced that people with co-occurring disorders present a significant and on-going management dilemma within their systems; (2) they need to recognize that they can be more effective in treating this population if they combine their efforts with personnel in other systems and devise complementary services; (3) they should undertake integration efforts not only with the goal of making their own systems more effective, but also in the best interests of people with co-occurring disorders, and the communities in which they will be living.

## "No Wrong Door" Policy for Successful Systems Integration:
## King County (Seattle), Washington

In 1997, the King County Council created the Bureau of Unified Services (BUS) in response to an ordinance calling for a new behavioral health program that combined portions of the existing mental health and alcohol and substance abuse programs.

The purpose of the BUS is to promote integration of systems engaged in developing and providing services to persons who are experiencing mental illness and/or chemical dependence/addiction, especially those who are also homeless or at imminent risk of homelessness, and/or individuals with a history of repeated or chronic use of public services providing acute care and/or more restrictive environments. The goal of the BUS is to create "no wrong door" to the existing service systems by making every doorway into treatment the "right" door, regardless of presenting issues. It supports the sharing of information, planning, clients and resources across the Department of Community and Human Services, Mental Health Division, the Seattle/King County Department of Public Health, Division of Alcoholism and Substance Abuse Services and, indirectly, with the Department of Adult Detention. A newly appointed BUS Coordinator reports to and is supervised jointly by both Divisions/Departments.

Major BUS goals for 1998 included the following:

- Seek to resolve information sharing/confidentiality issues across mental health/substance abuse service systems

- Reconfigure Jail Alternative Services (JAS) in conjunction with the Pilot Crisis Triage Center in order to explore creating viable pre-booking diversion function

- Explore opportunities for conjoining of mental health and chemical dependency involuntary treatment system into a single service serving both populations

- Explore consolidation of existing outreach and engagement services into a network of street and facility-based services

- Coordinate contracting processes within the Departments of Community and Human Services and Public Health to maximize impact and minimize duplication of services

One of the BUS's major projects for 1999 is to mobilize the Pilot Crisis Triage Center in collaboration with Harborview Medical Center. As of July 1998, Harborview is providing a site for triage and stabilization that integrates mental health and drug and alcohol services. In addition to collecting information about the individuals experiencing mental health and/or substance abuse disorders served in the Triage Unit and the services needed in the community to support the ongoing needs of these individuals, the pilot project also provides a realistic view of the feasibility of inpatient psychiatric hospital diversion for some patients who are currently hospitalized as well as a site for testing a more effective method for pre-booking diversion by local law enforcement authorities.
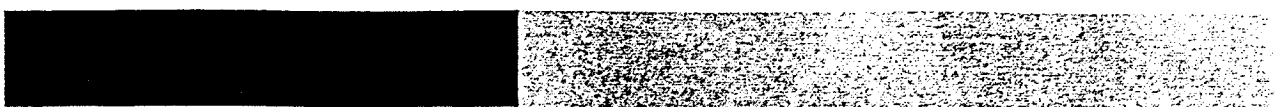
A BUS Advisory Council meets on a monthly basis to provide input and feedback concerning the systems integration activities of the Bureau of Unified Services. The Council is comprised of representatives of key stakeholder groups across a broad range of systems.

The goal of this document is to offer some ideas about developing, implementing, financing and sustaining programs that integrate the mental health, substance abuse treatment and justice systems for adult and youth populations with co-occurring disorders. It reports successes, but it does not provide a precise road map. It does not show exactly how to get from where you are now to Points B or C. Instead, it is more of a satellite view; it offers principles and perspectives with which to interpret local conditions and identify promising directions.

The principles summarized herein are intended to be used as a resource not only to begin social change, but also to sustain it. The programs that produced these key principles (see Appendix A) are living examples of how these core ideas can work. These initiatives are invaluable resources to help committed people with courage address the issues surrounding people with co-occurring disorders in the criminal justice system and to assist them in leveraging social change.

The principles and strategies for action in the following chapters are applicable, in most cases, to programs and services for both youth and adults who have co-occurring disorders and are involved in the justice system. Adults and youth can be helped if communities, treatment providers, service administrators and government officials show the political will to follow the examples of other communities in the United States and create integrated, comprehensive service models. These select communities can provide guidance about how services are planned and implemented. This information is reflected in the following chapters.

# BUILDING SUCCESSFUL
# COLLABORATIONS

M ental health clinicians, substance abuse counselors, police officers, jail staff and the judiciary all know the type of offenders with co-occurring mental health and substance abuse disorders we are addressing in this paper. Some even know them by name, because they see them so frequently. However, in the traditional arrangement of services, providers are confined to addressing only a fragment of a person's total needs. This is where system integration enters as a powerful mechanism for communities to improve service delivery and to treat people, not just problems.

System integration has many potentially positive impacts. It allows mental health and substance abuse treatment providers to apply a body of research that documents the need to treat co-occurring disorders cooperatively and simultaneously.[7] Where such treatment has been implemented, treatment providers have more effectively stabilized their patients, improved the patient's lifestyle and increased public safety because people with co-occurring disorders who are in stable condition are less likely to disturb other citizens and to commit crimes.

The criminal justice system also experiences positive effects from these efforts. If people with co-occurring disorders can be diverted to more effective treatment programs in the community, then correctional facilities can be managed more effectively. If the same individuals are stabilized in the community, they are less likely to commit crimes and return to jail.[8] Law enforcement officers can be trained to deal with people with co-occurring disorders and, if police have access to proper services, can link them to treatment instead of arresting them. Judges who know an offender's mental health and substance abuse status at the time of a court appearance are also able to offer more informed dispositions.

System integration can create a winning situation for everyone. However, for integration to work, the old ways of doing things will need to be challenged and new ways created.

System integration goes beyond service integration. In the latter, treatment services are combined at an individual level, often by a case manager who brokers a package of services for a client. System integration involves new arrangements between the service organizations themselves including their treatment services, administration, management information systems, assessments, and staff training. It does not require the creation of a single system, but it does demand an interconnected network of organizations that can complement each other through the transfer of appropriate information, resources, and clients among the component units.

## Why integrated services are in everyone's best interest

When people with mental illnesses and substance abuse disorders get treatment, case managers, and housing, the positive effects can be felt by many, including:

### The Public
- Reduction in homelessness
- Decrease in family, acquaintance and stranger violence
- Decrease in the use of high cost, intensive treatment services
- Reduction in public disturbance

### Clients
- Creation of user-friendly services
- Reduction of inappropriate detention
- Increase in treatment involvement
- Break in cycles of decompensation arrest - incarceration

### Corrections Managers
- Fewer disruptive detainees
- Fewer detainees
- Reduction in liability

### Mental Health / Substance Abuse Professionals
- More client willingness to accept treatment
- Ability to handle more types of clients
- Reduction in client disturbances

Despite the potential payoffs of system integration, most communities do not view themselves as having the time, money, knowledge, or sometimes even the interest, to change how people are processed through the criminal justice system. Therefore, the challenge lies in getting the financial and political clout to create policies and programs that change the system and are optimum for this population, for the service systems that need to interact, and for the general public.

Some mental health and substance abuse service providers in the justice system have a good idea of what interventions people with co-occurring disorders need and they also know how to organize their services to properly deliver these interventions. Granted, nothing works for everyone all of the time, but programs and policies are in place in many U.S. communities that are beginning to foster systems integration.

Organizations and agencies change over time. How to apply the lessons from other successful programs varies according to the stage of program development. A collaboration that is in the start-up phase, where the need is for coalition building and strategic planning, may require different applications than a community that is further along in developing joint programs between systems.

The following principles that our experts group identified based on current research and best practices are presented in two phases — starting-up and implementing integrated services.

# STARTING UP INTEGRATED SERVICES

- ■ Organize a coordinating body/task force/coalition
- ■ Start small, but carry a big vison
- ■ Commit to cultural sensitivity
- ■ Emphasize strategic planning
- ■ Identify motivators
- ■ Recruit political support
- ■ Clarify funding strategies
- ■ Recognize that there is no one best way

## Organize a coordinating body/task force/coalition

**Identify the key agencies** in the community and the people in those agencies who need to be involved. These usually will include: sheriff and/or police officials, jail administrators, jail mental health and health service providers, district attorneys and prosecutors, public defenders, local judges and magistrates, probation officers, community mental health and substance abuse treatment programs, and housing and social service providers.

**Consumers and consumer advocacy groups** should also have an early and continuing role in the coalition because they are invaluable in defining problems and identifying answers. Also, consider building collaborations with community groups that are not traditional treatment providers, but often deal with people with co-occurring disorders on the streets, such as ministers, school principals, and guidance counselors. They can make initiatives more comprehensive and flexible.

The next step is to designate a person who will take charge of the planning process for the group. A **strong leader** with good communication skills and an understanding of the systems and the informal networks involved is needed to put the necessary pieces in place.

## Start small, but carry a big vision

Once the coordinating body is assembled, the group must decide on **a common goal.** This will take time because each person at the table will bring a different set of objectives and goals. The group needs to work togther to devise a vision that represents a commingling of the individual goals. Goals need to remain broad enough to encourage a general buy-in, but narrow enough to keep the target in mind.

