Improving Effective Supervision of Justice-Involved Women with Serious Mental Illness and Co-occurring Substance Use that are Multisystem-Involved

Summative Evaluation Report
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Points of view represented in this report are those of the authors, and do not necessarily represent the official position of BJA, Maricopa County, POCN, David’s Hope, Hope Lives/Vive La Esperanza, or Magellan Health Services

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EXECUTIVE SUMMARY

**Program purpose and partners** - This report summarizes the activities and results of a two-year project designed to plan and pilot gender-specific, criminogenic-responsive, and trauma-informed services for justice-involved women with a serious mental illness or co-occurring substance abuse disorders in Maricopa County, Arizona. The grant was initiated in 2012 as a Category 2 Planning and Implementation Grant from the Bureau of Justice Assistance and the initial time frame for the project was extended for 6-months to allow for additional services to be provided to the program participants as the initial funding had not been exhausted. The grant funds were used to achieve three major program goals:

1. **To increase the knowledge, skills, and abilities of probation officers, detention officers, correctional health staff, court and judicial staff, and comprehensive community-based behavioral health services and case management staff** through an integrated program of information dissemination (including web-based resources, briefing and FAQ sheets, informational posters), awareness raising in-service workshops, skill enhancement learning circles and cross-training workshops.

2. **To develop a program of treatment and support services targeting justice-involved women with serious mental illness and/or co-occurring disorders that is gender specific, trauma informed, and criminogenic responsive** that when implemented includes screening, assessment, and referral to Forensic Assertive Community Treatment (F-ACT) with transitional housing to females in jail and evidence-based probation supervision focused on relationship building, incentives for progress toward supervision goals, and graduated responses to issues of noncompliance to program participants upon release.

3. **To enhance the quality, impact, and reach of interagency collaboration among and between those agencies engaged in the arrest, confinement, adjudication, supervision, treatment, and support of women with psychiatric impairments in general and women with SMI/co-occurring disorders** through the development of cross-agency protocols, joint training activities, and the strengthening of the existing structure and processes of the Arizona Mental Health and Criminal Justice Coalition which serves as an inter-agency coalition of criminal justice, behavioral health, and advocacy organizations.

Multiple agencies were involved in the planning and subsequent implementation of this project: Maricopa County Adult Probation (MCAP), Maricopa County Correctional Health Services (MCCHS), People of Color Network (POCN), Maricopa County Sheriff’s Office (MCSO), Hope Lives/Vive la Esperanza, David’ Hope, the Maricopa County Mental Health and Criminal Justice Coalition and Arizona State University’s Center for Applied Behavioral Health Policy (ASU). This collaborative team was responsible for the planning and implementation of this project with principals from each of the organizations representing the project management team.
Purpose of evaluation - The evaluation was designed to collect compulsory information for ongoing quarterly and semi-annual reporting; inform implementation strategies; and assess the outcomes realized for each of the grant’s three main goals.

Methods - Information gathering techniques utilized for this evaluation included: key informant interviews with coalition members, collaboration partners and program participants; quarterly monitoring of pilot program participants for activities and services delivered; as well as tracking of training and technical support provision, and collaboration meetings.

Results - As a result of the grant, the following achievements were evidenced:

GOAL 1: Increase the knowledge, skills, and abilities of probation officers, detention officers, correctional health staff, court and judicial staff, and comprehensive community-based behavioral health services and case management staff

1. Cross-agency training was provided to over 2,000 participants (795 unduplicated criminal justice and behavioral health personnel) throughout Arizona on gender-specific, criminogenic-responsive, trauma-informed treatment. Over 90% of those participants surveyed (n=900) expressed that the training increased their knowledge and skills regarding trauma-informed care.

2. A curriculum was developed for the Maricopa County Sheriff’s Office (MCSO) to replace their mandatory 2.5 hours refresher training formerly called “Handling the Mentally Ill” as the training was outdated, inaccurate and contained content that was stigmatizing to individuals with behavioral health conditions. All correctional officers are required to take the course that now incorporates concepts associated with criminogenic risk, need and responsivity, trauma-informed care practices and gender-responsive services. The training is also co-facilitated by MCSO and MCCHS.

GOAL 2: Develop a program of treatment and support services targeting justice-involved women with serious mental illness and/or co-occurring disorders that is gender specific, trauma informed, and criminogenic responsive.

1. During the project period, 172 women were screened and 20 women were served under a pilot program that consisted of re-entry assessment and services, including mental health treatment, substance abuse treatment and housing. As of the date of this report, all 20 women accepted into the pilot study were referred for housing and mental health/and or substance abuse services. Nineteen remain in the community, one has returned to jail.

2. Approximately 238 women attended newly established Trauma, Addiction, Mental Health and Recovery (TAMAR) and/or trauma-focused groups while in jail custody. Four of the 20 program women completed a twelve week trauma-informed counseling group.
3. Processes to increase in-reach, conduct re-entry planning, and improve coordination of service delivery upon discharge were successfully implemented and several barriers removed. For example, the F-ACT team staff now meet regularly MCAP officers to review clients jointly served, coordinate jail visits and have been issued security clearance badges from the MCSO to facilitate easier entry to the jail.

4. Pre-release planning by the F-ACT team staff and MCAP officers now includes both mental health and substance abuse assessment as well as a review of criminogenic risks and needs.

Goal 3: Enhance the quality, impact, and reach of interagency collaboration among and between those agencies engaged in the arrest, confinement, adjudication, supervision, treatment, and support of women with psychiatric impairments in general and women with SMI/co-occurring disorders.

1. An interagency Project Management Team (PMT), comprised of representatives from all of the collaborating agencies (MCAP, MCSO, MCCHS, POCN, RBHA) met initially on a weekly basis to ensure the implementation and management of the project and eventually transitioned to quarterly meetings. In total, more than 40 meetings were convened. As a result of these routine meetings, agency representatives became better acquainted and more informed of their system partners’ needs, issues, and restrictions in serving this population. The PMT is still meeting monthly.

2. The Maricopa County Mental Health and Criminal Justice Coalition formerly comprised of employees of the various state criminal justice agencies was reorganized and merged into David’s Hope, a 501c3 advocacy organization and 5013C. Project funds were used to provide board development and strategic planning assistance to support David’s Hope Organizations. During this project period, David’s Hope expanded its membership and meeting locations to a statewide presence with the Coalition meeting 24 times during the project period and attendance averaging 25 community members by the conclusion of the project.

3. A collaborative agreement between MCAP and the RBHA was updated and executed on 9/12/14. This new agreement, stimulated as a result of the change in the RBHA entity from Magellan Health Services to Mercy Integrated Care (MMIC) was informed by the project. Specific changes in this collaborative agreement that were informed by this project included the following: expanding the assessment of service needs to include housing, requirement of cross trainings opportunities, and sharing of information. A copy of the agreement may be found in Appendix H.

4. The RBHA revised their F-ACT admission criteria by eliminating the required number of jail days needed for admission and incorporating a risk score from the MCAP.
Offender Screening Tool (OST) as a criteria for eligibility. Additionally, referrals for the F-ACT are now initiated by the MCAPD, and not the behavioral health clinical teams.

5. The RBHA launched a second F-ACT team in 2014.

Findings and Recommendations—The grant was successful in achieving progress and outcomes with each of its three program goals. As previously noted, criminal justice and behavioral health staff were exposed to training and other information to make them trauma informed, sensitive to the unique needs of women, and aware of the criminogenic risk and responsivity principle. A multi-agency model of providing targeted services to women with co-occurring disorders who are high utilizers of both behavioral health and criminal justice systems was implemented and carried out with more than 170 referrals, resulting in 20 women actually being served. A multi-agency project team was formed and met consistently throughout the life of the project, resulting in greater communication, collaboration, and trust between system partners. Finally, a grassroots advocacy organization that is focused on the issues of criminal justice systems as they interface for persons with mental illness was strengthened and expanded as a result of this project.

Despite these achievements, the project remained deficient in a number of areas, which limits the overall impact of the project and threatens the sustainability of the gains made in program effectiveness:

Raising Awareness and System Integration

1. The level of information sharing and training provided to the behavioral health and criminal justice staff was limited to awareness raising and basic information; no skill building or competency-based training was delivered. Training and technical assistance that focuses on changing practice and incorporates comprehensive skill-based training such as mentoring, coaching, clinical supervision and feedback is essential if the system partners are to experience proficiency in providing trauma-informed, gender responsive, and criminogenic responsive services. Maricopa County should consider ensuring ongoing training, clinical supervision, and fidelity monitoring processes that ensure sustainable practitioner proficiency (See Findings and Recommendations1, pp.29).

Pilot Program

2. The lack of program documentation (i.e. Program Manual) and Memorandum of Understanding among and between the system partners undermined the program fidelity and sustainability of the Pilot Program. (See Findings and Recommendations1, pp.29)
3. **The lack of reliable and viable housing and employment services to program participants plagued the Pilot Program throughout the project.** Housing and employment components of the post-release service environment were not fully realized and the service provider (PCON) was unable to maintain the housing units designated during the pilot. None of the pilot project participants were provided significant forms of employment supports despite referrals for supports. (See Findings and Recommendations 2, pp.29)

4. **F-ACT team staff appeared to lack the authority and/or ability to provide comprehensive assertive community treatment to meet the individual needs of the women upon their release.** The F-ACT team was limited by service authorization restrictions imposed by the RBHA that prevented pilot project participants’ access to individual or group counseling, peer support services, or intensive substance abuse services. Although the F-ACT team caseload was reduced relative to normal behavioral health caseloads and probation caseloads, the F-ACT teams still retained sizable caseloads requiring the teams to provide an intensive level of services that they were not trained or equipped to provide. PCN initially was not able to locate a counselor with the desired knowledge and experience with trauma informed care which delayed the hiring process for several months. Pilot program participants then received services from non-F-ACT providers, suggesting a lack of capacity/planning on the part of the F-ACT provider. The relative contribution of these and potential factors upon the service access restrictions encountered by the program participants is beyond the scope of this evaluation. Nonetheless, the RBHA should carefully evaluate the caseload capacity and service accessibility provisions for this population (See Findings and Recommendations 2, pp.29).

5. **The program design of the pilot project underestimated the participants’ needs for safe, recovery-focused social outlets and meaningful daytime activities.** Future initiatives that target re-entry programs could better leverage consumer-operated service program (COSP) agencies to better meet the early-re-entry needs of this population. (See Findings and Recommendations 2, pp.29)

**Strengthening and Expanding the Coalition**

6. **The leadership of David’s Hope and the meaningful engagement of affiliated members of this organization remains restricted and tenuous.** Though several system enhancements have occurred, such as increasing the number of coalition partners and their diversity, the Arizona Mental Health and Criminal Justice Coalition efforts are driven by a few key individuals and not all members are fully engaged. Although specific barriers to implementation were identified by the coalition, some key issues have not been addressed, preventing full implementation of the program. To increase the impact of the Coalition and provide strategic focus to sustain its achievements, the
Coalition should renew its charter, define its long term strategic goals and specifically address the barriers identified through the pilot and during the monthly Coalition meetings. (See Findings and Recommendations 3, pp.30)
INTRODUCTION

Purpose of the Report

This summative evaluation report describes the implementation of the pilot and additional outcomes for a Category 2 Department of Justice, Bureau of Justice Assistance Planning Grant designed to reduce recidivism for a target population of justice-involved women with co-occurring disorders. The period of the grant was January, 2012 through March 2015. This report describes the grant purpose and goals as well as the evaluation scope, methods, activities, and initial outcomes from the pilot implementation. Program implementation and pilot outcomes were measured for 20 women in the pilot who were in the custody of the Maricopa County Jail, but eligible for re-entry into the community. Findings and recommendations for effective strategies to support future program outcomes, program sustainability, and replication are also included in this report.

