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SUMMARY REPORT:
TTI 2021 FOCUSED ON JAIL-BASED MENTAL HEALTH SERVICES

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This work was funded by the Substance Abuse & Mental Health Services Administration under Contract HHSS283201700024I75S20321F42001, Task 5.4., and the National Association of State Mental Health Program Directors (NASMHPD), Inc.

1 in 4
ADULTS IN JAIL

VS.

1 in 20
ADULTS LIVING IN THE COMMUNITY

REPORTED PAST 30-DAY SERIOUS PSYCHOLOGICAL DISTRESS (SPD)

INTRODUCTION

People with behavioral health challenges, such as serious mental illness (SMI) and/or substance use disorders (SUDs), are overrepresented in jails.[1] An estimated 1 in 4 (26%) adults in jail reported past 30-day serious psychological distress (SPD) compared to 1 in 20 (5%) adults living in the community.[2] Many of these individuals enter jail already in poor physical or mental health partly due to pre-incarceration lives that often include economic hardships, problematic substance use, exposure to stress and trauma, and a lack of access to healthcare and treatment.[3] Once in jail, people with a mental illness are more likely to self-harm or commit suicide, spend time in restrictive settings or receive punitive sanctions, and to stay in jail longer.[4] In order to improve individual health outcomes, facility safety and management, community safety, and public health it is imperative that people in jail with mental health needs receive the appropriate treatment and services while incarcerated *and* during the reentry period. An important element of reentry planning includes healthcare planning and establishing a continuity of care between correctional facilities and community behavioral health providers is important for a success transition.[5] Typical reentry challenges, such as securing safe and affordable housing, often become more complex when the person has a serious mental illness or substance use disorder.[6]

There are many challenges inherent with providing jail-based mental health services, despite the constitutional right of people in jail to receive necessary healthcare. In the US, jails are operated at the local level and hold people with a sentence of less than one year or who are pretrial and not convicted. This means that people typically don't stay in jail very long, with an average length of stay of two weeks, versus an average of two years for prison stays.[7] This short length of stay and everchanging influx in jail populations complicates jails'

[1] Bronson, J. and M. Berzofsky. (2017). Indicators of Mental Health Problems Reported by Prisoners and Jail Inmates, 2011–12. Washington DC: Bureau of Justice Statistics. https://www.bjs.gov/content/pub/pdf/imhprpji1112.pdf; Bronson, J. J. Stroop, S. Zimmer and M. Berzofsky. (2017). Drug Use, Dependence, and Abuse among State Prisoners and Jail Inmates, 2007–2009. Washington DC: Bureau of Justice Statistics.

[2] Bronson, J. and M. Berzofsky. (2017). Indicators of Mental Health Problems Reported by Prisoners and Jail Inmates, 2011–12. Washington DC: Bureau of Justice Statistics. https://www.bjs.gov/content/pub/pdf/imhprpji1112.pdf

[3] Binswanger IA, Krueger PM, Steiner JF. (2009). Prevalence of chronic medical conditions among jail and prison inmates in the USA compared with the general population. *Journal of Epidemiology & Community Health* 2009;*63*:912–919; Prison and Jail Reentry Health. (2021). Health Affairs Health Policy Brief. Prison And Jail Reentry And Health | Health Affairs.

[4] Treatment Advocacy Center (2016). Serious Mental Illness (SMI) Prevalence in Jails and Prisons. smi-in-jails-and-prisons.pdf (treatmentadvocacycenter.org); Lurigio, A. J. (2011). People with serious mental illness in the criminal justice system: Causes, consequences, and correctives. *The Prison Journal*, 91(3), 66S–86S; Bronson, J. and M. Berzofsky. (2017). Indicators of Mental Health Problems Reported by Prisoners and Jail Inmates, 2011–12. U.S Department of Justice: Bureau of Justice Statistics. https://www.bjs.gov/content/pub/pdf/imhprpji1112.pdf

[5] Willison, B., J., McCoy, E.F., Vasquez-Noriega, C., Reginal, T. & Parker, T. (2018). Using the Sequential Intercept Model to Guide Local Reform. Urban Institute. http://www.safetyandjusticechallenge.org/wp-content/uploads/2018/10/2018.10.11_Using-the-SIM_finalized.pdf.

[6] Prison Policy Initiative. (2018). Nowhere to go: Homelessness among Formerly Incarcerated people. Nowhere to Go: Homelessness among formerly incarcerated people | Prison Policy Initiative; Zajac, G., Hutchison, R., & Meyer, C. (2013). An Examination of Rural Prisoner Reentry Challenges. Pennsylvania State University. https://cjrc.la.psu.edu/wp-content/uploads/sites/21/2020/10/CRPA-Rural-Reentry-Report-Final-Justice-Center-version.pdf

[7] Zeng, Z. (2018). Jail Inmates in 2017. Washington DC: Bureau of Justice Statistics. https://bjs.gov/content/pub/pdf/ji17.pdf

Collectively the 13 awardees used TTI funds to expand existing jail-based mental health services and develop new ones in order to improve behavioral health outcomes, train and engage new and existing partners, stop cycles of rearrest and incarceration, facilitate engagement in treatment and recovery for various jail populations, and advance peer support services and models.

efforts to deliver treatment for mental illness and substance use disorders. Other barriers to providing mental health and/or reentry services are significant staffing shortages that impact both jail staff and the availability of mental health providers who want to work with justice-involved populations, a lack of adequate treatment space inside jails, and a lack of resources and training. Some of these challenges can be overcome through partnerships and coordination with various state agencies and community and mental health agencies and providers.[8] Such interagency collaborations can offer a means to deliver improved mental health services to people in jail and those reentering the community.[9]

In recognition of the need for improvement in jail-based mental health services, in FY2021, SAMHSA issued funding to expand or develop better services within correctional facilities and enhance the coordination of jail-based treatment and the transition back into the community. This funding was provided through SAMHSA's Transformation Transfer Initiative (TTI), which assists states in transforming their mental health systems of care. The TTI provides, on a competitive basis, flexible funding awards to states, the District of Columbia, and the territories to strengthen innovative programs. In the FY2021, 13 states and territories applied and were approved for TTI Application C funding to focus on jail-based mental health services.

Funding was distributed by NASMHPD through contracts with each of the awardees for up to $150,000.

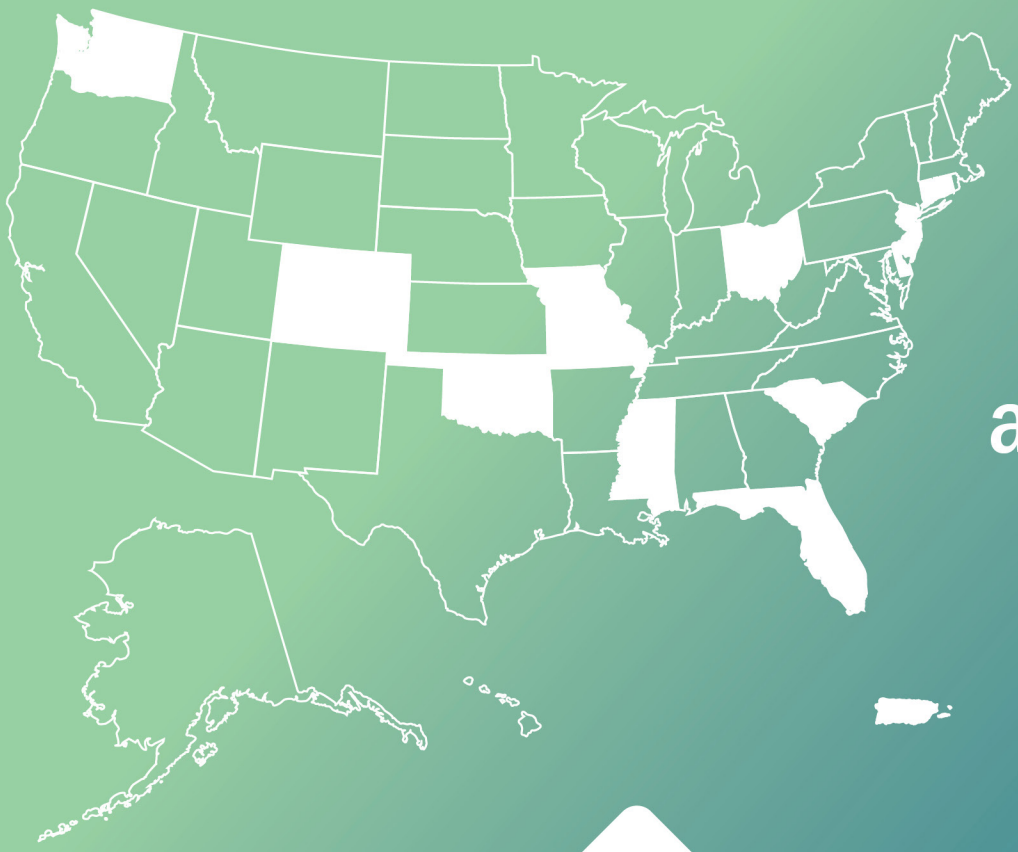
NASMHPD staff were in regular contact with TTI state project directors to support their work including in-person and telephone discussions about their progress. These discussions provided the framework for post-project interviews conducted by NRI with awardees in June and July 2022 to learn about the impact of the COVID-19 pandemic on the project, barriers and challenges, lessons learned, and outcomes and project successes. The information collected through these interviews was condensed and synthesized into a 1–2 page overview of each awardee's TTI efforts that follows the summary report.