The goals then become the vision, which must be refined into a simple concept that captures the complex issues at hand. A short and catchy phrase, like King County, Washington's "no wrong door" policy, appeals to people because they can understand and remember it.

## Commit to cultural sensitivity

According to the U.S. Department of Justice, Bureau of Justice Statistics[9], 68 percent of jail inmates in 1997 belonged to racial or ethnic minorities. This is a figure that cannot be ignored when designing services. Plans to improve **cultural sensitivity within systems and initiatives** should be incorporated at the vision stage.

Successful programming relies on considering the connections between organizations and individuals, including racial and ethnic connections. Ideally systems need to look at each person individually and prescribe individual treatment, which require cultural sensitivity. Systems must collaborate to assemble adequate resources to offer this kind of individualized and culturally sensitive treatment to everyone who needs it.

## Emphasize strategic planning

Strategic planning should aim at producing **immediate, but sustainable, results.** Strategic planning should begin with regular meetings that involve the key players who work together to:

*Include short-term objectives for the group.* Short-term goals need to be manageable, such as holding regular meetings or collecting information that is useful to the group. Every time the coalition has a meeting, it should set goals for the next meeting, such as, assigning members to make telephone calls to recruit support, or asking members to collect data from their respective systems to help the collaboration to further define the needs of the target population. These small steps can help a collaboration learn to work as a team to build upon small successes, and to monitor progress toward long-term goals.

*Plan for the long haul.* Short-term pilot programs often help identify best practices, but tend to provide high-quality care to only a small population. Effective planning will require that collaborations have long-term plans going beyond the pilot stage and that provide both high-quality treatment and attention to a larger volume of consumers. Also, bear in mind that progress for this population must be measured in years.

## Identify motivators

The basic goal of improving services often does not provide enough incentive to get a coalition moving. The immediate push may rise out of a lawsuit, in which a jail facility is being sued for having insufficient services. It may come from new funding opportunities which can be used only by projects that blend their services. A damaging story in the media can also call attention to a problem and demand action. These motivators attract public attention, and often the attention of county commissioners, community leaders, legislators and advocates. Whatever the motivators are, identify them early and then strategize how they can be used to promote the coalition's goals.

## Recruit political support

The coordinating body of an interagency collaboration can provide tremendous drive and vision, but support from critical community leaders is often the key to crystalizing that drive and vision

into concrete programs. Ideally, a coalition to promote system integration will already have at least one member of the judiciary among its ranks. If not, the group should focus on forging a positive alliance with the judges who are the most involved with offenders with co-occurring disorders. Judges are important allies because they control offender processing and placements in both the juvenile and adult justice systems. Judges are particularly useful advocates because they often are receptive to alternatives to incarceration, have more job stability, and can continue to offer their support for many years.

Legislators are also key decision makers who can be effective in promoting and enforcing collaboration. For example, the Texas Council on Offenders has worked with the Senate Finance Chair and House Appropriation Chair and their respective staffs to represent their interests in the state legislature. As a result, Texas now has legislation to blend funding, enforce unified screening standards, and require cross-training for anyone, including law enforcement personnel, who works with offenders with co-occurring disorders.

## Clarify funding strategies

Secure funding is one of the most daunting challenges that programs face. The following ideas are elementary, but important. The "Financing Your Program" section below expands on this issue.

*Have a financing plan.* Refer back to the group's strategic plan on a regular basis to evaluate funding needs. Keep reviewing and updating this plan to ensure that there is an effective strategy to use funds once they are secured.

*Identify multiple funding streams.* Garner support from government agencies at the local, state and federal levels. In particular, federal and state agencies often require multiple streams of funding for multi-system collaborations — it usually takes many independent funding streams to pay for integrated services. Often federal dem-

onstration funding like the SAMHSA Jail Diversion Initiative can be used to fund programmatic efforts.

*Recognize the pitfalls and potential of managed care.* Generally managed care has limited effects on this population because the people who tend to predominate the criminal justice system rarely have private insurance and a minority are Medicaid recipients. However, managed care eventually could play a significant role in discharge planning and linkage to community services if a favorable financial environment is developed. The section on "Financing Your Program" further discusses this issue.

*Be creative with small amounts of money and with funds that are already available.* Movement in systems can take place without a lot of new resources. For example, in Tennessee, the Memphis Police Department collaborated with the West Tennessee Alliance for the Mentally Ill (AMI) to create a police-based diversion program. The AMI appealed to the local mental health agencies to create a curriculum and pro-

vide training to the police academy on how to deal with people with substance abuse and mental health problems. The cost to the corrections system was $10 per month in added duty pay for each of the 100 officers who went through the training and formed the city's Crisis Intervention Team.

## Recognize that there is no one best way

A cookie cutter approach will not work. This is apparent in the lessons learned from Ohio's recent experience in developing youth justice, mental health and substance abuse programs to effectively link institutional and community services, which are summarized in its architect's, Dr. Lee Underwood, keys to success below. Each community has to develop its own way of applying these principles. Each coalition must take account of its own unique driving forces when planning a jail diversion program. In every case, an interagency coalition needs to identify the best way to handle new services, who those services need to reach, and how well the services mesh with the community's existing resources.

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### Keys for Successful Youth Programs

- Local Interagency Agreements
- Demystification of "Confidentiality"
- Continuum Minded
- Collaboration with Mental Health, Juvenile & Adult Justice System, Substance Abuse, Court, & Human Services
- Create and Formalize Theoretical & Guiding Principles
- Charismatic Leadership
- Cross Training
- Information is Powerful
- Strategic Policy Designs
- Challenge the Status Quo

*Provided by Lee Underwood, Psy.D., Executive Clinical Director of the Pines Residential Treatment Center in Portsmouth, Virginia.

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- Begin moving from informal to formal arrangements

- Devise a marketing strategy

- Build systems to coordinate and share information

- Ensure accessibility to services

- Determine the common, shared approach at the service level for cross-training

- Create boundary-spanning positions

- Build in outcome evaluations for all "customers"

- Respect each system's stage of development

## Begin moving from informal to formal arrangements

As jurisdictions advance in the development of options, they usually progress from informal to formal arrangements through four phases.[10]

**Phase I. — Cooperation**, in which key personnel from substance abuse, mental health, corrections, and the courts begin to share information evidence willingness to help each other on an ad hoc basis.

**Phase II. — Coordination**, in which system representatives begin to consciously merge their efforts through joint staff meetings and joint program planning and in which they learn about each other's operating programs.

**Phase III. — Collaboration**, in which key players from each system have regular meetings, cross-train their staffs, formalize joint planning, secure joint funding, and eventually form interagency agreements through memorandums of understanding (MOU).

**Phase IV. — Integration**, in which systems form a designated planning council and a joint budget, share funding of key positions, unify intake and assessment requirements, and view clients as a shared responsibility.

From a service delivery and system development standpoint, a jurisdiction is more likely to do a better job for offenders with co-occurring disorders as the agreements move further along into these phases. Also, it is possible for agencies to be at different levels of agreement at the same time, some agencies may not share information with the other agencies, while other agencies in the collaboration may have shared contracts.

## Devise a marketing strategy

*Shifting the paradigm.* Mental health and substance abuse disorders are public health issues and should be treated as such, no matter where the person resides. An offender with a dental problem receives the health care he needs; an offender with an infection receives the health care appropriate to his ailment. It should be no different for an offender suffering from depression and an addiction to heroin — that offender should receive whatever medical and behavioral health care he or she needs. Only when systems acknowledge that mental health and substance abuse are public health issues and treat the whole offender within the context of providing overall proper health care will we deal effectively with the population in the criminal justice system.

*Numbers.* The right data can be vital to defending and promoting a coalition's efforts. The information collected should address five main issues:

- *Whom* does the interagency coalition currently serve — is this the population that was targeted?
- *What* services does the coalition provide?
- *How* many people are receiving or have access to services and what are the characteristics of this group?
- *Is* the coalition achieving its intended outcomes?
- *Are* there case studies that can be used to make these issues more understandable for advocates and the public, and more marketable to potential funders?

*Benefits to Stakeholders.* Frame the social and economic issues in ways that people can understand. Affirm the savings that go beyond the criminal justice costs, such as in public health and welfare budgets, in the workforce, and in private businesses. Also, emphasize the social benefits of reducing family break-ups and child abuse, especially when many of the families being served have literally been in the component systems for generations.

*Identify Media Strategies.* Efforts to devise a media plan to get support from the wider community can have profound effects on the political world. People in the press, along with policy makers, private foundations and board members, look for a central organizing principle around which these services can be provided. Use the coalition's vision to demonstrate to the media why its efforts are important.

## Build systems to coordinate and share information

*Uniform screening and assessments.* A good clinical assessment can enable a person to move more quickly from place to place in a multisystem diversion project. If screenings and assessments aren't uniform, a person can be constantly reassessed and rediagnosed, which delays entry into treatment and prolongs the time spent in treatment.

*Managed Information System* — A coordinated MIS can readily identify the target population of high-utilizers as they enter the justice system. In order to do so, agencies need to maximize their ability to share timely information, coordinate services, and become more efficient. The key players of the coordinating body should develop a basic management information system to keep track of where people are in the diversion process — this can be anything from informal 3 x 5 cards to standardized data entry screens on networked personal computers.

