Best Practices Review:

Transition Planning for Homeless Persons Leaving Local Jails Initiative

What is transition planning?

Transition Planning: Preparation and strategy for each individual prisoner's release from custody, preparing them for return to the community in a law-abiding role after release.

Overview of Presentation

I. Homelessness among jail and prison populations: How large of a problem?

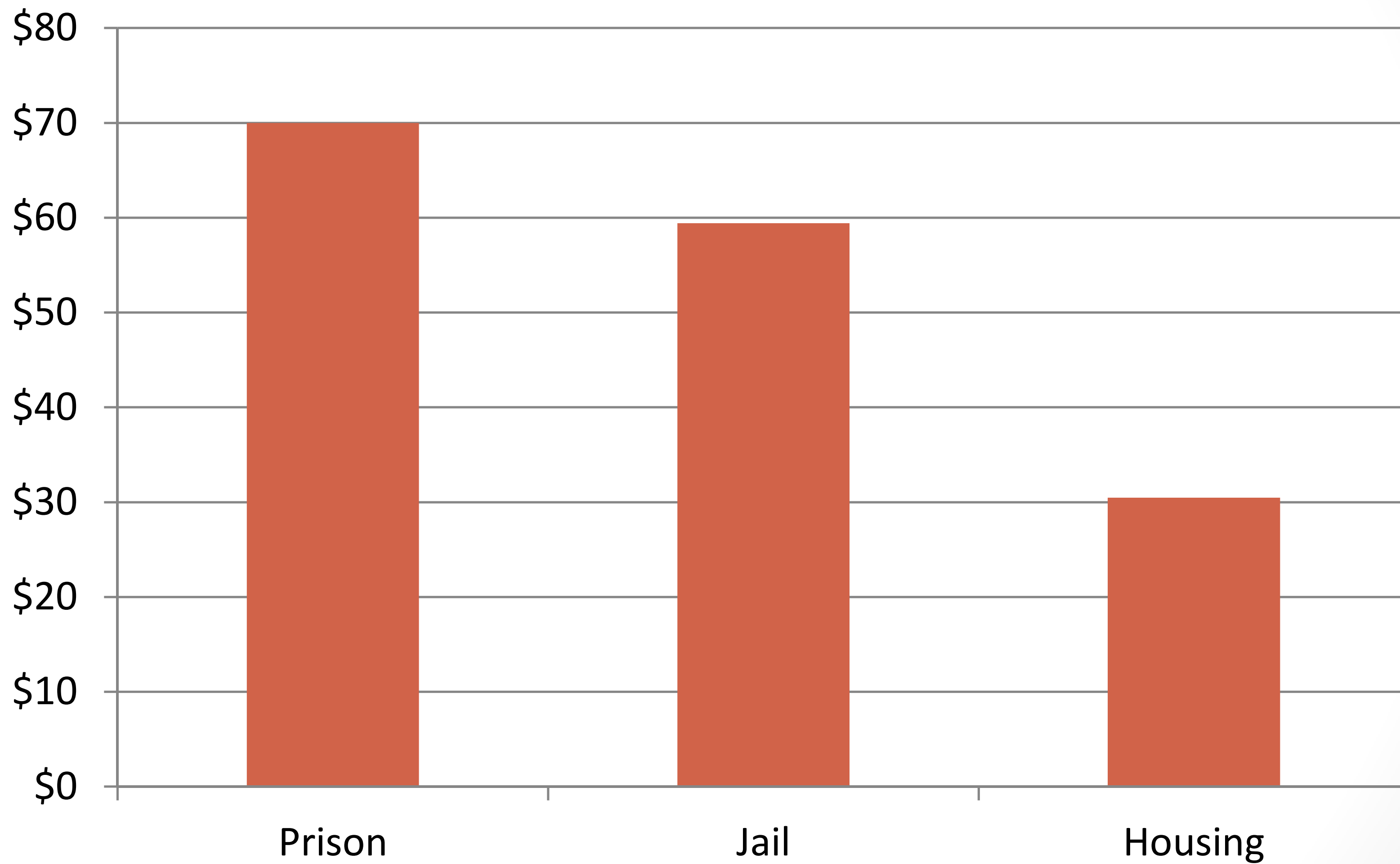
II. Evidence-based Best Practices

III. Broader Models to Consider

How Big of A Problem?