HOW WERE TTI TOPIC C FUNDS USED?

The purpose of the TTI grant was to improve mental health services for people in jail, with an emphasis on reentry and transition planning to better support these individuals upon return to the community. Collectively the 13 awardees used TTI funds to expand existing jail-based mental health services and develop new ones in order to improve behavioral health outcomes, train and engage new and existing partners, stop cycles of rearrest and incarceration, facilitate engagement in treatment and recovery for various jail populations, and advance peer

[8] Principles of Community-based Behavioral Health Services for Justice-involved Individuals: A Research-based Guide (samhsa.gov)

[9] Principles of Community-based Behavioral Health Services for Justice-involved Individuals: A Research-based Guide (samhsa.gov)



13 awardees

support services and models. The specific jail populations of interest included people who were pre-trial, serving a sentence in jail, recently returned to the community from jail, in jail awaiting an inpatient bed, and people returning to jail from a hospital. Some awardees focused more on the development and delivery of training and technical assistance to different stakeholders, whereas others used the majority of funds to provide direct service delivery to individuals with a mental illness. In addition to these activities, almost all of the states incorporated peer support services and trauma-informed care into their TTI project.

WHO WAS THE TARGET POPULATION OF THE TTI PROJECT?

The TTI grant designated that funds should be used to address the needs of people in jail with SMI, but many states also included those with an SUD or a co-occurring SMI and SUD in the scope of the TTI project. These states said that it was difficult to separate out SMI only patients or exclude those with SUDs because of the overlap between mental illness and substance use among jail clients. However, at least one state that restricted the focus to people with SMI communicated that it was a limitation to implementation because they wanted to include people with SUDs in the program.

More specifically, six awardees (SC, Palau, OK, CO, MS, and OH) had a target population that included any adult in jail with a mental illness and/or SUD. Puerto Rico also included any person in jail with a mental illness but with an emphasis on supporting those who have experienced trauma that might be unrecognized. Two states (DE and CT) focused on women in jail with a mental illness and/or SUD. Missouri and Florida were interested in addressing the needs of forensic patients in jail, such as those waiting a pre-trial or competency evaluation or inpatient bed, and those recently returned to jail from the hospital. New Jersey focused on its

pre-trial population identified as having a mental illness. Washington was the only awardee to have a training-dedicated project, and they focused on developing and providing virtual trainings about trauma-informed care to law enforcement, jail staff, community providers and hospital staff. Palau and Mississippi also provided trainings to jail staff, law enforcement, and/or hospital staff as part of their project.

WHAT WAS THE ROLE OF PEER SUPPORT SPECIALISTS AND SERVICES?

Peer support services incorporate individuals with lived experience (i.e., mental health, substance use, homelessness, and/or justice involvement) into various treatment teams, such as mental health or reentry programming. These peers provide important services such as help navigating the mental health system, providing support during treatment and recovery, serving as role models for success, and educating providers on cultural competencies to better serve the population at hand.

Twelve of the 13 TTI states incorporated peer support services directly in their TTI program. Specific names for peer support specialists, used by the awardees, included recovery support specialist, forensic peer specialist, and peer navigator but the role all involved a person with lived experience providing support to a legally involved adult with a mental illness. In some states peers joined forensic mobile teams, provided reentry support, and encouraged engagement in treatment. Delaware said that the TTI grant facilitated their peers becoming certified. In other states, the focus was on providing training and technical assistance that communicated the importance of peer support services to stakeholders, community partners, agency staff, and jail facilities about how to best utilize them. Additionally, a few states also said they used peers to inform the development of programs and

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TTI states incorporated peer support services directly in their TTI Program

data collections, and to review the language used in grants and proposals; Ohio reported they do not contract with organizations that do not hire peers. While Missouri did not use peer support services in the TTI project, they do incorporate peers in crisis stabilization and 988 services.

Several awardees discussed the difficulties that jail background checks posed to hiring peer support specialists and this barrier should be examined. Many jail facilities also have policies that prevent a person who was formerly incarcerated in that facility from returning as a provider or volunteer. However, Mississippi shared that in those instances where a formerly incarcerated person was able to return to the same jail as a peer specialist, it was a "morale boost" for law enforcement and correctional staff who were happy to see a success story.

HOW WAS TRAUMA-INFORMED CARE BUILT INTO SERVICES?

Almost all of the TTI states had some component of trauma-informed care built into the TTI project because trauma-informed care was already the framework for the provision of behavioral health services. These awardees reported that trauma-informed care was incorporated into their agency's mission and overall service approach, all of the staff were trauma-informed, or their existing jail-based mental health program was already trauma-informed. For example, Delaware stated that providing trauma-informed care is a provision established by the Governor's office and South Carolina reported that "the Department of Mental Health is a trauma-informed agency and we incorporate that into any service we provide." Missouri has incorporated trauma-informed care questions into their interview process to ensure that potential employees are aware of trauma-informed practices and also understand the state's commitment to providing trauma-informed care. Colorado's existing Jail-Based Behavioral Health Services program, of which the TTI money expanded, was already a trauma-informed program.

Additionally, about half of the states' TTI projects were dedicated to expanding trauma-informed care either through training and technical assistance on the topic or by virtue of their focus population. For example, Connecticut's goal was to develop and expand trauma-informed practices and provider networks for women in the criminal legal system. Puerto Rico's project provided trauma-informed reentry services to people with a history of trauma that is unrecognized by community providers. Washington developed a series of virtual trainings specifically to educate and inform law enforcement, hospital staff, and correctional staff about trauma and trauma-informed care. And as part of their project, Palau conducted a trauma-informed training series for correctional staff.

WHO WERE THE KEY PARTNERS IN THE TTI EFFORT?

The cross-system nature of this TTI grant necessitated collaboration between state agencies, correctional agencies and facilities, courts and judiciary partners, state hospitals, and community providers and organizations. Every awardee had at least one criminal justice partner involved with the TTI grant, the majority of which was collaboration with a local jail facility. Partnerships with courts, pre-trial and probation officers, criminal justice coordinating or advisory committees, and law enforcement agencies were also mentioned by awardees.

More than half of the TTI states (MO, CT, OK, CO, DE, PR, & NJ) built or expanded collaborations between state agencies (i.e., Department of Mental Health) and community partners. Examples of community partners included mental health provider groups, family

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STATE TTI PROJECTS WERE DIRECTLY IMPACTED BY JAIL CLOSURES (SC, CT, PALAU, OK, CO, OH, FL, DE, PR) THAT CAUSED THEM TO RETHINK HOW TO FULFILL THE VISION OF THE GRANT.

resources centers, food banks, nonprofit organizations and recovery centers, organizations that hire peer specialists, and universities. Several states said that partnerships with other state agencies were critical to the success of their TTI project. These partnerships included collaborations with the Division of Forensic Services (CT), Department of Corrections or Ministry of Justice (CT, DE, Palau), Department of Health and Human Services (Palau, DE), and the Department of Labor (DE).

WHO PROVIDES MENTAL HEALTH SERVICES IN JAILS?

Jail facilities organize their correctional health system's staffing plan in various ways. Some jail-based behavioral health staff are jail employees or state employees, but most facilities use outside vendors to provide health services. This latter organization can be further subdivided by whether or not the same vendor provides both the medical and behavioral health services.

More than half of the TTI states (SC, MO, CT, OK, CO, OH, DE, & PR) reported that their jail facilities use contractors to provide mental health services in jail. Mentioned vendors were Advanced Correctional Healthcare, Corizon, and WellCare. For some awardees, working with contracted health providers posed a challenge due to concerns over "territory" or philosophical differences about recovery models and peer support services.

WHAT IMPACT DID THE COVID-19 PANDEMIC HAVE ON MENTAL HEALTH SERVICES IN JAIL?

The ongoing COVID-19 pandemic greatly impacted the operational and programming capabilities of the correctional system. The greatest impact to TTI states was the closure of jails to prevent general exposure and limit the spread of the COVID-19 virus. Nine of the 13 state TTI projects were directly impacted by jail closures (SC, CT, Palau, OK, CO, OH, FL, DE, PR) that caused them to rethink how to fulfill the vision of the grant. The solution for these states was to focus on the community side of reentry and partner with community-based providers that also work with formerly incarcerated individuals or that still had access to the jail. An additional two states (MO, & NJ) reported that while their jails did not close, TTI initiatives were slowed down from COVID-19 policies that limited jail access and slowed down admissions, court trials, or referrals.

On the positive side, Missouri and Delaware significantly increased their use of telehealth during COVID-19. Missouri was able to adopt telehealth to legal-involved individuals with ease because virtual and remote options were already being utilized in courts prior to COVID. Lastly, one state (Washington) was largely unaffected by the COVID-19 pandemic because their purpose was to deliver online trainings.

WHAT WERE THE BARRIERS/ CHALLENGES TO IMPLEMENTING AND PROVIDING SERVICES?

There were three main themes that emerged in the discussions on barriers and challenges to implementing the TTI projects: the COVID-19 pandemic, staffing issues and turnover, and the short project time period.

