COLORADO
Office of Behavioral Health
Department of Human Services

Jail Based Behavioral Health Services Annual Legislative Report

Fiscal Year 2018
July 1, 2017–June 30, 2018

PREPARED FOR
The Correctional Treatment Board

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Executive Summary

The Jail Based Behavioral Health Services (JBBS) Program annual report provides a review of the program's fiscal information, goals, services, and outcomes for Fiscal Year 2017-2018 (FY18), as well as an outline of future directions for the program.

The JBBS program was originally implemented in October 2011 to support county sheriffs in providing behavioral health treatment to individuals needing treatment in jail, and coordinating treatment to a community provider after release from jail. There are 54 county jails within the 64 counties of Colorado. As of July 1, 2017, JBBS programs are in 45 county jails.

The Correctional Treatment Board oversees and allocates funds pursuant to C.R.S. 18-19-103. OBH expended $4,647,843 of the $5,256,185 allocation for the program in FY18. JBBS funding is derived from two funding streams:

1. The Correctional Treatment Cash Fund created by the passage of SB 12-163

2. SB 2013-215 Recreational Marijuana Tax Revenue Funds

Services JBBS programs provide include screening, assessment and treatment for substance use disorders and co-occurring substance use and mental health disorders. In FY18 statewide, programs screened a total of 4,389 individuals for mental illness, substance use disorders, trauma, and traumatic brain injuries. There were 3,281 individuals admitted to JBBS programs and 3,089 individuals discharged. Clinicians and case managers provided screening, treatment groups, and approximately 20,668 hours of individual behavioral health services and case management in jails.

Expansion of SUD JBBS programs in up to six more jails is expected in Fiscal Year 2020. In addition, funds have been allocated as part of SB 18-250 to address the gaps in services for mental health disorder screening, assessment, diagnosis and treatment. The funding shall become available in January 2019 to rural and frontier county jails to support psychiatric provider staffing and purchase of medications.

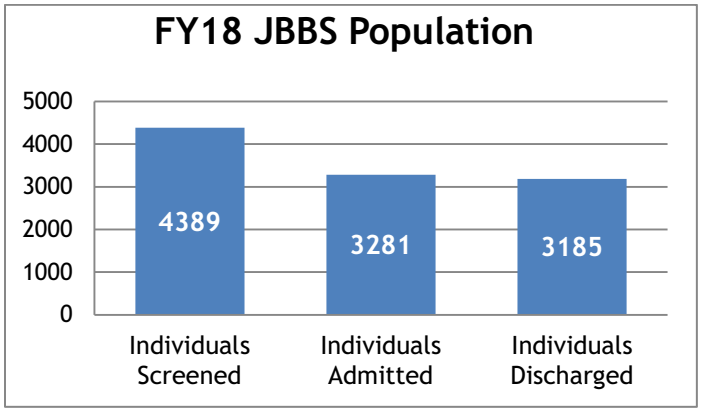


Figure I. FY18 Number of Individuals Screened, Admitted, Discharged

Program outcomes currently focus on tracking an individual's progress in the community after involvement in the JBBS program during incarceration. According to follow up with individuals in the community one month after successful discharge from the JBBS program, 65.6% of individuals statewide were reported to be treatment compliant in the community. Two months after a successful discharge, 60.1% of individuals were reported to be in treatment or having completed treatment.

Introduction

The Jail-Based Behavioral Health Services (JBBS) program funds provision of evidence-based behavioral health treatment within county jails in the state of Colorado and continuity of care extending into the community.

The JBBS program was originally implemented in October 2011 to support county sheriffs in providing screening, assessment and treatment for substance use disorders and co-occurring substance use and mental health disorders to people who need such services while they are in jail. The program is funded by two funding streams:

1. The Correctional Treatment Cash Fund created by the passage of SB 12-163
2. SB 2013-215 Recreational Marijuana Tax Revenue Funds

OBH contracts with sheriff departments (either individually, or as a multiple-county partnership) who contract with licensed community providers. In accordance with legislation, all funds are used to screen and treat adults (18 years of age and older) with substance use disorders or co-occurring substance use and mental health disorders. JBBS clinicians and case managers provide screenings, assessment and treatment in the jail, as well as transitional care to ensure seamless re-entry into treatment services in the community.

Because substance use disorders are determined to be a criminogenic risk factor and behavioral health issues may impact an individual's ability to respond to interventions, the JBBS program seeks to provide quality behavioral health services within jail and a focus on continuity of care into the community when the individual is released from jail. The goals of the JBBS program are as follows:

PROGRAM GOALS
• **Provide appropriate behavioral health services to inmates**
• **Support continuity of care within the community after release from incarceration**
• **Better identification and treatment of behavioral health needs during incarceration, leading to shorter jail sentences and decreased recidivism for JBBS participants**

The current FY18 report outlines the operation of JBBS programs statewide, including contracts, screening, admission, treatment services, discharge, and transition into behavioral health services in the community.

Program Operations

CONTRACTS

JBBS services are provided through contracts between OBH and county sheriff departments across the state. There are 54 county jails within the 64 counties of Colorado. As of July 1, 2017, JBBS programs are in 45 county jails. Each fiscal year, OBH renews annual JBBS contracts with county sheriff departments. Expansion of SUD JBBS programs in up to six more jails is expected in fiscal year 2020.

Table 1. FY18 Contracts, Partnering Providers

JBBS CONTRACTS AND TREATMENT PROVIDER PARTNERSHIPS

County Contract	Treatment Provider
Alamosa (partnering with Conejos)	San Luis Valley Behavioral Health
Adams	Community Reach Center
Arapahoe	Aurora Mental Health Center
Boulder	Behavioral Treatment Services
Clear Creek County	Jefferson Center for Mental Health
Delta (partnering with Ouray, Gunnison, Hinsdale, Montrose and San Miguel)	The Center for Mental Health
Denver	GEO Reentry Services Mile High Behavioral Health Empowerment
Douglas	AllHealth Network
El Paso	El Paso County Jail
Garfield (partnering with Eagle, Grand, Mesa, Moffat, Pitkin, Summit and Routt counties)	Mind Springs Health
Jefferson	Jefferson Center for Mental Health Behavioral Treatment Services
La Plata (partnering with Archuleta and Montezuma)	Axis Health Systems
Larimer	Summitstone Health Partners
Logan (partnering with Cheyenne, Elbert, Kit Carson, Lincoln, Morgan, Phillips, Washington and Yuma)	Centennial Mental Health Center
Otero (partnering with Baca, Bent, Crowley Kiowa and Prowers counties)	Southeast Health Group
Pueblo	Health Solutions Southern Colorado Court Services
Weld	Behavioral Treatment Services North Range Behavioral Health

INTAKE PROCESS

SCREENING AND ADMISSION

All JBBS programs are required to screen for presence of substance use disorder (SUD), mental health disorder (MH), traumatic brain injury (TBI) and trauma. Clients who screen positive for a substance use disorder or a co-occurring substance use disorder and mental health disorder are eligible for the JBBS program. After an individual is admitted to the program, clinicians and case managers complete a full clinical assessment to determine diagnosis, treatment needs and appropriate services.

Contractually, JBBS programs are required to utilize *one* of the screening tools for each screening category (SUD, MH, TBI, Trauma) listed in Table 2 below. This requirement was implemented for consistency of program eligibility criteria across the state.

Table 2. JBBS Program Screening Tool Options

Substance Use Disorder Screening	•Standardized Offender Assessment- Revised •Addiction Severity Index •Simple Screening Instrument- Revised
Mental Health Disorder Screening	•Colorado Criminal Justice Mental Health Screen – Adult (CCJMHS-A) •Brief Behavioral Health Screen
Trauma Screening	•Post-Traumatic Stress Disorder (PTSD) Checklist •Trauma Symptom Inventory
Traumatic Brain Injury Screening	•HELPS Brain Injury Screening Tool •Traumatic Brain Injury Screening Tool

Figure 1. FY18 Number of Positive and Total Screens

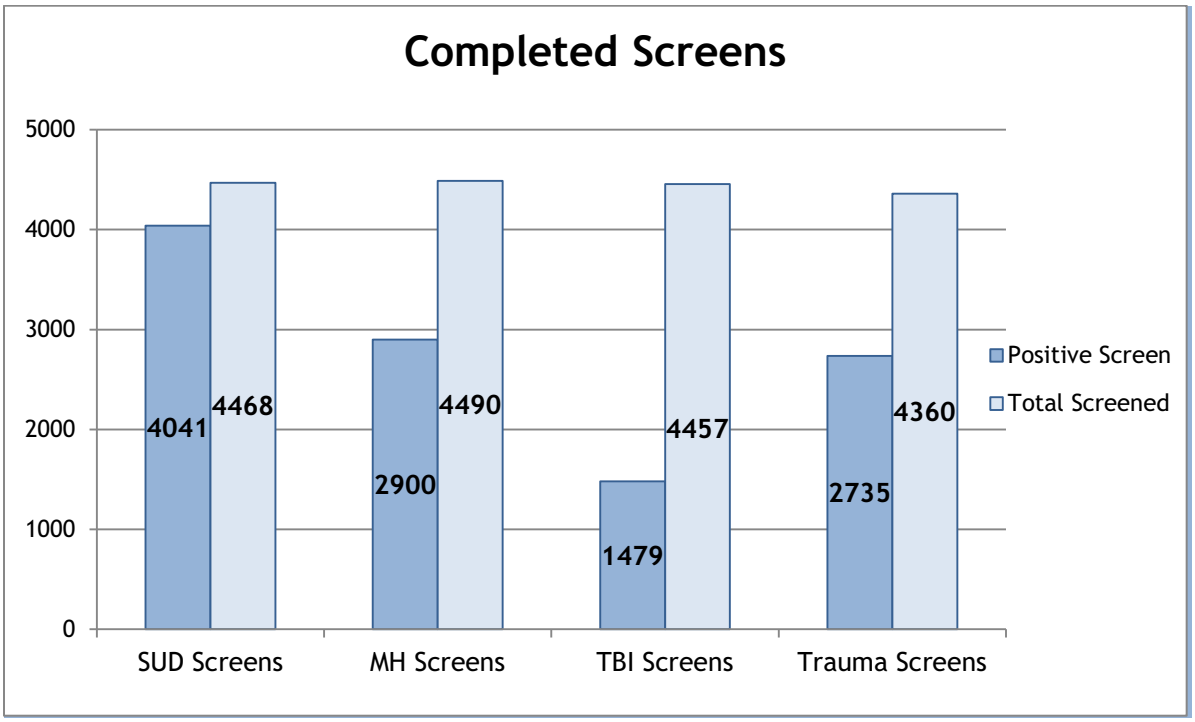
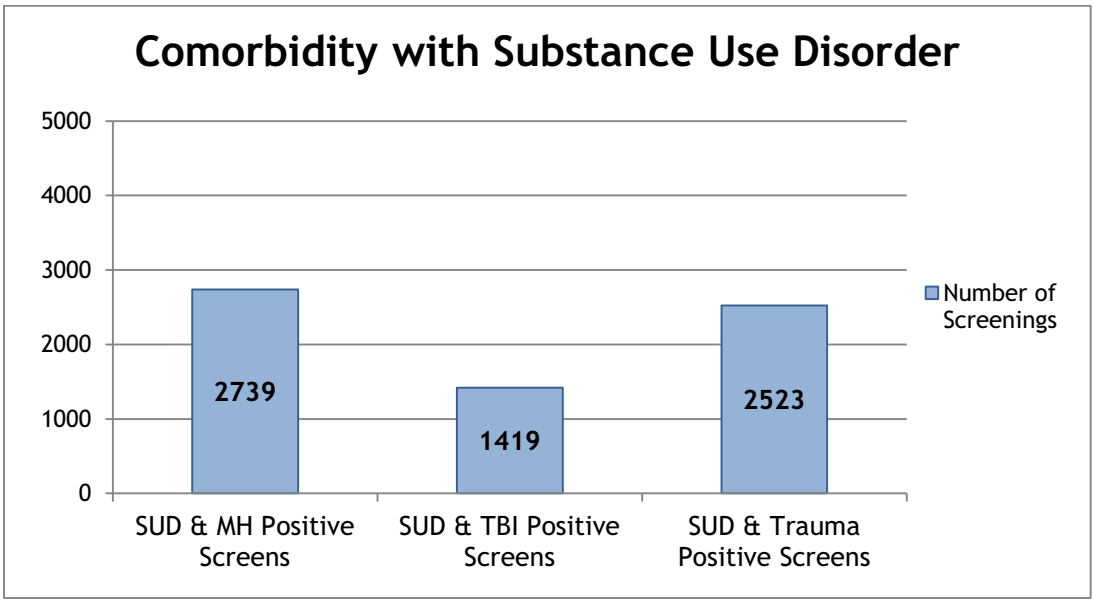


Figure 1 above shows the statewide total number of positive screens out of the total number of screens completed for SUD, MH, trauma, and TBI. Because an inmate could be screened for all four categories, they may be represented multiple times in the figure above. Figure 2 below shows the comorbidity of positive screens of SUD with other screening types.

Figure 2. FY18 Number of Positive Screens Comorbid with Positive SUD Screen



JBBS ADMISSION CRITERIA BY CONTRACT

Each JBBS program has selection and screening criteria and processes based on facility need and size. Some programs are able to screen all inmates who are booked into the county jail. Other programs screen based on an inmate's history or treatment need identified by jail staff. As a result of these differing methods, the number of individuals admitted after screening will vary between programs. The results presented in this report should not be viewed as an indication of the actual number of offenders with mental health issues, substance use disorders, trauma or traumatic brain injuries in the jails across the state. Table 3 below shows facility admission criteria in addition to the minimum criteria required by OBH (facilities not listed below require only the minimum criteria).

Minimum JBBS Admission Criteria:

- Presence of substance use disorder or Co-occurring substance use disorder and mental health disorder
- Age 18 or older
- Voluntary engagement in programming

Table 3. JBBS Program Admissions Criteria (Only county contracts with criteria in addition to OBH's minimum criteria)

Contract	Additional Admission Criteria
Alamosa (includes Conejos)	• Must score for needing treatment on the MMS or MSSI SA
Arapahoe	• Participants sentenced to a minimum of 4 months when accepted into program • Participants will be entering into the community upon release from ACSODF • Participants do not have to be sentenced but the goal is that they will be in custody for a minimum of four months to complete the program • Presence of a DSM-V diagnosis for substance abuse or dependence and who may also meet DSM-V criteria for a co-occurring mental illness • There is an expectation that participant will make progress toward treatment goals while receiving this level of care (if progress is not being made or client is disruptive in treatment, they may be removed from the program based on JBBS team judgment) • Participants with sex offenses are may be excluded from the program • Participants with violent felonies in his/her recent past will be discussed on a case by case basis; acceptance into the program will be agreed upon by the entire JBBS treatment
Boulder	• Must be present in facility for at least 45 days • Not anticipating DOC sentence
Denver	• Must be post-conviction

