I. Statement of the Problem

Montgomery County, Maryland has vital missing elements needed to allow for more effective reentry of individuals with serious and persistent mental illness and co-occurring behavioral health disorders. The grant would allow the County to create a continuum of care from booking to stability in the community for non-violent individuals with co-occurring behavioral health disorders who will transition to community beds that are, hopefully, permanent with access to supportive community based treatment services. Currently, services for this population are fragmented between the Montgomery County Departments of Health and Human Services (HHS) and Correction and Rehabilitation (DOCR); clients receive services while incarcerated that are not linked to community based care. These individuals recidivate at nearly 100% and are booked into the jail system repeatedly for non-violent nuisance offenses. These offenses are directly related to behavioral health disorders that could be managed more effectively and safely in the community if housing and community services were available and better coordinated with jail-based services. While the number of individuals entering the jail system with co-occurring disorders is large, this program targets a much smaller subset of "frequent fliers" who expend substantial police, judicial and correctional resources.

The Montgomery County, Maryland Correctional System

Montgomery County is Maryland's most populous county, with nearly 1 million residents, located in the west central part of the state adjacent to Washington, D.C. Law enforcement officers in Montgomery County process all newly arrested individuals through the Montgomery County Detention Center Central Processing Unit run by DOCR. It provides progressive and comprehensive services for individuals accused and convicted of crimes through the use of pre-trial supervision, secure incarceration, community treatment and reintegration programs.

In January 2014, Montgomery County received the results of a year-long master confinement study conducted by one of the leading correctional planning and architectural firms in the country.[1] The report indicated that additional programming is required to meet the needs of the one in five individuals in county corrections facilities identified as being mentally ill and the one in two classified as having drug or alcohol issues. Study authors recommended substantial expansion of diversion and reentry programs to reduce jail populations and get offenders with co-occurring disorders into situations in which they could be stabilized and re/connected with services in the community. It found that the discharge planning resources largely ended at the time of release.

The Target Population consists of those individuals with serious and persistent co-occurring disorders who have recidivated within the past three years, have no outstanding warrants or detainers in other jurisdictions and are either sentenced to a local sentence (less than 18 months) or are facing charges that will not present with public safety concerns. In 2013, HHS' Clinical Assessment and Transition Services (CATS), located in the correctional facility, identified 19% (1,571) of the incoming population as having co-occurring mental health and substance abuse disorders. HHS discharge planners served 474 individuals with reentry services in 2013. Among them, 120 were identified as seriously and persistently mentally ill with substance abuse disorders, often homeless, and cycling through the system with multiple misdemeanor and nuisance offenses. It is expected that nine in ten participants in the program would be defined as high risk to reoffend based on LSI-R scores and that 20% would be women.

Baseline Recidivism Rate Since July 2012, the Montgomery County Pre-Release and Reentry Services (PRRS) Division has calculated one and three year recidivism rates of individuals released from the Pre-Release Center. Recidivism rates for individuals released from PRRS are 11% for one

[1] Montgomery County, Maryland Master Facilities Confinement Study, Ricci Greene Associates, January, 2014.

year and 29% over a three-year span with the definition of a recidivist event as a new conviction or a violation of probation and parole (see attachment). As these rates are defined for the entire population of released individuals, they underreport the recidivism of individuals with co-occurring disorders. The target population recidivism rate is nearly 100% anecdotally. PRRS will recode the existing databases and identify those individuals who had been diagnosed with co-occurring behavioral disorders to recalculate recidivism rates for this subset population.

The Current Reentry Process Offenders identified with co-occurring disorders face many challenges upon release from jail, whether they are being diverted shortly after their arrest or after serving a local sentence. Reentry is a highly vulnerable period of time, especially when individuals face homelessness, lack adequate access to appropriate treatment and medications, and do not have family or social supports. They are at risk of quick relapse to substance abuse, acute psychiatric symptoms, an increased risk of overdose, and reoffending.