Almost half of the TTI states (MO, OK, OH, NJ, CO, & Palau) reported that staffing shortages were a challenge. Awardees noted that the difficulties with recruiting, hiring, and retaining staff were related to the larger behavioral health workforce shortage and difficulties hiring in a post-COVID environment. There were also challenges with hiring peer specialists, due to requirements that they had to pass a background check and/or a lack of work experience that could make working for a state agency a difficult fit for the peer. Additionally, some peer specialists with lived behavioral health and recovery experience might not have criminal justice or "street" experience, and this latter experience is key for working with incarcerated individuals. Awardees also discussed their desire to avoid peer burnout, adequately support peer specialists and utilize them in the most appropriate way, and the need to advance formal policies that codify the peer support roles and make them billable services.

The correctional system is also experiencing a national workforce shortage and one state shared that there were only two correctional officers for a jail of 100 people. Other awardees also reported that a lack of correctional staff and/or changes in jail facility leadership posed problems to implementation. However, for other awardees like South Carolina, changes in jail administration leadership improved collaboration as the new administrator was more supportive of the goals of the TTI project.

Four states mentioned that the short TTI funding period and timeline was a challenge for developing and implementing their mental health services in jail programs. The project period ran for eight months from January 2021 to August 15, 2021 and this timeline was difficult for some awardees due to COVID and the other challenges discussed above, particularly those related to hiring and onboarding peer support specialists. For example, one state had planned a large forensic training but it was cancelled due to a hurricane and the awardees were unable to reschedule it in the grant timeframe. A second state that was hampered by leadership turnover and staffing challenges was unable to fulfill their vision to hire and place peer support specialists during the project timeline. At least six states (SC, CO, MS, FL, NJ, and WA) mentioned that additional time would have benefited them in the implementation of their TTI project.

Almost half of the TTI states (MO, OK, OH, NJ, CO, & Palau) reported that staffing shortages were a challenge... difficulties with recruiting, hiring, and retaining staff were related to the larger behavioral health workforce shortage and difficulties hiring in a post-COVID environment.

Some of the other barriers and challenges mentioned during interviews were lack of early buy-in from law enforcement, jails or other criminal justice partners; higher level politics and internal conflicts in decision making; long wait lists coupled with low bed counts; and stigma against individuals with mental health needs and peer support specialists.

WHAT WERE THE MAIN LESSON(S) LEARNED?

The main lessons learned were the importance of early coordination and collaboration between mental health and correctional agencies and the increase in awareness around jail-based population's unique needs and the resources to serve them.

More than half of the TTI states (SC, MO, CT, OK, CO, MS, DE, WA) stated that the need for coordination with the relevant criminal justice partner (i.e., jail facility, law enforcement) early in the project was an important lesson learned. Without upfront collaboration in the grant writing stage, state mental health agencies may not best understand the strengths, needs, and limitations (i.e., staffing shortages, no Wi-Fi in the jails) of correctional partners and incorrectly design a project that doesn't suit the facility. One state shared that they did not engage law enforcement in the initial development of the training and as a result, they "missed the mark" in a few places and some law enforcement were not happy. This feedback however provided an opportunity to collaborate with law enforcement and better tailor the training for their needs and positions.

More than half of the TTI states (SC, MO, CT, OK, CO, MS, DE, WA) stated that the need for coordination with the relevant criminal justice partner (i.e., jail facility, law enforcement) early in the project was an important lesson learned.

Several states shared that the TTI project had caused a shift or increased awareness within the agency about the importance of working with peer support specialists, the need to incorporate recovery throughout their scope of services, the consideration of women's unique reentry needs into other areas of criminal justice programming, and the discovery of the richness of resources available to help the focus population.

HOW WAS BEHAVIORAL HEALTH EQUITY IMPROVED?

Behavioral health equity is the right of everyone to be as healthy as possible by increasing and facilitating access to appropriate, high-quality, and affordable healthcare services and supports to each person in a fair and just manner.[10] Part of health equity is providing services and supports that are culturally sensitive and tailored (i.e., language, components, and approach) to best serve all people such as Black, Latino, Asian Americans, Pacific Islanders and Native Hawaiians, Native Americans and Indigenous populations, and people of multi-racial backgrounds; people who speak languages other than English and immigrant communities; people with disabilities; people who are lesbian, gay, bisexual, transgender, nonbinary, genderqueer or other member of the LGBTQ+ community; and people from different religious backgrounds.

Health equity is influenced by the social determinants of health that can leave some

[10] Behavioral Health Equity | SAMHSA

groups more protected against adverse health outcomes than others, such as safe neighborhoods and health insurance. Incarceration is a critical social determinant of health and people who are justice involved represent a population in need of improved health equity. Data show that adults in prison and jail are significantly more likely to have a chronic health condition, disability, substance use disorder, and/or experience a mental illness than their counterparts in the general population.[11] Justice-involved populations are also more likely than people in the community to need additional support services, such as housing and employment, in order to facilitate and sustain positive behavioral health outcomes.

Each awardee said in their interview that the need to increase health equity among justice-involved populations with a behavioral health challenge was an essential motivation to apply for the TTI funding. Awardees understood that this group experiences health inequity, not only because of their justice involvement, but also due to their behavioral health challenges that make access to affordable and high-quality interventions and services important for their health and wellbeing. As such, many states used funds to include peer support specialists with lived criminal justice experience as a means to better engage justice populations in behavioral health treatment and stop future justice involvement. Another example of health equity work is Ohio which used TTI funds to hire a dedicated housing coordinator to solely work on securing housing for their reentry clients who were unhoused. As a result of this focused attention to housing, they were able to secure housing for every client in need. Health equity can be further illustrated by Delaware and Connecticut's TTI projects that were dedicated to women in jail with behavioral health needs and both spoke about the importance of gender-based services. For example, a woman cannot be released from jail at night if she does not have a ride, due to concerns for their safety from victimization and this resulted in additional incarceration time. Delaware recognized this gap in services and used TTI funds to provide transportation services to women leaving a jail without a secure ride.

[11] Bronson, J. and M. Berzofsky. (2017). Indicators of Mental Health Problems Reported by Prisoners and Jail Inmates, 2011–12. Washington DC: Bureau of Justice Statistics. https://www.bjs.gov/content/pub/pdf/imhprpji1112.pdf; Binswanger IA, Krueger PM, Steiner JF. (2009). Prevalence of chronic medical conditions among jail and prison inmates in the USA compared with the general population. *Journal of Epidemiology & Community Health* 2009;63:912–919 ; Maruschak, L., M.Berzofsky, J. Unangst. 2015. Medical Problems of State and Federal Prisoners and Jails Inmates, 2011–12. Washington DC: Bureau of Justice Statistics. https://bjs.ojp.gov/content/pub/pdf/mpsfpji1112.pdf.

ENHANCING THE JAIL-BASED BEHAVIORAL HEALTH SERVICES (JBBS) PROGRAM IN RURAL AND FRONTIER JAILS

COLORADO

Project Background, Vision, and Outcomes

In 2011, Colorado established the Jail-Based Behavioral Health Services (JBBS) program to oversee behavioral health contracts and provide technical assistance for the delivery and coordination of jail-based mental health, substance use, and co-occurring treatment services for the 46 jails in Colorado. Colorado wished to expand and enhance the current JBBS to provide targeted technical assistance for up to six rural jails to assist them with their population with serious mental illness (SMI), assess the quality of their services and overall service provision, and evaluate referral and linkages processes. Colorado also partnered with the University of Colorado to create and facilitate an integrated peer support community to foster successful implementation of best practices and the sharing of team successes, barriers, lessons learned, and problem solving amongst the participating jails÷. The vision expanded during the funding period to include more community outreach than originally intended, which was reported as helpful for establishing and strengthening relationships and creating a continuity of care pipeline for patients.

Outcomes included the establishment of biweekly meetings with the six participating jails (measure of engagement); the creation of a more consistent intake process; improvement with Medicaid enrollment at time of reentry; and the implementation of warm handoffs through peer recovery specialists. Additionally, one of the project outcomes was the development of an intake process map and this activity will continue to inform and frame the JBBS program (Figure 1). More information and up-to-date resources can be accessed on the JBBS resource page at: *https://bha.colorado.gov/behavioral-health/jbbs*