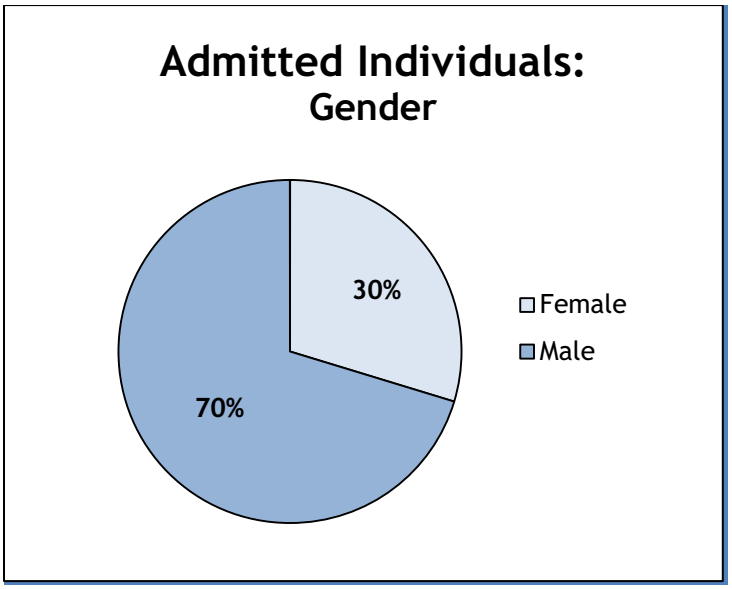
JAIL BASED BEHAVIORAL HEALTH SERVICES	
El Paso	• Must have a minimum of a 60-90 day sentence or referral from the courts or probation/parole • No sex offense charges, violent offenders (F2 or greater)
Jefferson	• Jefferson Center criteria: must have a substance use issue and screen positive for severe and persistent mental illness • Behavioral Treatment Services criteria: must screen positive for trauma • Clients must have 90 days remaining in the jail from screening date
Larimer	• The likelihood for being in the facility for at least 6 weeks from date of enrollment • Previous mental health diagnosis/history of treatment or high probability of meeting criteria for a mental health disorder.
Logan (includes Elbert, Lincoln, Morgan, Washington and Yuma)	• Must have substance use concerns within the past year identified by screening
Otero (includes Baca, Bent, Crowley, and Prowers)	• Must report a substance abuse problem within the past twelve months identified by screening
Pueblo	• Must be in jail for a minimum of 90 days from the time they are placed in the program • Risk score of 4 or higher on the MRT assessment • Criteria for Level II: must have DUI or DWAI
Weld	• Must not be sentenced to Department of Corrections

CLIENT DEMOGRAPHICS

ADMITTED INDIVIDUALS

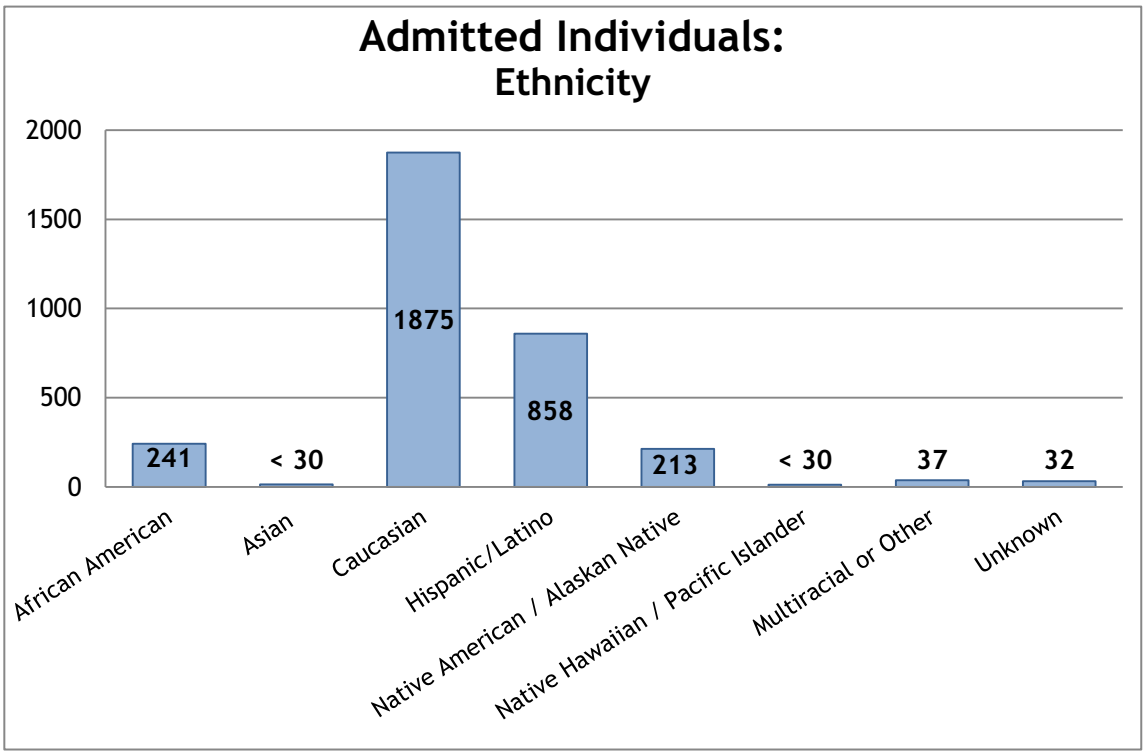
Demographic information, by individual report, is collected at admission. This reporting is optional. Missing information is represented as "Unknown" in the current report. Ethnicity demographics are shown in Figure 4 below. For a breakdown of FY18 admissions and discharges by program see Appendix A.

Figure 3. FY18 Males and Females Admitted into JBBS Programs



In FY18, 975 females and 2,306 males were admitted in JBBS programs across the state for a total of 3,396 admissions (115 admissions represent individuals who were admitted more than one time). This is a 7.5% increase from the 3,159 admissions to JBBS programs in FY17.

Figure 4. FY18 Reported Ethnicity of Individuals Admitted into JBBS Programs Statewide



SERVICES PROVIDED

OVERVIEW OF SERVICES

Individuals may receive individual or group treatment focusing on substance use disorders, mental health disorders, co-occurring disorders, trauma, and psychoeducation. Case management services include assistance or referrals for benefit acquisition, housing, vocational needs, employment acquisition, meeting legal obligations and transportation.

The major categories of services are:

- Individual Treatment
- Treatment Groups
- Case Management Services

JAIL BASED BEHAVIORAL HEALTH SERVICES

Individual Treatment

During FY18, 18,710 individual treatment services were provided across all JBBS programs. This includes individual treatment sessions provided directly by jail based clinicians as well as internally referred services (e.g. medication management with the jail medical team).

Case Management

During FY18, 21,095 case management services were provided across all JBBS programs. This includes services that were provided directly by jail-based clinicians, as well as referred services in the community.

Treatment Groups

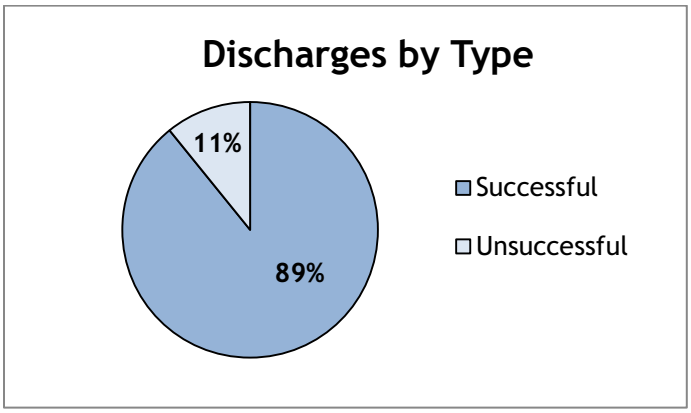
In JBBS programs statewide, 211 treatment groups were running over the course of FY18. Because group composition depends on the specific needs of the population of the jail at a given time, the number of groups available is often not the same as the number of groups offered.

DISCHARGES

SUCCESSFUL AND UNSUCCESSFUL DISCHARGES

A successful discharge is defined as one in which the client completes the program according to the treatment plan or is transferred or released from jail while they are fully compliant with treatment requirements. An unsuccessful discharge is defined as a discharge for non-compliance, disengagement from treatment, or disciplinary sanctions within the jail. During FY18, there were 2,772 successful discharges and 337 unsuccessful discharges.

Figure 7. FY18 Discharges: Successful and Unsuccessful



Program Outcomes

TRANSITION TRACKING

Programs are required to follow-up with all clients who are successfully discharged from the program and released to the community at 1, 2, 6 and 12 months after release. Clinicians are required to either call the client or track treatment engagement at the community-based treatment provider to which the client was referred.

The following outcomes are tracked for transition tracking:

1. In Treatment: Client engaged in community-based treatment services as recommended at discharge
2. Not In Treatment: Client not engaged in treatment services as recommended at discharge
3. Treatment Completed: Client has completed treatment recommended at discharge
4. New Crime/Regressed: Client returned to jail for violations or committed a new crime
5. Status Unknown: Client cannot be reached or tracked after multiple contact attempts
6. Deceased: Client is deceased
7. Not Applicable: Client sentenced to Dept. of Corrections or not tracked due to previous tracking of “New Crime/Regressed,” “Treatment Completed,” or “Deceased”

Performance Incentive

Based on the transition tracking timeframes above, JBBS programs are incentivized to raise the percentage of individuals engaged in community-based treatment 30 days after release. Of the six possible outcomes for tracking, "In Treatment," "Treatment Completed," and "Not Applicable" are considered to reflect successful continuation of care into the community. Ten percent of each program's budget is initially withheld; when the jails within a given contract maintain 55% engagement at one month, the withheld 10% of the contract is awarded to the program(s) at the end of the fiscal year.

Transition tracking data demonstrates which programs show consistency in follow-up with clients upon release. In FY18, 65.63% of clients (3,297 of 5,024) were engaged in treatment services as recommended in their transition plan 30 days after release. Table 4 below shows statewide tracking outcomes. See Appendix C for a breakdown of month one transition tracking outcomes by program.

Table 4. FY18 Statewide Transition Tracking: One Month after Discharge

Transition Tracking Status	Number of Individuals	Percentage of Individuals
In Treatment	2,339	46.56%
Treatment Completed	92	1.83%
Not Applicable	866	17.24%
New Crime/ Regressed	158	3.14%
Not in Treatment	637	12.68%
Status Unknown (Unable to contact)	926	18.43%
Deceased	6	0.12%
Total Individuals Tracked	**5,024**	**100%**

Two, Six, and Twelve Month Tracking

After two months the percent of clients engaged in community-based treatment services was 60.1% (1,613 of 2,685). At the six month follow-up, 51.3% (1,374 of 2,679) of clients tracked were engaged in or had completed treatment services. At 12 months, 47.7% (1,251 of 2,623 clients) were engaged in or had completed services.

RECOVERY SUPPORT SERVICES

In order to address immediate needs and basic necessities for individuals leaving jail, all programs are able to utilize specific funds to assist clients with a variety of services that support recovery. These services include transportation options to include bus tokens or taxi cab vouchers in areas with no or limited public transport, funding to pay for obtaining identification, basic hygiene items, medication, food, and emergency housing. To be eligible for these funds, clients must be successfully discharged from the jail program and transitioned to community based treatment services as recommended at discharge from the jail. A list of allowable Recovery Support Services can be found under Appendix B.

Future Directions

OPIOID ADDICTION SPECIALTY SERVICES

Due to the heroin and opioid use prevalence in Colorado and across the country, and the high number of drug overdose deaths upon release from incarceration, OBH has encouraged jails to make evidence-based Medication Assisted Treatment (MAT) available to opioid using individuals. JBBS contracts offer guidance for sheriff departments on policies to consider implementing in response to the current prevalence of opioid use.

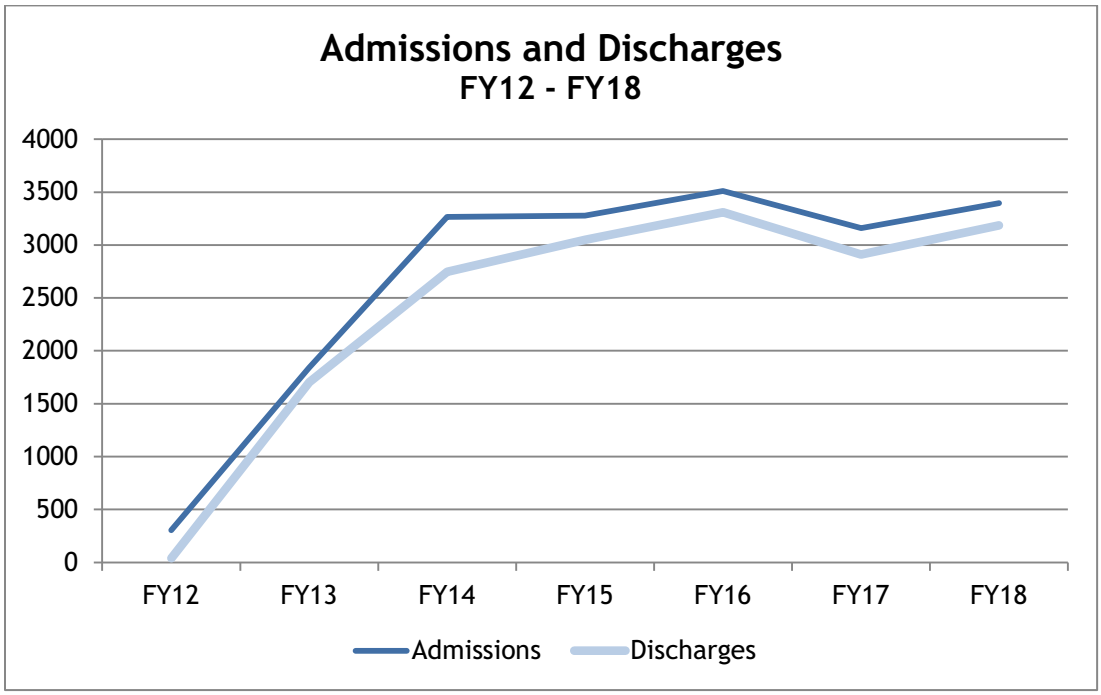
In FY16, OBH funded 4 pilot projects to distribute Narcan nasal kits (an FDA approved opioid overdose reversal medication) at jails in the metro area. OBH partnered with Harm Reduction Action Center to train medical staff at jails to identify individuals who may be at high risk of heroin overdose post release. Due to the success in the implementation of the pilots, FY17 contracts provided funding to allow all JBBS programs to purchase Narcan nasal kits. These kits may be distributed to any individuals deemed to be at high risk for opioid overdose upon discharge from jail. In a continued effort to confront the opioid epidemic, FY18 contracts have expanded the requirements surrounding the funding initially allocated for Narcan kits; jails are now able to use this funding to purchase all FDA approved medications for opioid specific MAT. This allows JBBS programs to provide multiple medications to opioid using individuals at discharge (in addition to Narcan) to support their continued recovery.

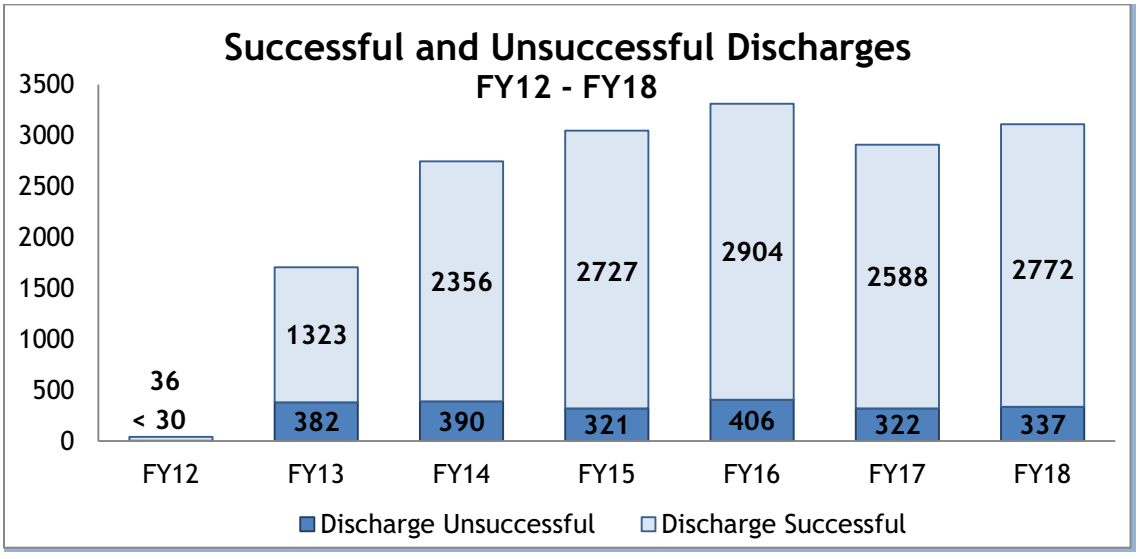
PROGRAM EVALUATION COMPLETED

In FY16, OBH received funding from the Correctional Treatment Board to contract with an independent consultant, Health Management Associates, to evaluate the JBBS program. The evaluation, now complete, focused on program improvement, best practices, data collection, program expansion, standardizing of program elements across sites, screening protocols, resource needs, behavioral health outcomes, and recidivism. The final report of this evaluation is available on the OBH website: https://www.colorado.gov/pacific/cdhs/jail-based-behavioral-health-services

APPENDIX A

Admissions and Discharges since Program Inception





APPENDIX B

FY18 Approved Recovery Support Services

Services	Limitations
Emergency Housing	30 days limit per person
Medications	30 days limit per person
Application Fees ID/Birth Certificates	One time per client
Bus Pass - Daily, Monthly	One time per client, 15 rides for daily passes
Taxi	Only if no public transportation available in area
Basic Hygiene Items	Limit of $15 per person
Phone Cards	Limit of $15 per person
GED program/testing	
Job placement training	
Lifeskills training	
Printed brochures to referral sources	
Medical assistance - copays/ infectious disease testing	Limit of $100 per person
Gas vouchers	Limit of $30 per person
Clothing vouchers	Limit of $100 per person
Personal hygiene care	Limit of $20 per person
UA/Bas	Limit of $100 per person
Transportation to residential treatment	Limit of $1200 per contract
Food Assistance	
Backpacks	
Educational costs (books, supplies and fees)	
Utilities	1 month limit per client
Child care	1 month limit per client

APPENDIX C

FY18 Transition Tracking Data

The number of clients tracked within performance incentive eligible categories ("In Treatment," "Treatment Completed," and "Not Applicable") at one month post-discharge from the JBBS program are presented below for each county, along with the total number of clients tracked.