Problem

Recidivism in the criminal justice system is costly to public funds and community safety. Offenders with co-occurring mental health and substance abuse disorders have high rates of recidivism, more so than offenders with substance abuse only (Prins and Draper, 2009). This population also has limited access to necessary community resources due to their offenses and involvement in the justice system. Common re-entry challenges experienced by probationers include homelessness, lack of family and social supports, unemployment, absence of reliable Community behavioral health care services, and limited access of services by offenders on community supervision (Feucht and Gfroerer, 2011). Providing for these re-entry needs should promote successful re-entry to the community, contribute to reductions in recidivism, make communities safer and improve the effectiveness of public spending.

Target Population- With a population in excess four million, Maricopa County Arizona is the fourth largest county in the United States, encompassing the Phoenix metropolitan area, including a number of smaller communities, rural farming communities, and abutting the Gila River and Salt River Native American nations. Serving as a centralized booking facility, Maricopa County Jail (MCJ) processes 130,000 adults (26,600 of whom are female) annually, with a daily census ranging between 7,000 and 9,000 individuals. Researchers at Arizona State University (ASU), replicating the Arrestee Drug Awareness Monitoring (ADAM) study methodology, report that approximately 48% of offenders booked into MCJ meet diagnostic criteria for substance use disorders, while an additional 28% display conditions of co-occurring mental illness and substance use disorders. (Choate, Shafer & Katz, 2008). Among female arrestees, rates of substance use disorders (36%) approximated that of males, while rates of co-occurring disorders (34%) exceeded the rates of their male counterparts. Disturbingly, less than 5% of respondents reported receipt of community behavioral health treatment and more than 30% identified needing services. These data corroborate reports of the Maricopa County Correctional Health Services (MCCHS), suggesting that upwards of 1/3 of female offenders present with significant mental health needs as well, with co-occurring substance use disorders the norm.
A 2005 Arizona Department of Corrections (ADOC) study on recidivism found that 42% of released offenders returned to prison during a three-year follow-up period (ADC, 2005). ADOC also reports from its intake assessment data that 75% of inmates have significant histories of substance abuse. More than 23% of inmates receive continuing mental health services while in the custody of ADOC. From 2010 through 2012, 40% of probation terminations in Maricopa County were due to revocation with return to prison. One substantial gap evidenced by MCAP’s risk assessment data showed that 34% of the medium and high risk males being released from prison to probation were in need of treatment services for co-occurring substance use and mental health problems.

Consistent with past research conducted in other communities, women engaged in the criminal justice system reported extremely high rates of trauma and symptomology consistent with PTSD. Among those arrestees with a co-occurring disorder, 63% reported some form of trauma (Choate et al., 2008), with 27% and 42% reporting being threatened and assaulted with a gun, respectively. For these women, their trajectory through the criminal justice system and their ultimate re-entry into the community requires a coordinated system of care including criminogenically-informed supervision, case management, housing, and gender responsive and trauma-informed co-occurring treatment. Criminal justice and behavioral health staff need to be knowledgeable of the unique needs of traumatized women with co-occurring disorders.

At the time that this program proposal was developed, Maricopa County was limited in their capacity for meeting the unique needs of women with co-occurring disorders. All arrestees processed into the Maricopa County Jail receive a preliminary health screening at booking that includes screeners for mental health, substance use and withdrawal issues, and potential exposure to traumatic events. Trauma symptomology is not included in this screening. Jail booking rosters are electronically transferred to the countywide behavioral health authority to identify enrolled individuals with serious mental illness only. Roster matching and client identification of non-seriously mentally ill individuals does not occur at this time. Nonetheless, for those identified individuals with serious mental illness that are arrested, the booking roster matching facilitates potential post-adjudication diversion programming.

Initially, Magellan Health Services served as the Regional Behavioral Health Authority (RBHA), coordinating all mental health substance abuse treatment services in Maricopa County, with funding from a Medicaid 1115 waiver and a SAMHSA SAPT block grant, under contract by the Arizona Department of Health Services/Division of Behavioral Health. Magellan employed four (4) full time court-liaisons, and contracted with four (4) comprehensive behavioral health care provider networks, providing a comprehensive array of case management, outpatient, residential treatment, and housing services. Only one of these provider networks was contracted to operate a Forensic Assertive Community Treatment Team (F-ACT) and as such, was the only collaborating network provider to this project. In 2014, the RBHA contract was awarded to Mercy Maricopa Integrated Health Services (MIHS) and the employs and structure were transitioned to the new administrative entity.
Identifying Existing Problems and Gaps- A number of significant problems and gaps in services existed within Maricopa County, particularly for justice-involved women with SMI or co-occurring disorders. Three specific problems were prioritized for this project.

- First, criminal justice staff, including detention and probation officers, were identified as not sufficiently knowledgeable to provide services that are sensitive to the needs of women with co-occurring disorders, trauma-informed, and responsive to criminogenic risk. As such, project funds were used to develop and deliver in-service training and information dissemination to elevate awareness, skills, and knowledge in caring for, and working with female offenders with co-occurring disorders and serious mental illness. These training and information dissemination efforts focused upon evidence-supported models, such as TAMAR, to meet the gender-specific and trauma-related issues of criminal justice involved women.

- Second, gaps existed in much needed services for female offenders with co-occurring disorders as they transitioned from jail to the community and while they are under probation supervision. As such, project funds were utilized to provide a “risk corridor,” ensuring immediate access to services at the point of discharge and re-entry to the community.

- Third, need existed to enhance public awareness of and advocacy for criminal justice systems involved persons with behavioral disorders, including co-occurring disorders. As such, project funds were used to provide strategic planning and organizational development support to a grassroots advocacy organization.

PROGRAM GOALS, LOGIC MODEL AND EVALUATION METHODOLOGY

Program Goals

1. To increase the knowledge, skills, and abilities of probation officers, detention officers, correctional health staff, court and judicial staff, and comprehensive community-based behavioral health services and case management staff through an integrated program of information dissemination (including web-based resources, briefing and FAQ sheets, informational posters), awareness raising in-service workshops, and skill enhancement learning circles and cross-training workshops.

2. To develop a program of treatment and support services targeting justice-involved women with serious mental illness and/or co-occurring disorders that is gender specific, trauma informed, and criminogenic responsive that when implemented includes screening, assessment, and referral to Forensic Assertive Community Treatment (F-ACT) with transitional housing to females in jail and evidence-based probation supervision focused on relationship building, incentives for progress toward supervision goals, and graduated responses to issues of noncompliance to program participants upon release.
3. To enhance the quality, impact, and reach of interagency collaboration among and between those agencies engaged in the arrest, confinement, adjudication, supervision, treatment, and support of women with psychiatric impairments in general and women with SM/occurring disorders through the development of cross-agency protocols, joint training activities, and strengthening of the existing structure and processes of the Arizona Mental Health and Criminal Justice Coalition which serves as an interagency coalition of criminal justice, behavioral health, and advocacy organizations.

Logic Model

One of the first initiatives of the evaluation team was to establish a program theory and program logic model. The logic model provides a visual framework for program designers and program implementers to have a shared understanding of the inputs, throughputs, outputs and outcomes of a program. The Logic Model depicted in Figure 1 was developed by the ASU evaluation team and modified throughout the project, based upon input from the project staff of the various involved agencies.

Maricopa County Justice & Mental Health Collaboration Project

Program Logic Model, v. 6

Evaluation Methodology
Using a mixed methods design, the evaluation focused primarily on formative elements with performance measurement, training assessment and program monitoring through tracking tools of the pilot. Qualitative measures included key informant interviews, client interviews, and a focus group of collaboration partners. The evaluation plan was reviewed and approved by the Arizona State University Institutional Review Board (IRB) prior to the implementation of any data collection processes. Each of the data sources used in this evaluation study is summarized below:

Pilot Study Master-List of Referrals. Maricopa County Adult Probation (MCAP) provided a master-list of client names and unique identifiers to track important referral information for all women screened by MCAP, CHS or POCN on a quarterly basis. People of Color Network (POCN) maintained the master-list with all identifying information and coordinated MCAP’s data contribution through quarterly inquiry on screenings, current probation status, referrals and probation outcomes.

Pilot Tracking of Performance Measures. Tracking surveys were developed to track status changes of women accepted into the pilot program. Copies of these performance tracking surveys are included in Appendix A.

Group Attendance Tracking. Attendance of jail inmates participating in the trauma groups were tracked on an event basis.

Client Interviews-Semi-structured qualitative interviews were conducted with 9 of the 20 women accepted into the pilot program. These interviews explored the women’s personal experiences with the care they received. The interview protocol is included in Appendix B.

Government Performance Reporting Act (GPRA) Surveys. ASU collected participant information for all project sponsored trainings and technical support in accordance with Government Performance Reporting Act (GPRA) standards operationalized by SAMHSA. These data provide descriptive information on the training recipients and their perceptions of the impact of the trainings and technical support.

Key Informant Needs Assessment Interviews. Semi-structured interviews were conducted with key informants, employees with direct responsibility for the conceptualization, operations, or delivery of services associated with the project as part of a needs-assessment conducted at the outset of the project.

Summative Focus Group - A focus group was held in February, 2015 during the regularly scheduled monthly collaboration meeting with 20 people in attendance representing all project agencies as a mechanism to provide closure for the grant members, discuss any lessons learned and identify key successes and areas for improvement.
RESULTS

Program Goal 1: To increase the knowledge, skills, and abilities of probation officers, detention officers, correctional health staff, court and judicial staff, and comprehensive community-based behavioral health services and case management staff through an integrated program of information dissemination (including web-based resources, briefing and FAQ sheets, informational posters), awareness raising in-service workshops, and skill enhancement learning circles and cross-training workshops.

ASU led several efforts to develop and deliver awareness raising in-service workshops and disseminate information material designed to enhance the knowledge, skills, and abilities of criminal justice and behavioral health personnel that interact with offenders in general and female offenders with co-occurring disorders in particular at critical intercept points: detention officers of the Maricopa County Sheriff’s Office; jail clinical personnel (e.g. psychologists, nurses, health clerks, counselors) of the Maricopa County Correctional Health Services; probation and surveillance officers of Maricopa County Adult Probation, and community clinical personnel (e.g. case managers, counselors/therapists, nurses, peer recovery coaches) of the People of Color Network, and other community-based behavioral health provider agencies.

During the course of the project, training was delivered to over 2,000 participants (795 unduplicated participants) statewide at 28 trainings/workshops conducted over the course of the two year project period. Over half (713) of the attendees were from Maricopa County.

ASU utilized cross agency "champions" in the delivery of awareness building workshops/presentations. These individuals formed the basis of the project training team, co-facilitated awareness building and cross-agency training efforts while ensuring the sustainability of the project as they institutionalized new information on gender responsive and trauma informed care within their respective organizations. Continuing education hours (i.e. NASW, NAADAC, and AZPOST) were provided for recipients of these training events. More than 90% of participants responded to post-training evaluation surveys that they “strongly agree” or “agree” the training enhanced their skills.
Training Evaluation Results (N-900)

In addition to the aforementioned training events that the project hosted, ASU also coordinated the redesign of the mental health module of a mandatory annual refresher course for all detention officers working in the Maricopa County Sheriff’s Office. The updated curriculum for the “Working with Inmates- Behavioral Health and Cognitive Impairments” that incorporated the concepts of trauma-informed and gender specific care will continue to be delivered jointly by the MCSO and CHS. This new curriculum included updated information on mental illness, substance abuse, evidence-based treatment, and trauma. The revised curriculum represented a collaborative effort involving ASU, MCSO, and MCCHS. The revised curriculum is presented several times a month on an ongoing basis as all detention officers are required to attend. Unfortunately, no evaluative information was captured from the detention officers attending this training. The course outline is included in Appendix I.

ASU also designed and disseminated one “tip sheet” and one clinician pocket guide (See Appendix F and Appendix G). ASU has also established a trauma informed page on their website (https://cabhp.asu.edu/content/trauma-informed-care) and facilitated approximately 6 presentations about the project at various state conferences.