Next plan for the collection of basic data for the management information system and outcome data. Outcome data can later help justify the program and help obtain future funding. Also, these data can identify how to target funding where it will have the greatest effect and even identify areas of a program that are not working as planned or are unnecessary.

## Ensure access to services

Many jail detainees and inmates who have co-occurring disorders have problems accessing substance abuse and mental health services prior to entry into the justice system. One way to try to bridge this gap is to find out where the target population is coming from in the community and then promote the community's mental health and substance abuse services in those areas.

Once a person with co-occurring disorders enters the justice system, he or she should have access to the variety of services that he or she needs. Consolidated referral and screening processes and collaborating teams can provide comprehensive assessment and treatment services, thus reducing duplication in service provision and speeding a person's entry into appropriate treatment. Non-discriminatory laws in treatment contracts can help too. For example, in Texas, all agencies that provide human services have a clause written into their contracts that specifically states that they cannot discriminate against consumers with co-occurring disorders.

Access to services is important not only for consumers, but also for the people who refer the consumers into services. Access to consumers' records is often blocked by confidentiality laws and without a combined set of mental health and substance abuse records, referrals have to be made according to whichever record the referrer is allowed to see. To begin addressing confidentiality concerns, program directors must clarify what requirements exist and whether a release of information must be obtained to share relevant client information between treating programs. Memoranda of understanding may be created to facilitate information sharing for program evaluation purposes.

## Determine the common, shared approach at the service level for cross-training

System change cannot exist solely as assurances at the top levels of participating agencies; it must penetrate to the line worker level if it is to make a real difference. A vision should require that all disciplines be cross-trained — from police officers, emergency/crisis workers, and corrections employees, to case managers, psychologists, and substance abuse and mental health treatment counselors. Cross-training brings together service providers of varied orientations and allows them to share their different perspectives regarding treatment and supervision as well as maximize their expertise to provide the best treatment possible.

Managed behavioral health care poses another challenge. The level of clinical skills necessary to work with people with co-occurring disorders is high. This comes at a time when managed behavioral health care is forcing systems to cut costs at all levels, from clinical through administrative. Managed care is using what the market will bear as its criteria for the quality of the staff at all levels of these systems and this is impacting the quality of care. Keep aiming for a consistent change and demand a high standard of staff skill. Hire and retain only those people who have multidisciplinary training.

## Create boundary spanning positions

Many times the goals of the mental health, substance abuse, and criminal justice systems don't easily mesh. Boundary spanners,[11] who are knowledgeable about more than one system, can manage the interactions among the systems. If an interagency position is created, and jointly supported, the paramount concern is finding the right candidate for the position — someone who is familiar with the interacting systems and their key members. A critical factor to the success of a boundary spanner is the credibility and trust afforded to her from all systems.

## Build in outcome evaluations for all "customers"

In terms of jail diversion, for example, a program should try to accommodate the number of people diverted at both the pre-book and post-book levels. Also, a program should monitor the number of formal linkages that a detainee or inmate makes with services and how long the person continues to use these services. To discover if a coalition's efforts are working for consumers the relevant questions include:

- *Does* the client report she was connected with a treatment provider?

- *Did* the client receive services and complete a treatment program?

- *Are* the same clients recycling through the justice system or emergency rooms?

- *Is* there a reduction of symptomatology over time as measured by a variety of indexes?

- *How* does the individual consumer rate his or her quality of life?

| **Potential Evaluation Markers** |
| --- |
| • Number of units of services delivered |
| • Number of clients served |
| • Characteristics of the target population |
| • Rates of arrest |
| • Seriousness of arrest |
| • Number of days of re-hospitalization |
| • Clients quality of life |
| • Ethnographic case studies |

In addition to evaluating consumer outcome, encourage consumers, coalition members, and the involved agencies to evalute the coalition's programs and methods. Continuous feedback is crucial to keeping the vision in focus and the efforts moving along the right path.

### Respect each system's stage of development

Progress takes time. Each of the involved systems has succinct obstacles that it must overcome to collaborate successfully. A community that has a strong correctional structure and has several substance abuse treatment programs, but lacks receptive mental health services will have different challenges from a community that has open resources for all three systems. Two systems may quickly develop a beneficial working collaboration, while the third may have trouble blending in. Nurture and encourage the collaborations that are working, but be patient and persistent in helping those that are taking a little bit longer.

## PUTTING THE PIECES TOGETHER

The above principles are derived from the experiences of successful programs and coalitions around the country. Use them. Adapt them. Refine them as you develop local coalitions and strategies to respond to the needs of persons with co-occurring mental health and substance abuse disorders in the justice system.

These principles represent the initial challenges of integrating services for this special population. The next step is to find ways to maintain and sustain your efforts through creative financing and establishing the political and fiscal groundwork that are necessary to turn a pilot program into the new norm in service provision for people with co-occurring disorders in the justice system.

# FINANCING
# PROGRAMS

C learly, funding is the obstacle that confounds program advocates the most. Financing is challenging in the start-up phase and remains a challenge throughout the life of a project. When dealing with integrated service programs, the GAINS Center found that the programs that secure money from several different sources and blend funds according to the specific needs of their localities are the ones that have the best chance of carrying pilot programs into the mainstream and ultimately achieving their goals.

This section focuses on how successful programs have overcome financial barriers and how they look to the future to identify funding sources that will help them to sustain successful programs.

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### Key Financial Strategies

■ Custom-blend funding sources

■ Pick a funding leader

■ Reorganize existing funds

■ Develop an action plan

■ Consider managed care roles

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### Custom-blend funding sources

A program that focuses on integrating several different types of services for holistic treatment should identify a mix of funds to develop an integrated funding stream as well. At first glance this might seem to make funding more difficult because currently most funding streams for treatment services are categoric, focusing on one type of treatment. However, the mix of essential services can also expand the funding possibilities, if a coalition is creative in bringing different sources of funds together to fit the needs of its target population and the resources in its locality.

# Blended Funding at Work

## Maryland Department of Health and Mental Hygiene Administration
## Division of Special Populations

Piecing together funds to deal with special populations is challenging, but some jurisdictions, such as the state of Maryland, are proving that it is not only possible, but it can be extremely effective as well.

The Maryland Department of Health and Mental Hygiene Division of Special Populations fosters the development of innovative programs for consumers of mental health services with special needs. This includes individuals with psychiatric disabilities who are homeless, are in jail and could be appropriately served in the community, have co-occurring substance abuse disorder, and/or are deaf. Innovative programs include prevention of recidivism to homelessness, detention centers and psychiatric hospitals, delivery of coordinated services to adults with special needs, research on the effectiveness of special projects, and application for funding of gaps in the provision of services for this population.

Maryland's Mental Hygiene Administration (MHA) has been particularly innovative in the funding area and has created an intricate patchwork of funding to address the needs of this special population. In addition to identifying mental health- and substance abuse-specific funding sources, MHA also secured funds to address trauma and housing issues. Following are examples of MHA's programs and the grants it utilizes in order to offer more complete services to this population.

- **Maryland Community Criminal Justice Treatment Program**

MHA has implemented the Maryland Community Criminal Justice Treatment Program (MCCJTP) in 18 local jurisdictions to meet the comprehensive needs of this vulnerable population and to reduce recidivism to state psychiatric hospitals, detention centers, and homelessness. Each participating jurisdiction is required to develop an advisory board that includes representatives from the various agencies that serve the client in the community, such as mental health, alcohol and drug abuse, public defenders, the judiciary, parole and probation, law enforcement, AIDS, social services, public defenders, and consumers. To receive the money from MHA to begin a program, each advisory board is required to develop a memorandum of agreement that defines the specific services each agency will provide. The MCCJTP case manager serves the consumer holistically involving a multitude of agencies and services beginning in the detention center and continuing into the community. Meaningful daytime activities, such as volunteer work and employment, are an integral part of each consumer's service plan. MCCJTP focuses on individuals who are 18 or older and have serious mental illnesses and/or are dually diagnosed, and are incarcerated in local detention centers or on intensive parole and probation caseloads. These services may also be provided to individuals with HIV/AIDS and/or individuals who are homeless.

MHA funds $1,000,000 annually to provide for case management and psychiatric services beginning in the detention center. Local county governments and detention centers have also provided funds as well as local agencies providing in-kind services. In 1998, 1,372 individuals were served through this program.

- **Byrne Memorial Grant Fund**

In 1996, MCCJTP received $340,922 from the federal government's Byrne Memorial Grant Fund Program to provide substance abuse services in conjunction with mental health services in seven local detention centers. In contrast to most states that put all Byrne Funds into state prison substance abuse treatment, Maryland has used these funds creatively, but within the program guidelines, to transitions detainees from local jails to the community. This grant was renewed for 1998 for $380,615. In 1998, case managers funded by the Byrne grant referred 548 new cases for assessment and treated 582 inmates.