FY18 Performance Incentive Eligibility by County

Contract Totals	Eligible Total	Total Clients	Eligible %
Adams	190	291	65.29%
Alamosa/Conejos	42	84	50.00%
Arapahoe	182	224	81.25%
Boulder	150	196	76.53%
Clear Creek	85	98	86.73%
Delta *	148	230	64.35%
Denver	342	659	51.90%
Douglas	111	162	68.52%
El Paso	225	375	60.00%
Jefferson	145	188	77.13%
La Plata*	453	690	65.65%
Larimer	211	284	74.30%
Logan *	224	408	54.90%
Garfield *	406	653	62.17%
Otero *	44	59	74.58%
Pueblo	192	217	88.48%
Weld	147	206	71.36%
Statewide Total	**3297**	**5024**	**65.63%**

* Sum of counties in contract catchment

Counties in Contract Catchment	Eligible Total	Total Clients	Eligible %
Baca	< 30	< 30	60.00%
Bent	< 30	< 30	62.50%
Crowley	< 30	< 30	100.00%
Otero	< 30	< 30	100.00%
Prowers	< 30	< 30	84.62%
Otero Total	**44**	**59**	**74.58%**
Delta	57	87	65.52%
Gunnison	< 30	< 30	55.00%
San Miguel	< 30	< 30	50.00%
Montrose	78	119	65.55%
Delta Total	**148**	**230**	**64.35%**
Archuleta	< 30	< 30	30.77%
La Plata	312	479	65.14%
Montezuma	137	198	69.19%
La Plata Total	**453**	**690**	**65.65%**
Elbert	< 30	35	68.57%
Kit Carson	< 30	< 30	30.43%
Lincoln	< 30	< 30	50.00%
Logan	97	164	59.15%
Morgan	70	125	56.00%
Washington	< 30	< 30	33.33%
Yuma	< 30	< 30	39.13%
Logan Total	**224**	**408**	**54.90%**
Eagle	35	48	72.92%
Garfield	46	82	56.10%
Grand	< 30	66	34.85%
Mesa	250	351	71.23%
Moffat	< 30	36	33.33%
Pitkin	< 30	< 30	70.83%
Summit	< 30	46	50.00%
Garfield Total	**406**	**653**	**62.17%**

Jail Based Behavioral Health Services Program Evaluation Appendices Fiscal Year 2018

Appendix A

Evidence-Based Practices in the Identification and Treatment of Behavioral Health Disorders in Jails

This section reviews the evidence on factors that contribute to improvement in behavioral health, including substance use disorders, in the correctional setting. The majority of research about mental health programs pertains to prison settings, but we largely focus here on programs in jails to stay relevant to the JBBS population.

Effective Identification and Treatment Models for Criminal Justice Populations

The Substance Abuse and Mental Health Services Administration (SAMHSA)[1] estimates that around 17% of U.S. adults in jail have serious mental health disorders[2] and that 68% face substance use disorders (SUD).[3] When diagnosed with a serious mental disorder, 72% are diagnosed with co-occurring SUD.[4] When diagnosed with SUD, 33% are diagnosed with co-occurring serious mental disorder.[5] The following summarizes the evidence on identification and treatment of behavioral health disorders, SUD, and co-occurring disorder in the jail setting.

Screening Standards and Protocols

Cost-effective screening for behavioral health, SUD, and co-occurring disorder is required to identify an individual's needs and to appropriately target treatment and intervention. A 2015 report on the

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[1] Blandford, A. M., Osher, F. (2013). Guidelines for the Successful Transition of People with Behavioral Health Disorders from Jail and Prison. The Council of State Governments Justice Center. https://csgjusticecenter.org/mental-health/publications/guidelines-for-successful-transition/

[2] Steadman, H. J., Osher, F. C. Robbins, P. C., Case, B., and Samuels, S. (2009). Prevalence of serious mental illness among jail inmates. Psychiatric Services, 60(6): 761–765. http://ps.psychiatryonline.org/article.aspx?articleid=100482

[3] Karberg, J. C., and James, D. J. (2005.) Substance dependence, abuse, and treatment of jail inmates, 2002. Washington, DC: U.S. Department of Justice, Office of Justice Programs, http://www.csdp.org/research/sdatji02.pdf

[4] Adapted from Abram, K. M., and Teplin, L. A. (1991). Co-occurring disorders among mentally ill jail detainees. Implications for public policy. American Psychologist, 46(10): 1036–1045. http://psycnet.apa.org/journals/amp/46/10/1036/

[5] Wilson, A. B., Draine, J. Hadley, T., Metraux, S., and Evans, A. (2011). Examining the impact of mental illness and substance use on recidivism in a county jail. International Journal of Law and Psychiatry, 34(4): 264-268. http://www.ncbi.nlm.nih.gov/pubmed/21839518

screening and assessment of co-occurring disorders in the justice system included the following recommendations (paraphrased)[6]:

- Screening for mental and substance use disorders should be provided for all individuals entering the criminal justice system and at the earliest possible point after involvement in the criminal justice system. Universal screening should also be conducted for history of trauma and for PTSD.
- Ongoing screening and assessment for co-occurring disorders should be provided at the different stages of criminal justice processing, to allow individuals who are initially reluctant the opportunity to become more receptive to treatment services. Extended screening and assessment are also important to assess accurate baseline functioning.
- Similar or standardized screening instruments for co-occurring disorders should be used across different justice settings, with results shared across all settings involved. Information from previously conducted screening and assessment should be communicated across different points in the criminal justice system.

There is very limited research on staff qualifications and training as a factor in the performance of screening tools. Since most facilities do not have the ability to complete full assessments for all inmates coming in, standards are general and do not specify that screenings must be completed by health care staff.[7] The National Commission on Correctional Health Care's standard is that an initial mental health screening must take place within 14 days of admission by a qualified mental health professional or mental health staff.[8] Nurses who have received instruction and supervision in identifying and interacting with individuals in need of mental health qualify as able to conduct mental health screenings. However, nurses may not conduct the subsequent evaluation of inmates who screen positive for mental health problems.[9] A review of the literature suggests that the amount of training, rather than the professional background of the screener, is important to the effectiveness of the screen.[10,11]

Some screening tools are more appropriate for health care personnel to administer. For example, the Brief Jail Mental Health Screen, Community Mental Health Screen, and the England Mental Health Screen are all brief tools that can be administered by health or custodial staff, while the Jail Screening Assessment Tool is longer and must be conducted by nursing or psychology staff.[12] One study suggests that SUD screenings such as the Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST)

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[6] Substance Abuse and Mental Health Services Administration. Screening and assessment of co-occurring disorders in the justice system. HHS Publication No. (SMA)-15-4930. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2015.

[7] Consultation with accreditation surveyors with the California Institute of Medical Quality.

[8] Kistler, J and Chavez, S. "Expert Advice on NCCHC Standards: Mental Health Screening by COs". Correct Care. Winter 2011. 25(1).

[9] Kistler, J and Chavez, S. "Expert Advice on NCCHC Standards: Mental Health Screening Personnel". Correct Care. Summer 2010. 24(3).

[10] Steadman HJ, Scott JE, Osher F, et al.: Validation of the Brief Jail Mental Health Screen. Psychiatric Services 56:816–822, 2005

[11] Substance Abuse and Mental Health Services Administration. Screening and assessment of co-occurring disorders in the justice system. 2015.

[12] Martin, M. S., Colman, I., Simpson, A. I., & McKenzie, K. (2013). Mental health screening tools in correctional institutions: A systematic review. BMC Psychiatry, 13, 275.

can be validly and reliably conducted using computer-administered self-interviewing (CASI) technology.[13]

Treatment of Substance Use Disorder

In *Promising Practices Guidelines for Residential Substance Abuse Treatment,* the Advocates for Human Potential, Inc. provide promising practice guidelines for the United States Department of Justice's Residential Substance Abuse Treatment for State Prisoner's Program (RSAT).[14] Jail-based programs must be at least 90 days in length and, if the facility permits, participants should be physically separated from the general population.

The guidance states that individuals should be screened for a substance use disorder using a validated instrument. Following screening, individuals should be assessed for behavioral, physical health, and criminogenic needs. Assessments should be used to develop an individualized treatment and case management plan. Treatment services should be evidence based and focused on developing cognitive, behavioral, social and recovery skills. For individuals with alcohol, opioid use or co-occurring mental illness, medications should be considered part of the standard of care.

RSAT treatment programming should be culturally sensitive and responsive to a diverse population, include both group and individual counseling, and should include compatible social services. RSAT programs should also be trauma-informed. The National Institute on Drug Abuse names the following behavioral therapies as effective components of RSAT: Cognitive behavioral therapy (CBT), Therapeutic Communities (TC), Contingency Management (CM) interventions/motivational incentives, Community reinforcement approach (CRA) plus vouchers, Motivational Enhancement Therapy (MET), The Matrix Model, Twelve-step facilitation therapy, Family behavior therapy (FBT), Behavioral therapies (Multi systemic Therapy).

The Substance Abuse and Mental Health Services Administration (SAMHSA) names the following evidence-based alcohol and substance use disorder treatment programs for young and working aged adults (18–25 and 26–55) in correctional facilities:

- Correctional Therapeutic Community for Alcohol and Substance Abusers (CTC) six months from prison release,
- Creating Lasting Family Connections Fatherhood Program (CLFCFP) for family reintegration for men,
- Forever Free for women,
- Helping Women Recover and Beyond Trauma for women (manual driven treatment),
- Interactive Journaling,
- Living in Balance (LIB) (manual based),
- Moral Reconation Therapy (MRT) (cognitive behavioral approach), and

[13] Wolff N, Shi J. Screening for Substance Use Disorder Among Incarcerated Men with the Alcohol, Smoking, Substance Involvement Screening Test (ASSIST): A Comparative Analysis of Computer-Administered and Interviewer-Administered Modalities. J Subst Abuse Treat. 2015;53(0):22–32.

[14] Advocates for Human Potential, Inc. (2016) Promising Practices Guidelines for Residential Substance Abuse Treatment.

- Texas Christian University (TCU) Mapping-Enhanced Counseling (MEC), a communication and decision-making technique designed to support delivery of treatment services.

Behavioral Health Treatment

There is a lack of empirical research about effective treatment for individuals with mental illness in correctional settings. Although meta analytic results are based on a small sample of available studies, results from one review suggest interventions do reduce symptoms of distress while improving the affected inmate's ability to cope, resulting in improved behavioral markers.[15] Although results were statistically inconclusive with regard to effects on criminal or psychiatric recidivism, this review suggests that positive treatment effects can be achieved with offenders who have mental illness.

The most helpful jail-based mental health services focus on identifying patients, performing crisis intervention, stabilizing patients, and referring patients at release.[16] Proper screening is an important first step in providing adequate future mental health treatment to individuals with mental illness in jails. The American Medical Association, the American Psychiatric Association, the American Correctional Association, and the American Association of Correctional Psychologists have established standards for screening inmates for mental illnesses as well as potential violent or suicidal behavior. Effective mental health intake screening is best done by trained booking officers and comprises three parts: reviewing health-related records or papers that inmates bring to central booking; asking inmates about their mental health histories; and, conducting a brief mental health status examination. To ensure effective relationships for facilitating community-based treatment and aftercare services for incarcerated individuals with mental illness, jails staff are advised to establish long-term linkages and memoranda of agreements with local or state mental health agencies.

Co-Occurring Disorder Treatment

Individuals who are incarcerated with a co-occurring substance use disorder and mental illness present a particular challenge. Offenders with a dual diagnosis require an integrated treatment approach. Edens, et al., conducted an integrative review of prison programs treating inmates with co-occurring disorders which highlighted that screening, referral, and assessment procedures are often complicated by the complex interaction of substance use and mental health symptoms.[17] All programs surveyed included an intensive initial period of assessment during which prior diagnoses are reevaluated, structured assessment instruments and interviews are conducted, medications are evaluated, case managers are assigned, and treatment plans are developed. Typical assessment methods and instruments include the MMPI-2, the MCMI-II, the Addiction Severity Index (ASI), the Symptom Checklist-90, diagnostic interviews conducted by psychologists or psychiatrists, extensive psychosocial and criminal histories, self-report drug history questionnaires, and various cognitive and/or academic screenings.

The programs reviewed by Edens, et al. use a highly structured approach consisting of an initial assessment and orientation period, an intensive treatment phase, and a relapse prevention/transition

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[15] Morgan, Robert D., Flora, David B., Kroner, Daryl G., Mills, Jeremy F. (2012) Treating Offenders with Mental Illness: A Research Synthesis. Law and Human Behavior, 36(1), 37–50.

[16] Lurigio, Arthur J., Swartz, James A. (2000) Changing the Contours of the Criminal Justice System to Meet the Needs of Persons with Serious Mental Illness. Policies, Processes and Decisions of the Criminal Justice System, 3, 45-108.

[17] Edens, John F., Peters, Roger H., and Hills, Holly A. (1997). Treating Prison Inmates with Co-Occurring Disorders: An Integrative Review of Existing Programs. Behavioral Sciences and the Law, 15, 239-457.

phase. Programs that do not provide specific treatment phases still incorporate these three basic components. Some programs follow specific time frames and require completion of all treatment phases for graduation, whereas other programs have a more flexible approach. Given the functional limitations of many individuals with dual diagnosis and their need for structure, strong emphasis is placed on orientation to program goals, expectations, rules treatment activities.

Adaptations to traditional treatment are needed when working with inmates with co-occurring disorders. Counselors often have smaller caseloads and provide more individualized counseling. Meetings and psychoeducational classes are simplified and shorter. Programs educate inmates about the importance of medication compliance and potential side effects. In programs where inmates with dual diagnosis are blended with inmates who have only substance use disorder, it is important to co-educate about the need and usefulness of some psychotropic medications so that peers are not discouraging medication compliance due to a belief that use of any drug is counter therapeutic. Another adaptation is to minimize confrontation. Confrontation by peers is a common intervention method in substance abuse treatment, but inmates with co-occurring disorders are often less able to tolerate the interpersonal stress. Programs for co-occurring disorders provide a more supportive approach in encounter groups.

All programs reviewed have procedures for transitioning inmates from treatment into aftercare services. The type of aftercare services available range from services provided in another prison facility for the remainder of the sentence to transitional living arrangements. Although extensive controlled studies have not yet been conducted in the settings described here, the programs are generally tracking rates of program completion and recommitment to prison.

A review by Peters et al., reflected the growing recognition that population of inmates with dual diagnosis requires specialized services using an integrated approach, building on evidence-based approaches that have been developed in community setting. The most common mental disorders treated in these programs included major depression (26%), posttraumatic stress disorder (PTSD) (19%), bipolar disorder (15%), schizophrenia (15%), anxiety disorders (13%) and schizoaffective disorder (6%). Prison inmates referred to co-occurring disorders treatment programs are often diagnosed with one or more Axis II (personality) and Axis III (medical) disorders, reflecting the need for a structured treatment approach and a comprehensive array of services.