- More than 25% of offenders entering jails and prisons in the U.S. are **homeless** in the months prior to their incarceration (Bureau of Justice Statistics [BJS]).
- The rate of homelessness among offenders is **doubled** for those with mental illnesses (BJS).

Comparing Cost Per Day



Source: Manhattan Institute for Policy Research, 2000 constant dollars

Challenges Among this Population

- Mental illness and substance problems
- High-risk: i.e., medical issues
- Inadequate pre-release preparation
- Resource constraints

II. Evidence-based Transition Practices

Programs by Planning Stages

1. **Prevention and Diversion**
   - Macomb County, Michigan: Mental Health Jail Reduction Program (MHJRP)
   - Boulder, CO: Partnership for Active Community Engagement (PACE)
2. **Identifying Homeless Offenders and Assessing Needs**
   - Frequent Users Service Enhancement (FUSE)
   - Hampden County, MA: Correctional and Community Health Program
3. **Transition and Discharge Services During Incarceration**
   - Allegheny County, PA: Allegheny County Jail Collaborative (ACJC)
   - Auglaize County, OH: Auglaize County Transition Program (ACT)
4. **Sustainable Housing Programs Post-Release**
   - Olympia, WA: Mentally Ill Offender Community Transition Program (MIO-CTP)
   - Portland, OR: Multnomah County Transition Services Unit (TSU)

1. Prevention and Diversion

Macomb County, Michigan

- **The Mental Health Jail Reduction Program (MHJRP)**
- Designed to reduce non-violent, mentally ill population in jails
- Collaborative:
  - Law enforcement
  - County mental health
  - Courts

MHJRP: Elements

1. Diversion

- Police officers are trained to identify mental illness
- Some offenders end up in jail

2. Multiple Sanctions

- Requests made for early release to:
  - Residential treatment
  - Outpatient treatment

MHJRP: Services

Services Before Release:

- **Housing assistance**
- Treatment with psychiatrist
- Medication
- Transportation
- Individual assessments

Diversion includes a range of community sanctions:

- Substance abuse treatment
- Monitoring services
- Substance use testing
- Community service
- Pretrial release supervision

MHJRP: Cost Savings

MHJRP Yearly Estimated Cost	$292,000 (for 100 participants)
Average length of stay expected to divert	60 days per participant
Jail bed days saved per year	6,000

- Reduction in incarceration time saves county an estimated $733,200/year (6,000 x $122.2/day)
- Additional beds are saved in the long-term by providing intervention

Colorado: PACE

- **Partnership for Active Community Engagement (PACE)**
- PACE is a **Boulder County** initiative that has expanded to more jurisdictions, including various Colorado cities and elsewhere
- Integrated program to reduce jail use by targeted homeless and mentally ill population
- Effort between community agencies and county jail
  - Non-residential diversion program
  - Must have mental illness

PACE: Services

- One-stop services
- Case management
- Daily support
- Employment, housing, and benefits assistance
- Life skills training
- Substance abuse and mental health treatment

PACE: Success 2000-2006

Clients	Before	After
Employed	33%	61%
Receiving Disability	15%	27%
Substance Abuse	98%	32%

CAVEAT: Selection Bias! Comparison group of homeless, mentally ill jail releases from a time period before the program was implemented

Cost-Benefit Analysis

	Daily	Annual
Jail Cost Per Person	$59	$21,535
Program Cost Per Person	$21	$7,655
Savings Per Person	**$38**	**$13,880**

Total Annual Savings: $902,200 (for 65 participants)

2. Identifying & Assessing Needs

Frequent Users Service Enhancement (FUSE)