- **HUD Shelter Plus Care**

In July 1995, the United States Department of Housing and Urban Development granted MHA a $5.5 million Shelter Plus Care grant to provide housing for five years for homeless, seriously mentally ill consumers coming out of jail. This rental assistance is also available to individuals who are homeless and leaving public psychiatric hospitals as well as individuals on parole and probation who are homeless and in danger of re-incarceration. A total of 366 adults and 224 children have been housed in 19 counties through this program. One indication of the effectiveness of this program is demonstrated in the recidivism rate of 6 percent to jail and 1 percent to the hospital.

- **PATH Funds**

In 1998, the Division of Special Populations received a $335,000 in Projects for Assistance in Transition from Homelessness (PATH). The funds are used to provide outreach, screening and diagnostic services, rehabilitation services, mental health, alcohol and drug treatment services, case management, and job training and educational services. In 1998, 1,280 individuals were served through this program.

- **Phoenix Project**

The Division of Special Population has received $1,575,442 over three years from the Substance Abuse Mental Health Services Administration (SAMHSA) for a pre- and post-booking diversion, treatment and support program in Wicomico County for women with serious mental illness and co-occurring substance abuse disorder. As one of nine study sites in the United States, the Phoenix Project will provide a wide array of services for the women and their children. The University of Maryland Center for Mental Health Research Services will evaluate the project.

- **TAMAR Project**

MCCJTP recently received $569,000 a year for two years from SAMHSA to provide trauma treatment for women in detention centers and in communities. The TAMAR Project (Trauma, Addictions, Mental Health and Recovery) will provide holistic services through an integrated system for women with histories of violence, as well as therapeutic services for their children.

**Future plans**

Future plans envision inclusion of the remaining Maryland jurisdictions in MCCJTP, as well as expansion of substance abuse services in existing programs. The Division of Special Populations plans to expand to provide services to families served by our programs and to educate across systems the importance of recognizing trauma in individuals and the necessity of treatment.

* **Prepared from materials provided by Joan Gillece, Ph.D., Assistant Director, Mental Hygiene Administration Division of Special Populations.**

In order to most appropriately identify and blend funds, a coalition should know who is in its target population. Program experience clearly indicates the target group has multiple vulnerabilities that requires considering the person in holistic terms. With this in mind, programs for people with co-occurring disorders can recruit expanded funding sources beyond the substance abuse and mental health services to housing programs, job training and programs already in place for the homeless population. They must look to community resources currently helping people in all of these systems to identify funding sources and potential supporters of their own program or initiative.

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It is key to have someone who can identify and coordinate all of the potential and established funding streams.

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### Pick a funding leader

The first step for managing the funding process is to put someone in charge. It is key to have someone who can identify and coordinate all of the potential and established funding streams. This person can be hired at the municipal, county, or state level and put in charge of finding the money to which the target group is entitled. He or she must understand funding streams in mental health, substance abuse and criminal justice and how to creatively tap into them.

### Reorganize existing funds

While seeking new money, it is important to look at how existing funds can be reorganized to better serve the population. The coalition must work to strengthen its focus on the needs of the target population and on developing the political support that is integral to a successful program.

Piecing together full-time positions by multiple agencies, each funding some portion of that position, has proven successful in a number of localities across the country.

### Develop an action plan

Once funds are secured, it is vital to have in place a concrete plan of action and a method to account for how funds are being used. Be careful to keep funding issues closely linked to the objectives of the program -- if the program changes too much you could lose funders. Also, the best way to keep funders interested in your efforts is to show them how effectively their money is being used.

One program organizer suggested that all money should go directly into the programs because this helps to create and preserve strong partnerships. For example, the Maryland Department of Health acts as the grantee to 18 of its 23 counties and it monitors all of the involved counties to ensure they secure enough money on their own to retain federal match money. Another suggestion is to use funds as seed money to invest in other agencies that are working toward the same goal or to integrate with other agencies to get grants.

### Consider managed care roles

The impact of managed behavioral health care on financing services for people involved with the criminal justice system is becoming increasingly complex. When we think about paying for medical care, people fall into one of three categories:
- Privately insured (commercial health care plan)
- Publicly insured (Medicaid and Medicare)
- Uninsured

To date, managed care has had its greatest impact on people who have private health insurance but, most individuals with co-occurring disorders in contact with the justice system, are either publicly insured (primarily through Medicaid) or un-

insured. Medicaid is an insurance program for medically indigent or needy persons (those whose income falls below a standard where private health insurance is deemed unaffordable) and other categorically eligible persons, such as women and children and disabled persons, on Supplemental Security Income (SSI).

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Specifically include people leaving the justice system as priority populations in managed behavioral health care contracts.

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Uninsured adults, who are the predominant type in the criminal justice system and are presently estimated at over 40 million individuals in the United States, are those who do not meet these income or categorical requirements. When people are incarcerated in jails or prisons, they lose their Medicaid eligibility because the costs of these public institutions are identified in federal law as the historic responsibility of state and local government.

Because persons in correctional facilities are not covered by Medicaid, and almost none have private insurance, all institutionally-based services come from special state and local government appropriations within correctional or mental health agency budgets. Within correctional facilities, behavioral health services may be provided directly by correctional employees, by another community agency, or contracted out to a private health care provider. In the latter instance, the services have been "privatized," but they may or may not have been brought under a managed care arrangement.

In light of these issues, there are few funds and little interest in building integrated service systems for this population. However, programs can begin to prepare for managed care's involvement through the following suggestions:

- Identify managed care plan members at the pre-book stage and work with judges and district attorneys to get substance abuse or mental health placement covered by a managed care organization (MCO).

- Be aware that Medicaid-eligible persons being discharged after long jail stays will need to be reconnected to their health plans in order to restore benefits. "In reach" to jails and prisons by entitlement specialists can be particularly effective.

- Work with community mental health and substance abuse agencies on discharge planning and aftercare services. The cost of their services may be covered under the managed health care plan, but realize that there is a disincentive for managed care organizations (MCO) to cooperate. While incarcerated, the person is not using community-based services covered by the managed behavioral health plan and, therefore, the MCO is avoiding costs it otherwise would incur if the person was in the community under these circumstances.

- Work with the purchaser of care — the county or state agencies that operate the Medicaid program — to ensure that mentally ill offenders cannot be ignored while in jail or at the point of release into the community. Specifically include people leaving the justice system as priority populations in managed behavioral health care contracts.

## Conclusion

Financing is an issue that dominates every stage in the life of any program. There are novel, effective strategies to use. It takes vision; a vision already shaping creative initiatives across the United States.

# Funding Information on the World Wide Web

The Internet can be a valuable tool to identify and learn more about funding opportunities. Several government agencies have special sections that announce their available funds and list descriptions and eligibility requirements right over the World Wide Web. Many grant programs have Web pages, as well as state agencies and foundations. The following Web site addresses are good places to start.

**Substance Abuse and Mental Health Service Administration** — www.samhsa.gov.

**U.S. Department of Justice** — www.usdoj.gov.
     **Local Law Enforcement Block Grants** — www.iir.com/grants/

**National Institute of Health** — www.nih.gov/grants.html

**The National Institute of Mental Health's**
     **Knowledge Exchange Network (KEN)** — www.mental health.org.

**Robert Wood Johnson Foundation** — www.rwjf.org/text.html

**The Soros Foundation** — www.soros.org/crime/index.html

**The Pew Charitable Trusts** — www.pewtrusts.com/

The Internet also has several databases, some of which are commercial, that have information about federal, foundation, corporate and private sponsorships. A few to check out are: the Catalog of Federal Domestic Assistance, Federal Information Exchange (FEDIX), the Sponsored Programs Information Network (SPIN), GrantsNet, and GrantsWeb.

# Sustaining Successful Programs

Meetings are being held, funds are secured and programs are underway. The initial struggles are over. How do you consolidate the gains and ensure the program continues beyond the first round of funding?

No systematic research has been conducted to identify why and how some programs for co-occurring disorders in the justice system have successfully survived, while others have faded away after the pilot stage. Despite the lack of formal research, there is guidance from some of these successful programs about the causes of their longevity. Their experiences suggest some general principles. We have collected them here for others to use and refine.

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### Key Survival Strategies

- Plan for the future from Day One

- Data, data, data

- Some cost data are helpful

- Political vs. financial stability

- Market shamelessly

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### Plan for the future from Day One

Planning for sustainability must begin on the first day of the program. Even though a program may initially have funding for only a year or two, program planners must structure their plans as if they intend to run it indefinitely. This includes collecting data that can be used to substantiate the program when reapplying for funds or appealing for political support, being prepared for a media crises that can destroy a program's credibility, and generally making sure that the program can deliver on its initial promises past the pilot stage.

## Data, data, data

Data are crucial to sustaining a program, but it is the one thing many programs lack. Most programs don't have staff or money specifically allocated to design and collect data, but if programs are to have any hope of stability, they must incorporate data collection into their work plans from the beginning. The program needs to develop at least a minimal administrative database and find someone to oversee it.

The first goal of data collection should be to determine whether the program reaches its stated target population. The initial funding was provided to meet the stated needs of a defined target population. When the time comes to request second-round or more permanent funding, it is essential to demonstrate that the promises were met. A second, closely related goal is to be able to describe the volume and types of services actually delivered in the program. Did the funding agencies get what they were paying for? Basic outcome data to show that the program works, or, more accurately, for whom and under what circumstances it works is crucial.