Activities designed to prepare for reentry and transition to the community are important for inmates with co-occurring disorders, and include the development of reentry plans, relapse prevention skills, engagement with ongoing mental health and substance abuse services, and review of housing, transportation, and employment needs. Most co-occurring disorder treatment programs have designated staff responsible for linking inmates to community services.

Several studies have explored outcomes associated with prison-based co-occurring treatment programs. Sacks et al. examined the effectiveness of a modified therapeutic community (MTC) in comparison to traditional prison mental health treatment services (MH) for inmates with co-occurring disorders.[18] In this controlled study conducted within the Colorado prison system, inmates with co-occurring disorders

[18] Sacks S, Banks S, McKendrick K, Sacks JY. Modified Therapeutic Community for Co-Occurring Disorders: A Summary of Four Studies. Journal of substance abuse treatment. 2008;34(1):112-122. doi:10.1016/j.jsat.2007.02.008.

were assigned to one of three levels of treatment: MTC, MH, and MTC plus involvement in aftercare treatment services. Twelve-month follow-up results showed that inmates assigned to receive MTC plus aftercare treatment had the lowest rate of re-incarceration (5%), followed by those in the MTC group (16%) and the MH group (33%). The MTC plus aftercare group also experienced the lowest rate of arrest for drug-related offenses (30%), in comparison to the MTC group (44%) and the MH group (67%). These findings reveal the cumulative positive effect of specialized treatment for inmates with co-occurring disorders.

As in prisons, there are few specialized treatment programs for inmates with co-occurring disorders in jails. Jails are often understaffed and lack the capacity to provide more than screening, stabilization and routine monitoring (e.g., for suicidal and violent). Jail-based treatment programs operate differently from prison because incarceration is brief. Rather than providing long term treatment, jail programs for co-occurring disorders often focus on screening and assessment, psychoeducation, and reentry planning. Jail-based treatment programs are organized around four key principles: 1) Meet immediate needs including stabilization, detoxification, screening for suicide risk; 2) Integrate delivery of services; 3) Prepare for release; and 4) Collaborate with community agencies to enhance continuity of care.

Continuity of care is essential for any individual with a single or dual diagnosis who is re-entering the community following incarceration. Pre and post release case management systems should be included in programming to help support a smooth transition to the community. The RSAT program asserts that it is essential for graduates of the program to have access to Medicaid or other health insurance, as well as basic health care literacy in order to use the health care system appropriately.

Critical time intervention (CTI) is a nine-month, three-stage intervention that strategically develops linkages in the community for individuals reentering society, and seeks to enhance engagement with treatment and community supports. It is an empirically supported practice shown to enhance continuity of care for people with mental illness after discharge from homeless shelters and psychiatric hospitals and was examined as a promising model of reentry from prison for individuals with mental illness (Draine, Herman, et al.).

The CTI intervention has two components, the first is to strengthen the individual's long-term ties to services, family, and friends. The second to provide support and advocacy during the critical time of transition. A randomized trial testing the effectiveness of CTI with persons with mental illness reentering the community from incarceration is currently being implemented. This model addresses prisoner reentry as it applies to people with co-occurring disorders. It emphasizes the role of community ties in individual and social outcomes. In the model the CTI intervention is positioned as a connector between prison and community. Growth in community ties mediates the effect of CTI on consumer outcomes. This mediator represents a growth in social capital, conceptualized at the individual level. The model also includes community-level factors included as potential moderators. Therefore, in addition to providing a framework for testing the effectiveness of the CTI intervention on mental health outcomes, a theoretical framework is provided for testing individual and community mechanisms that have an impact on outcome in reentry.

A handful of alternative therapies are named in the literature as potential treatment options for inmates with single or dual diagnosed mental illness and substance use disorders. Mindfulness-based stress-reduction courses were offered in drug units in six Massachusetts Department of Corrections prisons. A total of 1,350 inmates completed the 113 courses. Evaluation assessments were held before and after

each course, and highly significant pre- to post-course improvements were found on widely accepted self-report measures of hostility, self-esteem, and mood disturbance. Improvements for women were greater than those reported for men and improvements were greater for men in minimum security versus medium security settings. The results show the promise of meditation based interventions in correctional settings especially as it relates to impact on measures of hostility and mood disturbance (Samuelson, Carmody, et al.).

In corrections, where staffing limitations tax an overburdened system, telemental health is an increasingly common mode of mental health service delivery. Telepsychiatry is a potentially cost effective addition to jail and prison based treatment programs. Deslich et al., explored the use of telepsychiatry and its effect on access to care and costs of providing mental health care. They found telepsychiatry provided improved access to mental health services for inmates, and this increase in access was instrumental in increasing quality of care for inmates. Use of telepsychiatry saved correctional facilities from $12,000 to more than $1 million. Although telemental health presents an efficient treatment modality for a spectrum of mental health services, it is important to study how this modality influences key elements of the treatment experience. Brodey et al., determined in a study of 43 forensic psychiatric patients that patients were moderately satisfied with the services they received through telepsychiatry. Morgan et al., compared inmates' perceptions of the therapeutic alliance, post session mood, and satisfaction with the mental health services delivered through two different modalities: telemental health and face-to-face. Participants consisted of 186 inmates who received mental health services. Results indicated no significant differences on any of the factors when telemental health and face-to-face modalities were compared.

Finally, Dialectical Behavioral Therapy (DBT), a comprehensive cognitive behavioral treatment that combines the basic strategies of behavior therapy with Eastern mindfulness practices that involves a balance between validation and acceptance of individuals as they are, within the context of simultaneously helping them to change, is a promising treatment option for incarcerated individuals. McCann et al., contend that several factors support the use of DBT in a forensic inpatient setting among which is that DBT is a comprehensive cognitive-behavioral treatment that is highly structured with a clear behavioral hierarchy. Cognitive behavioral therapy (CBT), which addresses faulty cognitions, has been used successfully with incarcerated offenders.

DBT has been conducted recently in approximately 12 forensic institutions and at least eight criminal justice settings. Contact was made with clinicians at seven forensic/correctional sites within North America to glean information about the utilization of DBT within each setting. Published articles describing the programs in three of the settings were also reviewed (Berzins, Trestman, et al.). A current research initiative involves a collaboration between the State of Connecticut Department of Correction (CDOC), the University of Connecticut Health Center (UCHC), and Correctional Managed Health Care (CMHC)to provide all medical and mental health services to all inmates incarcerated in the state of Connecticut. This collaboration presents an opportunity to formulate, implement and evaluate a corrections modified DBT (DBT-CM) within three difficult to manage, impulsive and aggressive male correctional population.

Outcomes Associated with Behavioral Health Treatment Programs in Jail

Most behavioral health and SUD treatment programs in jails use some combination of the above evidence-based modalities to offer treatment. Most of the program evaluations focus on recidivism as

an outcome metric, measured by the rate of re-arrest. Others compared drug use pre-and post-incarceration and utilization of community resources once released. The following table summarizes select programs with published evaluation data and associated outcomes:

Program	Description	Key Outcomes
San Francisco County Jail - Psychiatric Sheltered Living Unit[19]	Designed to serve chronically mentally ill patients who may also have co-occurring SUD. Equips inmates with life skills to manage illness, fosters positive social skills, and develops educational, vocational, and volunteer skills.	Almost all (95%) of the clients that leave the program return to the community. They continue care through Behavioral Health Court, residential programs or outpatient treatment programs.
Kentucky Substance Abuse Treatment Program[20]	Six to nine month residential substance abuse program that utilizes the therapeutic community model to provide substance abuse services to those with a history of substance dependence.	Drug use from pre-incarceration to 12 months post-release decreased from 96% to 48%. Recidivism analysis showed 68% of jail participants were not reincarcerated in the one-year post release period.
Kenton County, KY Jail Substance Abuse Program[21]	Launched in 2015, a six-month program which uses a peer-driven support model that includes cognitive behavioral therapy, individual and group 12-Step counseling, and spiritual programming.	An internal analysis reportedly observed that by mid-2016 the recidivism rate was less than 30 percent for the nearly 200 inmates that completed the treatment program, compared to 70 percent for the jail's general population.
Richmond City Justice Center Recovering from Everyday Addictive Lifestyles program[22]	Classes 40 hrs/week ranging from remedial math and creative writing to anger management, parenting and drug abuse treatment.	30% of those participating for >90 days re-offended within a year compared with 55% for non-participants. No difference in recidivism for those who participated for a shorter time.
Hampden County Correctional Center Public Health Model of Correctional Care[23]	Uses dually-based physicians and case managers working at the jail and at four community health centers.	The program was associated with increased post-release visits to mental health providers.

[19] San Francisco Department of Public Health Jail Health Services. "Overview of Services FY 11-12". https://www.sfdph.org/dph/files/hc/Orientation%202013/11-12%20Overview%20jail.pdf

[20] Criminal Justice Kentucky Treatment Outcome Study FY 2015. http://cdar.uky.edu/CJKTOS/Downloads/CJKTOS_FY2015_Report.pdf

[21] Manatt Health. "Communities in Crisis: Local Responses to Behavioral Health Challenges". October 2017. https://www.manatt.com/Manatt/media/Media/PDF/White%20Papers/REL-Manatt-Communities-in-Crisis-10-26-FINAL.PDF

[22] Rockett, Ali. "Richmond jail program lowers recidivism, if inmates participate long enough, study finds". Richmond Times-Dispatch. May 10, 2017. http://www.richmond.com/news/local/city-of-richmond/richmond-jail-program-lowers-recidivism-if-inmates-participate-long-enough/article_291631a3-5863-5aab-b8b7-9a2d95c6cba7.html

[23] Abt Associates, Inc. "Evaluation of the Hampden County Public Health Model of Correctional Health Care Final Report". February 2004. http://hcsdma.org/wp-content/uploads/2015/03/HCTYreport.pdf

Allegheny County Jail Collaborative Reentry Programs[24]	1) Link to reentry services and programming in the jail and community after release 2) Link to reentry probation officers who engaged in services pre-release and supervised post-release	Reduction in re-arrest and prolonged time to re-arrest, especially after the first 90 days post-release. For example, at 180 days post-release, 10 percent of the treatment group were rearrested compared to 27 percent of the comparison group.

Evidence Based Therapies and Program Components that Lead to Lower Recidivism

It is difficult to confidently demonstrate the impact of a program or practice on recidivism rates. Even Assertive Community Treatment, one of the most enriched models for criminal justice populations, has been demonstrated to improve mental health recovery and level of functioning but not impact risk for recidivism.[25] Recidivism outcomes are often measured differently (rearrest vs. reconviction vs. reincarnation), target populations could be high or low risk, programs vary in intensity and length, and research quality is variable.[26] However, our review of the literature suggests the following elements may contribute to a lower risk of criminal recidivism:

Risk-Need-Responsivity (RNR) Principle

According to a report by Carter and Sankovitz, recidivism can be reduced when three key principles are followed:

- The risk principle suggests that justice system interventions should be matched to offenders' risk level, focusing more intensive interventions on moderate and high-risk offenders.
- The need principle asserts that justice system interventions should target those factors that most significantly influence criminal behavior.
- The responsivity principle demonstrates that interventions are most effective when they are based on research-supported models and tailored to the unique characteristics of individual offenders.[27]

The research shows how well interventions are implemented also matters to their success. In one meta-analysis of supervision-based programs, authors found programs that adhered to the risk and need principles achieved lower recidivism rates.[28]

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[24] Wllison, J., Bieler S, and Kim, K."Evaluation of the Allegheny County Jail Collaborative Reentry Programs.". The Urban Institute. October 2014. https://www.urban.org/sites/default/files/publication/33641/413252-Evaluation-of-the-Allegheny-County-Jail-Collaborative-Reentry-Programs.

[25] Rotter, M and Carr, W. A."Reducing Criminal Recidivism for Justice-Involved Persons with Mental Illness: Risk/Needs Responsivity and Cognitive-Behavioral Interventions". SAMHSA's GAINS Center for Behavioral Health and Transformation. October 2013. https://www.prainc.com/wp-content/uploads/2016/02/ReduceCrimRecidRNR.pdf

[26] Ibid.

[27] Carter, M and Sankovitz, R. "Dosage Probation: Rethinking the Structure of Probation Sentences". Center for Effective Public Policy. January 2014. https://nicic.gov/dosage-probation-rethinking-structure-probation-sentences

[28] Lowenkamp, C. T., Pealer, J., Smith, P., & Latessa, E. J. (2006). Adhering to the risk and need principles: Does it matter for supervision-based programs? Federal Probation, 70, 3–8.

Cognitive Behavioral Therapy

Existing research supports cognitive behavioral interventions as central to recidivism reduction for offenders.[29] One meta-analysis found that cognitive behavioral therapy programs were more effective in reducing recidivism than the behavioral ones, with an average approximate 30% reduction in recidivism for treated groups.[30] A 2007 review found that high quality implementation (low number of dropouts, monitoring for implementation fidelity and quality, adequate training for providers) most impacts the effectiveness of the CBT program.

Family Engagement / Peer Supports

Certain programs that have demonstrated effectiveness emphasized prerelease contact between inmates and key supports.[31] For example, Optum, a Regional Support Network in Pierce County, Washington, found that linking Peer Support Counselors to the top repeat offenders with mental health issues reduced bookings by 83% after one year among the 55 participants.[32] A study of Allegheny County Jail inmates suggests positive family social supports are a dominant predictor of lower recidivism as well as improved perceptions of the helpfulness and support of community-based services.[33] A meta-analysis of the effect of prison visitation on reentry success found that experiencing visitation resulted in a 26% decrease in recidivism with a stronger effect for males.[34]

Access to Insurance / Medical Care

Achieving health care coverage upon or prior to release, allowing for access to care and medications in the community, may lead to reductions in recidivism, but findings are not conclusive. For example, the Michigan Prisoner Reentry Initiative links newly released prisoners to a medical home, helps them access needed medications and primary and specialty care, including assistance with co-payments. Pre and post implementation comparisons of recidivism show that the rate has fallen since the program began, from 46% in 2007 to 21.8% in 2012 among 2-year parolees.[35] Similarly, a study reviewing data from jail programs participants with SMI in King County, Washington and Pinellas County, Florida, found that Medicaid benefits and behavioral health services were associated with a small reduction in arrests and more time in the community before subsequent arrests.

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[29] Lipsey, M. W., N. A. Landenberger, and S. J. Wilson. 2007. "Effects of Cognitive-Behavioral Programs for Criminal Offenders." Campbell Systematic Reviews, 6.

[3030] Pearson, F. S., Lipton, D. S., Cleland, C. M., & Yee, D. S. (2002). The effects of behavioral/cognitive-behavioral programs on recidivism. Crime and Delinquency, 48(3), 476- 496.

[31] Wilson, JB, Bider, S and Kim K., 2014. "Evaluation of the Allegheny County Jail Collaborative Reentry Programs". Urban Institute Research Report.

[32] Optum. "Pierce County Regional Support Network (RSN)". 2015. https://www.optum.com/content/dam/optum3/optum/en/resources/case-studies/Pierce%20Cty%20Case%20Study.pdf

[33] Spjeldnes, S, Jung, Y., Maguire, L., & Yamatani, H. "Positive Family Social Support: Counteracting Negative Effects of Mental Illness and Substance Abuse to Reduce Jail Ex-inmate Recidivism Rates". Journal of Human Behavior in the Social Environment, 22:130–147, 2012.

[34] Mitchell, M, Spooner, K, Jia D, & Zhang, Y. "The effect of prison visitation on reentry success: A meta-analysis". Journal of Criminal Justice, 47: 74-83, 2016.