Program Goal #2: To develop a program of treatment and support services targeting justice-involved women with serious mental illness and/or co-occurring disorders that is gender specific, trauma informed, and crimogenic responsive that when implemented includes screening, assessment, and referral to Forensic Assertive Community Treatment (F-ACT) with transitional housing to females in jail and evidence-based probation supervision focused on relationship building, incentives for progress toward supervision goals, and graduated responses to issues of noncompliance to program participants upon release.
To begin the planning and design of the pilot program, a series of system maps or flow charts were created to understand the flow and process of individuals through the criminal justice system and back into the community. A series of five flow charts were developed for five intercepts in the system:

- Arrest and Jail Processing
- Treatment Referral Processing
- Probation and Court Processing
- Re-entry Support Processing
- Psychiatric Evaluation & Housing Processing

These system maps were utilized to plan, implement and modify the pilot program as needed, providing accurate visual representations of key processes. They also served as benchmarks to assist coalition partners in identifying mechanisms that would affect outcomes, as pedagogical tools to help coalition partners understand and better manage the complexity of the undertaking and to assist them in managing implementation barriers. As a result of this key step in process mapping, the project partners were able to modify program requirements to support successful implementation. The system maps are found on the accompanying pages.

**Arrest and Jail Processing Map**
**Treatment Referral Processing Map**

- Jell Data Unit flags all SAMH clients booked for non-felony and notifies chaplain.
- MCAP adds inmate to screened 'NOT ELIGIBLE' list.
- MCAP screening eligibility based on, screening & current change.
- MCAP adds inmates to screened 'PENDING' list for continued monitoring of intake process and screening continues after signing the plea and notifies S. Clay/Court Liaison to coordinate with Public Defender.
- MCCHS obtains R01 (MH & SA) from intake and makes referral packet to POBN at POBN.
- PCN reviews packet and completes screening and F-Act eligibility.
- If determined NOT ELIGIBLE for F-Act, Team notifies MCAP and POBN documents decision on spreadsheet.
- Mental Health Court Liaison - For the first of mental health court, the client would go to a staffing that includes the judge, service provider (PO), F-Act CM, Hope Lives and RHPA Court Ushers. After the staffing, client meets with her PO (client only). The PO updates the PO then client goes to front of the judge. PO will review what the client needs to do, the case manager will say if they have anything to add, and the judge will also comment. Afterwards, sentences are given out by the judge, prior, gift cards, etc., then the judge will go through the sanctions. Senations may include “no intoxication” for Jail up to 120 days.

**Probation & Court Processing Map**

- Detention Officer (DO) transmits from 6th Avenue Jail inmate to Superior Court.
- Preliminary hearing with Public Defender, Mental Health Specialist & Judge.
- Determine if need Rule 11 or plea.
- Sentencing to bench to Housing Flow Chart.
- If sentenced to jail time refer to Housing Flow Chart.
- Sentencing Hearing.
- Inmate is released and given reporting instructions.
- Client reports to probation and sees the 2nd screening who conduct OOT and screen for SA treatment. First participants are assigned a counselor.
- MCCHS Discharge Planner gets involved (may see inmate) and PO complete presentence report.
- PO and their Probation Officer, and they develop their case plan (must update every 6 weeks).
- Issue with following (not clear)
- Remains on probation until terms are met or time frame expires. Probation will participate in PCN-FACT for development meetings, and reviews with their client.
### Reentry Planning and Support Processing Map

- PCN TIC liaison goes to jail with MD to complete grant screening. AGD to determine F-ACT eligibility and coordinate transitions to PCN if needed.
- Transfer to PCN can take up to 2 weeks.
- Client released at 10AM two people from PCN will transport to clinic & meet with F-ACT representative to schedule assessments.
- Within 30-90 days: F-ACT completes Demographics (DA-121), Psych. Eval., Housing, Food, AGD, MCAS, HRA, Ch, At-Risk Cross Plan & TIC Counselor Assess.
- Person reviews & signs the plan, then it is returned to the F-ACT team to also sign & Clinical Coordinator “hands-over” ISP to Correctional by entering the date signed by the inmate.
- Consultation with the Clinical Team to develop recommendations (30 minutes).
- Referral packets created by Office Assistant with ROI.
- Review Medical Record, 3 hour psychopharmacologist.
- F-ACT OM meets with person to discuss goals and conducts Motivational Interviewing Conducted with Inmate – 1 hr. TIC.
- Develop ISP within 7 days: Face-to-face interview with BHR, & F-ACT meets within the person to draft plan – 30 minutes. Ideally would include 300 MO, TIC Counselor and others requested by the person.
- Client will see the TIC Counselor within the first two weeks and complete TIC Assessment.

### Psychiatric Evaluation and Housing Processing Map

- Maricopa County Sheriff’s Office & Correctional Health Services: Housing

  - Transport Officer brings inmate to Estrella Jail.
  - Inmate accepted into the holding cell and logged into the system.
  - Inmate will be showered in a group shower, check her clothes to weed out and is unsearched process.
  - Inmate is transported to Medical & Mental Health Unit (Lower Buckeye Jail) for psychiatric or medication intervention or if petition required.
  - Inmate is sent to Mental Health Unit (Lower Buckeye Jail) for psychiatric or medication intervention or if petition required.
  - Inmate is sent to Mental Health Unit (Lower Buckeye Jail) for psychiatric or medication intervention or if petition required.
  - Correctional Health Services denotes mental health, treatment plans, and conduct follow-up visits, psychological evaluations, and discharge coordination.
  - Inmate is assigned to an individual housing assignment. Check-in, bank assignments, building & unit.
  - Inmate is assigned to an individual housing assignment. Check-in, bank assignments, building & unit.
  - Inmate is assigned to an individual housing assignment. Check-in, bank assignments, building & unit.
  - Inmate is released or serves sentence and returns to their community in no new charges or infractions.
  - Inmate is released or serves sentence and returns to their community in no new charges or infractions.
  - Inmate is released or serves sentence and returns to their community in no new charges or infractions.
  - Inmate is released or serves sentence and returns to their community in no new charges or infractions.
  - Inmate is released or serves sentence and returns to their community in no new charges or infractions.
Pilot Project Eligibility Criteria

The target population for the service pilot program was female offenders 18 or older with serious mental illness and co-occurring substance use disorders with a Global Assessment of Functioning (GAF) score of 60 or less, no Axis II Personality Disorder or violent offenses, continuous high service needs (3 of 7 indicators on F-ACT Admission), a medium or high risk score on the Offender Screening Tools (OST)¹ and incarcerated a total of 6 months or more during the past 12 months.

Early on in the project, the screening and referral requirements were modified by relaxing the six month incarceration requirement. This requirement was relaxed for several reasons including overcrowding in the jails that was leading to early release for otherwise eligible women. All pilot program participants were post-plea/post-trial and on probation supervision.

Pilot Project Participant Characteristics

A total of 172 women were screened for eligibility and 113 women identified as having an SMI diagnosis and receiving behavioral health services through the RBHA and 95 with co-occurring disorders. Twenty women were admitted to the pilot program for services and placed on the caseload of an F-ACT team as part of the pilot program.

Pilot Project Service Provision

For the 20 women who met the eligibility criteria, all were assessed while still in jail to prompt referrals to specialized treatment and support service that could not be provided by the F-ACT Team, such as intensive substance treatment and transitional housing. MCAPD, MCCHS, and POCN all maintained a role in the assessment process. The MCCHS nurse completed a health & physical health assessment (referred to as the EPI) that included screening for mental illness, physical health, and trauma, risk and substance use disorders. Inmates are referred to a specialized SMI probation officer who will be the supervising officer prior to sentencing to assist with discharge planning. This is a probation officer who supervises a specialized caseload of individuals with serious mental illness. The probation officer completed the Offender Screening Tool (OST) to assess criminogenic risks and needs. Of the 172 women screened, approximately one-third were screened by the FROST or OST as high or medium high risk, making them eligible for the grant based on criminogenic risk. The F-ACT completed multiple assessments, including a psychiatric evaluation, nursing assessments, employment, housing, independent living skills, substance abuse and entitlements. The POCN TIC counselor completed a gender specific trauma assessment tool developed specifically for this grant. The F-ACT Team coordinated a multidisciplinary meeting with the participant and their SMI/MH probation officer. The SMI/MH probation officers were co-located with the F-ACT team to enhance coordination.

¹ The OST is a validated assessment tool developed locally and utilized by the MACAPD. The OST screens for 10 need domain areas including: physical health, mental health, alcohol and drug use, education, financial/vocational, residence, family and social, attitudes, and criminal behavior – and is normalized separately for males and females. A companion assessment tool, the FROST, is used to re-assess offenders. The FROST is also used by the AZ Department of Corrections with parole and community corrections populations.
and communication. The main product of this coordinated effort was a comprehensive treatment and service plan that included the following:

- risk, needs and protective factors
- individual recovery goals
- mental health (including trauma and gender specific) and substance abuse services and supports
- quality of life (housing, employment/education, family/social)
- medical needs

Services delivered- Over the course of the two year grant cycle, the women in the pilot program were under supervision from the Maricopa County Adult Probation Department who assessed the participant’s criminogenic risks and developed a probation case plan consistent with those risks. The supervising officer coordinated with treatment staff to identify and deliver services based on the individual’s criminogenic risks, mental illness, and level of functioning. MCAPD provided evidence-based probation supervision, which included relationship-building, motivational interviewing skills, incentives for progress toward supervision goals, and graduated responses to issues of noncompliance. POCN provided services based on the service plan. All POCN services were gender-specific, trauma-focused and criminogenic responsive, including adaptation of their current assessment processes to include a trauma-informed assessment. POCN provided coordination of care with MCCHS treatment staff, discharge planning, and assistance with the completion of benefit applications while in custody, and F-ACT services upon return to the community.

POCN also initiated referrals for all 20 women for short-term transitional housing upon release from jail. Crossroads, the original provider, was replaced in year 1 of the grant by POCN who directly secured apartments for the women by signing leases. About half of the women were provided housing between 30-90 days, the remaining were referred to housing services. In the final year of the grant, the program worked with Native American Connections to secure permanent supported housing for the women. Four women were assessed for employment and one was referred and received employment services. For the duration of the grant, none of the 20 women were employed. 14 of 20 women had health insurance (12 had Medicaid and 2 Medicare) when they entered jail and 2 obtained health insurance during the grant period. 3 of the 30 women experienced hospitalization while in jail. Upon release, all 20 women received mental health services through an F-ACT team, and 11 received treatment for co-occurring disorders.

Pilot Project Outcomes

Of the 20 women who met eligibility criteria for the program, all but 1 accepted services. Of these women, four individuals were re-arrested due to violations of their probation orders, but only one was re-incarcerated. One additional participant had absconded and 2 had been non-responsive to program services and were likewise discharged as unsuccessful. At the conclusion of the program, 15 of the originally released [19] program participants remained in the community.
Lessons Learned and Observations from the Pilot Project

The pilot project accomplished its result by engaging in a level of service monitoring and delivery which was very labor intensive. Coordinated teams provided comprehensive assessment and case planning prior to release, connected program women to peers on the day of their release and linked women to comprehensive wrap-around support post-release, including treatment for substance abuse and mental health disorders. Undergirding these processes were several factors that enhanced the opportunity for success. First, health care reform permitted the target population to access behavioral health services more quickly and effectively. Specifically, the women in the pilot did not lose their eligibility for health care upon entering jail, it was simply deferred. Second, critical personnel on the F-ACT team instituted effective engagement strategies to promote attachment, individual responsibility and positive outcomes for the women in the pilot program. These individuals were true champions of the program and executed their job duties with program goals in mind. They also maintained reduced caseloads. For the women in the pilot, the F-ACT team worked together successfully to provide a level of support that is not typical under standard or even intensive community supervision. Third, although relatively inadequately, the program attempted to link the women upon re-entry with transitional or bridge housing, monitored their housing and addressed housing problems as they arose to assure community stability.