An effort should be made to develop case studies to complement the more quantitative data. No matter how good a program is, it is bound to have failures. Case studies can be used to prove that success not failure is the norm for the program. It is important to have such information ready as early as possible — often a negative news story will strike too quickly to prepare a case study after the fact.

Data plays a crucial role in political and financial stability. Strong data also helps local champions to defend the coalition's cause and to recruit more political support. It is easier to get the first appropriation than the second, but strong data can help attract and keep funders interested not only in the program, but also in the general principles derived from it that promote sustainability.

It is easier to get the first appropriation than the second...

## Some cost data are helpful

Data on cost are one type of data that a program may want to collect, but it must be done with caution. Cost data often measure only the first year or so when clients enter intensive community-based services, a very expensive time. These data will be better indicators, and probably more favorable, after two to four years when services are less intense and cost savings are being realized. Cost studies also tend to take a lot of money, expertise, and sophisticated software to conduct and could detract from the original mission of the project.

## Political vs. financial sustainability

These two concepts do not necessarily go hand in hand. Political sustainability refers to the political will that needs to be generated and nurtured. Without a constituency that enthusiastically supports a program's continuance, financial resources are not likely to be forthcoming: So, while political support is a necessary ingredient to sustaining a program, it is not sufficient. All the good will and support in the world will not pay the staff, if someone has not capitalized on the political support to manage fiscal stability. It takes careful and aggressive action aimed at both dimensions of support to obtain the political backing and to ensure skillful strategic planning to bring in the money.

Political and financial sustainability should also be considered in the data collection process. Politicians and legislators need effective data to do their part in promoting the coalition's efforts. Funders need data to define how their money is being spent and to validate their funding efforts. If you can effectively show a difference in the number and quality of services between clients and law enforcement as a result of the program, you will likely be able to maintain support.

## Market shamelessly

**Develop a strategic plan with a strong vision and mission statements that people can buy into.** Focus on goals that are broad enough for general buy-in but narrow enough to keep the target audience in mind. Look at the effectiveness of the program: Are you reducing recidivism? Are consumers reporting better quality of life? You always must remember that this population is stimatized across the board and unless someone really focuses on them, they won't get help.

**Focus on key stakeholders.** Show the stakeholders that the same people are appearing in multiple systems and that system integration is necessary. Discuss what happens without system integration; invite them to spend a day following the footsteps of someone with a co-occurring disorder who is trying to navigate the system.

**Involve a diverse array of community providers and representatives in program planning.** A program's success doesn't rely on funds alone, but often a community commitment to serve this population as well. Successful programs must have a mix of staff, consumers, programs developers, police, wardens, and others who passionately want to help this population. People with this kind of passion can translate into commitment of agencies and support of legislators.

**Develop a board/policy forum.** Include service providers and the board of the local homeless program in planning and implementing your program. Organize a strategic planning committee that encourages other agencies to get involved with the policy board.

## Conclusion

Sustaining a program for co-occurring disorders requires that all facets of the initial program planning, implementation and organization be focused on the continuing development of the program. Strategies for sustaining the program must be an inherent part of the original vision of the program. Only then will these desperately needed programs have a fighting chance of being more than "pilots," and become part of the permanent landscape of care.

# Appendix A
# Program Descriptions & Resources

The following programs and initiatives were chosen to participate in this meeting because they are on the frontier of system integration. They have gone beyond the planning stages and have developed, often very slowly, into initiatives that are overcoming the challenges of merging systems and are setting the stage for change in the field.

**State of Colorado** — In 1995, representatives of juvenile justice agencies joined with providers of substance abuse services and other services for youth involved in the juvenile justice system, forming the Denver Juvenile Justice Integrated Treatment Network (the Network). The Network is multiagency and intergovernmental and includes agencies from every state and local juvenile justice agency dealing with Denver's juvenile offenders, state agencies, Denver city government agencies, the Denver public schools, family advocacy groups and families and public and private providers of education, employment training, health and mental health services, substance abuse treatment, family services, and pro-social activities. The Network agencies have collaborated to develop and implement a mental health screen for youth referred to the Network case management system for assessment and treatment of substance abuse problems. The Network also formed a Co-Occurring Disorders Task Force for Juvenile Offenders to specifically develop recommendations, policies and practices to adopt at all points in Denver's juvenile justice system.

**Broward County, Florida** — The County formed a highly collaborative coalition in response to its high rate of offenders with co-occurring disorders. The coalition includes enforcement (Broward Sheriff's Office), the judiciary (judges of the Mental Health and Drug Courts), all the major treatment agencies (Mental Health and Substance Abuse) and other agencies such as the United Way's Commission of Substance Abuse. Such collaborations have resulted in the establishment of the Drug Court Treatment program, the Mental Health Court, the Juvenile Intervention Facility, the Dual Diagnosis Task Force, the Healthy Start Coalition and other law enforcement/treatment initiatives.

**State of Maryland** — The Maryland Department of Health and Mental Hygiene Division of Special Populations fosters the development of innovative programs for consumers of mental health services with special needs. Programs include prevention of recidivism to homelessness, detention centers and psychiatric hospitals, delivery of coordinated services to adults with special needs, research on the effectiveness of special projects, and application of funding of gaps in the provision of services for this population. Maryland's Mental Hygiene Administration (MHA) has been particularly innovative in the funding area and has created an intricate patchwork of funding to address the needs of this special population. In addition to identifying mental health– and and substance abuse-specific funding sources, MHA also has secured funds to address trauma and housing issues.

**Rensselaer County, New York** — Rensselaer became a unified services county under the New York State Mental Hygiene Law in 1973. Subsequently, planning was implemented to include key county agencies and departments, such as the Law Enforcement agencies, Social Services, the courts, Probation and the Health Department. The County convened a Forensic Task Force in August 1996, to add the criminal justice system. The Task Force involves representatives from the jail, mental health, substance abuse, education, Mental Retardation and Developmental Disabilities, housing and consumers and calls on a number of ancillary members to help resolve special issues. Since its inception, the Task Force has organized a Day Reporting Center, a Drug Court, a housing program, and several treatment and aftercare programs for the Rensselaer County Correctional Facility.

**Portland, Oregon** — In 1994 the Portland Police Bureau joined in partnership with the Multnomah County Behavioral Health, the various community mental health clinics and the Alliance for the Mentally Ill (AMI) in organizing, training and implementing a specialized unit. This unique and creative alliance was established for the purpose of developing a more intelligent, understandable, and safe approach to people who are in mental crisis. This community effort was the genesis of the Portland Police Bureau's Crisis Intervention Team. Crisis Intervention Team (CIT) officers participate in specialized training under the instruction of mental health providers, family advocates (AMI) and mental health consumer groups. A 40 hour multi-discipline training program enables officers to understand that mental illness is a disease. The Portland Police Crisis Intervention Team has approximately 100 CIT officers. These officers maintain 24 hour, seven (7) day a week coverage. CIT training provides officers with education about what mental illness is and how to handle a person who is experiencing a crisis. With this training, CIT officers can, confidently, offer a more humane and calm approach.

**State of Texas** — The Texas Council on Offenders with Mental Impairments (TCOMI) was created by the Texas Legislature in 1987 to address issues impacting offenders with special needs (special needs includes: mental illness, mental retardation, developmental disabilities, serious medical conditions or the elderly). The 30-member TCOMI Board is legislatively charged with numerous mandates, but its primary mission is to establish a comprehensive continuity of care system for offenders with special needs. This activity is accomplished through the individual and collective efforts of the membership to improve their respective agencies role in its response to offenders with special needs. This occurs through changes in various statutory, regulatory, procedural or administrative practices that impact this offender population. In addition to TCOMI's on-going efforts toward addressing systemic issues, the membership collaborates on providing specialized programs for offenders with special needs. State funding is appropriated to TCOMI for community-based intervention services statewide continuity of care programs for pre-release and post-release aftercare services, and special needs parole. TCOMI's efforts to improve the state's response to offenders with special needs has been successful in large part due to the Legislative requirements for written memoranda of understanding (MOU) between state and local criminal justice and health and human services agencies. The MOUs have resulted in improving the overall communication and coordination among the various local and state agencies that have responsibility for treating and/or supervising offenders with special needs. To ensure on-going compliance, TCOMI is legislatively changed with monitoring the status of the MOU's, and reporting progress to the Legislature.

**State of Vermont** — Within the past three years, three key departments of state government in Vermont initiated a planning group to collaboratively assess and plan a coordinated approach for individuals with co-occurring disorders who were involved in the criminal justice system. This effort originated in a meeting between the Director of the Office of Alcohol and Drug Abuse Programs, the Commissioner of the Department of Corrections, and the Commissioner of the Department of Mental Health and Developmental Disabilities. After that meeting, a Planning Committee was established which has achieved a number of objectives. Utilizing data from all three departments, an assessment of the scope of the problem in each department and

the amount of duplication of services to this client population were determined. A methodology to blend funding for this population was agreed to, and a joint fund for a pilot project was created. A request for proposals was then released and a specific community agency was selected to pilot a regional community-based integrated treatment program for individuals with co-occurring disorders. The pilot program was initiated in 1998. Finally, a local steering committee was established to coordinate efforts at the local level and the Statewide Planning committee has been expanded to include consumers, and other criminal justice and community representatives.