[35] Woodbury, V and Sartorius, P. " Michigan Pathways Project links ex-prisoners to medical services, contributing to a decline in recidivism" (Rockville, MD: Agency for Healthcare Research and Quality, August 2013), https://innovations.ahrq.gov/profiles/michigan-pathways-project-links-ex-prisoners-medical-services-contributing-decline

Appendix B

Survey Instruments

Behavioral Health Provider Survey

Introduction

Thank you for responding to this survey. This version of the survey is intended for the behavioral health provider associated with the Jail Based Behavioral Health Services (JBBS) Program. The respondent should be familiar with the specific JBBS program components for the specific County. If you are a behavioral health organization serving multiple counties, you will need to identify a behavioral health provider to respond to the survey for each county in the JBBS program. The respondent will need to be familiar with that county's model and protocol.

The information you provide will be used to help the Office of Behavioral Health (OBH) and the Correctional Treatment Board explore the effectiveness of the JBBS program and participation in the program evaluation is expected. This survey will inform improvements to the JBBS program and make recommendations regarding best practices, potential expansion of the program, and standardization of some processes that are effective.

Health Management Associates (HMA) is collaborating with OBH and the Correctional Treatment Board to evaluate the JBBS program. As we discussed in the kickoff meeting for the evaluation the survey data will help to inform the evaluation and your feedback is highly valued by OBH and the Correctional Treatment Board.

The survey should take approximately 20-30 minutes to complete. Prior to completing the survey, please review the survey questions and the survey instruction sheet indicating the kind of data that you may find helpful to have with you when you complete the survey (both were attached to the email with the link to the survey). We believe this will help you complete the survey in one session.

You can access the survey multiple times. However, you cannot save a response and return at a later time to complete it. If you find yourself needing to exit the survey before completing it, please submit your response so that it can be collected. You can return to the survey to continue with the remainder of the survey at a later date.

If you have any questions as your complete the survey, please contact Robyn Odendahl at rodendahl@healthmanagement.com

Demographics

* 1. Name

* 2. County

* 3. JBBS Behavioral Health Provider (organization and name) completing Survey:

Organization

JBBS Position (e.g., Licensed therapist, case manager, etc

* 4. Please indicate the number of JBBS behavioral health staff working in the jail, including position types and roles.

* 5. Are there behavioral health staff working in the jail that are outside of the JBBS program?

- ◯ Yes
- ◯ No

If yes, please briefly describe how many and their roles

Screening Protocol

* 6. Please check all of the JBBS screening tools used in this county.

- [ ] Standardized Offender Assessment-Revised
- [ ] Addiction Severity Index
- [ ] Simple Screening Instrument-Revised
- [ ] Colorado Criminal Justice Mental Health Screen-Adult (CCJMHS-A)
- [ ] Brief Behavioral Health Screen
- [ ] PTSD Checklist
- [ ] Trauma Symptom Inventory
- [ ] HELPS Brain Injury Screening Tool
- [ ] Traumatic Brain Injury (TBI) Screening Tool

* 7. If there is a positive screen on one of the four JBBS screening tools, do you engage additional (non-required JBBS) validated screening tools for further screening?

- ◯ Yes
- ◯ No
- ◯ Comment

* 8. Please check any and all additional behavioral health screening tools used (these could be used at any point during an inmates time in jail).

- [ ] Patient Health Questionnaire (PHQ)-2
- [ ] Patient Health Questionnaire (PHQ)-9
- [ ] Generalized Anxiety Disorder (GAD)-7
- [ ] The Alcohol Use Disorders Identification Test (AUDIT)
- [ ] Drug Abuse Screening Test (DAST)
- [ ] CAGE-AID
- [ ] Alcohol, Smoking and Substance Involvement Screening Test (ASSIST)
- [ ] Alcohol Dependence Scale (ADS)
- [ ] Global Appraisal of Individual Needs (GAIN-SS)
- [ ] The Mini International Neuropsychiatric Interview (MINI)/Modified Mini Screen
- [ ] Brief Jail Mental Health Screen
- [ ] Texas Christian University Drug Screen (II) (TCUDS-II)
- [ ] Mental health Screening Form III
- [ ] Trauma History Screen (THS)
- [ ] Life Stressor Checklist (LSC-R)
- [ ] Life Events Checklist for DSM-5
- [ ] Beck Scale for Suicide Ideation (BSS)
- [ ] Adult Suicidal Ideation Questionnaire (ASIQ)
- [ ] Interpersonal Needs Questionnaire and Acquired Capability Suicide Scale (ACSS)
- [ ] Motivational or Readiness Assessment Tool (various forms)
- [ ] Other (please specify)

* 9. Please check the box that is most descriptive of your JBBS behavioral health screening protocol.

- ◯ Universal screening (screening every individual that enters the jail) at booking
- ◯ Criteria based screening (e.g., screened if inmate indicates history of substance use or mental health treatment)
- ◯ If criteria based, please provide description of the criteria that leads to screening and how criteria are identified

* 10. Based on the JBBS behavioral health screening protocol in this county, are all four screenings (SUD, MH, TBI, and Trauma) offered to the detainee identified for screening?

- ◯ Yes
- ◯ No

If no, what are the additional criteria for screening MH, TBI, or Trauma?

* 11. Does the capacity (or current openings) of the JBBS program change the screening protocol (i.e., do you stop or change screening protocol because the program is at full capacity)?

- ◯ Yes
- ◯ No
- ◯ I don't know

If yes, how?

* 12. Who provides the JBBS contract required screening to the inmate?

- ◯ Booking officer
- ◯ Behavioral health provider
- ◯ Other (please specify)

* 13. Who scores the JBBS contract required screening tool and determines positive score?

- ◯ Booking officer
- ◯ Behavioral Health Provider
- ◯ Other (please specify)

* 14. If there is a positive screen on one of the four JBBS screening tools (MH, SUD, TBI, or Trauma), do you engage in additional assessment? (face to face evaluation, use of standardized assessment tools, referral, etc.)

- ◯ Yes
- ◯ No
- ◯ Sometimes

If yes or sometimes, please explain your additional assessment process

* 15. Do you use the validated screening tool recommended range of scores for determining a positive screen
(e.g., score of 10 or above is positive)?

- ◯ Yes
- ◯ No

If no, what do you use?

* 16. Do all individuals with a positive screen get admitted to the JBBS Program?

- ◯ Yes
- ◯ No

If no, what additional criteria need to be met for referral to the program (i.e., sub-set of positive screens (i.e., only high scores are referred) or additional criteria)?

* 17. After a positive screen for SUD is indicated, how is the diagnosis for SUD determined?

- ◯ Face to face interview with JBBS Behavioral Health licensed provider
- ◯ Phone interview with JBBS Behavioral Health licensed provider
- ◯ Additional assessment instrument (please indicate what tool)

Describe additional assessment instrument

* 18. Please indicate the degree to which you perceive the current JBBS screening protocol is accurately identifying individuals with SUD?

- ◯ Very accurate
- ◯ Somewhat accurate
- ◯ Unsure
- ◯ Somewhat accurate
- ◯ Very inaccurate

If you perceive the current screening protocol is inaccurate, please describe whether it overestimates or underestimates individuals with SUD.

* 19. Are any services such as education offered to those with scores demonstrating risk but not qualified for JBBS program?

- ◯ Yes
- ◯ No
- ◯ If yes, describe the services?

* 20. Do you have evidence that some of the people that most need JBBS services are not enrolled?

- ◯ Yes
- ◯ No
- ◯ I don't know.

If yes, what is your evidence?

About the Jail Based Services

* 21. What are the criteria in your setting for program referral?

* 22. What factors inform this criteria? (Please check all that apply)

- [ ] JBBS funding
- [ ] Waitlists for the program
- [ ] Average length of stay in jail
- [ ] Jail staffing capacity
- [ ] Census and size of jail
- [ ] Capacity and staffing of Behavioral Health provider
- [ ] Other (please specify)

* 23. How is a referral made to the JBBS program?

* 24. What services are offered in the JBBS program at your site? (Please check all that apply)

- [ ] Intake
- [ ] Assessment/Evaluation
- [ ] Individual Therapy
- [ ] Group
- [ ] Case management
- [ ] Engagement
- [ ] Transition tracking
- [ ] Psychoeducation
- [ ] Crisis Intervention
- [ ] Medication Assisted Treatment
- [ ] Medication Management
- [ ] Narcan Kits
- [ ] Peer Led Services
- [ ] Other (please specify)

* 25. What evidence based treatment models are you using in the JBBS programming? (Please check all that apply)

- [ ] Cognitive behavioral therapy (CBT)
- [ ] Critical time intervention (CTI)
- [ ] Dialectical Behavior Therapy –Modified
- [ ] Dialectical Behavior Therapy –CM
- [ ] Matrix Model
- [ ] Contingency Management (CM)
- [ ] Motivational Enhancement Therapy (MET),
- [ ] Twelve-step facilitation therapy (Alcoholics anonymous, Emotions anonymous, etc.)
- [ ] Behavioral therapies (e.g., Multi systemic Therapy).
- [ ] Living in Balance (LIB)
- [ ] Moral Reconation Therapy (MRT)
- [ ] Texas Christian University (TCU)
- [ ] Mapping-Enhanced Counseling (MEC)
- [ ] Mindfulness
- [ ] Psychoeducation
- [ ] Seeking Safety
- [ ] Strategies for Self-Improvement and Change
- [ ] Therapeutic Communities (TC)
- [ ] Thinking for Change
- [ ] Peer Led Services
- [ ] Other (please specify)

* 26. Where are inmates seen for services? (Please check all that apply)

- [ ] Inmate cell
- [ ] Group room
- [ ] Public areas (when not used by others)
- [ ] Interview rooms
- [ ] Jail Health Services space
- [ ] Other (please specify)

* 27. Who delivers JBBS services? (Please check all that apply)

- [ ] Certified Addictions Counselor (CAC) (I-III)
- [ ] Licensed Behavioral Health Provider
- [ ] Licensed Behavioral Health Provider with CAC
- [ ] Peer
- [ ] Psychiatric Prescriber
- [ ] Other (please specify)

* 28. Are diagnoses re-assessed at any point in the treatment process?

- [ ] Yes
- [ ] No
- [ ] Sometimes

If yes or sometimes, please describe when and how.

* 29. What is the average length of stay in the JBBS program?

- ◯ 0 to 1 month
- ◯ 2 to 3 months
- ◯ 4 or 5 months
- ◯ 6 or 7 months
- ◯ 8 or 9 months
- ◯ 10 or more months

* 30. What is the average number of sessions JBBS program participants receive prior to release?

- ◯ 1-5
- ◯ 5-10
- ◯ 10-15
- ◯ 15-20
- ◯ 20-25
- ◯ 25-30
- ◯ 30-35
- ◯ 35 or more

* 31. Are family members included in any treatment programming or transitional planning?

- ◯ Yes
- ◯ No
- ◯ Sometimes

If yes or sometimes, please describe how family members are included.

* 32. If this county jail has other behavioral health providers (outside of the JBBS program), is there any referral between JBBS and services offered by jail behavioral health providers?

- ◯ Yes
- ◯ No

If yes, please explain when referrals occur

* 33. In this county, do the JBBS behavioral health providers coordinate care with jail based medical providers?

- ◯ Yes
- ◯ No

* 34. If yes, please indicate the kind of care coordination. (Please check all that apply)

- [ ] Shared treatment plan
- [ ] Team consultation or case discussion
- [ ] Email or phone communication

Other (please specify)

Expansion, Capacity, and Gaps in Service

* 35. Do you currently have a waitlist for the JBBS services (e.g., individuals who meet criteria but no space in the program)?

- ◯ Yes
- ◯ No

If yes, how many people on your waitlist and how long are they generally on the waitlist?

* 36. Do you turn away individuals from the JBBS program who have a mental health concern but do not meet criteria for SUD?

- ◯ Yes
- ◯ No
- ◯ Sometimes

If yes or sometimes, approximately how many cases did you turn away in 2016 who had a MH concern but did not meet criteria for SUD?

* 37. If your county expanded the JBBS program. what population would be a priority population for services?

- ◯ Individuals with mental health concerns
- ◯ Individuals with a traumatic brain injury
- ◯ Individuals with a trauma history/background
- ◯ Other (please specify)

* 38. What are the most challenging behavioral health issues in this county jail (e.g., the behavioral health concerns that you want resources to address)? (Please check all that apply)

- [ ] Risk for suicide
- [ ] Addiction and withdrawal risk
- [ ] Psychosis
- [ ] Anxiety and agitation
- [ ] Verbal outbursts
- [ ] Aggressive behavior
- [ ] Depression

Other (please specify)

* 39. What gaps in behavioral health service capacity are the highest priority for your site to address? (Please check all that apply)

- [ ] Crisis intervention (suicidal ideation assessment and treatment)
- [ ] Evaluation
- [ ] Psychiatric Medication Management
- [ ] Behavioral Modification
- [ ] Alternatives to restrictive housing for inmates with SMI

* 40. What services do you think could be offered to those inmates pre-sentence? (Please check all that apply)

- [ ] Assessment and Evaluation
- [ ] Engagement
- [ ] Psychoeducation
- [ ] Referral and Transition Information
- [ ] Other (please specify)

Outcomes

* 41. Please check any additional outcomes you measure for the JBBS program that are outside of the JBBS contract requirements (Please check all that apply)

- [ ] Inmate satisfaction with program
- [ ] Inmate engagement
- [ ] Inmate motivation for change
- [ ] Symptom reduction
- [ ] Clinical improvement
- [ ] Behavioral outcomes (e.g., fewer verbal outbursts, more compliant behavior, etc.)
- [ ] Critical incidents
- [ ] None (only track OBH required metrics)
- [ ] Other (please specify)

* 42. Are you currently measuring or tracking JBBS program enrollees' behavior compared to other inmates (e.g., number of behavioral or critical incidents, need for suicide assessment, etc.)?

- ◯ Yes
- ◯ No

If no, why not?

* 43. What factors have you found to be central to fostering ongoing engagement in community services post release? (Please check all that apply)

- [ ] Individual motivation to change
- [ ] Rapport built with BH provider
- [ ] Shared experience with other inmates in JBBS program
- [ ] Treatment Plan
- [ ] Appointments in Community Set Prior to Discharge
- [ ] Family Support of Treatment
- [ ] Individual Progress in Jail
- [ ] Criminogenic risk
- [ ] Criminal Justice Involvement (sentence)
- [ ] Other (please specify)

* 44. What factors have you found to be barriers to ongoing engagement in community services post release? (Please check all that apply)

- [ ] Transient housing
- [ ] Transportation
- [ ] Individual motivation to change
- [ ] Criminogenic risk
- [ ] Insurance or payment for services
- [ ] Family support of treatment
- [ ] Individual progress injJail
- [ ] Criminal Justice involvement (sentence)
- [ ] Other (please specify)

* 45. Does the BH provider in the community have training in treating individuals with criminal backgrounds and criminological risk factors?

- ◯ Yes
- ◯ No
- ◯ I don't know.
- ◯ If yes, can you describe the training?

* 46. What percentage of JBBS program participants are enrolled in Medicaid upon release?

* 47. What services are offered for individuals without Medicaid or other insurance once they are in the community? (Please check all that apply)

- ☐ Assessment/Evaluation
- ☐ Individual Therapy
- ☐ Group
- ☐ Case management
- ☐ Engagement
- ☐ Transition tracking
- ☐ Psychoeducation
- ☐ Crisis Intervention
- ☐ Medication Assisted Treatment
- ☐ Medication Management
- ☐ Peer Led Services

Other (please specify)

* 48. If you could measure outcomes, what are the outcome metrics that you think are most important to demonstrate the program's effectiveness?

* 49. Does your County have a process to identify an inmate at booking who may have been previously enrolled in JBBS and is returning following a re-arrest?

- ◯ Yes
- ◯ No
- ◯ Sometimes

If yes or sometimes, please describe the process to identify these individuals.

* 50. What activities do the JBBS behavioral health staff provide to help educate or engage the jail custody staff in the program?

- ☐ Training on behavioral health symptoms
- ☐ Education on the JBBS model and referral to the program
- ☐ Shared meetings to discuss inmate progress or behavior
- ☐ Review of JBBS program outcomes
- ☐ None

Other (please specify)

* 51. Please rate the level of collaboration between JBBS program staff and the jail staff (custody officers and deputies).

- ◯ High
- ◯ Moderate
- ◯ Low
- ◯ None

* 52. Please rate jail custody staff's understanding of the JBBS program goals, population served, and outcomes?