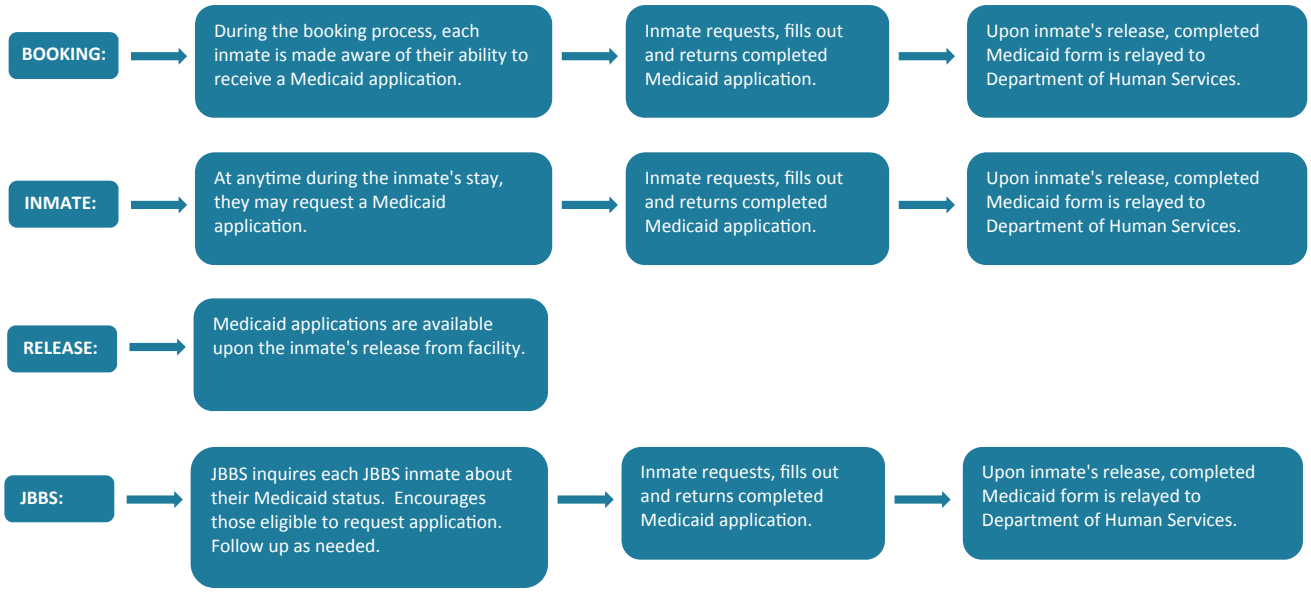
Project Implementation: Challenges and Lessons Learned

Challenges during the project period included troubles with hiring providers, the TTI grant's short time limitations, limiting SMI inclusion criteria, and barriers to hiring peer support specialists. To overcome some of these challenges, Colorado stated that additional planning time before implementation as well as the expansion of SMI inclusion criteria for other behavioral health populations such as those with substance use disorders would be helpful. More funding and more flexibility for case exemptions for peers undergoing background checks would help address other challenges.

Additionally, the ongoing Covid-19 pandemic limited physical access to jails and prevented in-person meetings. However, the latter turned into a positive because learning communities, etc. were moved to virtual platforms and that greatly

"When working with jails you need to clarify that we are here to help you and your staff."

FIGURE 1: JBBS INTAKE PROCESS MAP FOR GARFIELD COUNTY



improved attendance, particularly from people who lived far from Denver.

Sustainability and Project Legacy

The TTI funds were used to enhance the continuity of care already established by the JBBS project to reach people in rural and frontier jails who would be returning to the community. When TTI funding ends, Colorado plans to provide ongoing facilitation with the jails to support them in the adoption of peer recovery and patient care coordination models. The project legacy highlights that TTI funding helped establish good processes with the jails including ongoing learning communities with various speakers and training sharing best practices on diverse topics.

Health Equity

This project was designed to address the needs and improve equity of people with mental illness, substance use, or co-occurring disorders in rural and frontier jails preparing to return to the community; both legal-involved and rural/frontier health patients represent marginalized groups.

Peer Services Utilization

Peer support services are incorporated into the JBBS program, and peers have been added as a paid role though JBBS and other counties. Colorado is still navigating background check barriers so that peers can gain on-site access to jails.

Trauma Informed Care

The JBBS program was established as a trauma-informed program, and remained trauma informed throughout the TTI funding period.

For further information about this project contact Danielle Culp at *danielle.culp@state.co.us* or Kelley Russell at *kelly.russell2@state.co.us*.

PROVIDING TRAUMA INFORMED TRAININGS TO CORRECTIONAL STAFF & INCARCERATED WOMEN

CONNECTICUT

Project Background, Vision, and Outcomes

Connecticut wanted to expand its services for incarcerated women with mental health challenges, particularly in supporting reentry transitions and forming and strengthening a trauma-informed care (TIC) network of providers and peer navigators. In partnership with two community providers and York Correctional Institution, the only women's correctional facility in Connecticut, the goal was to provide trauma informed reentry-oriented trainings to both correctional staff and incarcerated women and support women upon reentry to their community. Initially the focus of the TTI grant funds was on providing services to women in the Southeastern part of the state, but based on referral numbers and capacity, the decision was made to provide reentry care across the state.

Referrals and trainings were established outcomes of the project, to include demographic and behavioral health data of the women referred to the program and those awaiting discharge at various time frames (3, 6, and 9 months). Grantees also reported that a new service was being offered through the TTI grant.

Project Implementation: Challenges and Lessons Learned

The ongoing Covid-19 pandemic impacted the project's vision because staff were not allowed in the facility and the logistics for virtual trainings were not yet in place. This however created an opportunity for outreach to community-based agencies providing reentry services to women.

The barriers to the project included losing people from the program that don't have cell phones and patients are sometimes only given a short period of bridge medication when released back into community settings. These barriers still remain and have not been overcome.

Additionally, at the time of the project's start, York was already providing internal trainings to its staff and felt like they did not need additional trainings at that time. This also pushed the grantees to consider alternative approaches to meet the TTI goals and offered a lesson about getting buy-in from the Department of Corrections early in the programming process to ensure the offered services are of need and/or appropriate.

Sustainability and Project Legacy

Without a continuance of grant funding, the current program is not sustainable. However, the legacy of the program is that, "the idea of recovery is spreading through the community," and it reinforced the need to "think about programming for incarcerated women in everything we do across the sequential intercept model."

Health Equity

Improving behavioral health equity for incarcerated women was the focus of the project, a unique population that is at the

"The project reinforced that we need to continue thinking about programming for incarcerated women in everything we do."

intersection of multiple vulnerabilities (e.g., behavioral health challenges, women, incarceration) to adverse health outcomes. Using TII funds, Connecticut was able to provide trauma-informed training to assist this special health population.

Peer Services Utilization

Peer services are completed by peer navigators in Connecticut. These peer navigators have lived experience and work with the target population. Policy barriers surrounding the length of time a peer has been released from a correctional setting remains a barrier for peers gaining access to Department of Corrections facilities. There is a continued need for training to understand stigma and harm reduction as it relates to peer navigators, and these ideas have spread through the agency.

Trauma Informed Care

The focus of this grant was on the understanding of trauma and trauma-informed care for correctional facility staff, reentry community partners, and among the women themselves.

For further information about this project contact Dana Begin at *dana.begin@ct.gov* or Christopher Burke at *christopher.p.burke@ct.gov*.

EXPANDING THE HOURS & REACH OF THE MOBILE BRIDGE TEAM TO FILL CARE GAPS FOR WOMEN

DELAWARE

Project Background, Vision, and Outcomes

Delaware was interested in filling in service gaps that existed for individuals with mental health and social support needs exiting correctional settings. Using TTI funds, Delaware was able to examine service gaps and then implement services to fill them. The first gap was limited weekend coverage in the jails, meaning that people with mental health needs were not being connected to services upon release. Second, due to safety concerns, women were not released at night without transportation back into their community and this kept women in jail longer than men.

The vision for this project was to expand the hours and reach of the Mobile Bridge program to provide behavioral health screenings, referral to treatment, and enrollment in other state services for women in jail during weekend hours. The expansion also resulted in transportation services, care coordination, and the use of certified peer specialists to connect with the women. The new transportation component means that woman can now be released at night. Additionally, a staff member follows up with every individual via a phone call, which can give clients an opportunity to talk to someone if they're lonely, depressed, or anxious.

The established outcome of this project was connecting people to behavioral health and other services upon release from a correctional setting. Additionally, the program worked with family members of incarcerated individuals to provide education and health/social supportive resources. A main outcome of this project was the creation of a consumer survey which was designed to capture the "community voice". Survey responses were then used to inform the delivery of services, such as the need to provide transportation to women leaving jail. One of the items developed using TTI funds was the Bridge Clinic Flyer, as seen in Appendix A, to communicate some of the services offered as well as contact information.

> "This grant allowed us to ask what gaps we are not meeting the needs of."

Project Implementation: Challenges and Lessons Learned

Challenges to implementing the project were primarily internal, and included staffing changes at the executive and operational level. Turnover in these agency job positions delayed project implementation, however, these positions have since been filled and do not remain as a barrier.

The ongoing Covid-19 pandemic changed the direction of the project in that it was originally designed to be jail-based. The closure of the jails pivoted the program to providing community-based, mobile services to people once they left jail. However, this shift in setting resulted in positive outcomes, such as partnerships with

food banks and hosting tables/mobile van tents at community agency fairs, that would not have occurred otherwise. The Covid-19 pandemic also delayed some critical meetings with community providers, partners and stakeholders and supply-chain issues delayed the delivery of program materials (i.e., shirts, stress balls, and other branded handouts).

The main lesson learned was to have a detailed thought process, rather than high-level, when imagining the development and implementation of a project. Additionally, they learned to use peers to inform the development of programs and identify the necessary data that should be collected before project implementation.

Sustainability and Project Legacy

The project was developed to expand the Mobile Bridge's hours and services to better meet the needs of women in jail. Using TTI funds, transportation services were provided to women leaving jail, patient care coordination was expanded to more community partners, and peer support specialists were able to become certified. The goal when TTI funding ends is to secure additional funding to expand the Mobile Bridge beyond New Castle County.