According to program staff, some aspects of the pilot program were touted as very successful; specifically peer and F-ACT team engagement strategies as well as pre-release planning. Nevertheless, critical but underdeveloped program components and other limitations were also identified by program staff.

Pilot demonstrated effects - The pilot was successful in:

- reducing immanent homelessness upon release by providing offenders bridge housing;
- connecting offenders with peers;
- referring offenders to substance abuse treatment;
- providing post release substance abuse/mental health treatment;
- providing effective community supervision through a F-ACT team;
- comprehensive assessment of the health needs of female inmates with co-occurring disorders;
- a twelve week trauma informed counseling group was started utilizing a modified version of the TAMAR groups in jail and also at the POCN clinic.
- comprehensive assessment of the health needs of female inmates with co-occurring disorders;
- coordination of mental health services prior to release;

However, the program did not demonstrate effectiveness in:

- providing safe and reliable transitional housing;
- minimizing re-traumatization upon release;
- promoting permanent housing; and
- promoting employment.
The program design offered the potential to reduce both immediate and long-term recidivism by a series of actions that connected women offenders prior to release into the community and after release, by delivering a wide array of community support services, including assessments and referrals for education, employment, and housing. The potential, however, was limited by very restrictive program requirements and underdeveloped program components. Specifically, program requirements were too stringent to adequately serve the target population; the level of service monitoring required to achieve outcomes was too labor intensive to extend to a larger population; and three core features, namely employment, education and housing, were too underdeveloped to ensure successful long-term outcomes for the women targeted under the grant.

Effective engagement strategies and peer support - According to client interviews, a key finding was the salience of the probation officer, and the peer support specialists that community providers were able to leverage as a component of community re-entry. Several women commented about their probation officer on the F-ACT team, illustrating that these special probation officers were connected to the population of women they were supervising. Specifically, they were engaging their clients, motivating them to succeed and increasing their chance of success in the community. When women described their relationship with their probation officer they indicated they were connected and engaged; that the PO was “helpful” and “understood.” During focus group discussion, F-ACT team members expressed concern for “not being able to do everything they wanted to “for the women in the pilot, suggesting they were very connected to the women’s outcomes, but constrained in their actions by existing protocol or other restrictions imposed by the RBHA for service delivery.

Another champion of good outcomes was the peer support specialist. The POCN peer support specialists picked up the client from jail on the day of her release and connected with her personally to provide support for subsequent steps in community treatment. All the women interviewed spoke about their peer support specialists who offered them some sense of connection to the community. Peer support has long been recognized as an effective practice in resiliency and recovery. Women connected to their peers at a personal level and provided an opportunity for engagement not typical in community re-entry. The women viewed their peer support specialist as someone “who had been there” and “understood what I was going through.”

Requirements too stringent - 172 women were referred with 20 women accepted for services into the pilot program. This is over a 5:1 ratio of program rejection to acceptance. The program found it very difficult to qualify women for the pilot based on the criteria developed. For example, the women could not have committed violent offenses to qualify. However, many women in this population may have acted out on an arresting officer and been charged for assault, thus disqualifying them. In fact, so many women were disqualified that the pilot program qualifications had to be relaxed in order to accept more participants. Because the requirements were so strident, more women went unserved in the pilot than served, calling into question whether the pilot requirements needed additional adjustment for the program to maintain feasibility and cost-effectiveness. 152 women were screened out, but still met the basic criteria of being justice-involved women with co-occurring disorders. We have little but anecdotal information about women who were screened out, as their outcomes were not tracked or compared with the women served by the program. To better understand the impact of the
pilot program requirements, MCAP should review the women screened out to determine what criteria could be relaxed to serve a higher percent of the target population. In addition, as the 20 women in the pilot met such strident requirements to be accepted, it is not clear that their results can be in any way meaningfully replicated to the wider target population. In addition, the program staff were almost exclusively focused on the 20 women in the pilot and assuring the success of the pilot by continuous monitoring through quarterly performance reviews and case management. This level of attention may not be realistic in a wider implementation plan.

Supported housing, education and employment lacking—Despite these positive indications for future success, limitations exist that could threaten the viability of the program going forward and preclude positive effects on recidivism. Key among these threats are the limits imposed by available employment, ongoing opportunities for social interaction, education and professional training as well as and permanent housing for the target population. The program originally contracted for “bridge” or temporary housing for all pilot-referred women. Bridge housing would provide an opportunity to stabilize women in the community and give sufficient time to pursue permanent housing. The program experienced difficulty in finding quality bridge housing as well as permanent housing. The program lacked a mechanism to transition the women into permanent housing if they could not find it on their own. In addition, bridge housing was also unstable, resulting in homelessness and re-traumatization of the women, as well as duplication of effort by the case manager. The housing component of the pilot program incorporated only transitional elements, thus delaying community re-entry issues, but not adequately addressing them. The program did not provide peer housing support specialists or supported housing to assure clients stability long-term and/or prevent placement instability and re-traumatization. Based on the quarterly performance surveys, on average, each woman was referred for housing 3 times over the grant period. Placement instability places justice-involved women at risk for homelessness and recidivism. In addition, the program did not set adequate standards for placement quality, client satisfaction or other indicators to ensure placement stability. In some instances, women were returning to housing they had prior to incarceration, placing them at continued risk for criminal activity or even personal harm. In one instance, a woman was abused by the boyfriend of her roommate; in another instance, two program women were roommates, but according the the F-ACT team officer, the relationship was not promoting wellness and optimal functioning for either woman.

With so much time and attention given to finding suitable housing, the F-ACT team had less time to devote to other program elements, namely suitable day activities such as education, engaging with peers and employment. None of the women were assessed for educational needs, only 4/20 women were assessed for employment and 3 women were assessed more than once for a total of 7 assessments on 4 women. Multiple assessments suggest that F-ACT team referrals are not successfully assisting women in finding and maintaining employment. None of the women became employed despite coalition membership that included consumer operated services. Research strongly supports transition/integration in the community through peer support. Consumer run agencies present a unique opportunity for supported employment that is very effective in promoting wellness and maintaining recovery for women with co-occurring disorders. Although the coalition partnership was very inclusive and involved members from all parts of the behavioral health system, including consumer-operated services, effectively leveraging those peer-run partnerships to provide specific employment opportunities for the
women in the pilot proved more difficult. None of the women transitioned to peer-supported employment at the coalition agencies. For sustainability, the program should develop a specific component to connect women to consumer operated services to promote long term wellness and opportunities for meaningful day activities, supported education and employment.

Research supports that significant gaps exist in housing, education and employment programs for populations with SMI (Choate et al, 2008). Since the program was primarily focused on short term housing to prevent homelessness and immediate recidivism, long term housing, employment or education needs did not receive the same attention in the program design. Secondly, the short term housing was also a new component for program staff and by all accounts, staff reported that they found this to be one of the most difficult components to execute successfully. Program staff concurred that the housing component was not successful because several women were not placed in housing settings conducive to recovery and resiliency in the community. However, program staff may not be aware of the full implications of this underdeveloped and underperforming program component. In interviews, staff described that their first focus was on stabilizing women in housing and providing assertive community treatment. Assessments for meaningful day activities including employment and education were of lower priority. Flaws in the transitional housing program design meant that women required multiple referrals as their housing became unsatisfactory, consuming considerable time and energy that could have been spent focusing on educational and employment. Since interviews with the pilot women confirm that the peer support component of the program was very successful, adding more peer support to transitional housing, developing additional opportunities for consumer-run organizations to participate in re-entry programs, and fully committing to education and employment could improve future program implementation.

Maricopa County’s efforts are laudatory. Coalition partners themselves recognized the very serious limitations in the program, but to date have not developed a comprehensive plan to redesign it or incorporate more permanent housing or promote meaningful day activities through consumer operated peer-supported organizations. Integrating COSPs to better promote meaningful day activities could significantly impact whether women with SMI/co-occurring disorders remain in the community or return to jail.

**Program Goal #3: To enhance the quality, impact, and reach of interagency collaboration among and between those agencies engaged in the arrest, confinement, adjudication, supervision, treatment, and support of women with psychiatric impairments in general and women with SMI/co-occurring disorders through the development of cross-agency protocols, joint training activities, and the strengthening of the existing structure and processes of the Arizona Mental Health and Criminal Justice Coalition which serves as an inter-agency coalition of criminal justice, behavioral health, and advocacy organizations.**

*Enhanced Interagency Communication-* ASU facilitated the formation of a planning task force leadership team called the Project Management Team (PMT) to provide project management oversight to the grant and ensure increased collaboration between the system partners. The Project Management Team (PMT), was comprised of members representing correctional health services (Maricopa County Correctional Health Services), the sheriff’s office (Maricopa County Sheriff’s Office), behavioral health providers (People of Color Network, Magellan), adult
probation (Maricopa County Adult Probation), peer support staff (Hope Lives – Vive La Esperanza), a community coalition (Arizona Mental Health and Criminal Justice Coalition), David’s Hope (grassroots advocacy organization) and a local evaluation and training team (Arizona State University, Center for Applied Behavioral Health Policy), consumer-operated programs, family members and advocates. The MCAPD and CABHP Project Managers co-chair the PMT. The PMT met more than 50 times during the course of the project; initially meetings were weekly and eventually quarterly. All meetings were held at the POCN Communidad Clinic. Throughout the course of these meetings, the need for specialized subcommittees was identified. Subcommittees created included the following: training, referral process, performance measures, and pilot program design. These subcommittees met on an as-needed basis throughout the two year period of the grant, with a mode of once per month.

The Arizona Mental Health and Criminal Justice Coalition (AzMHCJC) was created in 2008 to provide an inter-agency forum for addressing multi-system issues of offenders with mental health and co-occurring needs. Representing more than 25 governmental, community-based behavioral health agencies and advocacy organizations including consumer run organizations, members of this Coalition meet monthly to share information and coordinate services. This Coalition was initially chaired by representatives from the state agencies which posed a conflict when trying to address barriers, expand responsibilities and resolve issues when advocating or lobbying for system reform. As a part of the project, the founders and CEO of David’s Hope a grassroots non-profit advocacy organization, was recruited to serve as the Chair of this oversight body and the Coalition was formerly, through approval of their board, incorporated into their program. At each monthly meeting a progress report on the grant was provided to the membership and their feedback solicited. From 2012 to 2014, the average membership attendance was 25 at each meeting (ranging from a low of 10 up to 46), and each member often had multiple agency representatives attend. At six meetings, more than 30 people attended, indicating its salience to the member partners. The partners in the coalition shared a core goal in providing effective services to probationers and clients for successful integration back into their communities.

Since program partners included county agencies and non-profit, as well as providers and the University, ASU developed a strategy to strengthen the existing structure and processes of the Arizona Mental Health and Criminal Justice Coalition as a multi-agency coalition of criminal justice, behavioral health, and advocacy organizations. Specific efforts to improve the coalition functioning included:

- **Community Engagement** - ASU conducted four community roundtables to engage community partners and public officials to address issues (i.e. crisis response, re-entry housing, deferred prosecution and decisions in law enforcement) that have an impact on individuals with behavioral health conditions involved in the criminal justice system. Formal meeting minutes and recommendation from the community were reported to the AzMHCJC (see Appendix D).

- **Coalition Administrative Support** - Administrative support was provided specifically to document and distribute meeting communications support to PMT. The Coalition met
monthly during the project period with an average of 25 individuals in attendance from agencies and partners of the Maricopa County mental health and criminal justice community (see Appendix D). ASU provided both staff and student interns to assist the coalition, providing critically needed general secretarial and communication support. These staff and/or students attended the coalition meetings and served as the “worker bees” to maximize the productivity and follow through of Coalition activities.