- ◯ Very Limited
- ◯ Limited
- ◯ Fair
- ◯ Good
- ◯ Very Good
- ◯ Don't Know

Comment

Additional Needs

* 53. What resources are needed to make the JBBS program more effective? (Please check all that apply)

- [ ] Additional funding
- [ ] Training for Jail Based Staff
- [ ] Training for Behavioral Health Providers
- [ ] Standardized Processes
- [ ] Access to data on JBBS program participants statewide

Other (please specify)

* 54. What is the additional funding needed for?

* 55. What resources would support your county in increasing program capacity (e.g., adding populations or services to the JBBS program?)

* 56. Please describe any other comments or specific needs for your JBBS program.

Thank you for completing our survey.

Survey for Correctional Staff

Introduction

Thank you for responding to this survey. This version of the survey is intended for the Sheriff Department Program Coordinator (Fiscal Agent) or if necessary the appropriate jail representative who can speak to the specific elements of the Jail Based Behavioral Health Services (JBBS) program for this county. The respondent should be familiar with the specific JBBS program components for the County.

The information you provide will be used to help the Office of Behavioral Health (OBH) and the Correctional Treatment Board explore the effectiveness of the JBBS program and participation in the program evaluation is expected. This survey will inform improvements to the JBBS program and make recommendations regarding best practices, potential expansion of the program, and standardization of some processes that are effective.

Health Management Associates (HMA) is collaborating with OBH and the Correctional Treatment Board to evaluate the JBBS program. As we discussed in the kickoff meeting for the evaluation the survey data will help to inform the evaluation and your feedback is highly valued by OBH and the Correctional Treatment Board.

The survey should take approximately 20-30 minutes to complete. Prior to completing the survey, please review the survey questions and the survey instruction sheet indicating the kind of data that you may find helpful to have with you when you complete the survey (both were attached to the email with the link to the survey). We believe this will help you complete the survey in one session.

You can access the survey multiple times. However, you cannot save a response and return at a later time to complete it. If you find yourself needing to exit the survey before completing it, please submit your response so that it can be collected. You can return to the survey to continue with the remainder of the survey at a later date.

If you have any questions as your complete the survey, please contact Robyn Odendahl at rodendahl@healthmanagement.com

Demographics

* 1. Name

* 2. County

* 3. Sheriff Department Representative (Position Title and name) completing Survey:

Name

JBBS Position (e.g.,Sheriff Program Coordinator, Jail Commander or Captain, Jail Medical Provider, etc.)

* 4. Jail capacity (can be approximate):

* 5. Average jail census (can be approximate):

Demographics

* 6. Number of bookings per year (can be approximate):

* 7. What percent of bookings are pre-adjudicated and what percent are sentenced? (Can be approximations or estimates)

Pre-adjudicated

Sentenced

* 8. Please indicate the number of JBBS behavioral health staff that work in the jail.

Number

Positions/Roles

* 9. Are there behavioral health staff working in the jail that are outside of the JBBS program?

- ◯ Yes
- ◯ No

If yes, please briefly describe how many and their roles:

Screening Protocol

* 10. Do you provide any medical and behavioral health assessment in your booking process for all detainees? Select all that apply.

- [ ] Mental health (MH) screening and assessments completed
- [ ] Substance use disorder (SUD) screening and assessments completed
- [ ] Assessment data reviewed when developing care plan
- [ ] Interviews or in-person screenings
- [ ] Laboratory or medical screens provided, including vitals
- [ ] Review of medical history
- [ ] Other (please specify)

* 11. If your jail provides behavioral health assessment at booking, who completes these assessments?

- ◯ RN
- ◯ Booking Officer
- ◯ Jail Deputy
- ◯ Other Staff (please indicate staff classification)

* 12. If your County jail does not already use universal screening, would you be willing to try a period of universal screening (screening everyone that is booked) to evaluate the total positive behavioral health screen in the population?

- ◯ Yes
- ◯ No
- ◯ Unsure
- ◯ If yes, what resources (if any) would be needed to make it happen?
  If no, what are the barriers to trying universal screening?

* 13. Does your setting conduct drug testing upon booking?

- ◯ Yes for some detainees
- ◯ Yes for all detainees
- ◯ No
- ◯ Other

14. If yes for some detainees (from question 13), please provide criteria for drug testing:

* 15. Please check any and all additional behavioral health screening tools used (these could be used at any point during an inmates time in jail).

- [ ] Patient Health Questionnaire (PHQ)-2
- [ ] Patient Health Questionnaire (PHQ)-9
- [ ] Generalized Anxiety Disorder (GAD)-7
- [ ] The Alcohol Use Disorders Identification Test (AUDIT)
- [ ] Drug Abuse Screening Test (DAST)
- [ ] CAGE-AID
- [ ] Alcohol, Smoking and Substance Involvement Screening Test (ASSIST)
- [ ] Alcohol Dependence Scale (ADS)
- [ ] Global Appraisal of Individual Needs (GAIN-SS)
- [ ] The Mini International Neuropsychiatric Interview (MINI)/Modified Mini Screen
- [ ] Brief Jail Mental Health Screen
- [ ] Texas Christian University Drug Screen (II) (TCUDS-II)
- [ ] Mental health Screening Form III
- [ ] Trauma History Screen (THS)
- [ ] Life Stressor Checklist (LSC-R)
- [ ] Life Events Checklist for DSM-5
- [ ] Beck Scale for Suicide Ideation (BSS)
- [ ] Adult Suicidal Ideation Questionnaire (ASIQ)
- [ ] Interpersonal Needs Questionnaire and Acquired Capability Suicide Scale (ACSS)
- [ ] Motivational or Readiness Assessment Tool (various forms)
- [ ] Other screening tools used

Screening Protocol

* 16. What is the maximum number of people served per month (FY16 Estimate) in JBBS in this jail?

* 17. How many people are served on average per month (FY16 Estaimte) in JBBS in this jail?

* 18. How many people are referred on average per month (FY16 Estimate) to JBBS in this jail?

* 19. How is a referral made to the JBBS program?

* 20. What services are offered in the JBBS program in your county? (Please check all that apply)

- [ ] Intake
- [ ] Assessment/Evaluation
- [ ] Individual Therapy
- [ ] Group
- [ ] Case Management
- [ ] Engagement
- [ ] Transition Tracking
- [ ] Pscyhoeducation
- [ ] Crisis Intervention
- [ ] Medicaid Assisted Treatment
- [ ] Medication Management
- [ ] Narcan Kits
- [ ] Peer Led Services
- [ ] Other

* 21. If OBH and the Correctional Treatment Board had recommendations for universal behavioral health screening at booking, how likely would your jail be to accept recommendations and implement universal screening?

- ( ) Very likely
- ( ) Somewhat likely
- ( ) Unsure
- ( ) Not likely
- ( ) Very unlikely
- ( ) Other

* 22. What are the barriers to universal screening currently?

* 23. If this county jail has other behavioral health providers (outside of the JBBS program), is there any referral between JBBS and services offered by jail behavioral health providers?

- ◯ Yes
- ◯ No

If yes, please explain when referrals occur

* 24. In this county, do the JBBS behavioral health providers coordinate care with jail based medical providers?

- ◯ Yes
- ◯ No

25. If you answered yes to Question 24, please indicate the kind of care coordination (check all that apply):

- ☐ Shared treatment plan
- ☐ Team consultation or case discussion
- ☐ Email or phone communication
- ☐ Other (please specify)

Expansion, Capacity, and Gaps in Services

* 26. Do you currently have a wait-list for the JBBS services (e.g., individuals who meet criteria but no space in the program)?

- ◯ Yes
- ◯ No

If yes, how many people on your wait-list and how long are they generally on it?

* 27. Do you turn away individuals from the program who have a mental health concern but do not meet criteria for SUD?

- ◯ Yes
- ◯ No
- ◯ Sometimes

If yes or sometimes, approximately how many cases did you turn away in 2016 who had a MH concern but did not meet criteria for SUD?

* 28. If your county expanded the JBBS program, what population would be a priority population for services based on your jail's needs?

- ☐ Individuals with mental health concerns
- ☐ Individuals with a traumatic brain injury
- ☐ Individuals with a trauma history/background
- ☐ Other (please specify)

* 29. What are the most challenging behavioral health issues in this county jail (e.g., the behavioral health concerns that you want resources to address)? (Check all that apply)

- [ ] Risk for suicide
- [ ] Addiction and withdrawal risk
- [ ] Psychosis
- [ ] Anxiety and agitation
- [ ] Verbal outbursts
- [ ] Aggressive behavior
- [ ] Depression
- [ ] Other (please specify)

* 30. What gaps in behavioral health service capacity are the highest priority for your site to address? (Please check all that apply)

- [ ] Crisis Intervention (suicidal ideation assessment and treatment)
- [ ] Evaluation
- [ ] Psychiatric Medication Management
- [ ] Behavioral Modification
- [ ] Alternatives to restrictive housing for inmates with SMI
- [ ] Other (please specify)

* 31. What services do you think could be offered to those inmates pre-sentence? (please check all that apply)

- [ ] Assessment and Evaluation
- [ ] Engagement
- [ ] Psychoeducation
- [ ] Referral and Transition Information
- [ ] Other (please specify)

Outcomes

* 32. Please check any additional outcomes you measure for the JBBS program that are outside of the OBH contract requirements. (Please check all that apply)

- [ ] Inmate satisfaction with program
- [ ] Inmate engagement
- [ ] Inmate motivation for change
- [ ] Symptom reduction
- [ ] Clinical improvement
- [ ] Behavioral outcomes (e.g., fewer verbal outbursts, more compliant behavior, etc.)
- [ ] Critical incidents
- [ ] None (only track OBH required metrics)
- [ ] Other (please specify)

* 33. Are you currently measuring or tracking JBBS program enrollees' behavior compared to other inmates (e.g., number of behavioral or critical incidents, need for suicide assessment, etc.)?

- ( ) Yes
- ( ) No

If no, why not?

* 34. What percentage of JBBS program participants are enrolled in Medicaid upon release?

* 35. If you could measure outcomes, what are the outcome metrics that you think are most important to demonstrate the program's effectiveness?

* 36. Does your County have a process to identify an inmate at booking who may have been previously enrolled in JBBS and is returning following a re-arrest?

- ◯ Yes
- ◯ No
- ◯ Sometimes
- ◯ If yes or sometimes, please describe the process to identify these individuals.

Outcomes

* 37. What activities do the JBBS behavioral health staff provide to help educate or engage the jail custody staff in the program?

- [ ] Training on behavioral health symptoms
- [ ] Education on the JBBS model and referral to the program
- [ ] Shared meetings to discuss inmate progress or behavior
- [ ] Review of JBBS program outcomes
- [ ] None

Other

* 38. Please rate the level of collaboration between JBBS program staff and the jail staff (custody officers and deputies)

- ◯ High
- ◯ Moderate
- ◯ Low
- ◯ None

* 39. Please rate the jail custody staff's understanding of the JBBS program goals, population served, and outcomes.

- ◯ Very limited
- ◯ Limited
- ◯ Fair
- ◯ Good
- ◯ Very Good
- ◯ Don't Know
- ◯ Other (please specify)

Additional Needs

* 40. What resources are needed to make the JBBS program more effective (check all that apply)?

- [ ] Additional funding
- [ ] Training for Jail Based Staff
- [ ] Training for Behavioral Health Providers
- [ ] Standardized processes
- [ ] Access to data on JBBS program participants statewide

Other (please specify)

* 41. What is the additional funding needed for?

* 42. What resources would support your county in increasing program capacity (e.g., adding populations or services to the JBBS program?)

* 43. Please describe any other comments or specific needs for your JBBS program.

Thank you for completing our survey.

Appendix C

Selection of Counties for Interview

Survey Responses Used for Selecting Counties to Interview

Program Elements from Behavioral Health Provider Survey		Program Elements from the Correctional Staff Survey	
Program Element	**Response**	**Program Element**	**Response**
Are there behavioral health staff working in the jail that are outside of the JBBS program?	Yes	Jail Capacity and Jail Size	High capacity or size (i.e., 700+ inmates) and low capacity or size (i.e., 150-less inmates)
If there is a positive screen on one of the four JBBS screening tools, do you engage additional (nonrequired JBBS) validated screening tools for further screening?	Yes	Are there behavioral health staff working in the jail that are outside of the JBBS program?	Yes
Please check the box that is most descriptive of your JBBS behavioral health screening protocol.	Universal or Criteria Based	Do you provide any medical and behavioral health assessment in your booking process for all detainees?	Yes
Does the capacity (or current openings) of the JBBS program change the screening protocol (i.e., do you stop or change screening protocol because the program is at full capacity)?	Yes	If your County jail does not already use universal screening, would you be willing to try a period of universal screening (screening everyone that is booked) to evaluate the total positive behavioral health screen in the population?	Yes
Do all individuals with a positive screen get admitted to the JBBS Program?	No	Does your setting conduct drug testing upon booking?	Yes
Please indicate the degree to which you perceive the current JBBS screening protocol is accurately identifying individuals with SUD?	Somewhat accurate	What is the maximum number of people served per month (FY16 Estimate) in JBBS in this jail?	Created a ranking of high, medium and low based on numbers and desired a mix or rankings for interviews.
Do you have evidence that some of the people that most need JBBS services are not enrolled?	Yes	If this county jail has other behavioral health providers (outside of the JBBS program), is there any	Yes

		referral between JBBS and services offered by jail behavioral health providers?	
What factors inform criteria? (Please check all that apply)	Checked Capacity and Staffing	In this county, do the JBBS behavioral health providers coordinate care with jail based medical providers?	Yes
Who delivers JBBS services? (Please check all that apply)	Checked Psychiatric Provider	Do you currently have a wait-list for the JBBS services (e.g., individuals who meet criteria but no space in the program)?	Yes
Are family members included in any treatment programming or transitional planning?	Yes	Are you currently measuring or tracking JBBS program enrollees' behavior compared to other inmates (e.g., number of behavioral or critical incidents, need for suicide assessment, etc.)?	Yes
If this county jail has other behavioral health providers (outside of the JBBS program), is there any referral between JBBS and services offered by jail behavioral health providers?	Yes	What activities do the JBBS behavioral health staff provide to help educate or engage the jail custody staff in the program?	Yes
In this county, do the JBBS behavioral health providers coordinate care with jail based medical providers?	Yes	Please rate the level of collaboration between JBBS program staff and the jail staff (custody officers and deputies)	This question was on both surveys and so we looked for counties with alignment of “high” collaboration on both the BH and correctional survey as well as alignment for both surveys indicating “low” collaboration.
Do you currently have a waitlist for the JBBS services (e.g., individuals who meet criteria but no space in the program)?	Yes and No	Please rate the jail custody staff's understanding of the JBBS program goals, population served, and outcomes.	Very Good/Good
If your county expanded the JBBS program, what population would be a	Mental Health or		

priority population for services?	Trauma		
Please check any additional outcomes you measure for the JBBS program that are outside of the JBBS contract requirements.	All but none		
Are you currently measuring or tracking JBBS program enrollees' behavior compared to other inmates (e.g., number of behavioral or critical incidents, need for suicide assessment, etc.)?	Yes		
Does the BH provider in the community have training in treating individuals with criminal backgrounds and criminological risk factors?	Yes		
Does your County have a process to identify an inmate at booking who may have been previously enrolled in JBBS and is returning following a re-arrest?	Yes		
Please rate the level of collaboration between JBBS program staff and the jail staff	High and Low Alignment		
Please rate the jail custody staff's understanding of the JBBS program goals, population served, and outcomes.	Very Good/Good		

Each county, using their survey responses, were rated based on whether they did or did not have the program element of interest. A "high rating" indicates that over 55 % of the desired program elements existed within that program model. A "low rating" indicated that less than 45 % of program elements existed within that program model. Table 2 provides an example of the assessment matrix for the selection of counties to interview. The interview selection identified counties from both high and low ratings as an opportunity to learn more about why desired program elements were or were not implemented.