Health Equity

Improving health equity among women in jail with behavioral health challenges was the purpose of this project, and will continue even when the project ends. Delaware has included health equity initiatives within its strategic organizational planning, including employee selection. Grantees stated that Delaware strives to hire individuals who represent their target population and come from diverse racial/ethnic backgrounds, sexual orientation, gender, and those with lived experience. Currently, they are looking to hire more Latinx and multi-lingual peers to work with targeted populations.

Peer Services Utilization

Delaware has a committed stance on the use of peer support specialists to inform and deliver services. Peers are embedded within care teams and play an integral part in strategic planning and programming. Under this TTI grant, a certified peer support specialist was part of the Mobile Bridge team and they were able to meet individuals outside of the jail, immediately upon release.

Trauma Informed Care

Prior to receiving TTI grant funding, the Governor had made the development of trauma-informed agencies a directive. All agencies are training their staff, leadership, and providers on trauma informed care.

For further information about this project contact Alicia Emmanuel at *alicia.emmanuel@delaware.gov* or Kris Fraizer at *kris.fraser@delaware.gov*.

HIRING FORENSIC PEER SUPPORT SPECIALISTS TO INCREASE ENGAGEMENT IN TREATMENT

FLORIDA

Project Background, Vision, and Outcomes

Florida sought to enhance existing reentry services for people leaving jail with mental illness through the use of forensic peer specialists. To better inform mental health services delivery, Department of Children and Families (DCF) uses the Sequential Intercept Model (SIM) (shown in Figure 2) to keep individuals with mental health needs out of the legal system and state hospitals and this provided a framework for the TTI grant.

The vision for the project was to hire forensic peer specialists, which is an area that does not already utilize peer services yet it is the intercept with the highest number of people involved/in need of treatment. Forensic peer specialists would collaborate with jails to assess and coordinate treatment for individuals immediately after arrest and do "early engagement work to get people out of jail."

The outcome of the grant was to hire three forensic peer specialists to work in area jails, however, the project faced significant challenges to achieving its goal.

Project Implementation: Challenges and Lessons Learned

The main barrier to project implementation was the ongoing Covid-19 pandemic which closed the jails and prevented interviews for forensic peer specialists. Because DCF staff could not get to their jail patients, they concentrated on diverting people from jail to state hospitals in order to provide services.

Another large barrier was related to mandatory background checks that peer specialists often cannot pass. Although waivers exist, most peer specialists do not know about it and/or do not have the time to contest the process. For this reason, recruitment of FSPs was difficult because it was hard to find people who wanted to do the work, who were part of the population or had significant experience with it, and who can pass a background check to work in jail setting. Other barriers to hiring peers included many not being workforce ready and the need to have a "thick skin" to avoid burn out. It was also mentioned that managing peer specialists can be time consuming and more information and infrastructure is needed surrounding the use of peers among state agencies. Lastly, a few "naysayers" feel that using peers "isn't worth it" and are not receptive to peer support services.

Sustainability and Project Legacy

The sustainability of this project is unknown at this time. Changes in staff has caused a communication gap and inability to efficiently analyze the outcomes and process used to implement this project.

"We would definitely participate in the TTI process again."

Although the initial stages of the project were very slow and Florida faced many implementation challenges, Florida would participate in the TTI process again. Leadership was happy that a grant existed that could be used for individuals with lived experience.

Health Equity

This project was centered around individuals with mental illness and peers with lived experience in the criminal justice system. Both of these groups represent traditionally marginalized groups who could benefit from improved health equity.

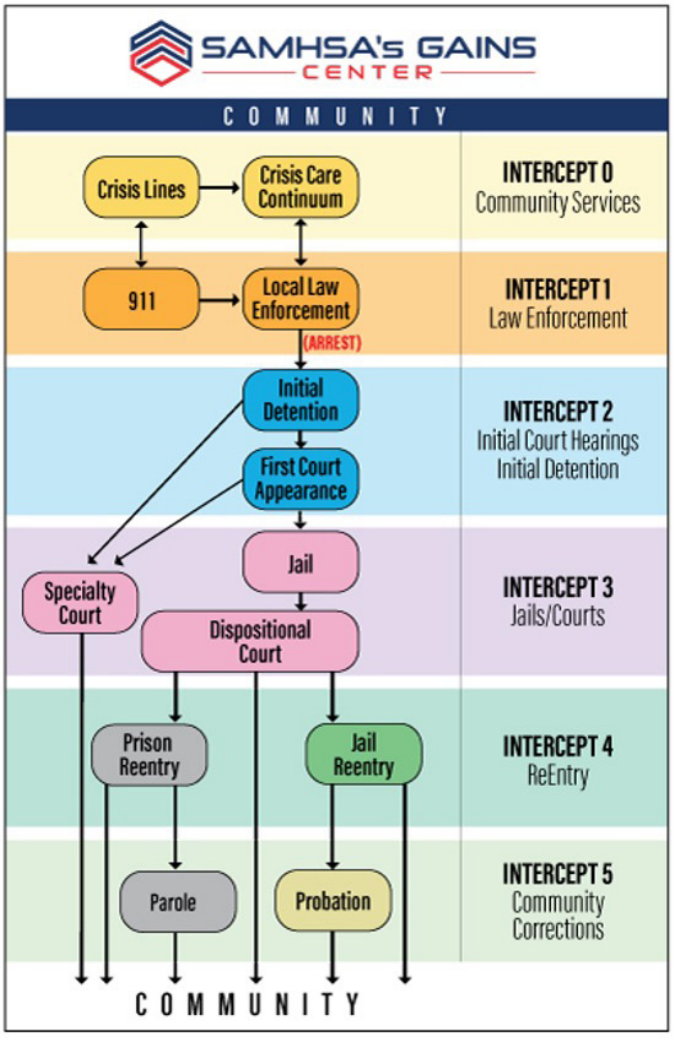
Peer Services Utilization

The purpose of this project was to hire three forensic peer specialists to help engage people in treatment and prevent psychiatric hospitalizations. Prior to the grant, peer support services were incorporated into several treatment models and were "part of the team," but significant gaps existed in the forensic spaces.

Trauma Informed Care

Prior to receiving TTI grant funding, DCF was incorporating trauma informed care information from the GAINS Center into the agency. Training peers in trauma informed care was part of the original vision, but challenges to hiring peer specialists hampered this goal.

FIGURE 2: SEQUENTIAL INTERCEPT MODEL (SIM)



For further information about this project contact Asta Trinh at *asta.trinh@myflfamilies.com*.

EXPANDING THE USE OF FORENSIC CERTIFIED PEER SUPPORT SPECIALISTS (FCPSS)

MISSISSIPPI

Project Background, Vision, and Outcomes

Prior to TTI funding, Mississippi established services at each intercept of SAMHSA's Sequential Intercept Model (See Figure 2) to divert individuals with mental illness and/or substance use disorders from the legal system and into treatment. To decrease incarceration counts and increase referral rates in three counties (Harrison, Forest, and Jones), Mississippi used TTI funds to provide trauma informed training to justice teams (i.e., law enforcement and correctional officers) and hire three forensic peer support specialists. The vision was two-fold, including training law enforcement and correctional officers and hiring three forensic peer support specialists to work in county jails.

The project had various established outcomes, including increasing the number of individuals trained and the number of follow-up appointments with community mental health centers, and reducing repeat incarceration rate among those with a serious mental illness. Data was collected on how Crisis Intervention Team (CIT) training has reduced incarceration rates, and no issues with collecting or reporting data were reported. One other measure of success was connections, or transfers, from jail to beds at the Alcohol & Drug Treatment facility.

Project Implementation: Challenges and Lessons Learned

The major barriers to implementation were a hurricane, workforce shortages, and Covid-19. A major hurricane canceled the forensic training and it could not be rescheduled due to time constraints. Indeed, the grant's quick timeline was a general barrier for implementation above and beyond rescheduling the canceled training. Ongoing workforce shortages have caused challenges in hiring staff at all levels, including clinical and administrative/operational personnel. Minor Covid-19 outbreaks in the jail prevented temporary access to patients inside the jails, but telehealth has been a useful solution to still connect with patients via virtual means.

A couple of lessons were learned throughout the grant period, mainly focused on the benefit of forensic certified peer support specialists (FCPSS). Mississippi strongly advocates for the use of peers to improve programming and they found that utilizing FCPSS increased morale among officers in correctional settings as well as patients. This is because law enforcement and correctional officers appreciated the FCPSS's "success story" and it helped them to "remain hopeful" about people's ability to change and grow.

Sustainability and Project Legacy

The project was originally designed to provide training to law enforcement, correctional officers, and FCPSS. When funding ends, Mississippi plans to continue training officers. The legacy of this project is the shifted perspectives for/from officers that have participated in the trainings with a peer support specialist. The officers feel more hopeful towards recovery and reductions in recidivism, and the peers feel less shame and

"We thought that placing individuals who have lived experience in the jails to work would help engage people into services and reduce recidivism."

increased self-efficacy by sharing their stories and working with law enforcement.

Health Equity

This project was designed to address the needs of people with mental illness and/or a substance use disorder in jail, clearly representing the recognition of the need to provide equitable mental health services for legal-involved individuals.

Peer Services Utilization

Peer support services were utilized before TTI grant funding, and will continue after funding ends. According to Mississippi, peers are part of most treatment teams and they have a vested interest in the success of the peer support model.

Trauma Informed Care

Currently, the Crisis Intervention Team programming and training are the largest representatives of trauma-informed care.