- **Project Advisory Team** - CABHP also facilitated the formation of a Project Advisory Board (PAB) with leadership from the partnering agencies that conducted quarterly meetings to review progress on the grants, identify and resolve barriers, and provide input into the evaluation methods and service delivery practices.

- **Strategic Planning** - Strategic planning & leadership development targeting the Coalition and advisory board was provided by ASU Lodestar Center for Non-Profit Management who was engaged to facilitate strategic planning processes and organizational development for the Coalition. ASU facilitated a one-day retreat for the coalition to develop strategic vision and mission. ASU also provided ongoing facilitation and technical support for organizational enhancements to coalition leadership through the PMT meetings. The key results of the Coalition organizational development efforts include:
  - Developing a strategy to sustain and strengthening the linkages between the Coalition and relevant state agencies (Administrative Office of the Courts, Arizona Department of Health, Governor’s Office of Substance Abuse Policy, AZ Council of Human Service providers, AZ Council of Chiefs of Probation).
  - Differentiating the role of David’s Hope as an advocacy organization and the Coalition as a separate organization with oversight for the Pilot Project.
  - Developing a coalition mission separate from David’s Hope and separate from the project purpose.
  - Identifying strategic goals for the Coalition to better achieve outcomes.
  - Developing a project sustainability plan (see Appendix E).

The coalition has taken on multiple strategic initiatives in addition to the pilot program implementation. A collaborative agreement between MCAP and the RBHA was updated and executed on 9/12/14. This new agreement, stimulated as a result of the change in the RBHA entity from Magellan Health Services to Mercy Integrated Care (MMIC) was informed by the project. Specific changes in this collaborative agreement that were informed by this project included expanding the RBHA screening to including assessing for housing needs, and sharing of information. A copy of the agreement may be found in Appendix H.

Multiple strategic initiatives, however, reflect agency specific interests that may put the coalition at risk for a loss of strategic collaborative focus specifically regarding justice involved women with co-occurring disorders. With the pilot now complete, the project partners has developed a sustainability plan, but the plan lacks both strategic focus and sufficient detail to be effective.
Further, the coalition efforts have not fully engaged the 25 members who have a seat on the coalition board, which may limit the coalition’s ability to create and engage new partnerships in needed areas. To increase the likelihood of full implementation, enhance the impact of the Coalition and provide strategic focus to sustain its achievements, the Coalition should define its long term strategic goals beyond the pilot program, prioritize those goals, identify risks and barriers, and outline specific time frames and actions that will sustain system enhancements and promote full implementation of the program.

Lessons Learned and Observations from Interagency Collaboration Efforts

Despite many notable accomplishments, the coalition recognizes the existence of ongoing issues to be addressed. The coalition sustainability plan (Appendix E) identifies other activities they plan to continue or implement going forward. For example, Maricopa County Adult Probation intends to:

- Continue co-location and participate in staffing including discussing criminogenic risk;
- Provide TIC and Gender training;
- Identify all mental ill individuals during the pre-sentence report and send to an SMI case load straight from sentencing; notify the court that they are eligible for a mental health addenda prior to sentencing;
- Create a new collaborative agreement with MMIC sharing of F/OST & pre-sentence reports;
- Provide cross training in collaborative agreement;
- Create a Specialized female offender case load (advocating for but not finalized);
- Enhance Community Restitution Unit for Community Reintegration SMI Specialist Senior Probation for Enhanced In-Reach Discharge Planning;
- Utilize EBPs to manage criminogenic risk (Thinking For Change at Hope Lives/TERROS);
- Create a Special Committee working on collaboration with community services providers.

The sustainability plan as developed by the PMT identifies several strategic initiatives as a follow up to the planning grant project. However, the specific objectives of the planning grant are at risk for not being pursued into the next phase (full implementation). In particular, many results of the planning grant have been disseminated to a wider population than that served under the pilot. The current sustainability plan supports further dissemination of activities developed under the grant, but does not specifically detail a plan for full implementation for the original target population served by the grant. Specifically, the Coalition should prioritize their goals for sustainability by employing program enhancements that can be disseminated through wider application from those that specifically target the pilot population. They should also identify potential threats to full implementation, set specific target dates for implementation and outline specific actions steps to address existing barriers and implementing goals. The coalition should also consider developing cross-agency strategic implementation plans for those goals that require multi-stage and multi-partner approaches. Finally, the coalition should consider expanding its membership to include more consumer-operated peer-support agencies who can promote
meaningful day activities and become the educational, employment and housing partners that the program needs to become sustainable.

**Plan lacks sufficient detail**-While the goals in the sustainability plan listed above are on track for disseminating many of the results from the pilot project, they omit critical goals in areas where the program had the most difficulty (housing and employment). In addition, the current plan goals lack sufficient detail to understand the mechanisms that are operating to achieve expected outcomes or mitigate risk of implementation. For example, the coalition has a formal collaboration agreement in place to share the pre-sentence reports for re-entry planning. The plan calls for the creation of a new agreement; however no details are provided regarding this new agreement, what changes may be made, why they are being made or what barriers may be encountered in implementation. Though dialogue and de-briefing, the new agreement can be an opportunity for coalition partners to review how effective the existing agreement was in achieving program goals, where gaps still exist in cross-agency protocols, and what changes could be made to increase impact. Coalition leadership will be critical in assuring that dissemination and sustainability planning addresses issues that were exhibited in the pilot.

**Plan does not incorporate behavioral health EBP protocol**-Similarly, the plan calls for the trauma group leader to continue to provide TAMAR and TIC groups in jail. However, there are no set goals for how many will be offered, tracking effectiveness or establishing protocols to assure fidelity to evidence-based practice. In addition, the plan suggests sending all identified mentally ill individuals to an SMI caseload but does not detail what protocols should be utilized by the case manager to promote effective engagement and successful transition. The plan suggests promoting evidence-based practices in re-entry planning such as “Thinking for Change.” Promoting the use of EBPs is a positive step in assuring good outcomes. However, “Thinking for Change” is currently not considered an EBP but only a “promising practice” under SAMHSA’s best practice registry. In addition, this program is designed to reduce criminogenic thinking and not specifically facilitate the management of behavioral health disorders. Before Maricopa County commits additional funds to specialized SMI caseloads or specific re-entry programming such as T4C for women with co-occurring disorders, a comprehensive review of the re-entry evaluation evidence for this target population should be made. In addition, they should consider integrating technical support, coaching and mentoring for SMI case managers and evaluation protocol for any new programs or interventions with the RBHA to assure expected outcomes.

**Agency differences may undermine effective collaboration**- The collaboration partners agreed that agency differences, rules, procedures and resources frequently inhibited them from being more effective in providing needed support for the pilot women. For example, one collaboration partner described the difficulty in simply obtaining a state identification card for the women in the pilot, a small procedure that prevented the women from accessing certain benefits and other resources in a timely manner. *Ad hoc* procedures developed under the grant to achieve success are not necessarily sustainable and limit the future success of the program in wider implementation. Detailed interagency agreements, memoranda of understanding and codified cross-agency procedure manuals will support coalition efforts to sustain program accomplishments.
Problem-solving coalition workgroup needed. Interagency conflicts of mission have precluded effective collaboration in some areas. For example, Maricopa County Probation required very strict criteria for pilot program eligibility, so strict that no woman was eligible for the program. These stringent criteria were eventually relaxed, but only the threat of not meeting the mandate of the grant to serve a pilot population functioned to support the change. In addition, over 170 women were screened to find 20 who met the relaxed eligibility requirements. Furthermore, the coalition is comprised of members whose influence is highly variable. Coalition leadership should be conscious of power differentials within the membership and establish rules and procedures to assure that no one agency, interest or voice dominates the agenda. For example, a gender specific F-ACT team is a coalition goal, but it may be difficult for Maricopa County Probation to make this a higher priority than other agency needs. Similarly, promoting safe and stable permanent housing, connecting offenders to meaningful activities, education or employment are all critical system enhancements that reduce recidivism, but are not the central mission of Maricopa County Probation. Agency Coalition members expressed that they feel conflicted between serving their own agency’s interests and mission over that of the Coalition’s mission and purpose. The coalition created under the grant increased membership beyond criminal justice, but the concerns of criminal justice can easily overwhelm the intent of the coalition. When specific agency requirements are not subject to compromise, some coalition members can inadvertently preclude the coalition from functioning as a unitary decision-making body. To promote better collaboration and achieve the system enhancements as envisioned by the grant, the coalition should take several steps: 1) identify agency-specific issues that prevent program expansion and work to reach effective compromise on these issues with a problem-solving workgroup; 2) consider cost-sharing arrangements with collaboration partners to budget for proposed system enhancements going forward and diffuse the cost; 3) consider expanding the partnership to engage more diverse partners system-wide; 4) sufficiently engage all coalition partners to sustain the program; 5) prioritize the publication of a coalition-written program manual to formally codify cross-agency policies and procedures and 6) seek additional funding from Maricopa County, State or Federal agencies, as well as granting authorities such as the Bureau of Justice Assistance to make pilot system enhancements more permanent.

Coalition should find its own voice in statewide advocacy. David’s Hope, the coalition partnership leader is a relatively new advocacy agency in Arizona, which under the grant played dual roles. As a separate advocacy group, David’s Hope has benefitted from collaboration by developing its own mission and purpose more clearly and apart from that of the coalition. The grant provided an opportunity for the coalition to develop organizationally. However, power differentials and multiple competing priorities may pose future threats for coalition functioning. The coalition should review its organizational priorities, specifically its strategic plan and take steps to address the collaboration challenges identified in the pilot. In addition, the coalition may want to write an organizing charter, formalize coalition board succession planning, and revise chartering principles to better promote equitable participation by collaboration membership. To increase the impact and effectiveness of the coalition going forward, coalition members should consider additional technical support in organizational development to sustain the enhancements gained through the project, continue to improve collaboration and further develop their leadership on issues of mental health and criminal justice in Arizona.
SUMMARY and RECOMMENDATIONS

To summarize, there are findings and recommendations concerning all three project goals:

1. Maricopa County has improved awareness regarding the treatment of and collaboration required among system partners to adequately serve justice involved women with co-occurring disorders. However, awareness has not translated into ongoing consistent practices supported with additional technical assistance, training, mentoring, coaching supervision and fidelity monitoring. In addition, the key components of the program are at risk of being modified or diluted because policies and procedures have not been manualized. Maricopa County should take steps to provide ongoing training, additional coaching, mentoring, technical assistance and fidelity monitoring to support consistent program practices going forward. In addition, Maricopa County should also codify awareness into effective, consistent and sustainable evidence-based practice by completing a comprehensive program manual.

2. The Pilot Program demonstrated several positive effects such as modifying processes to refer persons with SMI/co-occurring disorders to specialized caseloads. The RBHA also revised their F-ACT admission criteria eliminating the number of jail days needed for admission and incorporated a risk score from the MCAP Offender Screening Tool (OST) as criteria for eligibility. The RBHA launched a second F-ACT team in 2014. However, serious limitations threaten future outcomes. Specifically, the F-ACT team did not directly provide all necessary services to sustain and support pilot women long term. The RBHA limited service provision to case management rather than actual services. By modifying the F-ACT team to incorporate Maricopa County probation, the F-ACT team emphasized a criminogenic more than assertive community treatment posture. Improved F-ACT team functioning would balance these two, occasionally competing approaches. In addition, specific components critical to addressing recidivism, namely, the housing, education and employment components of the post-release service environment were not fully realized by the F-ACT team. As a result, Maricopa County should take steps to meet the employment, education and housing components of the program. Among the steps it should take, Maricopa County should partner with consumer-operated agencies and promote more peer support specialists in housing, education and employment to meet the needs of the target population and reduce the risk of recidivism.