Following is a list of useful resources to begin searching for more information on several of the topics and principles mentioned in this publication. This list is far from inclusive, but it is hoped that it will serve as a starting point for those who are interested in programs for people with co-occurring mental health and substance abuse disorders.

## Co-Occurring Mental Health and Substance Abuse Disorders

**The National GAINS Center for People with**
**Co-Occurring Disorders in the Justice System**
Policy Research, Inc.
262 Delaware Avenue
Delmar, New York 12065
Phone: (518) 439-7415
Fax: (518) 439-7612
E-mail: gains@prainc.com
Web Site: www.prainc.com/gains

The GAINS Center gathers information about mental health and substance abuse services provided in the justice system, tailors materials to the specific needs of localities, and provides technical assistance to help them plan, implement and operate appropriate, cost-effective programs. The GAINS Center is a federal partnership between two centers of the Substance Abuse and Mental Health Service Administration — the Center for Mental Health Services and the Center for Substance Abuse Treatment — and the National Institute of Corrections. The GAINS Center is a rich resource of information on co-occurring disorders and key issues that are closely related to this population, including: screening and assessment, intervention strategies, boundary spanning positions, service and system integration, cross-training, policy making, research, jail diversion, strategic planning, and juvenile issues.

**Center for Mental Health Services**
**Knowledge Exchange Network**
P.O. Box 42490
Washington, D.C. 20015
Phone: 1-800-789-CMHS (2647) — Monday-Friday, 8:30 a.m. to 5 p.m. EST
Fax: 301-443-9006
E-mail: ken@mentalhealth.org
Web site: www.mentalhealth.org

KEN was developed to provided mental health information to the users of mental health services and their families, the general public, policy makers, providers and the media. It is a national, one-stop source of information and resources on prevention, treatment, and rehabilitation services for mental illness.

## Evaluation

**InnoNet Toolbox**
1001 Connecticut Avenue, NW, Suite #900
Washington, D.C. 20036
Phone: (202) 728-0727
E-mail: Info@Inetwork.org
Web site: www.inetwork.org

According to the information on this Innovation Network, Inc. Web site, the InnoNet Toolbox is in place to "enable public and nonprofit organizations to better plan, execute, and evaluate their structure, operations, and services." At the site, users can sign-up to create their own plans, and learn more about program and evaluation planning and fund-raising.

**Office of the Assistant Secretary for Planning and Evaluation**
Hubert H. Humphrey Building
200 Independence Ave., S.W., Rm. 415F
Washington, D.C. 20201
Phone: (202) 690-8794
Inquiries: aspeinfo@osaspe.dhhs.gov
Web Site: http://aspe.hhs.gov/

The Assistant Secretary for Planning and Evaluation (ASPE) advises the Secretary of the Department of Health and Human Services on policy development issues in health, disability, human services, and science. The Office is also responsible for policy coordination, legislation development, strategic planning, policy research, evaluation, and economic development.

# General Information

**The American Correctional Association**
4380 Forbes Boulevard
Lanham, MD 20706-4322
Phone: 1-800-222-5646
Web site: www.corrections.com/aca/

The American Correctional Association is a multidisciplinary organization of professionals from corrections and criminal justice, such as federal, state and military facilities, and members from prisons, county jails and detentions centers, probation/parole agencies, and community corrections/halfway houses. The Web site offers information about membership, upcoming conventions, and publications.

**The American Jail Association**
2053 Day Road, Suite 100
Hagerstown, MD 21740
Phone: (301) 790-3930
Fax: (301) 790-2941
E-mail: jails@worldnet.att.net
Web site: www.corrections.com/aja/

The American Jail Association (AJA) is a national nonprofit organization dedicated to supporting those who work in and operate the Nation's jails. AJA publishes the magazine, American Jails, which focuses on jail issues in America and around the world.

**The Corrections Connection**
*The Largest On-line Resource for News & Information in Corrections*
159 Burgin Parkway
Quincy, MA 02169
Phone: 617-471-4445
Fax: 617-770-3339
Web site: www.corrections.com/index.shtml

This Web site is updated weekly and includes corrections links and several subject headings ranging from health care and technology to juveniles. The site also links users to chat rooms and subject-specific bulletin boards.

**The United States Department of Justice**
950 Pennsylvania Avenue, NW
Washington, D.C., 20530-0001
Web site: www.usdoj.gov/

The U.S. Department of Justice's Web site gives users access to publications and documents and information about community support and grants.

# Juveniles

**National Association of Child Care Resource and Referral Agencies (NACCRRA)**
1319 F Street, NW, Suite 810
Washington, D.C. 20004-1106
Phone: (202) 393-5501
Web site: http://www.childcarerr.org

NACCRRA is a national membership organization of over 400 community child care resource and referral agencies (CCR&Rs) in all 50 states. NACCRRA's mission is to promote the growth and development of high quality resource and referral services and to exercise leadership to build a diverse, high quality child care system with parental choice and equal access for all families. The CCR&Rs it represents are the only portion of the child care delivery system which maintains daily contact with both parents and child care providers in hundreds of local communities. CCR&Rs; work closely with a broad array of community leaders, including employers and unions. Increasingly, NACCRRA and its members offer innovative guidance to policy makers on service delivery and regulatory issues and strategies.

**National Black Child Development Institute**
1023 Fifteenth Street, NW, Suite 600
Washington, D.C. 20005
Phone: (202) 387-1281
Web site: http://www.nbcdi.org

The National Black Child Development Institute (NBCDI) serves as a critical resource for improving the quality of life of African American children, youth, and families through direct services, public education programs, leadership training, and research.

**National Clearinghouse on Families and Youth**
P.O. Box 13505
Silver Spring, MD 20911-3505
Phone: (301) 608-8098
Fax: (301) 608-8721
E-mail: Info@ncfy.com

NCFY's links those interested in youth issues with the resources they need to better serve young people, families, and communities.

**National Information Center for Children and Youth with Disabilities**
P.O. Box 1492
Washington, D.C. 20013
Phone: (800) 695-0285
E-mail: nichcy@aed.org
Web: http://www.nichcy.org

NICHCY is the national information and referral center that provides information on disabilities and disability-related issues for families, educators and other professionals. Its special focus is children and youth (birth to age 22).

**Office of Juvenile Justice and Delinquency Prevention**
Office of Justice Programs
U.S. Department of Justice
810 Seventh St., N.W.
Washington, D.C., 20531
Phone: (202) 307-5911
Web site: www.ncjrs.org.ojjdp

Juvenile Justice Clearinghouse
P.O. Box 6000
Rockville, MD 20849-8736
Phone: 1 (800) 638-8736
Fax: (301) 519-5212

The Office of Juvenile Justice and Delinquency Prevention's Web site is designed to provide information about juvenile justice and delinquency in an effort to help communities to combat youth crime. It offers a list of publications, grants and funding opportunities and other news and resources.


**Youth Law Center**
1325 G Street, NW, Suite 770
Washington, DC 20005
Phone: (202) 637-0377
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The Youth Law Center is a public interest law office organized as a nonprofit corporation to provide advice and assistance in matters relating to the legal rights of children. Since 1978, Center staff attorneys have worked with public officials, community groups, attorneys, and other children's advocates in more than 40 states around the country. Center staff have also brought civil rights law reform litigation in federal and state courts in 15 states to protect the rights of children in the juvenile justice system – particularly those confined in adult jails, detention centers, and similar correctional facilities – and the rights of children in foster care. Center staff also work in the areas of health care, education, mental health, and rights of the disabled.

the Center promotes the development of preventive, family-focused, comprehensive, community-based services to meet the multiple needs of children and families. The Center also aims to ensure accountability of public and private agencies by emphasizing cost-effective services and measurable outcomes. The Center is funded primarily through foundation grants, the State Bar Trust Fund, and contributions from law firms, corporations, and individuals.


## Policy

**The Center on Crime, Communities & Culture**
*A Program of the Open Society Institute*
400 West 59th Street, 3rd Floor
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The goal of the Center on Crime, Communities & Culture is to create a better understanding of and support for effective and humane responses to criminal behavior and victimization. The Center supports innovative programs in the field of criminal justice; by performing policy and research work in areas of national and international importance; and by providing academic and research fellowships to individuals committed to becoming leaders in criminal justice.


**The National Center on Institutions and Alternatives**
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The National Center on Institutions and Alternatives is a private, nonprofit agency providing training, technical assistance, research and direct services to criminal justice, social services, and mental health organizations and clients across the country. This site offers the latest publications in criminal justice reform and some research as well.

# Research

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P.O. Box 2138
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Rand is a nonprofit institution that help improve policy and decision making through research and analysis.  Rand's Web site has a few pages that focus on criminal justice including sentencing and corrections and violence prevention.

# APPENDIX B
# PARTICIPANTS LIST

This series of meetings was a combined effort of the Center for Crime, Communities & Culture (CCC&C) and the National GAINS Center for People with Co-Occurring Disorders in the Justice System. This series convened representatives from exceptional programs with federal project officers, members of GAINS and CCC&C, and the core group, which was carefully selected by members of CCC&C and GAINS.