Example Assessment Matrix for Selection of Programs for Interview

	Program Model (# counties to # providers)	Regional Location	Program Element 1	Program Element 2	Program Element 3	Program Element 4	Number of Program Elements Present	% of Programs Elements and Ranking	Ranking	OBH Input
Program A			X				1	25%	Low (<45%)	
Program B			X	X	X	X	4	100%	High (>55%)	
Program				X	X		2	50%	Mid (45-	

C									54%)	

Interview Guide

Background/Introduction

- This evaluation is designed to support further improvement of the JBBS program as well as support ongoing funding and enhancements of services.
- We want to pinpoint effective and best practice screening strategies with the goal to share effective strategies across the programs as well as determine resources needed to support best practice.Gin We want to ensure we capture size and capacity and how those influence program implementation and outcomes.
- The evaluation also seeks to inform all stakeholders on the impact of the program and suggest potential methods for capturing outcomes (especially recidivism) more systematically.
- In our report to OBH, we will largely aggregate data however may call out specific programs for an effective approach or an example of elements that can be standardized.
- Overall, our areas of inquiry pertain to the following:
    - Target population and your screening process
    - Program Implementation
    - Extent to which there is a need to expand the program, its current capacity and any gaps in services
    - What outcomes are perceived and where there is evidence for those outcomes, and
    - Understanding of outstanding operational needs and resources.
- We are not trying to evaluate or criticize any individual program—that is not our goal here.
- We are very impressed with their commitment to this program, that we understand the complexity of the work and that this is an innovative program in the country that we want to support by identifying what's needed to enhance the outcomes.
- Anything you say to us will be kept confidential and will be reported in aggregate, unless you agree to being quoted or part of a case study.
- Do you have any questions for us before we begin?

Interview Preparation: Review survey responses from both the behavioral health provider and the jail, including demographics:

- Jail census Corrections Questions (CQ)4-CQ7,
- JBBS admissions (FY16 data, CQ16, CQ17, CQ18), JBBS completions, number of JBSS staff (CQ8, BH Questionnaire (BQ) 4,
- Performance Incentive Eligible data
- Extent of collaboration between jail and JBBS behavioral health providers by comparing CQ38 and BQ51).

Areas of inquiry should reflect what was learned from the survey and expand upon those findings. Review interview guide and eliminate questions that that are not relevant to the county being

interviewed based on survey responses. We expect to revise this interview guide based on experience with the first few interviews.

Research Area: Target population and screening protocol

Objective: Understand screening protocol differences and rationale and perception of missed identification. Deliverable includes recommendations for best practices around screening protocols including best practice in screening tools for criminal justice population.

Research questions:

- How do the screening protocols vary by county?
- How do the different processes vary in effectiveness of identifying all individuals who fit program criteria?
- Are the screening protocols identifying the right people for enrollment in the program?

Survey Questions to Review include: BQ6-BQ20; CQ10 to CQ25

Interview Questions:

1. If answer to BQ5 and CQ9 is yes, that there are behavioral health staff outside of JBBS program, explore the extent to which there is collaboration with the behavioral health staff outside of the JBBS program.

    a. Is there any referral between JBBS and services offered by the jail Behavioral Health provider? When does this referral occur (BQ32 CQ23)?
        i. If appropriate ask: What kind of patients do the two sets of providers tend to focus on? All patients? The more severe SMI/SUD issues? Behavioral challenges?
        ii. If appropriate ask: If they are both treating the same inmate, do they share any treatment planning or communicate about what they are doing to streamline the care?
    b. Are there any limitations to this process? Would you recommend it to other JBBS programs?

2. If the jail is screening during booking (BQ12 and CQ11 response booking officer), how are jail staff informed about JBBS program and criteria? How do the jail booking staff refer to the JBBS program?
    a. If an inmate refuses referral to JBBS, is there any information given to the inmate about how to engage later? Is there any information given to the JBBS staff to follow-up later in the stay to see if inmate becomes interested?

3. If answer to BQ7 is yes, that additional screening takes place, explore why the additional screening takes place? What is the screening tool? What perceived benefits or outcomes are achieved as a result of this additional screening? Would you recommend this additional screening to other JBBS programs and why?

4. If answer to BQ9 is yes, that the program conducts universal screening, explore their experience with universal screening.
    a. Can you describe your universal screening protocol? When, who, what?
    b. Does this create a waitlist for JBBS services? What kind of capacity is needed to meet the full need?
    c. Do you feel you are capturing more of those in need than if screening was criteria based? Would the county recommend universal screening to other JBBS programs? If yes, why? If no, why not?
    d. If answer to BQ9 is no, explore to what extent they feel their criteria-based screening protocol is capturing all those in need? Why is there hesitancy to conduct universal screening?

5. If answer to BQ16 is no, that not all individuals with a positive screen get admitted to JBBS, explore what additional criteria are needed to be admitted. Why is this the protocol? How do you feel this protocol impacts JBBS enrollment and participation? Would you recommend this process to other JBBS programs and why or why not?

    a. Do you prioritize services for those with longer stays?

6. If answer to BQ18 regarding the effectiveness of a screening protocol is "somewhat accurate" at identifying those with SUD, explore why it is perceived to overestimate or underestimate individuals with SUD. What makes it somewhat accurate? What recommendations are there to improve the accuracy?
    a. Related, if there is not a wait list (CQ26/BQ35) and counties have low JBBS admissions, explore why admissions are low.
    b. Are the admissions low because you perceive that your screening process is missing the target population? What impact does the exclusion of individuals with MH issues impact your admissions? (CQ27)
7. To behavioral health providers, how often do you think inmates are screened with other tools (by County jail staff or other BH providers) and you don't get a referral or know about them?

Research Area: Implementation

Objective: Explore differences in how programs are implemented and variation in outcomes of these different programs, including an exploration of the degree to which treatments are being implemented with fidelity. Deliverable includes an exploration of which programs have better outcomes and make recommendations regarding best practices; additionally, we can use information from the survey and interviews to recommend the development of a tool to measure fidelity in a more standardized way in the future. The recommendations that stem from this will also offer ideas for best practice evidence based programming for short duration episodes for the jail based population including how other jail based services nationally examine evidence based practice, fidelity, and effectiveness.

Research Questions

- How do counties vary in their implementation of services and in their degree of engagement of EBP models? For example, examining the curriculum used in individual and group appointments, the frequency of sessions, and how closely the tasks matched the model in each of the counties.
- How does size, space and jail capacity inform program differences?
- Are there elements of effective models that can be standardized? (include exploration of communication between jail and JBBS staff and how BH need is met if there are other medical providers present)

Survey Questions to Review include: BQ21-BQ34, BQ45, BQ51 and CQ23 to Cq25

Interview Questions

8. What organizational and/or program characteristics do you feel most influence how your program is designed and implemented? For example, are size, space, or jail capacity factors that influence your program? If yes, how and why?
    a. Explore the extent to which factors influence the degree of collaboration between stakeholders, including jail staff and JBBS staff, and enrollment and outcomes
    b. To BH providers, what factors impact the average number of sessions (BQ30 5 to 10)?
    c. When capacity in the program is a challenge, are you tracking the number of individuals that need services if you had full capacity?
    d. Do you track the individuals that are not enrolled due to capacity and enroll them as space becomes available?
        i. Are these individuals given any information on community resources upon release or education on the importance of treatment?
        ii. Is there any triaging or risk stratification of the individuals when space becomes available? Preparation for release: backpack program

9. Referring to BQ27, have you found that who delivers the JBBS services impacts implementation, screening, referrals, and outcomes?

    a. If the county has a psychiatric prescriber (BQ27), how does this position impact the implementation of JBBS?
    b. Is there a recommendation about the level of staff required to effectively provide JBBS services?

10. If the answer to BQ31, that family members are included in any treatment programming or transitional planning, explore when and how family members are included? To what extent does the inclusion of family members impact outcomes or success in the program and in the community?

11. If the answer to BQ33 is yes., that JBBS behavioral health providers coordinate care with jail based medical providers, discuss the kind of care coordination (BQ34, CQ25). How effective do you feel this type of care coordination is? What would you change, if anything? What might help make the coordination easier? Would you recommend this kind of care coordination to other JBBS programs?

12. If BQ45 is no, that the BH provider in the community does not have training to treat individuals with criminal background and criminological risk factors, explore what the barriers are to this additional training?
    a. If BQ45 is yes, explore the type of training if not provided in the survey response.
    b. Ask about custody understanding and what works best to increase understanding.

13. We understand that you report successful and unsuccessful discharges. Could you tell us more about how you define a "successful discharge"? What qualified as an "unsuccessful discharge"?

Research Area: Expansion, capacity and gap in services

Objective: Explore expansion of populations served, need and capacity for additional services and significant gaps in current program. Specific areas of focus will include mental health (w/o SUD as primary), services for traumatic brain injury, and additions such as Medication Assisted Therapy. An important question here is around needs and gaps for those individuals with short stays (hours to days) and what level of service is best for this sub-population. Deliverable is to make recommendations around whether to expand the target population

Research Questions:

- Would the program be effective for individuals with other needs? What does evidence suggest? How easy can program be adapted?
- What additional needs exist for the jail based population? What needs rise to the top?
- What would it take in operational and financial changes to add capacity for additional services/populations?

Survey Questions to Review include: BQ35-BQ40, CQ26-CQ31

14. If answer to BQ20 is yes, that those in most need of JBBS services are not enrolled, explore the evidence they have for the gaps in service. What are the barriers to enrolling those in most need? What recommendation might there be to increase the enrollment of those in most need?
15. Many counties indicated that an expansion of JBBS services to those individuals with mental health conditions or history of trauma would be important (CQ28, BQ37).
    a. What are the mental health needs in the jail?
    b. As an estimate, how many more enrollees would be included if this was open without SUD diagnosis?
    c. What are the trauma needs? What services would you offer?
    d. As an estimate, how many more enrollees would be included if this was open without SUD diagnosis?
    e. When you say that you need capacity for behavioral modification, what does this mean?
        i. Do you get requests as a BH provider for behavioral modification?

16. Do you think that the JBBS program model can be adapted to serve other populations who do not have a primary SUD diagnosis (e.g., those with a primary mental health condition or with a history of trauma)? What if anything would need to be different? What barriers exist to expand

to other populations? What is currently missing but would be needed to serve these other populations?

17. What are your ideas for addressing the needs of individuals who have shorter stays in jail? What should be prioritized for these individuals to maximize community engagement in treatment?

Research Area: Outcomes

Objective: Explore the degree to which programs meet their intended outcomes, including reduced recidivism and increased engagement in services upon release, and the degree to which other outcomes are achieved (e.g., reduction of problematic behaviors in jail, increased engagement, reduction of symptoms). Explore any metrics captured by the individual programs on effectiveness (e.g., reduction in symptoms as measured by a validated tool, changes in patient engagement, reduction in use of kites and other behavioral changes). Deliverable is to make recommendations regarding the most effective programs and most effective factors.

Research Questions:

- How effective are the programs at increasing engagement in services upon release?
- Is there a statistically significant difference in recidivism rates for individuals engaged in the program?
- Are jail based metrics/behaviors different for the inmates served?

Survey Questions to Review include: BQ41-52, CQ32-39

Interview Questions

18. If response to BQ41 or CQ32 is anything other than "None" NO, explore the additional outcomes identified including how are they tracked and what the data indicates about differences between the JBBS population and other inmates. Does the data provide evidence that the program is having particular benefits? Are there any assessment or evaluation tools that may be replicable across other JBBS programs?
    a. If response to BQ42 or CQ33 is no, they do not track JBBS enrollee behavior compared to other inmates, what are the barriers to tracking JBBS program enrollee behavior compared to other inmates? What data do they track for all inmates that could be useful?
19. If response to BQ49, whether there is a process to identify an inmate at booking who may have been previously enrolled in JBBS and is returning following a re-arrest, explore the process. What is working about the process? What isn't working? Would you recommend this process to other JBBS counties? Can they track individuals who were in JBBS in their jail as well as in other county jail JBBS programs? How?

20. If CQ37 is anything of than none, that JBBS BH Staff provide training to educate and engage jail custody staff in the program, explore those activities. What activities are working well? What benefits do you see as a result of those activities? Would you recommend these activities to other JBBS programs? Who initiated the activities—the jail staff or the BH staff?

Research Area: Additional operational needs

Objective: Explore additional needs that the jails have in order to implement the program effectively. Explore not just staffing but other elements like training and advancement of EBP and community based services, as well as resources available and needs for those not eligible for Medicaid or Residential services. Deliverable is to provide information about how to maximize the effectiveness of the programs, if resource constraints are a challenge.

Recommendations: Findings would provide OBH with information about how to maximize the effectiveness of the programs, if resource constraints are a challenge

Research Questions:

- What other resources are needed to make program most effective?
- How can capacity be supported for different size and capacity issues?
- Can standardization of elements be tiered based on capacity?

Survey Questions include BQ53-BQ54, CQ40-CQ43

Interview Questions

1. Of the resources available to you now via JBBS funding, what would you prioritize as the most important/essential to your JBBS program's effectiveness?
    a. What would you consider the least important?
    b. If you could add one resource to improve the program, what would it be?

2. Review response to BQ53 and 54 and explore areas of need.

Appendix D

JBBS Program Data Variables Used in Analysis

Variable Name	Variable Values
UniqueID	Random ID
Gender	Male/ Female
Payer Source	Blank
Admission Date	00/00/0000
Discharge Date	00/00/0000
Discharge Type	Successful/ Unsuccessful
Referral Date	00/00/0000
Diagnosis 1	Drop Down Menu
Diagnosis 2	Drop Down Menu
Screening Date	00/00/0000
Substance Abuse Screening	Yes/No/Refused/Attempted/Blanks
Substance Abuse Disorder Results	positive, negative, inconclusive, blank
Mental Health Screening	Yes/No/Refused/Attempted/Blanks
Mental Health Screening Results	positive, negative, inconclusive, blank
TBI Screening	Yes/No/Refused/Attempted/Blanks
TBI Screening Results	positive, negative, inconclusive, blank
Trauma Screening	Yes/No/Refused/Attempted/Blanks
Trauma Screening Results	positive, negative, inconclusive, blank
1. LSI Domain: Criminal History	only 2016/17
2. LSI Domain: Education/Employment	only 2016/17
3. LSI Domain: Financial	only 2016/17
4. LSI Domain: Family/Marital	only 2016/17
5. LSI Domain: Accommodation	only 2016/17
6. LSI Domain: Leisure/Recreation	only 2016/17
7. LSI Domain: Companions	only 2016/17
8. LSI Domain: Alcohol/Drug Problems	only 2016/17
9. LSI Domain: Emotional/Personal	only 2016/17
10. LSI Domain: Attitude/Orientation	only 2016/17
LSI Total Score	only 2016/17
LSI Rater Box Total	only 2016/17
Month One Date Tracked	Format 00/00/0000; 2012-2017
Month One Transition Status	In Treatment; Treatment Completed; Not in Treatment; New Crime/regressed; Status Unknown; Not Applicable; Deceased[36]

[36] Definitions: “In Treatment”: Client is engaged in community-based treatment services as recommended on the transition plan. “Not In Treatment”: Client is tracked via the community-based treatment agency or the client reports to not be in treatment services as recommended on the transition plan. “New Crime/Regressed”: Client returned to jail for violations or committed a new crime. “Status Unknown”: Client cannot be reached or tracked.