For further information about this project contact Rita Porter at *rita.porter@pbmhr.org* or Connie Bienvenu at *connie.bienvenu@pbmhr.org*.

EXPANDING FORENSIC MOBILE TEAMS FOR SERVICE DELIVERY & JAIL DIVERSION

MISSOURI

Project Background, Vision, and Outcomes

Prior to TTI funding, Missouri had seen great success with the establishment of a forensic mobile team for the Western side of the state, however the Eastern region did not have the resources (i.e., funds and staffing) to create the teams necessary to provide this same level of care. Using TTI funds, Missouri developed an Eastern region forensic mobile team to conduct outreach and promote diversion for individuals with behavioral health needs from justice settings to the community. The forensic mobile team consists of a registered nurse, social workers, and a nurse practitioner.

The target populations were individuals in jail waiting for an inpatient bed or waiting for a pre-trial evaluation, and those returning to jail from the state hospital. There were adequate resources to support the target populations, however, they could have benefited from additional staffing (i.e., a prescriber and case manager) and more physical space for additional beds. Missouri stated that courts, jails, and community mental health centers were the major partners on this project.

The main established outcome was to increase staffing levels to adequately staff the new Eastern forensic mobile team. Data was collected on a variety of indicators, including the number of individuals seen, number of individuals restored to competency before hospital admission, and length of stay for clients that are followed by the mobile team. An additional success measure is the ability to complete clinical due process for involuntary medications in just a few days, instead of the weeks it previously took. Missouri was able to make a two pager, see Appendix A, overviewing the Forensic Mobile Team including the goals of the team, contact information, and court-ordered service areas.

Project Implementation: Challenges and Lessons Learned

Project challenges included a lack of collaborators for nurse practitioners, recruiting peers to fill open peer support specialist positions, and philosophical differences between agencies and care teams. To overcome the lack of collaborators, Missouri has begun providing compensation-based rewards to encourage MDs to serve as collaborators for NPs. Utilizing peer support services remains a challenge. Beyond philosophical differences between criminal legal and behavioral health professionals,

> **"We are battling how to help individuals navigate the system they are currently in and getting them out, and hopefully engaging them in treatment services and keeping them out of the criminal justice system so we are not dealing with a revolving door."**

differences were noticed in treatment planning and coordination between care teams (i.e., DMH and jail-based providers). Additional staffing and legislative support were mentioned as resources needed to address ongoing challenges.

The ongoing Covid-19 pandemic had positive and negative consequences for Missouri. Positively, the utilization of telehealth services increased due to heightened use of tele-court (virtual court hearings and proceedings) by the legal system. Alternatively, Covid-19 slowed down the overall admission process and increased turnover within the agency.

Discovering that the lack of suitable housing is a significant limitation to outpatient restoration and recognizing the importance of pre-establishing collaborative agreements for nurse practitioners were the main lessons learned throughout the project period. The two teachable moments were to develop meaningful partnerships with correctional agencies and that these collaborations can provide an opportunity to learn about interagency strengths and weaknesses.

Sustainability and Project Legacy

This project was designed to develop an Eastern region forensic mobile team. When funding ends, Missouri plans to increase team staffing by three case managers and 2.5 nurse practitioners (one for the eastern region, one for the western region, and one part-time employee to cover clients waiting for a high security bed). Additionally, leadership is looking into expanding jail-based services and outpatient restoration, so the mobile team's role may shift or grow in the future.

Health Equity

Health equity initiatives were built into this project, as TTI funding allowed Missouri to expand mental health services for legal-involved adults in predominantly rural settings. Missouri plans to continue sharing stories with communities to help address health deficits for legal-involved individuals with mental health needs. Basic demographic data, including race and ethnicity, is also collected to allow for data-driven equity decision making.

Peer Services Utilization

Peer support services are not currently utilized within jail-based programming and services in large part because of the challenges with recruiting peer specialists for jail-based services. However, peer services are integrated into crisis stabilization units and 988 initiatives throughout Missouri.

Trauma Informed Care

Missouri is dedicated to delivering trauma-informed services as various programming and service levels, "DMH is a trauma-informed agency so we incorporate that into any service we provide".

For further information about this project contact Jeanette Simmons at *Jeanette.Simmons@dmh.mo.gov*.

RECRUITING, TRAINING, AND DEPLOYING FORENSIC PEER SPECIALISTS (FPS) TO SUPPORT REENTRY PLANNING

NEW JERSEY

Project Background, Vision, and Outcomes

Recent bail reform in New Jersey has resulted in speedier trials and less people held in jails due to the near elimination of bail. While these changes have allowed individuals to move more quickly through the legal system, this quicker due process limits the time available to complete a thorough psychological evaluation of people arrested and booked in jail and link them to appropriate treatment.

The vision of this project was to hire two forensic peer specialist to engage with people suspected of having a mental illness and who are in the pre-trial phase. Forensic peer specialists use their lived experience to establish connections and shepherd them into community-based services. The partners that assisted in completing this work included the community provider(s) who hire the peer specialist, county jails, local courts, and pre-trial and probation officers.

The main established outcome were connections between forensic peer specialists and pre-trial individuals. Data was collected on the number of people in jail screened for a mental illness, number of people connected to follow up support, and how long the connection took. The project led to increases in connections to service among a historically underserved population.

Project Implementation: Challenges and Lessons Learned

The ongoing Covid-19 pandemic impacted both programming and operations in jails. Overall, process was slowed down from the start during the pandemic. Additional barriers to service delivery also produced delays in "getting things moving, defined, in place, and funded". Several challenges to implementation were competing priorities, slow decision making and change management processes among judiciary partners, staffing shortages, and differences in timeline expectation among partners. To overcome some of the staffing shortages, leadership increased For example, some positions that traditionally paid a $75k annual salary are now posted for $95k annually.

Sustainability and Project Legacy

This project was developed to recruit, train, and deploy forensic peer specialist to work with pre-trial individuals with a mental illness, and support them in community settings. When funding ends, New Jersey would like to make peer specialists a credentialed role who can be used throughout the system on various treatment teams. Additionally, leadership is exploring Medicaid reimbursement for mental health peer services or other avenues to make that a billable service.

Health Equity

The project was designed to address people in jail, and those recently released, with a mental

"We have peers everywhere. It is important to have the view of a peer as you are developing peer initiatives."

health need in order to facilitate access to appropriate treatment and services that can prevent decompensation and improve mental health outcomes. From an equity standpoint, the program serves people who "historically had no connections to mental health services."

Peer Services Utilization

Currently, both mental health and substance use peer support services are embedded in hospital care teams. Additionally, peers review requests for proposals and other administrative documents to ensure that appropriate and person-first language is used. Leadership continues to work towards making sure everyone understands what the peer's role is.

Trauma Informed Care

Prior to receiving TTI grant funding, leadership was already creating a trauma informed agency. Trauma informed care is incorporated into organizational trainings, and leadership strives to incorporate trauma informed care into most programming areas.

For further information about this project contact Steve Fishbein at *Steve.Fishbein@dhs.nj.gov*.

EXPANDING AND ENHANCING MENTAL HEALTH TREATMENT & REENTRY HOUSING COORDINATION FOR PEOPLE IN JAIL

OHIO

Project Background, Vision, and Outcomes

Ohio was concerned about the overrepresentation of persons with mental illness in jails, many of whom do not receive the necessary mental health services during incarceration and at time of reentry to the community. Additionally, this population experiences high levels of homelessness which complicates treatment and can further criminal-legal involvement. To address this problem, two counties in Ohio (Hancock County and Clermont County) sought to expand and improve their current mental health treatment and supportive services for individuals in local jails or who were reentering community settings.

The vision was to expand and enhance treatment and housing services to adults with mental illness and/or substance use disorders (SUDs) in and recently released from jails to mitigate the "revolving door" of people who return to jail, experience repeat homelessness, and/or become disconnected from treatment or services. Hancock County used TTI funding to hire a full-time clinician to provide trauma-informed de-escalation training to correctional staff and provide psychiatric services to individuals in jail with a serious mental illness. Clermont County focused on obtaining supportive and permanent housing for individuals returning to community from jail. Additionally, several core services including initial screening, treatment services, and linkage to community health and supportive services were expanded during the TTI grant period.

"We aren't just connecting people to treatment; people are staying in treatment."

Data was collected on a variety of indicators, including information on the number of people in jail who received services, needed crisis services, or were admitted to inpatient care. Data from Hancock County showed that the program served 719 individuals in jail, 168 of whom needed crisis services, and 11 who were admitted to inpatient care. There were also 269 completions of the GAINS discharge form during the time period. Other outcomes were a reduction in jail recidivism among persons with a serious mental illness and/or substance use disorder(s) and that they "found housing for everyone that needed it". Additionally, the grantees reported that many people who connected with treatment through the program were able to stay in treatment.

Project Implementation: Challenges and Lessons Learned

Project challenges included a limited availability of housing for forensic clients causing them to "lose people" upon discharge to the community, and significant workforce shortages that impacted both mental health and criminal justice partner agencies.

The ongoing Covid-19 pandemic impacted the state behavioral health and correctional

programming and operations systems. Specific to this TTI grant, jail closures limited and even prevented behavioral health staff from physically accessing people in jail for a lengthy period of time. This was a significant challenge that impacted some partnerships between correctional facilities and agencies.