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# APPENDIX C
# REFERENCES

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# PROGRAM BRIEF

## A Guide for Communities to Create Integrated Services for People with Co-Occurring Disorders in the Justice System

## The Emerging Landscape

About 10 million adults each year are booked into U.S. jails.[1] In 1997, about two-thirds of these people belonged to racial or ethnic minorities, most of them poor.[2] Approximately 700,000 of these 10 million people each year enter the justice system with serious mental disorders and 75 percent of these 700,000 people have co-occurring substance abuse disorders.[3] Likewise, a majority are persons of color, who are poor and have higher risks of physical and sexual abuse.

Each year, over two million youth under the age of 18 are arrested. A million of them will have formal contact with the juvenile justice system, and over 100,000 will eventually be removed from their homes and placed in juvenile detention and correctional facilities. Available research indicates that at least 20 percent of all youths who enter the juvenile justice system experience serious mental disorders, with a much higher percentage experiencing some level of mental health problems.[4] There is also a growing recognition that many of these youths — nearly 50 to 75 percent — have serious substance abuse problems. Further, the service needs of minority populations with co-occurring disorders, such as adolescent girls and youth of color, are frequently overlooked or misunderstood within the juvenile justice system.

In the past, little attention has been paid to these youth. Much like adults with co-occurring disorders, youth with co-occurring disorders have wandered through service systems and communities unrecognized and misunderstood. Youth with co-occurring disorders often have problems at home, at school and in their neighborhoods. Neglect, physical and sexual abuse, violence, crime, lack of health care and poverty are just a few of the difficulties that many of these young people face. Unlike adults who enter the justice system through a criminal arrest, a youth can be brought into the system for status offenses, which are behaviors that would not be considered crimes if committed by someone 16 years of age or older, such as truancy and running away from home.

The lives of both youth and adults with co-occurring mental health and substance abuse disorders are characterized by unproductive cycles of decompensation, disturbance and arrest that cannot be altered by usual interventions. In most places in the United States, mental health, substance abuse and criminal justice systems offer only patchworked, uncoordinated responses. Because so many of these people have serious mental illnesses and substance abuse disorders simultaneously, treatment interventions that deal with only one of their disorders are doomed to fail.

When treatment fails, these people often end up in the system of last resort, the justice system. This system is arguably the least effective place for these people to be. The police, courts and corrections staff often lack even basic knowledge about substance abuse and mental health. Further, they do not have the resources to appropriately respond to these conditions that, if overlooked, are life-threatening.

Despite this bleak picture, there are effective solutions. In fact, there are many exciting innovations around the country where communities have devised more effective ways of working with this population.

These communities have found ways to develop new linkages between mental health, substance abuse and criminal justice systems that, often for the first time, provide appropriate interventions to break the cycles of decompensation and incarceration in these people's lives that repeatedly harm them and the communities in which they live.

When these successful communities were examined,[5,6] it was found that many of their innovations reflected an investment in the concept of systems integration. The essence of this concept is that people in all three systems recognize the need for a holistic approach to treating each person and that the agencies providing the essential services are willing to share information, money, and clients across systems.

The principles summarized here are resources not only to begin social change, but also to sustain it. The programs that produced these key principles are living examples of how these core ideas can work. These initiatives are invaluable resources to help committed people with courage address the issues surrounding people with co-occurring disorders in the criminal justice system and to assist them in leveraging social change. Full elaborations on how these principles and strategies can be used by your communities are available in this program brief's companion booklet, "The Courage to Change: A Guide for Communities to Create Integrated Services for People with Co-Occurring Disorders in the Justice System."

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### "No Wrong Door" Policy for Successful Systems Integration: King County (Seattle), Washington

In 1997, the King County Council created the Bureau of Unified Services (BUS) in response to an ordinance calling for a new behavioral health program that combined portions of the existing mental health and alcohol and substance abuse programs.

The purpose of the BUS is to promote integration of systems engaged in developing and providing services to persons who are experiencing mental illness and/or chemical dependence/addiction, especially those who are also homeless or at imminent risk of homelessness, and/or individuals with a history of repeated or chronic use of public services providing acute care and/or more restrictive environments. The goal of the BUS is to create "no wrong door" to the existing service systems by making every doorway into treatment the "right door," regardless of presenting issues. It supports the sharing of information, planning, clients and resources across the Department of Community and Human Services Mental Health Division, the Seattle/King County Department of Public Health Division of Alcoholism and Substance Abuse Services, and, indirectly, with the Department of Adult Detention. A newly appointed BUS Coordinator reports to and is supervised jointly by both Divisions/Departments.

Major BUS goals included the following:
• Seek to resolve information sharing/confidentiality issues across mental health/substance abuse service systems
• Reconfigure Jail Alternative Services (JAS) in conjunction with the Pilot Crisis Triage Center in order to explore creating viable pre-booking diversion function
• Explore opportunities for conjoining of mental health and chemical dependency involuntary treatment system into a single service serving both populations
• Explore consolidation of existing outreach and engagement services into a network of street and facility-based services
• Coordinate contracting processes within the Departments of Community and Human Services and Public Health to maximize impact and minimize duplication of services

One of the BUS's major projects for 1999 is to mobilize the Pilot Crisis Triage Center in collaboration with Harborview Medical Center. As of July 1998, Harborview is providing a site for triage and stabilization that integrates mental health and drug and alcohol services. In addition to collecting information about the individuals experiencing mental health and/or substance abuse disorders served in the Triage Unit and the services needed in the community to support the ongoing needs of these individuals, the pilot project also provides a realistic view of the feasibility of inpatient psychiatric hospital diversion for some patients who are currently hospitalized as well as a site for testing a more effective method for pre-booking diversion by local law enforcement authorities.

A BUS Advisory Council meets on a monthly basis to provide input and feedback concerning the systems integration activities of the Bureau of Unified Services. The Council is comprised of representatives of key stakeholder groups across a broad range of systems.

System integration goes beyond service integration. In the latter, treatment services are combined at an individual vel, often by a case manager who brokers a package of services for a client. System integration involves new arrangements between the service organizations themselves including their treatment services, administration, management information systems, assessments, and staff training. It does not require the creation of a single system, but it does demand an interconnected network of organizations that can complement each other through the transfer of appropriate information, resources, and clients among the component units.

## Planning Integrated Services

- Organize a coordinating body/task force/coalition
- Start small, but carry a big vision
- Commit to cultural sensitivity
- Emphasize strategic planning
- Identify motivators
- Recruit political support
- Clarify funding strategies
- Recognize that there is no one best way

## Implementing Integrated Services

- Begin moving from informal to formal arrangements via memoranda of understanding
- Devise a marketing strategy
- Build systems to coordinate and share information
- Ensure accessibility to services
- Determine the common, shared approach at the service level for cross-training
  Create boundary-spanning positions across the mental health, substance abuse and criminal justice systems
- Build in outcome evaluations for all participating agencies to justify their funds and participation

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### Why integrated services are in everyone's best interest

When people with mental illness and substance abuse disorders get treatment, case managers, and housing, the positive effects can be felt by many, including:

**The Public**
- Reduction in homelessness
- Decrease in family, acquaintance and stranger violence
- Decrease in the use of high cost, intensive treatment services
- Reduction in public disturbance

**Clients**
- Creation of user-friendly services
- Reduction of inappropriate detention
- Increase in treatment involvement
- Break in cycles of decompensation – arrest – incarceration

**Corrections Managers**
- Fewer disruptive detainees
- Fewer detainees
- Reduction in liability

**Mental Health/Substance Abuse Professionals**
- More client willingness to accept treatment
- Ability to handle more types of clients
- Reduction in client disturbances

---

## Financing Programs

Key financial strategies:
- Custom-blend funding sources
- Pick a funding leader
- Reorganize existing funds
- Develop an action plan
- Consider managed care roles

## Funding Information on the World Wide Web

The Internet is a valuable tool to identify and learn more about funding opportunities. Many grant programs, state agencies, and foundations have Web pages, and several government agencies have sections that announce available funds and list descriptions and eligibility requirements. The following Web site addresses are good places to start:

- **Substance Abuse and Mental Health Service Administration** — www.samhsa.gov.
- **U.S. Department of Justice** — www.usdoj.gov.
   - **Local Law Enforcement Block Grants** — www.iir.com/grants/
- **National Institute of Health** — www.nih.gov/grants.html
- **The National Institute of Mental Health's Knowledge Exchange Network (KEN)** — www.mental health.org.
- **Robert Wood Johnson Foundation** — www.rwjf.org/text.html
- **The Soros Foundation** — www.soros.org/crime/index.html
- **The Pew Charitable Trusts** — www.pewtrusts.com/

The Internet also has several databases, some of which are commercial, that have information about federal, foundation, corporate and private sponsorships. A few to check out are: **the Catalog of Federal Domestic Assistance, Federal Information Exchange (FEDIX), the Sponsored Programs Information Network (SPIN), GrantsNet, and GrantsWeb.**

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### Blended Funding at Work

### Maryland Department of Health and Mental Hygiene Administration
### Division of Special Populations

Piecing together funds to deal with special populations is challenging, but some jurisdictions, such as the state of Maryland, are proving that it is not only possible, but it can be extremely effective as well.