3. Many significant system enhancements have occurred, such as increasing the number of coalition partners and their diversity. Specifically, the Arizona Mental Health and Criminal Justice Coalition has expanded its membership from various state criminal justice agencies to include a diverse and comprehensive community membership representing 25 community partners. With these added participants, the coalition has enhanced its potential to advocate for all justice-involved individuals with co-occurring disorders in the state. An interagency Project Management Team, comprised of
representatives from all of the collaborating agencies (MCAP, MCSO, MCCHS, POCN, RBHA) met on a monthly basis throughout the project period to monitor implementation. The PMT meet on a monthly basis to address ongoing issues in the treatment of all justice involved persons with behavioral health needs. These routine meetings offer agency representatives an opportunity to become better acquainted and more informed of their system partners’ needs, issues, and restrictions in serving this population.
REFERENCES


APPENDIX A Performance Tracking Surveys

BJA Performance Measures Survey for People of Color Network (PCN)
BJA Justice & Mental Health Collaboration

Participant Name: __________________________ Reporting Period: __________________________

1. Was the participant treated for mental illness during this reporting period? No Yes
2. Was the participant treated for substance abuse during this reporting period? No Yes
3. Was the participant treated for co-occurring disorders during this reporting period? No Yes

Employment Services
4. Was participant assessed for employment services during this reporting period? No Yes
   a. If yes, was she recommended to receive services for employment services? No Yes
5. Did PCN provide employment services to participant during this reporting period? No Yes
6. Was this participant referred to other agencies (that were NOT PCN) to receive employment services during this reporting period? No Yes
7. If participant was directly provided employment services during this reporting period did she,
   □ Obtained Employment □ Employed for 3 Months □ Employed for 6 Months □ Has Not Obtained Employment

Educational Services
8. Was participant assessed for educational services during this reporting period? No Yes
   a. If yes, was she recommended to receive services for educational services? No Yes
9. Did PCN provide educational services to participant during this reporting period? No Yes
10. Was this participant referred to other agencies (that were NOT PCN) to receive educational services during this reporting period? No Yes
11. If participant was directly provided educational services during this reporting period did she,
    □ Earn a GED □ Earn a High School Diploma □ Earned a Higher Education Degree

Housing Services
12. Was participant assessed for housing services during this reporting period? No Yes
    a. If yes, was she recommended to receive services for housing services? No Yes
13. Did PCN provide housing services to participant during this reporting period? No Yes
14. Was this participant referred to other agencies (that were NOT PCN) to receive housing services during this reporting period? No Yes
15. If participant was directly provided housing services during this reporting period did she,
    □ Obtained Housing 30 days or less than 30 days □ Housed 31 - 90 days □ Housed 90 days or more
16. While in the grant did the participant spent time in a hospital and/or in-patient mental health facility because of a mental health crisis during this reporting period? No Yes
   a. If yes, how many total days did she spend in hospital and/or in-patient mental health facility? Days ______

Health Care Coverage
17. Did participant have health coverage prior to this reporting period? No Yes
18. Did participant attain health coverage during this reporting period? No Yes
   a. If yes, participant has health care coverage please select all that apply.
      □ State Funded (AHCCCS) □ Private Insurance Self Employed □ Direct-Purchase Health Insurance
      □ Medicare □ Medicaid □ Military Health Care (TRICARE/CHAMPVA) □ Other
19. Does the participant have Medicaid (not Medicare)? No Yes
20. Does the participant have Medicare (not Medicaid)? No Yes
21. Please list the facilities and/or providers of mental health, substance abuse, and primary care services received by the grant participants during the reporting period.

<table>
<thead>
<tr>
<th>In-Patient/Outpatient Facilities</th>
<th>Direct Services for Mental Health</th>
<th>Direct Services for Substance Abuse</th>
<th>Direct Services for Co-occurring D/O</th>
<th>Other-please list</th>
</tr>
</thead>
</table>

22. Please state any other information you feel we should know about the grant participant [Optional]

________________________________________________________

________________________________________________________
### BJA Performance Measures Survey for Maricopa County Adult Probation Department (MCAPD)
BJA Justice & Mental Health Collaboration

**Participant Name:**

**Reporting Period:**

*Note: Only answer if it occurred during this reporting period, if it did not then select no.*

1. During this reporting period what is the most recent risk assessment level for the participant?
   - [ ] Low
   - [ ] Moderate/Medium (include low-medium)
   - [ ] High (include medium-high)

2. During the reporting period did the participant successfully complete probation?
   - [ ] No
   - [ ] Yes

3. Please select what was the probation standing for the participant during this reporting period.
   - [ ] Continues to be in grant
   - [ ] No longer in grant due to court or criminal involvement (technical violation, arrest, re-incarceration, revocation)
   - [ ] No longer in grant due to lack of engagement (no-shows, non-responsive participants)
   - [ ] No longer in grant due to absconding
   - [ ] No longer in grant due to relocating or case transfer
   - [ ] No longer in grant due to death or serious illness

4. Was participant arrested during this reporting period for new offenses?
   - [ ] No
   - [ ] Yes

5. Was participant sent to jail or prison during this reporting period for administrative violations of probation conditions of supervision (not involving new offense charge)?
   - [ ] No
   - [ ] Yes
   - a. If yes, how many days did participant spent in jail/prison during the reporting period?
     **Specify number of Days**

6. Was participant sent to jail or prison during this reporting period for new offenses?
   - [ ] No
   - [ ] Yes
   - a. If yes, how many days did participant spent in jail/prison during the reporting period?
     **Specify number of Days**

7. Did the participant successfully complete the grant within the past 12 months?
   - [ ] No
   - [ ] Yes

---

**Answer the following questions only if the women has completed the program during the reporting period**

8. If this participant was arrested for the first time after successfully completing the grant was she arrested for administrative violation of conditions of supervision?
   - [ ] No
   - [ ] Yes

9. If this participant was arrested for the first time after successfully completing the grant was she arrested for new offenses?
   - [ ] No
   - [ ] Yes

10. Please state any other information you feel we should know about the grant participant. **[Optional]**

    ![Optional field for additional information]
BJA Performance Measures Survey for Correctional Health Services (CHS)
BJA Justice & Mental Health Collaboration

Participant Name:________________ Reporting Period: __________

Note: Only answer if it occurred during this reporting period. Example Q4: IF initial assessment occurred last period and client has not been re-assessed this period then answer no for this period.

1. Was grant participant eligible to receive any services while in jail from CHS during this reporting period? □ No □ Yes
   a. If yes, please specify what kind of services: ____________________________________________

2. Did participant receive a transition or case plan while in jail during this reporting period? □ No □ Yes

Mental Illness Related Services in Jail

3. While in jail was participant assessed for mental health services by CHS during this reporting period? □ No □ Yes
4. Was participant recommended for mental health services during this reporting period? □ No □ Yes
5. Was participant referred to receive mental health services from other agencies? □ No □ Yes
   a. If yes, please specify:

   Service: __________________ Received from/Agency: __________________
   Service: __________________ Received from/Agency: __________________
   Service: __________________ Received from/Agency: __________________

Substance Abuse Related Services in Jail

6. While in jail was participant assessed for substance abuse services by CHS during this reporting period? □ No □ Yes
7. Was participant recommended for substance abuse services during this reporting period? □ No □ Yes
8. Was participant referred to receive substance abuse services from other agencies? □ No □ Yes
   a. If yes, please specify:

   Service: __________________ Received from/Agency: __________________
   Service: __________________ Received from/Agency: __________________
   Service: __________________ Received from/Agency: __________________

Co-occurring Disorders Related Services in Jail

9. While in jail was participant assessed for co-occurring services by CHS during this reporting period? □ No □ Yes
10. Was participant recommended for co-occurring services during this reporting period? □ No □ Yes
11. Was participant referred to receive co-occurring services from other agencies? □ No □ Yes
    a. If yes, please specify:

    Service: __________________ Received from/Agency: __________________
    Service: __________________ Received from/Agency: __________________
    Service: __________________ Received from/Agency: __________________

12. Please state any other information you feel we should know about the grant participant. [Optional]

________________________________________________________________________
________________________________________________________________________
APPENDIX B  Interview Protocol for Women Served through the Pilot Program

MARICOPA COUNTY JUSTICE AND MENTAL HEALTH COLLABORATION
PILOT QUALITATIVE INTERVIEW - GUIDING QUESTIONS

Instructions for Interviewer: Questions are in blue and are italicized. [Definitions and further explanation to interviewee about meaning etc. are in gray]. [Notes to interviewer are in black and bolded]. Remember that not all questions will be asked and/or answered in the order outlined in this script.

READ TO PARTICIPANT:
As I previously mentioned and as I read in the consent form, I’d like to hear about your experiences as a woman who received services while in jail and in the community from correctional health services, probation and community service providers. I am interested in understanding experiences that you found helpful or supportive as well as those that may have been disappointing or upsetting to you. I want to know this information so that we can help improve the services and programs offered to people who have experienced similar situations and make those services available and effective for more people in the future. I understand that some of the questions and topics are sensitive and may bring up some emotions; my intention is not to make you feel uncomfortable. Remember participation is voluntary and confidential. This means you have the right to skip questions and stop the interview at any time. There are no right or wrong answers, you are the expert here. The questions I have are a guide to get the conversation started. Feel free to ask questions or tell me things you think are important. Remember that the following questions are based on services you have received since being released from jail, meetings you have had with your probation officer or past experiences from the last time you were in jail.

Do you have any questions for me?

1. To start off, could you please share with me a bit about yourself?
   - How did you end up here?
   - What has your life been like?
   - What are some of the things that have happened in your past that have led you to end up in jail?
   [Note to interviewer ex: drug/substance abuse problems, acquaintances, etc.]

2. I’m going to ask about the services and types of support you received recently:
a. Please tell me about the services and type of support you received while in jail.

- Was your overall experience in jail different compared to other times you were in jail?
- How well do you think that while in jail the DO’s (detention officers), nurses, correctional health staff and anyone you were in contact with, understood or tried to understand and address issues specific to you as a woman?
- How well do you think the DO’s (detention officers), nurses, correctional health staff in the jail understood or tried to understand and address your experience with or history of trauma?  
  o How did that make you feel?  
  o Has that happened before?
- How well do you feel that the things you mentioned earlier like ____________ were understood or attempted to be understood by jail staff as factors that led you lead you in jail?  
  [Note to interviewer ex: refer to criminogenic factors/risk such as drug/substance abuse problems, acquaintances, etc.]

b. Please tell me about the services and type of support you have received since being released back to the community.

I’d like to start by asking you about probation ...

- What has your experience been like being on probation this time around since you have been released from jail?
- What was it like to be on probation before you were incarcerated?
- Can you please share with me what your relationship/interactions with your probation officer are like?
- How well do you think your probation officer understood or tried to understand and address issues specific to you as a woman?
- How well do you think your probation officer understood or tried to understand and address your experience with or history of trauma?
- Tell me about the plan your probation officer has established with you, what are some of the things you have to follow up with?
- Do you feel your probation plan ties in to the services you are receiving at PCN?
- How well do you feel that the things you mentioned earlier like ____________ were understood or attempted to be understood by your probation officer as factors that led you lead you in jail?  
  [Note to interviewer ex: refer to criminogenic factors/risk such as drug/substance abuse problems, acquaintances, etc.]

Next, I’d like to know more about your experience in receiving services PCN ...
• How well do you think your case manager or therapist understood or tried to understand and address issues specific to you as a woman?

• How well do you think your case manager or therapist understood or tried to understand and address your experience with or history of trauma?

• With regards to receiving services (like medication, housing, counseling etc.) what would you say your experience to actually get them has been like? (by “get them” I mean actually having a place to live after released from jail, and access to medical care instead of having to wait some time)

• What was this process like (receiving services after released from jail) the last time you were released from jail?

• Now that you are receiving services here at PCN and/or with other agencies, can you tell me what the plan for you looks like? (by plan I mean what are some of the things you have to do as part of treatment etc.)