During the grant period, Clermont County hired a designated staff member to solely work on housing and they noted that this dedicated focus increased their success with placing people in housing.

Sustainability and Project Legacy

This project was used to expand existing reentry efforts that were already in place. When funding ends, they plan on advocating for additional funds from the local county boards and other sources to sustain current and future staffing and programming needs within their health and housing initiatives. A representative from Hancock County stated that they plan to continue engaging with providers that are familiar with legal-involved patient populations and the unique health and supportive services needs for this special health population.

Health Equity

This project was designed to address the needs of people with mental illness and/or a SUD who were currently in jail or preparing to return to the community from jail, and these populations represent marginalized groups due to their justice involvement.

Peer Services Utilization

Ohio has a clear stance about the importance of peer support services, and more specifically forensic peer support services in the development of treatment plans and overall programming. Ohio does not contract with external service providers that do not hire peers within their own organizations. This shows a dedication to the peer support model of care and conscious collaboration with community providers with a shared vision on the utilization of peers within health treatment.

Trauma Informed Care

Prior to receiving TTI grant funding, leadership was already creating a trauma informed agency. All of the agency staff have been training in trauma informed care, and this continued during the expansion and enhancement of forensic health treatment and reentry housing coordination.

For further information about this project contact Jennifer Roach at *jennifer.roach@mha.ohio.gov* or Christopher Nicastro at *christopher.nicastro@mha.ohio.gov*.

IMPLEMENTING THE TREATMENT IMPROVEMENT PROTOCOL (TIP) MANUAL, TREATMENT AND REENTRY SERVICES SPECIFIC TO JAILS

OKLAHOMA

Project Background, Vision, and Outcomes

Oklahoma wanted to expand upon their use of evidence-based interventions to address the behavioral health needs of people in jail. To accomplish this goal, Oklahoma used TTI funds to develop and pilot interventions modeled after the Substance Abuse Treatment for Adults in the Criminal Justice System Treatment Improvement Protocol (TIP) Manual, with the purpose of decreasing incarceration lengths and leveraging existing partnerships.

The vision was to improve mental health treatment and reentry services for jail populations by using the TIP Manual to provide education on community resources and initiate engagement in mental health treatment and reentry services. As an example, they brought in medication-assisted treatment (MAT) including suboxone and methadone into some of the county-level in-jail services. Key stakeholders for this work included DMH, DHHS, Public Defenders Office, county jails and Commission and their Board(s), and the Criminal Justice Advisory Council (CJAC).

There were barriers to collecting outcome measures because the infrastructure for collecting treatment data is still being developed. Additionally, there were barriers with combining data from the county jail with electronic health systems due to an "archaic system" that doesn't allow "data drops". Information technology teams on the mental health and correction sides are working together, and making progress, to mitigate some of the technology-based challenges to data sharing. Project successes included increasing their contact and engagement with people in jail and an increase in risk-need-responsivity screens.

Project Implementation: Challenges and Lessons Learned

Several challenges related to jail access arose during the project period including correctional staff turnover, no/limited access to jails at certain points in time, violence in the jails, a bed bug outbreak, and limited physical infrastructure (i.e., no meeting room, no Wi-Fi, and one elevator for ten floors).

The Covid-19 pandemic prevented physical access to patients within the jails. Because of a lack of access to patients, the project team leveraged technology to provide behavioral health services (i.e., telehealth upon release). Patients were provided with physical resources (i.e., paper copies) to continue learning about resources and reentry services available upon release.

The main lesson learned throughout the TTI project period was to ask more questions about jail facilities' strengths, weakness, and infrastructure. There is also a need to understand current jail programming so that new programs don't duplicate existing treatment and/or reentry efforts and best match the facilities' needs. Additionally, there needs to be strong

"This is not a project that is going to stop when funding ends."

collaboration during project implementation to troubleshoot interagency internal barriers that can arise.

Sustainability and Project Legacy

This project was designed to improve mental health treatment and reentry services by using the TIP Manual to assist individuals in county jails. When funding ends, there are plans to continue programming and treatment initiatives developed and/or maintained during the TTI project period. Project leadership stated that "this is not a project that is going to stop". Many community-based providers are Certified Community Behavioral Health Clinics (CCBHCs) utilizing the Prospective Payment System, so funding for community partners is not a major issue to continue this work.

Health Equity

This work sought to improve access to behavioral health treatment and reentry services for individuals in jail with mental health needs. Since legal-involved individuals have traditionally been a marginalized health population, Oklahoma's in-jail behavioral health services are representative of and align with health equity initiatives.

Peer Services Utilization

Oklahoma is embedding the recovery support specialist (RSS) role in various treatment teams across several behavioral health programs. The presence of RSS allows peers to share their stories to individuals in jail and those who have been recently released with the goals of fostering engagement in treatment and providing support.

Trauma Informed Care

Oklahoma screens individuals in jail for adverse childhood experiences (ACEs), which has been linked to an increased likelihood of legal involvement and mental health treatment needs in adulthood. By completing ACEs screening, Oklahoma remains informed on the links between negative experiences in childhood and legal involvement among adults in county jails.

For further information about this project contact Dedra Hansbro at *dedra.hansbro@odmhsas.org*, Stephanie Cottrell at *stephanie.cottrell@odmhsas.org*, or David Wright at *david.wright@odmhsas.org*.

PROVIDING BEHAVIORAL HEALTHCARE REHABILITATION & RECOVERY TRAINING TO JUSTICE & BEHAVIORAL HEALTH STAFF

PALAU

Project Background, Vision, and Outcomes

Palau wanted to expand behavioral health services for individual with a serious mental illness and/or substance use disorder in jail. Traditionally, jail-based health services in Palau have been medical-based and could benefit from expanding its recovery support and psychiatric services. In recognition of this, Palau used TTI funds to train peer support specialists, providers and law enforcement officers in behavioral health care, rehabilitation and recovery. TTI partners included Behavioral Health Council members, persons with lived experiences and family members, the Ministries of Justice (i.e., public safety, LEO, and jails/prisons), Health and Human Services and Courts (i.e., probation, parole board, and transition programs) to help develop and implement behavioral health services in jails.

The vision was to provide more training and technical assistance for peer development. Several trainings were delivered throughout the funding period including a trauma-informed training series on sex offenders and those with sexualized behavior problems; Family Protection Act training for Ministry of Justice staff for working with target population in jails, deviance and violence (dual program); Trauma-Informed Peer Support (TIPS) training focused on using storytelling for healing, emotional quotient/ intelligence, and crisis support coordinated services hotline for de-escalation rather than hospitalization.

The established outcomes were measurement of jail diversion and the number and type of trainings provided (i.e., gender-based violence for peers), to include information on appropriate training space and training quality. In the near future, pre- and post-test training data will be collected to evaluate training and change of knowledge outcomes. Program successes include more awareness among project staff and partners about the quality of life among people in jail and a deeper understanding and support for recovery and trauma. Due to engagement in the TTI project, Palau got the opportunity to learn about the "richness of resources out there" regarding behavioral health care in jail settings. Also, peer specialists reported that they appreciated being a key part of a team and felt good about the services they were providing.

Project Implementation: Challenges and Lessons Learned

The ongoing Covid-19 pandemic was the major challenge throughout the funding period. The borders to Palau were closed for the majority of the funding period. Additionally, staff were not allowed access to jails due to Covid-19 lockdowns. Due to this, Palau shifted to providing trainings outside of jail settings until staff can gain access to jails (jails remained closed as of this report). Other project challenges included significant staffing limitations in jails and some criticism and push back from jail-based medical staff about the use of peer support specialists. These challenges are still being addressed and mitigated, although progress has been made.

"A good takeaway for our local peers was hearing from other peers that are already doing services, which distilled their confidence; and I want to have more peer sharing so they have more confidence in the services they provide and being a key part of a team."

Sustainability and Project Legacy

This project was designed to provide behavioral health training to peer support specialists, behavioral health staff, and justice staff including law enforcement officers. When funding ends, they plan to continue improving the recovery service(s) offered in prisons. Outside of jail settings, leadership would like to recruit more peer support specialists and create a social marketing plan to establish a community for those in recovery. At this time, Palau is planning for future behavioral health endeavors and programming in jails.

Health Equity

Improving behavioral health equity was part of the project, mainly by providing trainings that educate individuals on the rehabilitation and recovery process for individuals living with a mental illness and/or substance use disorder. Mental health block grant demographic data is used to inform decision making. Outside of the TTI grant, Palau works with organizations that strive for health equity for various groups including veterans (Palau Veteran Association), a LGBTQ+ visibility group, mothers and families, Alcoholics Anonymous, and other ethnic groups (i.e., (people from Taiwan, Bangladesh and the Philippines).

Peer Services Utilization

TTI project leadership have embraced the use of peers. Palau is looking into creative recruitment mechanisms to attract and hire new peers, because hiring peers has been a problem. Additionally, there is an ongoing struggle with gaining support for the use of peer support services in a predominantly medical model spaces, although there has been movement in shifting perspectives. Support from leadership seems to help in gaining buy-in from interagency partners.

Trauma Informed Care

Trauma-informed care is the core component of the TIPS training, and trauma-informed care has been incorporated into other trainings (i.e., strengthening family support, youth suicide prevention for those with serious emotional disturbance, and mental illness and/or substance use).