The Maryland Department of Health and Mental Hygiene Division of Special Populations fosters the development of innovative programs for consumers of mental health services with special needs. This includes individuals with psychiatric disabilities who are homeless, are in jail and could be appropriately served in the community, have co-occurring substance abuse disorder, and/or are deaf. Innovative programs include prevention of recidivism to homelessness, detention centers and psychiatric hospitals; delivery of coordinated services to adults with special needs; research on the effectiveness of special projects; and application for funding of gaps in the provision of services for this population.

Maryland's Mental Hygiene Administration (MHA) has been particularly innovative in the funding area and has created an intricate patchwork of funding to address the needs of this special population. In addition to identifying mental health- and substance abuse-specific funding sources, MHA also secured funds to address trauma and housing issues. Following are examples of MHA's programs and the grants it utilizes in order to offer more complete services to this population.

- **Maryland Community Criminal Justice Treatment Program**

MHA has implemented the Maryland Community Criminal Justice Treatment Program (MCCJTP) in 18 local jurisdictions to meet the comprehensive needs of this vulnerable population and to reduce recidivism to state

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**Office of Juvenile Justice and Delinquency Prevention**
Office of Justice Programs
U.S. Department of Justice
10 Seventh St., N.W.
ashington, D.C., 20531
Phone: (202) 307-5911
Web site: www.ncjrs.org.ojjdp

**The Corrections Connection**
*The Largest On-line Resource for*
*News & Information in Corrections*
159 Burgin Parkway
Quincy, MA 02169
Phone: 617-471-4445
Fax: 617-770-3339
Web site: www.corrections.com/index.shtml

**The United States Department of Justice**
950 Pennsylvania Avenue, NW
Washington, D.C., 20530-0001
Web site: www.usdoj.gov/

**Juvenile Justice Clearinghouse**
P.O. Box 6000
Rockville, MD 20849-8736
Phone: 1 (800) 638-8736
Fax: (301) 519-5212

**Youth Law Center**
25 G Street, NW, Suite 770
Washington, DC 20005
Phone: (202) 637-0377
Fax: (202) 347-0493

## Research

**RAND – Corporate Headquarters**
1700 Main Street
P.O. Box 2138
Santa Monica, CA 90407-2138
Phone: 310-393-0411
Fax: 310-393-4818
Web site: www.rand.org

## Policy

**The Center on Crime, Communities & Culture**
*A Program of the Open Society Institute*
400 West 59th Street, 3rd Floor
New York, NY 10019
Web site: www.soros.org/crime/cccc

**The National Center on Institutions and Alternatives**
3125 Mt. Vernon Avenue
Alexandria, VA 22305
Phone: 703-684-0373
Fax: 703-684-6037
E-mail: ncia@iga.apc.org
Web site: www.ncianet.org/ncia/index.html

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psychiatric hospitals, detention centers, and homelessness. Each participating jurisdiction is required to develop an advisory board that includes representatives from the various agencies that serve the client in the community, such as mental health, alcohol and drug abuse, public defenders, the judiciary, parole and probation, law enforcement, AIDS, social services, public defenders, and consumers. To receive the money from MHA to begin a program, each advisory board is required to develop a memorandum of agreement that defines the specific services each agency will provide. The MCCJTP case manager serves the consumer holistically involving a multitude of agencies and services beginning in the detention center and continuing into the community. Meaningful daytime activities, such as volunteer work and employment, are an integral part of each consumer's service plan. MCCJTP focuses on individuals who are 18 or older and have serious mental illnesses and/or are dually diagnosed, and are incarcerated in local detention centers or on intensive parole and probation caseloads. These services may also be provided to individuals with HIV/AIDS and/or individuals who are homeless.

MHA funds $1,000,000 annually to provide for case management and psychiatric services beginning in the detention center. Local county governments and detention centers have also provided funds as well as local agencies providing in-kind services. In 1998, 1,372 individuals were served through this program.

- **Byrne Memorial Grant Fund**

In 1996, MCCJTP received $340,922 from the federal government's Byrne Memorial Grant Fund Program to provide substance abuse services in conjunction with mental health services in seven local detention centers. In contrast to most states that put all Byrne Funds into state prison substance abuse treatment, Maryland has used these funds creatively, but within the program guidelines, to transitions detainees from local jails to the community. This grant was renewed for 1998 for $380,615. In 1998, case managers funded by the Byrne grant referred 548 new cases for assessment and treated 582 inmates.

- **HUD Shelter Plus Care**

In July 1995, the United States Department of Housing and Urban Development granted MHA a $5.5 million Shelter Plus Care grant to provide housing for five years for homeless, seriously mentally ill consumers coming out of jail. This rental assistance is also available to individuals who are homeless and leaving public psychiatric hospitals as well as individuals on parole and probation who are homeless and in danger of re-incarceration. A total of 366 adults and 224 children have been housed in 19 counties through this program. One indication of the effectiveness of this program is demonstrated in the recidivism rate of 6 percent to jail and 1 percent to the hospital.

- **PATH Funds**

In 1998, the Division of Special Populations received a $335,000 in Projects for Assistance in Transition from Homelessness (PATH). The funds are used to provide outreach, screening and diagnostic services, rehabilitation services, mental health, alcohol and drug treatment services, case management, and job training and educational services. In 1998, 1,280 individuals were served through this program.

- **Phoenix Project**

The Division of Special Population has received $1,575,442 over three years from the Substance Abuse Mental Health Services Administration (SAMHSA) for a pre- and post-booking diversion, treatment and support program in Wicomico County for women with serious mental illness and co-occurring substance abuse disorder. As one of nine study sites in the United States, the Phoenix Project will provide a wide array of services for the women and their children. The University of Maryland Center for Mental Health Research Services will evaluate the project.

- **TAMAR Project**

MCCJTP recently received $569,000 a year for two years from SAMHSA to provide trauma treatment for women in detention centers and in communities. The TAMAR Project (Trauma, Addictions, Mental Health and Recovery) will provide holistic services through an integrated system for women with histories of violence, as well as therapeutic services for their children.

## Sustaining Successful Programs

Key survival strategies:
• Plan for the future from day one
• Gather as much data as possible
• Collect cost data
• Balance political and financial stability
• Market shamelessly
> • Develop a strategic plan with strong vision and mission statements that people can buy into
> • Focus on key stakeholders
> • Involve a diverse array of community providers and representatives in program planning
> • Develop a board/policy forum

## Resources

### Co-Occurring Mental Health and Substance Abuse Disorders

**The National GAINS Center for People with Co-Occurring Disorders in the Justice System**
Policy Research, Inc.
262 Delaware Avenue
Delmar, New York 12065
Phone: (518) 439-7415
Fax: (518) 439-7612
E-mail: gains@prainc.com
Web Site: www.prainc.com/gains

**Center for Mental Health Services**
**Knowledge Exchange Network**
P.O. Box 42490
Washington, D.C. 20015
Phone: 1-800-789-CMHS (2647) – Monday-Friday, 8:30 a.m. to 5 p.m. EST
Fax: 301-443-9006
E-mail: ken@mentalhealth.org
Web site: www.mentalhealth.org

### Evaluation

**InnoNet Toolbox**
1001 Connecticut Avenue, NW, Suite #900
Washington, D.C. 20036
Phone: (202) 728-0727
E-mail: Info@Inetwork.org
Web site: www.inetwork.org

**Office of the Assistant Secretary for Planning and Evaluation**
Hubert H. Humphrey Building
200 Independence Ave., S.W., Rm. 415F
Washington, D.C. 20201
Phone: (202) 690-8794
Inquiries: aspeinfo@osaspe.dhhs.gov
Web Site: http://aspe.hhs.gov/

## General Information

**The American Correctional Association**
4380 Forbes Boulevard
Lanham, MD 20706-4322
Phone: 1-800-222-5646
Web site: www.corrections.com/aca/

**The American Jail Association**
2053 Day Road, Suite 100
Hagerstown, MD 21740
Phone: (301) 790-3930
Fax: (301) 790-2941
E-mail: jails@worldnet.att.net
Web site: www.corrections.com/aja/

### Juveniles

**National Association of Child Care Resource and Referral Agencies (NACCRRA)**
1319 F Street, NW, Suite 810
Washington, D.C. 20004-1106
Phone: (202) 393-5501
Web site: http://www.childcarerr.org

**National Black Child Development Institute**
1023 Fifteenth Street, NW, Suite 600
Washington, D.C. 20005
Phone: (202) 387-1281
Web site: http://www.nbcdi.org

**National Clearinghouse on Families and Youth**
P.O. Box 13505
Silver Spring, MD 20911-3505
Phone: (301) 608-8098
Fax: (301) 608-8721
E-mail: Info@ncfy.com

**National Information Center for Children and Youth with Disabilities**
P.O. Box 1492
Washington, D.C. 20013
Phone: (800) 695-0285
E-mail: nichcy@aed.org
Web: http://www.nichcy.org