Montgomery County does have in place many of the necessary components of successful reentry in a collaborative effort between HHS and DOCR. Within 24 hours of booking into the Montgomery County Detention Center, inmates are screened; those with behavioral health concerns are further evaluated by staff of CATS to determine their treatment needs and diversion potential. Those not diverted are then tracked throughout their stay, with CATS staff monitoring their changing legal status in an effort to prioritize discharge planning for those likely to be released within 30-45 days. During their incarceration they receive a variety of services, including psychiatric care, and access to therapeutic communities offering mental health, substance abuse or CBT services.

HHS discharge planners, who serve county residents with behavioral disorders, utilize evidence-based practices including early screening and integrated needs assessment, Motivational Interviewing (an EBP enhancing the likelihood of engaging a client in services) and a close adaptation of the

APIC (Assess, Plan, Identify, Coordinate) model for reentry developed by the SAMHSA-funded National GAINS Center for People with Co-occurring Disorders in the Justice System.[2]

Discharge planners within the jails attempt to engage co-occurring offenders, motivate them to accept treatment and stabilize them, using existing programming, pending their release. Once offenders are released, however, case management services are extremely limited. Inmates are referred to community based resources upon release but without follow up, inmates fail to connect with them.

II. Project Design and Implementation - What BJA Funds Would Enable Us to Do

The BJA grant would provide an opportunity to create a Rapid Reentry Program (RRP) that would create a close operational collaboration and development of common vision on assisting a group of difficult-to-serve clients that are currently served by a fragmented system. These enhancements include:

1. Intensive wrap around case management that adapts in intensity according to individual risk/needs, is culturally sensitive and focuses on criminogenic factors. This service would begin within the jail, meet clients at the gate upon release and continue assisting them to problem solve and negotiate the multiple obstacles that can easily sabotage the reentry plan. This function would be performed by a newly-created FACT team to provide forensic case management, embedded within an existing ACT team. Case management and aftercare will continue for 10-12 months post release and will adapt to the emerging and changing needs of the clients.

2. Housing Location Services – the Montgomery County Coalition for the Homeless (MCCH), which operates all of the county's emergency shelters and 40% of transitional shelters and permanent supportive housing for the mentally ill, would provide housing location services to match

[2] http://gainscenter.samhsa.gov/pdfs/reentry/apic.pdf.

client needs to existing housing and locating new housing resources. MCCH would also bring advocacy to potential landlords on the needs of the mentally ill offender population to help overcome housing barriers existing due to stigmas around mental illness and criminal records.

3. Nationally recognized experts would train staff using SPECTRM (Sensitizing Providers to the Effects of Correctional Incarceration on Treatment and Risk Management) on the impact of incarceration on clinical needs; and RNR (Risk/Need/Responsivity), an emerging evidence-based practice that (a) identifies the appropriate level of treatment and supervision to match the risk of reoffending, (b) recommends treatment that addresses the clinical need associated with criminality and (c) designs an intervention that matches what the client is most responsive to with appropriate services.

Eligible program clients would be identified upon booking by the CATS program, a forensic assessment and clinical diagnosis would be made and a recommendation generated. Depending on the level of risk and clinical need and with concurrence from the Court, State's Attorney, Public Defender, and Corrections, these individuals would then be stabilized in a variety of settings for an estimated 60 days or less. The settings available for stabilization include the proposed new option to transfer to DOCR's 171-bed Pre-release Center (PRC) for approximately 60 days, or more traditional options such as stabilizing in jail detention, placement in residential treatment programs, or transitional housing, as deemed most appropriate in each case.

Rapid Re-entry Program staff (including the forensic case manager, the housing services provider, CATS and DOCR staff) would coordinate treatment planning, and utilize judicial supports, correctional structure and supervision, housing location services, FACT wrap around services, and enhanced options to stabilize participants including the PRC or other appropriate placement options. The staff would seek placements into transitional or permanent housing upon release and continue to provide services to each client for a minimum of 10-12 months.