• How well do you feel that the things you mentioned earlier like ____________ were understood or attempted to be understood by those in your team here at PCN as factors that led you in jail? [Note to interviewer ex: refer to criminogenic factors/risk such as drug/substance abuse problems, acquaintances, etc.]

3. Since being released from jail and are out in the community, who do you feel is your biggest supporter?

• Tell me about your interactions with him or her?

• Tell me about your interactions with your family/members?

• What was different about the support _____ provided you compared to everyone else that you felt made a difference?

4. For your future, what are you looking forward to the most?

• What do you feel hopeful for?

• Can you share with me some of your hopes and goals for the future?

• Do you feel like you are getting services that are preparing you to live a clean and sober lifestyle?

• What do you think will be different this time so that you don’t end up back in jail?

5. If you could change something about the services, interactions you have had with your probation officer or while in jail, what would it be?
What was the best thing or something you remember most about your most recent time in jail?
What was the best thing or something you remember the most about your interactions with your probation officer?
What was the best thing or something you remember the most about the services you are receiving?
What was the worst thing or something you did not like about your most recent time in jail?
What was the worst thing or something you did not like about your interactions with your probation officer?
What was the worst thing or something you did not like about your interactions with your case manager and/or therapist at PCN?

6. Thank you for answering all of my questions. Is there anything else you would like to share with me?
## APPENDIX C Summary of Trainings and Attendance

<table>
<thead>
<tr>
<th>Date</th>
<th>Attendees</th>
<th>Trainings</th>
<th>EBP’s Topic Areas</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/09/13</td>
<td>14</td>
<td>TAMAR Training (Tucson)</td>
<td>x</td>
</tr>
<tr>
<td>01/10/13</td>
<td>17</td>
<td>TAMAR Training (Phoenix)</td>
<td>x</td>
</tr>
<tr>
<td>02/19/13</td>
<td>24</td>
<td>Trauma Informed Peer Support Training (Tucson)</td>
<td>x</td>
</tr>
<tr>
<td>02/20/13</td>
<td>21</td>
<td>Trauma Informed Peer Support Training (Phoenix)</td>
<td>x</td>
</tr>
<tr>
<td>03/06/13</td>
<td>36</td>
<td>Programming by Proxy: Reducing Recidivism and the “Big 4” Training</td>
<td>x</td>
</tr>
<tr>
<td>03/13/13</td>
<td>94</td>
<td>Justice Involved Women, Trauma, and Traumatic Brain Injury: Black and White Answers for Your Grey Matter</td>
<td>x</td>
</tr>
<tr>
<td>04/30/13</td>
<td>248</td>
<td>Together Toward Tomorrow: Collaborating Today for a Justice and Mental Health Reentry System Conference (Tucson)</td>
<td>x</td>
</tr>
<tr>
<td>05/02/13</td>
<td>41</td>
<td>The Maricopa County Justice &amp; Mental Health Collaboration Project-Partnership Kick-Off Meeting</td>
<td>x</td>
</tr>
<tr>
<td>05/13/13</td>
<td>62</td>
<td>Healing of the Healers Workshops (Tucson)</td>
<td>x</td>
</tr>
<tr>
<td>05/14/13</td>
<td>85</td>
<td>Healing of the Healers Workshops (Phoenix)</td>
<td>x</td>
</tr>
<tr>
<td>05/13 &amp; 05/14/13</td>
<td>369</td>
<td>Arizona Problem Solving Courts Conference: Spotlight on Success</td>
<td>x</td>
</tr>
<tr>
<td>06/12, 06/19 &amp; 06/26/13</td>
<td>128</td>
<td>Trauma-Informed Care -POCN site-based trainings (La Communidad)</td>
<td>x</td>
</tr>
<tr>
<td>08/01/13</td>
<td>41</td>
<td>Maricopa County Adult Probation Evidence-Based Practices: Collaboration with Treatment Providers</td>
<td>x</td>
</tr>
<tr>
<td>08/26/13</td>
<td>101</td>
<td>TIC: Next Steps</td>
<td>x</td>
</tr>
<tr>
<td>08/27/13</td>
<td>67</td>
<td>TIC Learning Circles</td>
<td>x</td>
</tr>
<tr>
<td>10/10/13</td>
<td>69</td>
<td>Together Toward Tomorrow: Collaborating Today for a Justice and Mental Health Reentry System Conference (Phoenix)</td>
<td>x</td>
</tr>
<tr>
<td>01/01/14</td>
<td>172</td>
<td>Trauma-Informed Care (two hr. trainings)</td>
<td>x</td>
</tr>
<tr>
<td>01/08/14</td>
<td>79</td>
<td>Trauma-Informed Care Training</td>
<td>x</td>
</tr>
<tr>
<td>01/23/14</td>
<td>Varies: Ongoing several times per month</td>
<td>MCSO Training Academy Required Annual Refresher Course- Working With Inmates: Behavioral Health and Cognitive Impairments</td>
<td>x</td>
</tr>
<tr>
<td>01/30/14</td>
<td></td>
<td>Conference Worship: Maricopa Mental Health &amp; Justice Collaboration: Coordination &amp; Collaboration for Service Delivery (Phoenix)</td>
<td>x</td>
</tr>
<tr>
<td>02/26/14</td>
<td>120</td>
<td>Achieving More Successful Outcomes w/ Justice Involved Women (NIC &amp; NIJIW)</td>
<td>x</td>
</tr>
<tr>
<td>Date</td>
<td>Code</td>
<td>Description</td>
<td>2/27/14</td>
</tr>
<tr>
<td>------------</td>
<td>------</td>
<td>------------------------------------------------------------------------------</td>
<td>---------</td>
</tr>
<tr>
<td>2/27/14</td>
<td>20</td>
<td>NIC &amp; NCJIW conducted a facilitated dialogue/learning circle with F-ACT and SMI POs</td>
<td>x</td>
</tr>
<tr>
<td>2/27/14</td>
<td>15</td>
<td>NIC &amp; NCJIW conducted a facilitated dialogue /learning circle with MCSO and MCCHS</td>
<td>x</td>
</tr>
<tr>
<td>02/28/14</td>
<td>26</td>
<td>NIC &amp; NCJIW Training Academy for MCSO and MCCHS</td>
<td>x</td>
</tr>
<tr>
<td>03/10/14</td>
<td>86</td>
<td>ACEs TIC Training</td>
<td>x</td>
</tr>
<tr>
<td>03/27/14</td>
<td>60</td>
<td>Conference Worship: Maricopa Mental Health &amp; Justice Collaboration: Coordination &amp; Collaboration for Service Delivery (Phoenix)</td>
<td>x</td>
</tr>
</tbody>
</table>

The project partners also conducted a breakout presentation titled "Maricopa County Justice and Mental Health Collaboration Project-Criminogenic Responsivity, Trauma-Informed Care, and Gender-Responsive Services" to share the lessons learned and highlight outcomes achieved through the grant process at the following conferences:

- 15th Annual Summer Institute Conference on July 15, 2014
- Seeds Conference, "Intersection of Behavioral Health & Criminal Justice" on October 1, 2014
- Arizona Coalition to End Homelessness Conference on October 21, 2014.
APPENDIX D Arizona Mental Health and Criminal Justice Coalition Monthly Meeting Topics and Attendance

<table>
<thead>
<tr>
<th>Meeting Date</th>
<th>Arizona Mental Health &amp; Criminal Justice Coalition: Meeting Topics &amp; Presentations</th>
<th>Number of Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oct 2012</td>
<td>Information not available</td>
<td></td>
</tr>
<tr>
<td>Nov 2012</td>
<td>Information not available</td>
<td></td>
</tr>
<tr>
<td>Dec 2012</td>
<td>Evidence-Based Practices in prevention, treatment and reentry. Discussed creating ongoing work group.</td>
<td>23</td>
</tr>
<tr>
<td>Jan 2013</td>
<td>NAMI, media and unmet needs of SMI probationers. Identified critical needs of the formerly incarcerated and discussion regarding the lack of linkages to needed services.</td>
<td>33</td>
</tr>
<tr>
<td>Feb 2013</td>
<td>Bureau of Justice Administration (BJA) grant targeting justice-involved woman with SMI and co-occurring disorders with trauma history - Vicki Staples. Coalition will provide feedback and serve as advisory committee for BJA project</td>
<td>22</td>
</tr>
<tr>
<td>March 2013</td>
<td>Juvenile Justice - Dr. Kellie Warren. Discussed need to outreach juvenile justice community.</td>
<td>24</td>
</tr>
<tr>
<td>April 2013</td>
<td>BJA grant update on trauma-informed care (TIC) training - Vicki Staples. Work group developed.</td>
<td>10</td>
</tr>
<tr>
<td>May 2013</td>
<td>AZ State Hospital volunteers speak on human rights and recovery. Educating Coalition on AZ State Hospital Mission, human rights and safety issues.</td>
<td>19</td>
</tr>
<tr>
<td>June 2013</td>
<td>AZ State Hospital: Forensic and Civil Issues - Jon Strickler Training on Restoration to Competency and GEI criminal defense Hope Lives Forensic Peer Support - Chris Gonzalez</td>
<td>24</td>
</tr>
<tr>
<td>July 2013</td>
<td>Criminal Defense / Mental Health Issues in the Courts Pt I - Tammy Wray, Maricopa County Public Defender</td>
<td>33</td>
</tr>
<tr>
<td>August 2013</td>
<td>Presentations on Terros new SMI Reentry and Hope Lives Programs. Requested participation from ADC in future Coalition meetings</td>
<td>11</td>
</tr>
<tr>
<td>Sept 2013</td>
<td>Maricopa County Mental Health Court, Competency. GEI, Mental Health Issues in the Courts Pt 2 - Tammy Wray, Maricopa County Public Defender. Requested a copy of diversion proposal from Reentry Council</td>
<td>28</td>
</tr>
<tr>
<td>Oct 2013</td>
<td>Mental Illness within AZ state prisons and concerns regarding medication and psychiatrist access.</td>
<td>33</td>
</tr>
<tr>
<td>Nov 2013</td>
<td>HB 2310 Study of Community Mental Health Court - Mark Stodola - Arizona Office of the Court &amp; Mental Health Law &amp; Confidentiality Issues - Victoria Aims-ASU Sandra Day O’Connor College of Law</td>
<td>19</td>
</tr>
<tr>
<td>Dec 2013</td>
<td>Arizona Department of Corrections - Dr. Nicole Taylor, AZ Department of Corrections, Mental Health Monitor</td>
<td>27</td>
</tr>
<tr>
<td>Meeting Date</td>
<td>Arizona Mental Health &amp; Criminal Justice Coalition: Meeting Topics &amp; Presentations</td>
<td>Number of Participants</td>
</tr>
<tr>
<td>--------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>------------------------</td>
</tr>
<tr>
<td>Jan 2014</td>
<td>Individuals provided information on how to report issues and concerns. Discussed need to get additional data on issues reported.</td>
<td>23</td>
</tr>
<tr>
<td>Feb 2014</td>
<td><strong>Federal Probation</strong> - More Emmons&lt;br&gt;Discussed lack of services and no coordination for probationers with behavioral health issues. Housing continues to be a primary barrier for successful reentry</td>
<td>42</td>
</tr>
<tr>
<td>March 2014</td>
<td>Arizona Supreme Court/Administrative Office of the Courts - Krista Forster and Susan Alameda&lt;br&gt;Discussed of oversight of probation services in the state of AZ through the Administrative Office of the Courts. (AOC) Overview presented of the state of Arizona’s Treatment Mapping Project</td>
<td>12</td>
</tr>
<tr>
<td>April 2014</td>
<td>Mental Health Director of Maricopa County Correctional Health Services - Dr. Dawn Noggle&lt;br&gt;Focus at the jail being given to those with highest risk to recidivate. Need more resources provided for those with SMI. Communities of faith need to be welcomed and engaged in reentry work in our communities. Dr Noggle in collaboration with ASU under the BJA Grant has created a training curriculum for jail staff in dealing with those who are SMI. This program will be available to be shared with sheriffs across the state.</td>
<td>26</td>
</tr>
<tr>
<td>May 2014</td>
<td>Elizabeth Singleton - Founder, Singleton Housing&lt;br&gt;Ms. Singleton led a discussion of housing availability and barriers which exist in AZ for the at risk population of those with criminal backgrounds and mental health diagnoses. Explanation of Housing First and Supported Housing models. Community members commented that obtaining information on housing options is the most difficult of their challenges. Public commented, that it seems only “insiders” have the information needed on how to obtain assistance in gaining safe affordable housing. Removing barriers to housing will remain a coalition priority.</td>
<td>20</td>
</tr>
<tr>
<td>June 2014</td>
<td>Sherrie Fraley &amp; Laura Smith of Desert Vista Hospital&lt;br&gt;Discussion of court ordered evaluation (COE) Representatives from the ADC and MIHS agreed to meet to find ways to coordinate COE for individuals coming out of prison. MIHS also volunteered to coordinate trainings for ADC staff on the COE/COT processes</td>
<td>33</td>
</tr>
<tr>
<td>July 2014</td>
<td>No meeting due to July 4 holiday.</td>
<td></td>
</tr>
</tbody>
</table>
Meeting Date | Arizona Mental Health & Criminal Justice Coalition: Meeting Topics & Presentations | Number of Participants
--- | --- | ---
August 2014 | Fredrica Strumpf – Maricopa County Public Defender, Tom Weiss Maricopa County Adult Probation, and Shelley Curran - Mercy Maricopa Integrated Care, Director of Court Advocacy
Ms. Strumpf presented on constitutional rights during Court ordered TX process. Overview of Rule 11 and its place in the criminal process which can take up to two years explained. It is important to understand that competency restoration is not in any way therapeutic or considered a treatment program. Tom Weiss gave an overview of the Maricopa County Adult Probation units which specialize in supervising those with a serious mental illness. Shelley Curran gave an overview of Maricopa County’s Forensic Assertive Community Treatment Teams | 46
Sept 2014 | Dr Robert Williamson CMO ConnectionsAZ
Discussion of crisis response in the greater Phoenix area. Dr Williamson talked about the Maricopa County Crisis system being extremely robust and well-funded. Coalition members voiced concerns regarding likelihood that calls to crisis are too often resulting in a response by law enforcement which ends with criminal charges or injury to the individual in an acute psychiatric episode. Dr Williamson suggests that the coalition needs to ask CRN to respond to these public concerns. | 15