For further information about this project contact Everlynn Temengil at *Temengil.ej@gmail.com*.

INCORPORATING PEER SUPPORT SERVICES INTO TREATMENT TEAMS IN CORRECTIONAL FACILITIES & STATE HOSPITALS

PUERTO RICO

Project Background, Vision, and Outcomes

Puerto Rico wanted to better address the needs of individuals in jails with mental health challenges who were reentering into the community. Mental health treatment services were already being provided in two correctional facilities and two forensic psychiatric hospitals, but these services did not have a peer support service component. To address this problem, Puerto Rico applied for TTI funding to supplement existing mental health teams by hiring, integrating and training peer support specialists in trauma-informed care to provide reentry support.

Puerto Rico was particularly interested in helping people in jail with a history of trauma, which can impact decision making and behavior that goes unrecognized as trauma-related. Several partners were involved in implementing this project including non-profits that hire peers and provide services, case managers and coordinators from state and federal criminal justice agencies, judges, and the Department of Health who created visibility for their "invisible efforts and helped professionalize the peer support specialist role".

The main outcome for this project was the number of people served, which is about 100 individuals a month. Through the grant, 18 peer support specialists were able to attend an in-person training and 4-6 peer support specialists were hired with money allocated to assist them with specific barriers to employment (i.e., costs associated with being hired for the Puerto Rican government). Other measures of success included the ability to provide police with NARCAN training and increased collaboration with police officers.

> **"How do you [best] match the funding to a proper representation [of patients]… use peers."**

Project Implementation: Challenges and Lessons Learned

The main challenge to project implementation was a lack of collaboration between justice and mental health partners. Clinical staff that worked inside jails did not always understand or appreciate the peer support model and viewed it as a challenge to their authority or domain. Stigma against using peer support services in health treatment models was also mentioned as an ongoing challenge.

Covid-19 also posed a huge barrier to accessing jails. Correctional settings in Puerto Rico limited access to jails and this prevented peers from being able to connect with their clients as intended. To mitigate the restricted access, they started working with similar programs (i.e., NARCAN training team) that already had access to jails and increased engagement with post-release clients and those in the federal court system.

The teachable moment from this project was learning that peers need to be involved in more programming and service delivery initiatives including occupying administrative roles within state government. Additionally, more information and better systems are needed to understand how to best utilize and manage peers in the workplace (i.e., designated workspaces) and establish reporting relationships before starting on the job.

Sustainability and Project Legacy

This project was developed to expand peer support services within correctional facilities and state hospitals in Puerto Rico. After the project period, they plan on continuing to provide peer support services so long as funding is available. The legacy of this project was highlighting the utility of peer support services in programming at the intersection of mental health and criminal justice.

Health Equity

This project was designed to improve the health equity of individuals with mental health needs involved in the justice system using support from peers with lived experience. Peers that are hired represent the target population, which is one that is often underserved in behavioral health services and can benefit from additional supports.

Peer Services Utilization

This project was designed to increase the use of peer support services, by hiring and training more peers in trauma-informed care. The interviewee stated that there is an ongoing need to codify and formally incorporate peers into service delivery and mandatory training or understanding of peer support models would be useful.

Trauma Informed Care

Trauma informed care is already integrated into the health services programming for legal-involved individuals and the TTI funds were used to train 18 peers in trauma-informed care.

For further information about this project contact Juan Velez Court at *jvelez@assmca.pr.gov*.

INCREASING MENTAL HEALTH AND SUBSTANCE USE ACCESS FOR INDIVIDUALS ENTERING AND EXITING JAILS

SOUTH CAROLINA

Project Background, Vision, and Outcomes

South Carolina wanted to improve access to mental health and substance use disorder services for people entering and exiting jail by improving patient care coordination between Alvin S. Glenn Detention Center, drug and alcohol centers, and state mental health systems. Using TTI funds, South Carolina hired two behavioral health professionals to improve patient care coordination and increase referrals for individuals in jail to community-based mental health treatment within 30 days of release. By improving this treatment connection, South Carolina aimed to ensure continuity of care for jail-based populations.

Referral data was the main outcome collected for the project. With data on the percentage of referrals connected to care, South Carolina now has more information on how many individuals are seeing the most appropriate providers for their mental health and substance use treatment needs. Several data reporting challenges existed including complicated referrals, inadequate mental health and correctional staffing, and a lack of mental health screening at the detention center although the use of the Brief Mental Health Screener is encouraged.

Project Implementation: Challenges and Lessons Learned

Limited buy-in from law enforcement and an overall large reliance on human capital and resources from law enforcement were mentioned as prominent barriers to implementing the project. Following this experience, the main lessons learned were the need for early buy-in and upfront collaboration from partners to complete the strategic goals outlined in the grant. The interviewee said, "don't do it alone" and to work with partners starting at the grant writing stage. Additionally, it is important to be familiar with the existing law enforcement infrastructure (i.e., staffing levels and current internal barriers) to create realistic and feasible programming. The grant's quick timeline was also mentioned as a challenge and there was a suggestion for more time to allow for coordination with partners throughout the grant period.

The Covid-19 pandemic impacted operations where TTI project staff were "just trying to keep the mental health center afloat" and community programming had to "somewhat be put on hold". Closures at the jail prevented access to the clients inside and impaired the ability to provide jail-based services.

"The funding positioned us to have these conversations [with community partners] now, so we can absolutely now be productive."

Sustainability and Project Legacy

Funding from this project supported the hiring of two mental health professionals to improve patient care coordination and connections with community-based mental health providers for treatment; however, the program cannot be sustained without additional funding. One of the mental health professionals will remain at the state agency but their job duties and responsibilities will be expanded to support other organizational initiatives.

Health Equity

This project was designed as a "catch-all for anyone going in or coming out [of jail] with an identified mental health need". From an equity standpoint, the programs provide equitable services to legal-involved individuals with mental health needs, two groups that are often marginalized or underserved. Within the organization as a whole, "DMH has a big equity push right now", and is making plans to reach more special populations, such as military and veterans.

Peer Services Utilization

Peer support services are used on a limited basis. Currently, access to a peer support specialist is only available on a referral basis. There is only one peer support specialist at DMH, but plans are being made to hire one more peer.

Trauma Informed Care

The interviewee stated that "DMH is a trauma-informed agency, so we incorporate that into any service we provide". In this sense, trauma informed care is built into DMH's organizational framework.

For further information about this project contact Christian Barnes-Young at *Christian.barnes-young@scdmh.org* or Allison Farrell at *Farrell@scdmh.org*.

CREATING ONLINE TRAUMA INFORMED TRAINING MODULES FOR HOSPITAL STAFF, LAW ENFORCEMENT, AND JAILS

WASHINGTON

Project Background, Vision, and Outcomes

Washington wanted to increase individual and organizational knowledge regarding trauma informed care among criminal-legal and behavioral health partners by training law enforcement, jail staff, forensic hospital personnel and other community partners in the approach.

The vision was to integrate trauma informed care into the different systems that work with jail populations. Virtual training modules were developed with consultation from representatives from underserved health groups, tribal members, and trauma survivors to minimize the gap between training theory and practical knowledge applications. The initial trainings were later revised based on feedback from law enforcement and designed to be more general than proscriptive. Training topics included understanding trauma, vicarious trauma, intergenerational trauma, complex trauma, and adverse childhood experiences.

The established outcome of the project was the development of the training modules, which was successfully completed.

Project Implementation: Challenges and Lessons Learned

When conducting research on trauma informed jail programming, it was discovered that much of the correctional health literature and trainings were focused on prisons. Since jails have different

"TTI funds provided another avenue for trauma-informed training."

structures and programming needs than prisons, this limitation created the need for an inductive approach to creating a trauma informed training program that was appropriate for jail stakeholders. This led to another challenge wherein law enforcement did not think the training was reflective of their job positions and could see it was developed by someone "off the beat". By working closely with law enforcement to receive their feedback, Washington TTI grantees were able to focus the training at the more general level to be more reflective of various components of law enforcement.

The ongoing Covid-19 pandemic was not a barrier for this TTI project. The virtual nature of the trauma informed trainings meant that the modules could be developed without physically accessing jail and/or hospital settings. This project highlights the benefits of technology in delivering training and development tools for health and law enforcement despite major external factors.

Sustainability and Project Legacy

Using TTI funds, Washington has been able to increase and expand trauma informed training to various health, law enforcement, and jail job positions throughout the state. The legacy of

this project is the creation of a trauma informed system between health and justice partners that frequently service the same population.

Health Equity

This project was designed to improve the individual and organizational knowledge about trauma informed care. The grantees sought to increase awareness and education about trauma informed services so that partners could provide more equitable services to jail-based populations.

Peer Services Utilization

The focus of this grant was not peer-specific, although Washington currently utilizes peer support services are used within the health delivery model. There is a peer support specialist on various teams (e.g., hospital and community) and they have access to trauma informed training.

Trauma Informed Care

Prior to receiving TTI grant funding, Washington was already working to create a trauma informed agency and had worked with a contractor to develop a trauma informed training.

For further information about this project contact Tim Hunter at *timothy.hunter@dshs.wa.gov*.

This work was funded by the Substance Abuse & Mental Health Services Administration under Contract HHSS283201700024I75S20321F42001, Task 5.4., and the National Association of State Mental Health Program Directors (NASMHPD), Inc.