- **Target population:** individuals with a serious mental illness and/or co-occurring substance abuse.
- **Jurisdictions:** Began in Washington (DC), New York (NY)
- **Replicated**: Minneapolis (MN), Seattle (WA), Hartford (CT)

FUSE: Elements

- Requires **data sharing** and an **integration** of information systems.
- Match data between jails and community agencies.
- Eligibility varies across sites. For the NYC site, frequent users of jails are defined as individuals with:
  1. 4 or more jail episodes in the last 5 years
  2. 4 or more shelter episodes or more than 1 year of continuous shelter use in the last 5 years
  3. A qualifying serious and persistent mental health diagnosis

FUSE: Evidence-Based Practice

- Results displayed high-need
- Prevalence of co-occurring disorders
- Intervention saved cost
- Improved well-being

FUSE, NYC: DOC Savings

	FUSE	Comparison
Avg. Days Pre	52.8	45.0
Avg. Days Post	25.0	36.0
Avg. Days Avoided	27.8	9.0
% Days Avoided	53%	20%

Per Diem Jail/Shelter Cost from NY Cost Study (Culhane, 2002)	$129
Annual Cost Saved Per Person	$3,586

FUSE, NYC: DHS Savings

	FUSE	Comparison
Avg. Days Pre	58.2	26.6
Avg. Days Post	4.6	7.0
Avg. Days Avoided	53.6	19.6
% Days Avoided	92%	74%

Per Diem Jail/Shelter Cost from NY Cost Study (Culhane, 2002)	$68
Annual Cost Saved Per Person	$3,645
*Combined Annual DOC & DHS Cost Saved Per Person:	$7,231

FUSE: Housing

- Housing study completed in MN
- Conclusions may not be generalizable
- Placement in affordable/sustainable housing
- Case manager & structure until stability achieved
- Promising outcomes

Hampden County, MA

- **Hampden County, (MA) Correctional and Community Health Program**
- The Community Health Program is a public health model used to develop a database for hepatitis patients
- Patients assigned to a health team by zip code or prior association with health center.

Information Sharing

- **Information sharing**: the Community Health Program uses shared electronic medical records used by the jail and contracted community health centers.

- Relevant information regarding the transition plan is available to community providers to ensure the common understanding of release goals and objectives.

3. Transition & Discharge Services

Allegheny County, PA

- Allegheny County Jail Collaborative (ACJC)
  - In-jail human services to inmates
  - Transitional reentry services to released inmates through referrals to community-based organizations
  - Reduce recidivism
- New inmates screened during intake

ACJC: Elements

- Joint effort between county jail, Human Services, and the Health Department
- **Focuses**: Family reunification, housing, substance abuse & mental health treatment, employment and community engagement

ACJC: Evidence Based Practice

- Pre-ACJC (N=33,487) randomized comparison sample
- Post-ACJC (N=41,865)
- ~ 300 participants annually
- Quantitative data: violations, recidivism, completion of programming
- Qualitative assessment: focus groups and interviews

ACJC: Cost Savings

- Greatest cost-savings generated by ACJC:
  - Public Safety
  - Reduced Victimization
  - Decreased Institutionalization