The range of potential scenarios addressed by the Rapid Re-entry Program would include sentenced and moderately stable individuals who could be stepped down to the PRC, a new and innovative use of community-based correctional beds to serve the target population, for an average of 60 days and begin the transition to community services. The PRC would provide medical and behavioral health care in its structured and supervised environment in addition to community based services through HHS. Other individuals served by the RRP program who have legal cases pending may still be unstable psychiatrically. These individuals may be best served in the correctional facility and participate in treatment services there. Services in the correctional setting would include medication management in general population or housing in one of the following existing treatment pods: Choices for Change (addressing criminal thinking with a Cognitive Behavioral approach), Crisis Intervention Unit (staffed by mental health staff trained in Dialectical Behavior Therapy, or DBT) or Jail Addiction Services (JAS), a state certified substance abuse program.

All targeted clients, regardless of their legal status or chosen location of stabilization, would be served by the FACT team. The forensic case manager would engage participants early, starting upon entry into the detention facility through their discharge to the community, when the full FACT team services would provide the wrap-around supports necessary. FACT would provide a coordinated interdisciplinary approach including legal advocacy, discharge planning, psychiatric services and various treatment modalities to address clinical as well as criminogenic factors.

Project goals include:

- Identify 120 individuals with moderate to severe psychiatric and substance abuse disorders who are frequent utilizers of jail and community-based services
- Among the 120, address the needs of at least 25 women with gender-specific care
- Stabilize the target population in the most appropriate correctional setting, while progressively engaging them in community based treatment, prior to reentry
- Serve program participants through a forensic inter-disciplinary approach from booking to post release with dynamic ongoing assessment, individualized, trauma informed and culturally competent treatment services and case management that would engage behind the walls, meet the inmate at the gate upon release and support emerging needs that might interfere with carrying out the planned services

- Enroll all participants in the most appropriate benefits plan per the Affordable Care Act
- Provide housing location services prior to release for every individual facing homelessness
- Reduce one-year recidivism rates among participants by at least 15%. For those who do recidivate, lengthen the amount of time between release and the recidivist event by 15%. As the analysis captures both the occurrence of the recidivist event and the date, Kaplan-Meier Survivor Estimates will be calculated. The program will aim to increase the number of days by 15% at which the Survivor estimate equals a probability of .5.

Planning Phase

During the planning process, the HHS manager of Adult Forensic Services would assemble a Rapid Reentry Workgroup (RRW) to work closely with the BJA technical assistance provider, in order to complete the Planning and Implementation Guide in compliance with the grant's terms. The RRW would use the planning phase to elucidate details of each step of the proposed reentry model and the specific evidence based models of practice that would be used from screening and assessment to integrated forensic planning, treatment and continuous care after release. To start with, the Workgroup would examine the procedures for screening and assessing eligibility to ensure that procedures are objective and evidence-based. Next, the committee would continue HHS' current research efforts to find ways to use the Affordable Care Act to fund services for individuals with co-occurring disorders. Finally, the Workgroup would develop specific procedures to ensure that the project fully utilizes the enhanced Continuum of Care model (from arrest to 12 months post release) for service delivery. It would develop inter-agency Memoranda of Understanding; refine and adjust reentry procedures; and research and design training modules for staff of partner agencies. The training modules would introduce to staff both the SPECTRM (Sensitizing Providers to the Effects of Correctional Incarceration on Treatment and Risk Management) and the RNR (Risk, Need, Responsivity) models.

The Planning and Implementation Guide would include vision and mission statements, project goals, and risk assessment procedures, as well as a strategic plan that incorporates evidence-based programs, policies, and practices. Later in the project, the RRW would develop a strategic

plan to ensure long-term systems change and sustainability. Throughout the planning and implementation phases, the project would take advantage of the already existing Criminal Justice Behavioral Health Initiative (CJBHI) which is fully endorsing this proposal and will serve as an advisory board. The CJBHI is a long-standing collaborative body that has grown to incorporate public and private treatment providers, court personnel, drug court officials, judges, elected officials, corrections, NAMI, probation and parole agencies, police, public defender, state's attorney, housing agencies, hospitals, homeless resources, state mental hygiene administrators, and a representative of the county executive (see the attached roster). The CJBHI was instrumental in the creation of services such as CATS, CIT, Mobile Crisis, and a mental health pilot diversion program. During the planning phase, the RRW would meet weekly, while the CJBHI would receive project updates and presentations at bi-monthly meetings. Between meetings, the project director would communicate with members of the Rapid Reentry Workgroup and the CJBHI via email and phone to ensure that particular tasks were carried out, deadlines met, and the CHBJI kept abreast of emerging matters.