Month Two Date Tracked	Same as above
Month Two Transition Status	Same as above
Month Six Date Tracked	Same as above
Month Six Transition Status	Same as above
Month Twelve Date Tracked	Same as above
Month Twelve Transition Status	Same as above
Date Service Rendered	Date
Age at Date of Service	
Assessment	Linked/Provided; Planned; Referred; Blanks[37]
Benefit Acquisition	No values
CICP Application Assistance	Linked/Provided; Planned; Referred; Blanks
Client Acuity @ Service	No values
Client Follow Up / Scheduling	No values
Community Resources & Access	Linked/Provided; Planned; Referred; Blanks
Co-Occurring Group Session	Linked/Provided; Planned; Referred; Blanks
Type of Contact	With Client - In Person; With Client - Not In Person (e.g., on phone); With Family Member; With Other Service Provider - Client Follow-Up; With Other Service Provider - Make Service Referral; Blanks
Co-Occuring Individual Session	Linked/Provided; Planned; Referred; Blanks
Current Status @ Service	Admitted; Discharged; Not Admitted; Referred; Blanks
Department of Human Services	Linked/Provided; Planned; Referred; Blanks
Division of Vocational Rehabilitation	Linked/Provided; Planned; Referred; Blanks
Determination of Program Eligibility	Linked/Provided; Planned; Referred; Blanks
Duration of Service	Less than 15 minutes; 15 to 29 Minutes; 30 to 44 Minutes; 1 Hour; 1 Hour 30 minutes; 2 Hours; 2 Hours 30 Minutes; 3 Hours; 3 Hours 30 Minutes; 4 hours
Emergency Services	Linked/Provided; Planned; Referred; Blanks
Educational Services	Linked/Provided; Planned; Referred; Blanks
Employment	Linked/Provided; Planned; Referred; Blanks
Family Outreach	Linked/Provided; Planned; Referred; Blanks
Food Stamps Application	Linked/Provided; Planned; Referred; Blanks
Housing Acquisition	Linked/Provided; Planned; Referred; Blanks
Legal Obligation Assistance	Linked/Provided; Planned; Referred; Blanks
Level II DUI Education	Linked/Provided; Planned; Referred; Blanks
Level II DUI Therapy	Linked/Provided; Planned; Referred; Blanks
Location of Service Field	Jail; Community
Medicaid Application	Linked/Provided; Planned; Referred; Blanks
Medical Treatment	Linked/Provided; Planned; Referred; Blanks
Medication Assistance	Linked/Provided; Planned; Referred; Blanks

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"Not Applicable": Client sentenced to Department of Corrections or client not tracked. "Treatment Completed" Client completed treatment as recommended at release from jail.

[37] Definitions: "linked/provided" means that the clinician has either provided the service within the JBBS program, or has linked the individual to that particular service. "Planned" means that the service has been planned, but has not yet been provided, and "Referred" means that the individual has been referred to the service, but it has not yet been planned or provided.

Medication Evaluation	Linked/Provided; Planned; Referred; Blanks
Medication Management	Linked/Provided; Planned; Referred; Blanks
Mental Health Evaluation	Linked/Provided; Planned; Referred; Blanks
Mental Health Group Session	Linked/Provided; Planned; Referred; Blanks
Mental Health Individual Session	Linked/Provided; Planned; Referred; Blanks
Mental Health Treatment	Linked/Provided; Planned; Referred; Blanks
Office of the Public Defender	Linked/Provided; Planned; Referred; Blanks
Other CJCSs	Blank
Outside Counseling	Linked/Provided; Planned; Referred; Blanks
Peer Support Services	Linked/Provided; Planned; Referred; Blanks
Housing - Rent Assistance Resources	Linked/Provided; Planned; Referred; Blanks
Residential Treatment Services	Linked/Provided; Planned; Referred; Blanks
Seeking Safety Group	Linked/Provided; Planned; Referred; Blanks
SSI or SSDI Application	Linked/Provided; Planned; Referred; Blanks
Substance Abuse Group Session	Linked/Provided; Planned; Referred; Blanks
Substance Abuse Individual Session	Linked/Provided; Planned; Referred; Blanks
Substance Abuse Treatment	Linked/Provided; Planned; Referred; Blanks
Transition Tracking	Linked/Provided; Planned; Referred; Blanks
Trauma Group	Linked/Provided; Planned; Referred; Blanks
Transition Tracking	Linked/Provided; Planned; Referred; Blanks
Count Attended	Number of groups attended while in JBBS

Appendix E

County JBBS Program Admission Criteria

County	Admission
Adams	1. Must have a substance abuse issue and score higher than a 2 on the SSI. 2. Client must want services and voluntarily engage in programming
Alamosa/Conejos	Clients must score for needing treatment on the MMS or MSSI SA.
Arapahoe	1. Participants incarcerated in the ACSODF over the age of 18 2. Participants who are sentenced to a minimum of four months when accepted in the program 3. Participants will be entering into the community upon release from ACSODF 4. Participants do not have to be sentenced but the goal is that they will be in custody for a minimum of four months to complete the program) 5. Presence of a DSM-V diagnosis for substance abuse or dependence and who may also meet DSM-V criteria for a co-occurring mental illness 6. There is an expectation that participant will make progress toward treatment goals while receiving this level of care (if progress is not being made or client is disruptive in treatment, they may be removed from the program based on JBBS team judgment) 7. Participants with sex offenses are may be excluded from the program 8. Participants with violent felonies in his/her recent past will be discussed on a case by case basis. Acceptance into the program will be agreed upon by the entire JBBS treatment
Boulder	1. Must be present in facility for at least 45 days 2. Not anticipating a DOC sentence 3. Must want services and voluntarily engage in programming 4. Substance use disorder or dual diagnosed
Clear Creek	Must have a substance use disorder and/or mental health health diagnosis

Appendix F

Type of Client Contact By County

County	In Person	Not in Person	With Family	With Other Service Provider - Client Follow-Up	With Other Service Provider - Make Service Referral	N
Crowley	42%	3%	0%	51%	4%	73
Adams	46%	24%	4%	26%	1%	7207
Baca	53%	3%	0%	42%	3%	142
Pueblo	58%	29%	4%	7%	1%	2247
Arapahoe	60%	15%	4%	12%	9%	16432
Alamosa/Conejos	61%	17%	1%	22%	0%	1539
Otero	62%	3%	1%	32%	3%	313
Bent	63%	2%	1%	29%	4%	1232
Logan	66%	3%	0%	30%	1%	2553
Prowers	66%	1%	1%	27%	5%	1326
Larimer	67%	8%	1%	20%	5%	5076
Grand	68%	21%	2%	7%	2%	840
Morgan	73%	2%	0%	25%	0%	3193
Kit Carson	73%	10%	0%	16%	0%	207
Yuma	74%	3%	0%	22%	1%	625
Gunnison	75%	8%	1%	15%	1%	518
Lincoln	75%	12%	0%	11%	1%	226
Douglas	81%	12%	2%	4%	1%	3139
Pitkin	82%	1%	1%	14%	3%	199
Jefferson	83%	7%	1%	6%	3%	10939
Elbert	84%	9%	0%	7%	0%	283
Delta	86%	6%	1%	5%	3%	3300
El Paso	86%	14%	0%	0%	0%	6818
Mesa	86%	4%	0%	10%	0%	3618
Weld	86%	4%	0%	10%	0%	5155
Montrose	86%	7%	1%	4%	2%	3016
Garfield	86%	7%	0%	5%	1%	537
Denver	87%	8%	2%	3%	0%	9103
Washington	88%	1%	0%	12%	0%	355
Boulder	89%	3%	1%	6%	2%	13149

Clear Creek	90%	4%	1%	5%	1%	2265
San Miguel	97%	3%	0%	0%	0%	198
Eagle	99%	1%	0%	0%	0%	612
La Plata	99%	1%	0%	0%	0%	4307
Montezuma	99%	0%	0%	0%	0%	1430
Summit	99%	0%	0%	0%	0%	364
Archuleta	100%	0%	0%	0%	0%	53
Moffat	100%	0%	0%	0%	0%	63
Routt	100%	0%	0%	0%	0%	83

Appendix G

Average Number of Service Dates by County

County	Number of JBBS enrollees	Average number of Service Dates	Median # service dates	STD DEV
Lincoln	70	3	2	2.47472
Moffat	18	3	2.5	2.08324
El Paso	1,459	3	2	4.52093
Pueblo	678	3	2	2.34388
Kit Carson	46	3	2.5	2.67896
Montezuma	381	4	2	5.24813
Elbert	60	4	3	5.12179
Garfield	113	4	4	2.78155
Summit	71	5	3	4.03436
Denver	1,832	5	3	4.99965
Alamosa/Conejos	303	5	4	3.99211
Adams	1,378	5	5	3.03955
La Plata	784	5	3	5.45091
Eagle	112	5	4	3.71177
Mesa	570	6	4	6.38373
Pitkin	29	6	3	6.70325
Archuleta	9	6	2	5.64457
Washington	50	6	4	7.38915
Logan	350	6	5	5.3473
Yuma	77	7	7	5.39103
Grand	106	8	6	6.0181
Larimer	627	8	6	6.81759
Douglas	366	8	6	6.87613
Gunnison	51	8	7	6.92911
Otero	14	9	8	6.95827
San Miguel	20	9	5.5	7.79929
Crowley	2	10	10	2.82843
Morgan	294	10	8	7.84258
Baca	7	13	12	8.13283
Clear Creek	148	14	10	13.7508
Montrose	195	14	10	11.5124
Prowers	53	15	12	12.8983
Bent	52	15	11.5	12.5797

Jefferson	641	16	13	12.2153
Weld	300	16	13	10.6941
Delta	161	20	16	17.822
Boulder	553	22	14	24.3536
Arapahoe	646	24	17	22.7638

Appendix H

Average Length of Stay by County (from shortest average to longest average)

County	Average LOS (months)	County	Average LOS (months)
Crowley	1.0	Lincoln	3.1
Denver	1.6	Summit	3.1
Otero	1.8	Pueblo	3.2
Moffat	2.0	Gunnison	3.3
Weld	2.1	Logan	3.3
San Miguel	2.1	Mesa	3.3
Adams	2.2	Montezuma	3.3
Prowers	2.3	Eagle	3.4
Baca	2.4	Boulder	3.5
Bent	2.5	Arapahoe	3.7
Morgan	2.5	Archuleta	3.8
El Paso	2.7	Elbert	3.8
Washington	2.7	Yuma	3.8
Pitkin	2.8	Grand	3.9
Larimer	2.9	La Plata	3.9
Montrose	2.9	Clear Creek	4.1
Alamosa/Conejos	2.9	Jefferson	4.2
Delta	3.0	Garfield	4.2
Douglas	3.1	Kit Carson	4.3

Appendix I

Number of services and duration by county.

County	Average # of Services	Average # Groups Attended	Average # Services + Groups	Average Duration of Services + Groups	N
Garfield	3.8	0.1	3.9	1.1	128
Montezuma	6.0	2.6	8.6	6.2	372
Yuma	7.6	0.7	9.8	2.0	99
Washington	5.1	2.0	10.2	4.9	81
Alamosa/ Conejos	5.3	5.1	10.5	11.0	316
Moffat	4.5	7.2	12.2	15.3	22
Gunnison	10.3	0.2	12.4	1.4	71
La Plata	6.2	6.5	12.5	14.1	805
San Miguel	9.2	0.0	12.6	1.1	31
Archuleta	8.5	4.5	13.0	10.0	2
Lincoln	3.5	9.8	13.7	20.4	84
Mesa	4.9	8.3	14.2	17.5	722
Pueblo	7.7	7.4	15.1	15.9	683
Logan	6.7	6.5	15.6	13.7	507
Summit	9.7	6.9	17.4	14.6	79
Kit Carson	3.8	12.5	17.6	25.8	76
Elbert	4.9	12.3	17.9	25.4	77
Morgan	14.6	2.2	18.4	5.1	331
Douglas	8.7	8.1	18.9	17.1	455
Adams	17.4	1.8	20.2	4.0	1495
Eagle	7.1	13.3	20.6	27.4	116
Weld	18.5	1.1	22.1	2.9	362
Pitkin	18.7	5.1	22.4	11.3	31
Clear Creek	20.9	0.8	23.7	2.5	170
Montrose	14.7	4.7	24.1	10.2	266
Crowley	10.0	0.0	25.5	0.3	14
Baca	14.4	0.0	25.6	0.8	18
Otero	11.5	1.3	25.8	3.1	49
Prowers	9.9	0.7	25.8	2.0	218
Grand	17.0	9.0	26.2	18.9	106
El Paso	9.6	19.2	27.7	40.6	1531

Bent	12.5	0.7	28.0	2.2	158
Jefferson	16.9	10.4	31.6	21.6	849
Denver	12.2	29.3	41.7	59.7	1861
Delta	28.6	8.3	41.7	17.4	188
Larimer	34.2	15.7	50.2	31.8	645
Arapahoe	47.0	22.6	73.4	46.0	722
Boulder	53.3	20.2	88.9	41.6	767

Appendix J

Services by Service Category

Service	Category
Assessment	Assessment
CICP App Assist	Case Management
Community Resources	Case Management
Co-Occurring Group Session	Treatment
Co-Occurring Individ Session	Treatment
Dept. Human Service	Case Management
Determine Program Eligibility	Case Management
Division Vocation Rehab	Case Management
Education Services	Case Management
Emergency Services	Case Management
Employment	Case Management
Family Outreach	Case Management
Food Stamps Application	Case Management
Housing Acquisition	Case Management
Housing Rent Assist	Case Management
Legal Obligation Assist	Case Management
Level II DUI Education	Treatment
Level II DUI Therapy	Treatment
Medicaid Application	Case Management
Medical Treatment	Treatment
Medication Assist	Treatment
Medication Evaluation	Assessment
Medication Manage	Treatment
Mental Health Evaluation	Assessment
Mental Health Group	Treatment
Mental Health Individual	Treatment
Mental Health Treat	Treatment
Office Public Defender	Case Management
Outside Counseling	Treatment
Peer Support	Treatment
Residential Treatment	Treatment
Seeking Safety Group	Treatment
SSI or SSDI Application	Case Management
Substance Abuse Group	Treatment
Substance Abuse Individual	Treatment
Substance Abuse Treat	Treatment
Transition Tracking	Case Management
Trauma Group	Treatment

Appendix K

Average Dose of Service per Day in Minutes

County (highest to lowest)	Average Dose of Service per Day by Minutes	Average Dose of Service per Week by Minutes
Denver	77	538
Boulder	35	246
El Paso	33	231
Arapahoe	33	229
Larimer	24	165
Delta	21	150
Eagle	18	123
Jefferson	16	109
Douglas	14	101
Montrose	14	96
Moffat	13	88
Elbert	12	85
Lincoln	12	85
Mesa	12	83
Grand	12	83
Crowley	12	82
Kit Carson	11	76
Weld	11	76
Pueblo	11	75
Summit	11	74
Logan	11	74
Prowers	10	68
Morgan	10	67
Pitkin	9	66
Archuleta	9	62
Bent	9	61
La Plata	9	60
Alamosa/Conejos	9	60
San Miguel	8	59
Baca	7	52
Washington	7	50
Clear Creek	7	49
Otero	7	47
Montezuma	5	34

Adams	5	34
Gunnison	4	31
Yuma	2	17
Garfield	1	10

Appendix L

Services Delivered by Contract Model Type and By Year

Service Year		Contract Model Type		
		(1) One county jail is served by one behavioral health (BH) provider	(2) More than one county jail is served by one BH provider	(3) One county jail is served by more than one BH provider
2012	No. of services (avg)	22.2	20.1	10.4
	No. of groups attended (avg)	15.1	4.3	17.8
	No. of total service sessions (avg)	32.4	24.3	32.4
	hours of total service sessions (avg)	32.5	9.7	37.0
2013	No. of services (avg)	14.0	27.0	11.2
	No. of groups attended (avg)	15.1	7.8	20.6
	No. of total service sessions (avg)	29.0	37.8	33.0
	hours of total service sessions (avg)	32.1	16.6	42.5
2014	No. of services (avg)	17.7	16.9	19.6
	No. of groups attended (avg)	8.0	7.2	20.3
	No. of total service sessions (avg)	26.9	26.0	40.7
	hours of total service sessions (avg)	16.9	15.2	41.6
2015	No. of services (avg)	24.6	12.8	13.4
	No. of groups attended (avg)	10.0	8.2	19.2
	No. of total service sessions (avg)	35.6	24.1	33.2
	hours of total service sessions (avg)	21.0	17.3	39.4
2016	No. of services (avg)	24.1	12.6	11.5
	No. of groups attended (avg)	17.5	7.3	18.2
	No. of total service sessions (avg)	43.4	21.9	29.9
	hours of total service sessions (avg)	36.0	15.6	37.3
2017	No. of services (avg)	20.1	9.4	8.9

	No. of groups attended (avg)	20.2	6.9	16.7
	No. of total service sessions (avg)	41.8	17.9	25.6
	hours of total service sessions (avg)	41.5	14.9	34.3