ACJC: Results

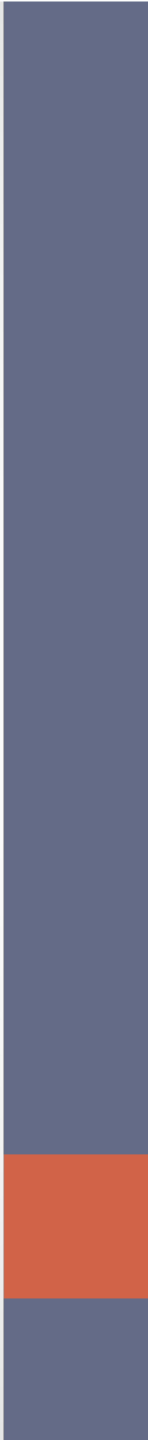
Proportion of Recidivists

	ACJC	Comparison Group

60
50
40
30
20
10
0

12-Month Recidivism Rate
2-Year Recidivism Rate

ACJC
Comparison Group



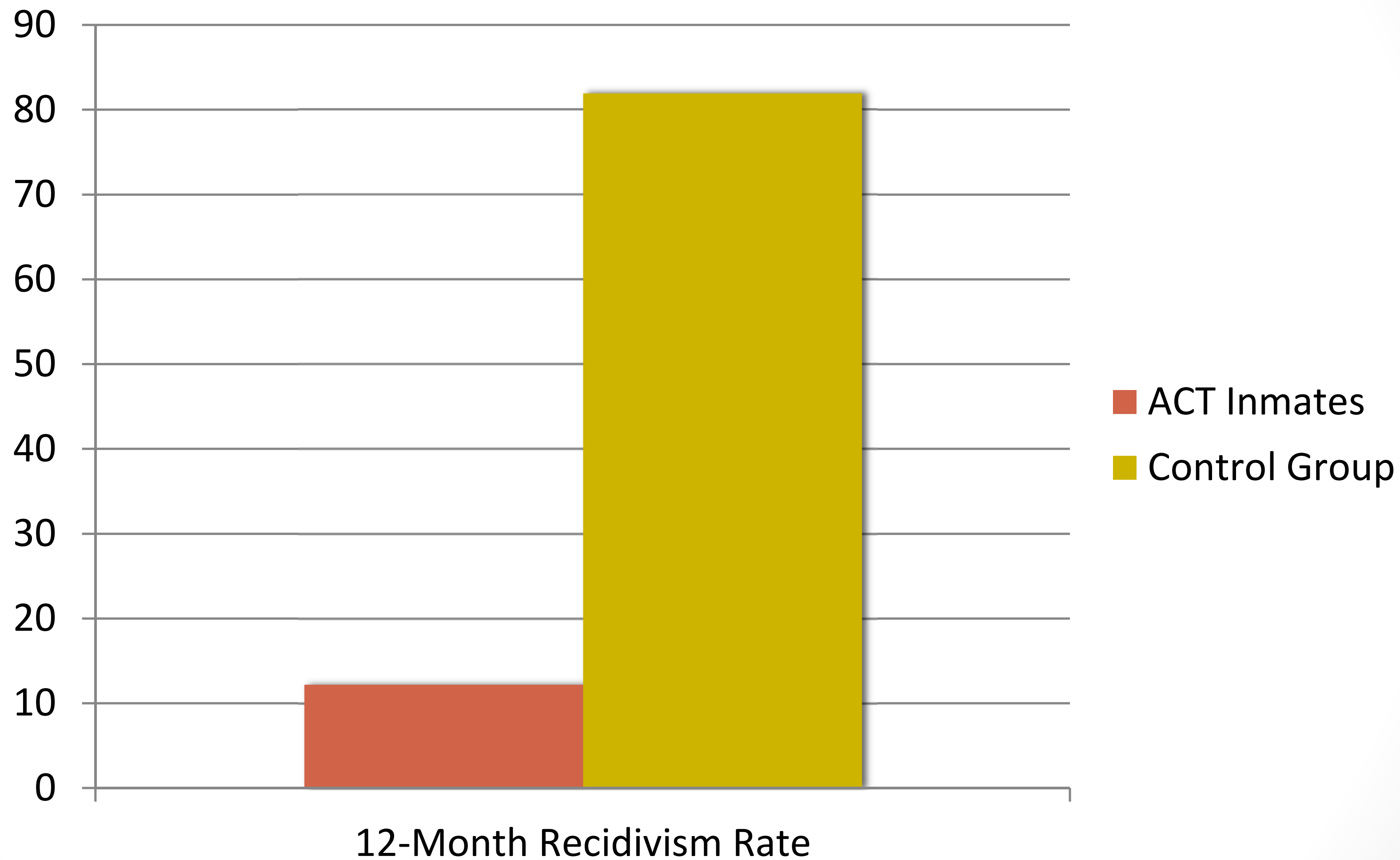
Auglaize County, OH

- **Auglaize County Transition Program (ACT)**
- Comprehensive approach to addressing individual inmate problems
- Interdisciplinary collaboration of partners
- Assess **immediately** at intake
- **"Reentry Accountability Plans"** to assist offenders both during and after incarceration based on individual needs