Operational Guidelines

The protocol will be flexible enough to address various clients who will differ in their current legal status, clinical stability and needs, preferred location of stabilization and range of services upon reentry. The various protocols would include:

1. *Sentenced and Stable*: Sentenced inmates who are moderately stable psychiatrically would be housed at the PRC in a structured and accountable environment for an average of 60 days. There they would be tested regularly for alcohol and illicit drug usage and receive assistance with employment and education, medical care, and reentry planning organized around criminogenic factors. They would be allowed to access community treatment and recovery oriented support groups including AA/NA meetings and family members will be invited to

meet with the FACT team case managers, housing locator and also attend support and educational groups.

2. *Pre-Trial and Stable*: Inmates with pending charges who are moderately stable psychiatrically would be diverted to appropriate community based settings and held in the correctional facility until such bed space is made available for a direct transfer. Those deemed appropriate to transition directly into community based residential treatments or transitional housing would also receive forensic case management, housing location services and integrated treatment services of the existing community based continuum of care.

3. *Sentenced and Acute* : Sentenced inmates with severe psychiatric symptoms who are deemed too unstable for the PRC setting, would be recommended for stabilization in the correctional facility and would be placed in the most appropriate therapeutic unit, already operating at MCCF. Such units include the Crisis Intervention Unit, the Choices for Change Unit or the JAS unit. They also could be housed in general population and receive DBT, and medication management, One Stop vocational services and enrollment in health care. Should their psychiatric status change, they would be considered for step down to the PRC.

4. *Pre-Trial and Acute*: Inmates who have pending charges and are deemed too unstable psychiatrically for community based placement would be referred to residential treatment programs in the community. They would be kept in the correctional facility until the designated bed space became available for a direct transfer. While detained for stabilization, they would participate in the most appropriate treatment unit. They also could be housed in general population and receive DBT, medication management, One Stop vocational services and enrollment in health care.

Regardless of the individual protocol, all participants in the Rapid Reentry Program would receive a common set of services. These include:

Early identification upon booking The RRP would identify potential candidates prior to their first court appearance for bond review or within 24-52 hours of arrest. Protocols for this initial screening are largely in place already and would be refined during the planning phase of the project. CATS staff would provide a full assessment of each potential candidate's clinical needs and level of motivation and make a recommendation. CATS' assessments would incorporate the LSI-R, the standardized and normed risk assessment instrument most widely used by criminal justice agencies (or other appropriate risk assessment tool) in addition to other diagnostic instruments currently in use.

Forensic intervention with the support of the Public Defender, State's Attorney's Office, Courts and DOCR RRP recommendations, with input from the CATS staff would be presented to Pretrial Services Unit, State's Attorney, public defender, and courts, which would collaborate on an appropriate disposition – either diversion or a plea with probation. In either case, participants would be under correctional and court supervision that would collaborate to enhance motivation and compliance.

Reentry Planning While individuals are in custody, the RRP team would begin discharge planning. The team would develop accountability procedures and a unique reentry plan for engagement with community-based providers with either Pre-Trial or Probation supervision. In its efforts to engage program participants, the RRP team would attempt to increase intrinsic motivation by using such evidence based practices as motivational interviewing, assessing level of motivation, and employing a variety of clinical interventions to encourage and support compliance with treatment. The team would develop an individual reentry plan that would lay out specific strategies to address each individual's specific criminogenic factors. Using the RNR model, the RRP team would follow an integrated continuum of care model that provides higher and more targeted services for individuals assessed with higher risk and needs, tailoring intervention modalities to what each client might best respond to while in care.

