

CONNECTIONS TO CARE

There are numerous reasons why there are challenges for justice-involved individuals to be connected to care. We do not have the capacity to serve those with behavioral health issues in the community due to:

- Lack of capacity in the workforce to provide services
- Lack of facilities to provide treatment
- Cumulative reduction in overall spending for behavioral health services

Nearly **1.3 million** people with mental illness are incarcerated in state and federal jails and prisons – compared to only about 70,000 people being served in psychiatric hospitals (Department of Justice, 2013).

The Journal of the American Medical Association reported that there were **22 psychiatric beds for every 100,000 people in the United States**. In addition, from 1998 to 2013, as the number of psychiatric beds fell from 34 to 22 per 100,000, the suicide rate increased by 24 percent to 13 per 100,000, significantly more than in other developed nations. In this most advanced of nations, there were 42,773 suicide deaths in 2014, up from 29,199 in 1999.

Around the country, state psychiatric hospital beds are in short supply and their numbers are declining. Advocates suggest at least 40 beds for every 100,000 people.

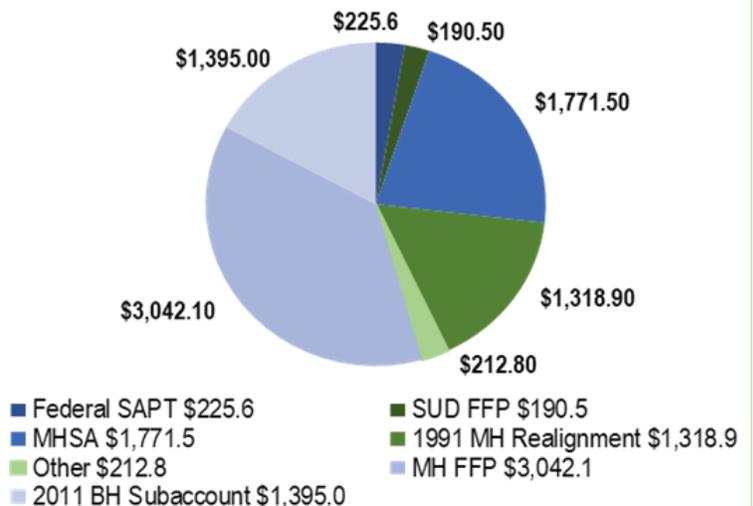
California, as of June 2016, had 15.1 beds per 100,000

(Treatment Advocacy Center)

“The inclusion of behavioral health services which are covered by health insurance means people will have greater access to the help that they need. But right now, 55 percent of U.S. counties do not have any practicing behavioral health workers and 77 percent reported unmet behavioral health needs. It’s clear our robust effort in promoting relevant professions, building skills, and making sure that communities in need have support will have a positive effect on many.”

- Anne Herron, SAMHSA

FY 16/17 Estimated Behavioral Health Funding



*Geiss Consulting

In state prison, prevalence of serious mental illness is 3 to 4 times higher than in the community.



Many people leaving prisons and jails have behavioral health disorders, frequently combined with physical illness, that need to be addressed within the context of a comprehensive reentry plan – a plan that builds on correctional agencies investment in an individual's treatment during incarceration. **The APIC (Assess, Plan, Identify, Coordinate) Model** (Osher, Steadman, & Barr, 2002) provides guidance for behavioral health, criminal justice system, and community stakeholders to work collaboratively across systems to design and implement evidence-based programming to forward the dual goals of individual recovery and risk reduction.

ASSESS the individual's clinical and social needs and public safety risk.

GUIDELINE I

Conduct universal screening as early in the booking/intake process as feasible and throughout the criminal justice continuum to detect substance use disorders, mental disorders, co-occurring disorders, and criminogenic risk. Valid and reliable screening instruments for the target population should be used.

GUIDELINE II

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

- Basic demographics and pathways to criminal involvement
- Clinical needs
- Strengths and protective factors
- Public safety risks and needs

PLAN for the treatment and services required to address the individual's needs, both in custody and upon reentry.

GUIDELINE III

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

- Determine appropriate level of treatment
- Identify and target individuals' multiple criminogenic needs
- Address aspects of disorders that affect function
- Develop strategies for integrating appropriate recovery support services into service delivery models
- Acknowledge dosage of treatment as an important factor in recidivism reduction

GUIDELINE IV

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

IDENTIFY required community and correctional programs responsible for post-release services.

GUIDELINE V

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

GUIDELINE VI

Develop policies and practices that facilitate continuity of care through the implementation of strategies that promote direct linkages for post-release treatment and supervision agencies.

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

GUIDELINE VII

Support adherence to treatment plans and supervision conditions through coordinated strategies

- Maintain a "firm but fair" relationship style
- Establish clear protocols and understanding across systems on handling behaviors that constitute technical violations of community supervision conditions

GUIDELINE VIII

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

GUIDELINE IX

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

GUIDELINE X

Collect and analyze data to evaluate program performance, identify gaps in performance and plan for long-term sustainability.

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