ACT: Evidence Based Practice

- 2010 Quantitative study
- ACT experimental group (N=73)
- Control group (N=72)

ACT: Results



- Based on ACT experimental group (N=73) & Control group (N=72)

4. Sustainable Housing Programs Post-Release

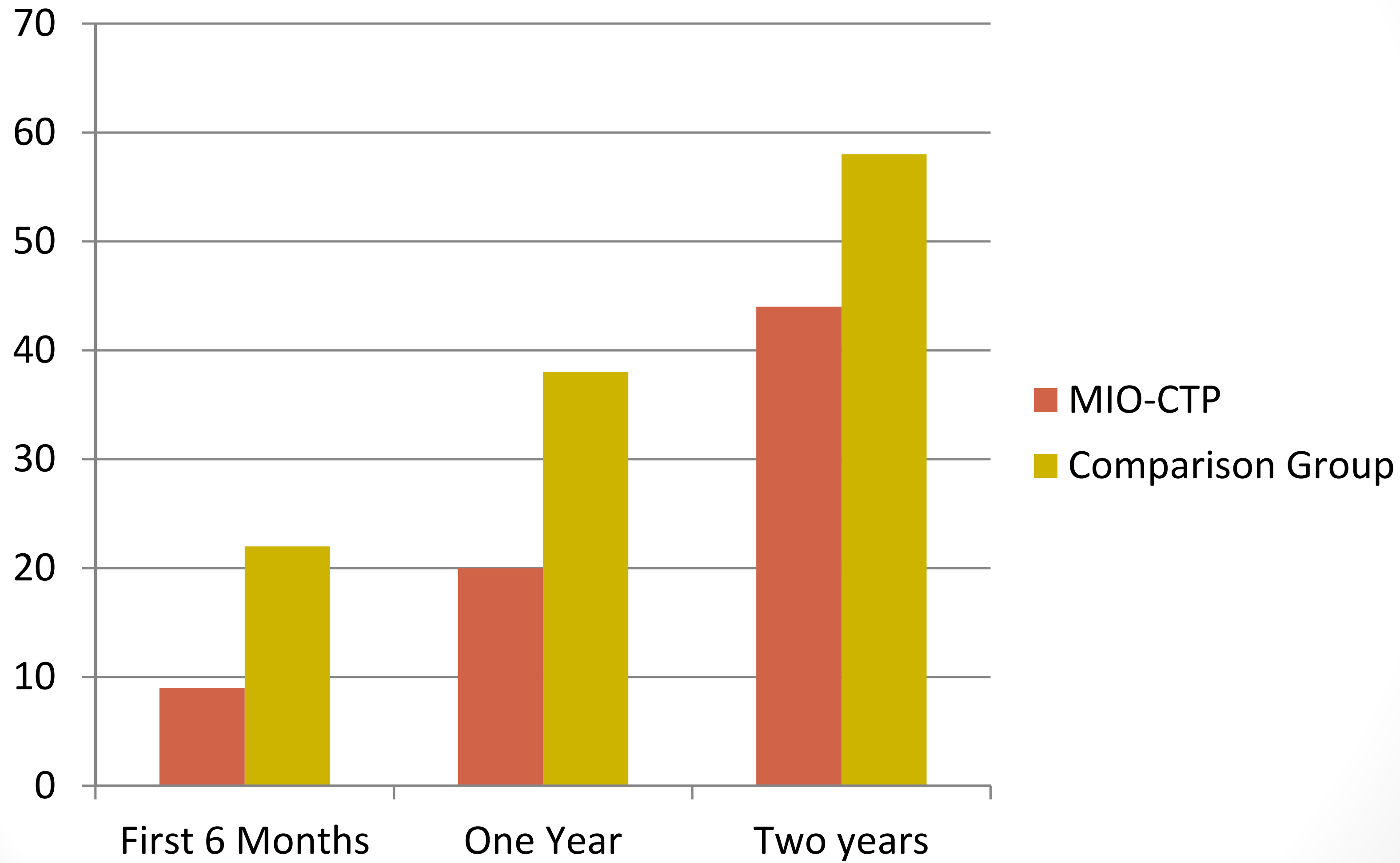
MIO-CTP: Washington

- **Mentally Ill Offender Community Transition Program (MIO-CTP)**
- **Targeted population**: nonviolent, mentally ill offenders. Referrals come from correctional facilities.
- MIO-CTP is a service-enhanced transitional and permanent housing model.
- Clients receive pre-release services and planning, as well as post-release monitoring and support.

MIO-CTP: Housing

- MIO-CTP contracts with a local organization who specializes in provided housing to ex-offenders.
  - However, most participants go directly into sponsored transition housing upon release to access services on-site.
- Residents receive ongoing:
  - MH and SA treatment
  - Counseling & monitoring
- As residents achieve stability, structure is attenuated as independence is ultimately reached.

MIO-CTP: Recidivism Rates



Multnomah County, OR

- **Transition Services Unit (TSU)**
- “Housing first” model
- **Target Population:** offenders with special needs including mentally, developmentally and physically disabled, elderly, and predatory sex offenders.

TSU: Services

- **Transition Planning**: provided 180 days prior to release
- **Priority**: locate and access safe and suitable housing
- Initiate appointments for MH & SA
- Medication assistance
- Initiate federal and state benefits
- **Self Sufficiency Supports**: Provide clothing vouchers for work clothes
- Community Services connection
- Family and Friends reunification

TSU: Housing

- **Collaboration**: TSU contracts with 6 local housing providers & offers contracted/subsidy housing for offenders.
- TSU meets twice monthly to review and implement inmate housing plans.
- TSU develops a long term housing plan for each offender placed in transitional housing.
- **Information Sharing**: TSU housing collaborates with community partners to guarantee appropriate housing placements, coordinate services, and share information.
- TSU Housing places an average of 323 offenders per month.

TSU: Outcomes

- TSU inmates are less likely to recidivate and have a greater likelihood of employment.
- TSU successfully offered stable housing, employment, completion of educational goals, and obtainment of entitlements if eligible to 87% of its high risk, high need offenders.