Forensic case management and FACT wraparound supports Once clients are transferred to transitional housing, they would engage with the whole FACT team array of services. Case management services would include medication management, independent living skills assessment, health promotion and nutritional training, supportive counseling, substance abuse treatment, vocational counseling, advocacy, and referrals to a wide network of community resources. The forensic case manager of the FACT team would act as a boundary spanner able to fluidly guide the client through the correctional system, treatment agencies, the courts, probation or pre-trial supervision agencies, law enforcement agencies and continuing to provide aftercare post-release in the community.

Housing location services Housing being a key factor in a successful transition, the RRP team would employ housing location services to identify transitional or permanent housing options that individuals will be moved to following stabilization and release. Current options include Shelters and Safe Haven transitional housing for those with mental illness. These would be enhanced with the advocacy of the RRP housing location services staff, who will make a determination of the appropriate choice of transitional housing based upon written protocols developed during the planning process.

Involvement of community supervising agency (probation officer or Pre-Trial Case manager) Upon release, for those who receive a sentence including probation or for those that are released on bond, the team would meet with either the probation officer assigned to the individual or the Pre-Trial case manager and ensure that that they are included as part of the post-release team. The FACT team would report on clients' progress, and for those continuing under probation, engaging the support of the supervising agent in enhancing treatment compliance. Knowing the likelihood of relapse in the population, if participants slip while in the community, they could be referred directly into more intensive levels of care currently available in the continuum of care. The reentry plans also may include procedures developed between the RRP team and police CIT to develop protocols for pre-

booking intervention and stabilization for any minor future incidents involving the police while participants are in the program.

III. Capabilities, Competencies, and Coordination

Management structure and staffing of the project. The responsible agency is HHS. The CJBHI will serve as an advisory board and facilitate problem solving at the highest administrative level. The HHS Manager of Adult Forensic Services, Athena Morrow, will administer the grant and create the multidisciplinary team for the RRP, which would be staffed by combining existing and proposed resources. Stefan LoBuglio, Division Chief for PRRS, will provide guidance and expertise from DOCR. Existing programs/staff include the HHS CATS assessment/discharge team, the DOCR Pre-Trial Assessment Unit and DOCR mental health, substance abuse and psychiatric staff to provide screening, assessment, recommendations to the courts and initiating the reentry process. Proposed staff would be hired as follows: a forensic case manager, a substance abuse counselor and an administrative support staff by the existing ACT team, managed by People Encouraging People (PEP), who would follow through with the reentry plan and provide case management and wraparound supports in the community. Housing location services and advocacy would be provided by the Montgomery County Coalition for the Homeless (MCCH). See the attached Position Descriptions.

Capabilities The project components would be embedded within the existing service delivery system, as part of a comprehensive and integrated model of behavioral health and somatic treatment. HHS is a large, full service agency offering a range of services including public health, an extensive continuum of care under behavioral health and crisis services, child welfare, income supports, aging and disability services and special needs housing. HHS has demonstrated experience and success in implementing grant-funded projects including funding from SAMHSA and BJA. In accordance with the Affordable Care Act, HHS is implementing a new Electronic Health Record

(EHR) that will provide an online medical record for all services HHS provides in primary care and behavioral health clinics, allowing our practitioners to access important medical information and better integrate services. The EHR will support billing of public and private insurers for the clinical services provided. DOCR's pre-trial and jail facilities and programs are accredited by the American Correctional Association, the Maryland Commission on Correctional Standards and the National Commission on Correctional Health Care. The previously cited Master Confinement study confirmed the county as a national leader in innovative programs that promote a least restrictive approach to serving pre-trial populations and individuals transitioning from jail to community. It details the many diversionary programs already developed and successfully implemented through a highly collaborative approach between criminal justice and health and human service stakeholders. It noted the county's resources for co-occurring offenders, including police officers trained in crisis intervention techniques, assessments on all individuals entering the jail, outstanding medical and psychiatric care in DOCR facilities, evidence based substance abuse services and reentry programs. DOCR received a Second Chance Act grant in 2010 that developed a Workplace Digital Skill Training program at PRC that still continues to operate after the grant's close-out.