III. Transition and Reentry Planning Models

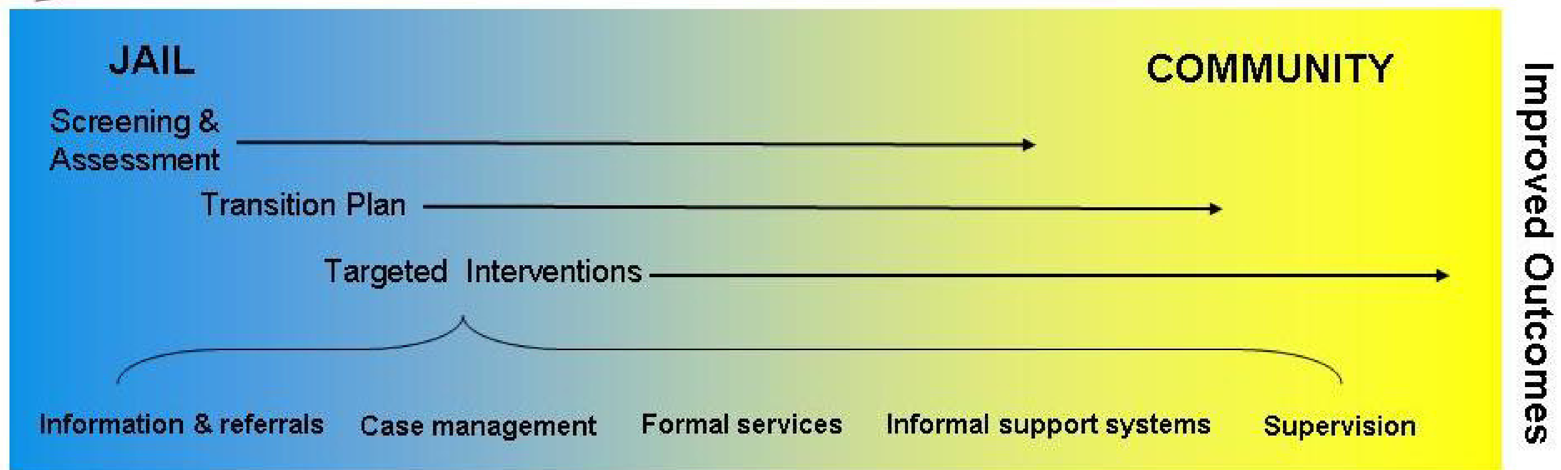
Transition and Reentry Models

1. Transition from Jail to Community (TJC)
2. Assess, Plan, Identify, Coordinate (APIC)

TJC

System Elements

Intervention Elements



APIC

Assess	Assess the inmate's clinical and social needs, and public safety risks
Plan	Plan for the treatment and services required to address the inmate's needs
Identify	Identify required Community and correctional programs responsible for post-release services
Coordinate	Coordinate the transition plan to ensure implementation and avoid gaps in care with community-based organizations

Elements of APIC

1) **Systems Integration**
2) **Immediate Screening Methods**
3) **Cultural Competence & Uniformity**
4) **Prioritize Planning**
5) **Ensure Coordination & Communication**

APIC Reentry Checklist

GAINS Re-Entry Checklist For Inmates Identified with Mental Health Service Needs

Detainee's Name	Gender	Date of Birth	Today's Date	Jail ID #
	☐ M ☐ F	__ __/__ __/__ __	__ __/__ __/__ __	SSN#
Name of Facility	**Name of Person Completing Form and Phone Number**	**Current Status** ☐ Pre-Trial Detainee ☐ Sentenced Inmate	**Date of Admission** __ __/__ __/__ __	**Projected Release Date** __ __/__ __/__ __

Potential Needs in Community After Release	Steps Taken by Jail Staff and Date(s)	Detainee's Final Plan & Contact Information for Referrals
Mental Health Services ☐		
Psychotropic Medications ☐		
Housing ☐		
Substance Abuse Services ☐		
Health Care ☐		
Health Care Benefi ts ☐		
Income Support/Benefi ts ☐		
Food/Clothing ☐		
Transportation ☐		
Other ☐		

Full plan completed and discussed with detainee? ☐ Yes ☐ No Attachments? ☐ Yes ☐ No
If no, why?
Detainee refused ☐ Court released before plan completed ☐
Incomplete for other reasons ☐ Specify:

Common Principles among TJC & APIC

- Models advocate for coordination and collaboration between jails and community support organizations to enhance transition planning; this includes information sharing and data integration.
- These models also articulate setting **standards**, **expectations**, and **accountability** as key to implementing collaboration.
- All support a "**one-stop shop**" of services
- Early Assessment; Early Intervention; Ongoing Services

General Recommendations

1) Strategies must overcome challenges of rapidly assessing and linking inmates to community supports.
2) Standardized, validated assessment tools must become available, followed by data collection to provide evidence-based assessments.
3) Community and correctional commitment among all relevant stakeholders must define, coordinate, and implement reentry initiatives, goals and objectives, and provide essential services upon release.
4) Partnerships must be established to provide continuity of care to effectively implement transition planning.

Closing Remarks

- **No single program** offers comprehensive planning and support
- Critical Elements:
  - Early intervention
  - On-going services
  - Permanent Housing
- Greatest cost-reductions associated with recidivism
- Information sharing is crucial

Questions?

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