Partnerships with community-based behavioral health treatment programs HHS and DOCR run collaborative programs in the correctional facilities that assist with linkages to the community: the HHS continuum of care with direct access to special needs housing, various levels of substance abuse treatment, including outpatient, intensive outpatient, residential and extended residential levels, all co-occurring enhanced and access to crisis services. HHS manages the contracts for treatment non-profits providing a continuum of mental health services, including PEP, all offering integrated care. Homeless resources are available from MCCH and Bethesda Cares, all providing a variety of transitional and permanent supportive housing and services. The applicant jurisdiction is <u>not</u> a current recipient of funds from other BJA administered programs.

IV. Impact/Outcomes, Evaluation, and Sustainment, and Plan for Collecting the Data Required for this Solicitation's Performance Measures

An independent evaluation will be conducted by Choice Research Associates (CRA). There are three primary purposes of this evaluation component. First, Shawn Flower, Ph.D., and Principal Researcher of CRA will utilize the Program Development and Evaluation (PDE) plan (see attached), to facilitate a series of workshops to engage key stakeholders in a collaborative effort to set implementation standards, short-term objectives and long term goals that are tied to empirically supported theory and best practices. In addition, all long term goals and short term objectives note not only when the program is likely to have an impact, but also the degree of impact, and stating precisely how it will be measured. For each important program component, implementation standards define the timing, the frequency and/or duration of the intervention, who receives the intervention, and who delivers the intervention, and how. These plans will be further informed and revised based on meetings and feedback from BJA. CRA will provide ongoing technical assistance to stakeholders to resolve any data issues; review existing data systems and make recommendations for changes to those systems to ensure that all the data necessary to implement the process and outcome evaluation are reliable measures. At the end of the first year, CRA will review recidivism data provided by PRRS and then at the end of the project, CRA will obtain state criminal history data and combined with program data, conduct a detailed recidivism analysis of the participants.

There are several sources of data that will be utilized in this evaluation. While the final data elements will be determined through the PDE process and in collaboration with BJA, we anticipate outcome and process data will be captured in an Access database customized to meet the program requirements and maintained by the RRP staff and/or obtained from existing administrative records. Anticipated program data elements include:

- Assessment and diagnosis information from the FACT team initial assessment;
- Level of Service Inventory Revised or other appropriate assessment tools data;

- Protocol designation (e.g., "Pre-Trial and Acute," "Sentenced and Stable");
- Rapid Reentry Program treatment and discharge plans;
- Dosage of treatment services provided by modality, number of sessions, and hours of treatment provided both within the community and while in MCCF;
- Housing status and changes in housing while engaged in the program;
- Referrals to wrap-around services and follow-up to ascertain if referrals were utilized;
- Dates of client specific meetings with project partners and outcomes of those meetings (e.g., probation officer to coordinate post-release plan);
- Compliance with treatment plan including urinalysis results, appointments kept/not kept; and medication compliance as indicated by prescription refills;
- Outcomes among participants include Emergency Room hospitalizations and housing stability;
- Recidivism outcomes (arrest, conviction and reincarceration) will compare participants to a matched or randomly assigned comparison group of non-participants.

All those assessed for program eligibility will be tracked and linked to recidivism data through their Maryland State Identification Number. An application to obtain criminal justice data has been submitted to the Department of Public Safety and Correctional Services, their letter of support is attached. Recidivism for program participants will be compared to those who do not participate. We will explore conducting a randomized controlled trial, but if that is not possible, we will conduct a strong quasi-experimental design using either regression discontinuity or propensity score matching based on CJIS criminal history data, assessment information, and administrative records.

Sustainability Long-term support and resources for the program will be available through billing for services after the initial investment to create the FACT team is made through the grant. There is strong support among the partners of the need for this program as evidenced by the attached letters of support. Once 70 consumers eligible for services billed to public programs are engaged, the FACT team will be self-sustaining based on the operations of eight Maryland based ACT teams by PEP. No new policies, statutes, and regulations are anticipated as needing to be put in place to support and sustain service delivery though after review with the BJA technical assistance provider during the Planning Phase, some may be identified.