APPENDIX E Coalition Sustainability Plan

<table>
<thead>
<tr>
<th>Agency</th>
<th>Sustain after 9/30/14</th>
<th>Modify, Let Go or Discontinue</th>
</tr>
</thead>
</table>
| People of Color Network | Initial screening and assessment (e.g. Trauma Symptom Inventory & ACES)
- Comprehensive/Clinical Assessment
- Psychiatric Assessment PA/MD
- Nursing Assessment-RN
Plan on how to include/modify services – manage symptoms, triggers and improve coping skills
Annual Site-Based Trauma Training
Sustain co-location with probation
Dedicate staff for reach-in for re-entry planning
Gender-responsitivy for F-ACT and modify F-ACT criteria to include criminogenic risk and women | Discontinue Bridge Housing – concerned with transition planning for women in the apartments now and need a plan for continuing housing
Referral process, specialized program on F-ACT for justice involved women (however grant women will remain the F-ACT team) and continue to advocate for expansion of F-ACT Teams
Multi-agency release of information- new RBHA need to redo entire process – |
<table>
<thead>
<tr>
<th>Agency</th>
<th>Sustain after 9/30/14</th>
<th>Modify, Let Go or Discontinue</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>POCN Clinic</strong></td>
<td>POCN Clinic licensed to provide TIC counseling and will continue possibly expanding to full time and also other sites.</td>
<td>Electronic health records</td>
</tr>
</tbody>
</table>
| **Maricopa County Adult Probation** | New collaborative agreement with MMIC sharing of F/OST & pre-sentence reports  
Continue co-location and participate in staffing including discussing criminogenic risk  
Specialized female offender case load (advocating for but not finalized)  
Enhanced Community Restitution Unit for Community Reintegration SMI Specialist Senior Probation for Enhanced In-Reach Discharge Planning  
TIC and Gender training (Norma to check with Holly and also ask about PREA)  
All mental ill individuals identified during the presentence report go to an SMI case load straight from sentencing and court notified that they are eligible for a mental health addenda prior to sentencing  
Cross training in collaborative agreement  
EBPs Criminogenic risk and thinking for change at Hope Lives/TERROS  
Special Committee working on collaboration with community services providers |                                                                          |
| **Correctional Health Services** | Badge a small group of POCN staff to sustain reach-in and accessibility  
Added TIC information into annual PREA  
MCSO Detention Officer Training  Annual Training  
Annual trainings at CHS staff for nursing, physicians, psychiatrist and counselors on TIC  
Mental Health Professionals at CHS on criminogenic risk |                                                                          |
<table>
<thead>
<tr>
<th>Agency</th>
<th>Sustain after 9/30/14</th>
<th>Modify, Let Go or Discontinue</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Start Now Program-DBT mindfulness program that is gender-responsive and trauma in MHU and continue in Estrella – identifying those at risk</td>
<td></td>
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<tr>
<td></td>
<td>TAMAR groups and materials in the MHU and Estrella</td>
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<tr>
<td></td>
<td>Deputy County Manager taking focus on SMI and women in the reentry council and Maricopa County Justice Community</td>
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<tr>
<td></td>
<td>Collaborate with POCN and MCAPD</td>
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<tr>
<td>David’s Hope</td>
<td>Probation involved in the coalition (on the board)</td>
<td>Not advising more advocating and educating</td>
</tr>
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<td>Agency representatives at Coalition Meetings (Rachel to follow up with Kim) and meeting</td>
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<tr>
<td></td>
<td>Quarterly Roundtables</td>
<td></td>
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<tr>
<td>CABHP</td>
<td>Website – add to CABHP website include on website on all tip materials</td>
<td>Delete Google project website</td>
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<td></td>
<td></td>
<td>TOT on DOT instead of Master Trainers</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Sustainability guide/Briefing Paper  vs Program Manual</td>
</tr>
<tr>
<td>Other</td>
<td>Shelley – trauma informed, ciminogenic RNR and gender responsive part of new RBHA?</td>
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<tr>
<td></td>
<td>Each of the partnering organization agreed to support the AZMHCJ by sending a participant to the meetings.</td>
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<tr>
<td></td>
<td>The SMART Justice Committee will be addressing the issue of gender-responsive services and will include representative from the PMT.</td>
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</tbody>
</table>
APPENDIX F Trauma-Informed Tip Sheet

The Four “Rs” in a Trauma-Informed Approach

A program, organization, or system that is trauma-informed realizes the widespread impact of trauma, and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system and responds to actively resist re-traumatization.

-SAMHSA’s Concepts of Trauma & Guidance for a Trauma-Informed Approach

“Universal Precautions” should be used, as the vast majority of justice-involved women have a history of trauma. Trauma-informed approaches should be applied to everyone (without any prior screening), as these approaches involve minimal risk and can be beneficial to all.

Asking “what happened to you?” instead of “what’s wrong with you?”

Women who have experienced trauma are likely to continue to cycle through criminal justice and behavioral health crisis systems until we offer a full continuum of trauma-informed services. These include screening, assessment and effective engagement in evidence supported practice, with continuing support for women and their families. Change how you approach the conversation from one that may be interpreted as victim blaming (“What’s wrong with you?”) to inquiring earnestly about women’s experiences (“What happened to you?”). This shifts the view of trauma survivors from “sick” or “bad” to people who have been injured.

Research shows that trauma survivors can and do overcome traumatic experiences with appropriate support and intervention.

Prevalence of trauma is extremely high for justice-involved women. According to the U.S. Department of Health and Human Services Office on Women’s Health, 56-99% of women in substance use treatment, and 85-95% of women in the public mental health system, report a history of trauma.

Trauma is linked to the onset of mental health conditions, substance abuse and women’s involvement in criminal behavior. Effects of traumatic experiences often remain well beyond the traumatic event, especially for people who have endured repeated traumatic events such as exposure to violence, chronic neglect and armed conflict. Depression, anxiety, strained relationships and suicidal tendencies are common symptoms of trauma survivors.

Trauma overweights coping resources, ignites the “fight, flight or freeze” reaction and frequently produces a sense of fear, vulnerability and helplessness.

Triggers (e.g. smells, a person who is reminiscent of a prior abuser) are stimuli that set off a memory of a traumatic experience. Research on trauma, including brain imaging, has shown that trauma survivors who are triggered may experience extreme stress, feelings of constantly being threatened, unconsciously scanning the environment for danger, misinterpreting interactions as threats, and difficultly regaining or maintaining a sense of safety or relaxation.

Trauma-related symptoms and behaviors are often ways women cope and survive. Mistranslated acts of defiance and non-compliance are actually coping mechanisms used by survivors to alleviate distress. Examples include self-harm, alcohol and drug use, passivity, sexual promiscuity and other sexualized behavior, bullying, withdrawing or isolating, difficulty being present, and nurturing oneself with food. While these trauma-related behaviors are often seen as destructive, “rule violations,” “treatment failures,” “manipulations” or as self-deprecating behavior, they actually provide relief and a sense of control to the survivor.

Research has shown many benefits to using trauma-informed approaches.

Reducions in the use of mental health units, restraints, critical incidents and staff turnover. Trauma-informed approaches also allow for more effective behavior management, enhanced engagement, and increases in client and staff satisfaction.

Educating women on the effects of trauma and helping them cope with these effects is key to many innovative programs.

Trauma experiences can complicate women’s capacities to make sense of their lives and to create meaningful, consistent relationships with their families, friends and others in their community. There is a growing number of empirically-supported clinical interventions for trauma responses with more than 15 interventions for the screening and treatment of trauma, available in SAMHSA’s National Registry of Evidence-Based Programs and Practice (http://www.nrep.samhsa.gov/).
"Trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual's functioning and physical, social, emotional, or spiritual well-being*  

-SAMHSA's Trauma and Justice Strategic Initiative

The Six Key Principles of a Trauma-Informed Approach¹

1. Safety. Provide a physical setting where interpersonal interactions promote a sense of safety for both staff and the people they serve.

2. Trustworthiness and Transparency. Build and maintain trust with your clients and their families. Conduct operations and decisions with transparency.

3. Peer Support and Mutual Self-Help. Establish hope, build trust and enhance collaboration. Encourage trauma survivors to use their stories and shared lived experience to promote healing and recovery.

4. Collaboration and Mutuality. Allow for the leveling of power differences between "staff" and "clients" so that decision-making is shared and healing is supported through genuine and meaningful relationships.

5. Empowerment, Voice and Choice. Recognize and build on clients' strengths and experiences to foster resiliency, support shared decision-making, and cultivate self-advocacy. Empower and support staff to facilitate recovery rather than control or direct a person's goals.

6. Cultural, Historical and Gender Competence. Recognize individuals' unique needs and offer and ensure access to gender-responsive services.

To create an environment that reduces the risk of re-traumatization, modify your correctional practices to eliminate those that can be trauma-inducing and trigger painful memories. Many practices that interfere with healing can be successfully transformed by giving options, helping to rebuild a sense of control and empowering the survivor. Examples are:

- Eliminate or reduce the use of restraints, seclusions and segregation through the use of trauma-informed de-escalation techniques such as lowering your tone, using the woman's name, providing information (empowerment), and using motivational interviewing techniques (encouragement for cooperation).

- Communicate with women before "hands on" activity like cuffing, especially during and after pat-downs or strip searches. Ask permission to proceed, explain why the procedure is needed, describe the procedure, and acknowledge/thank her for cooperating upon completion.

- Update supervision protocols used during sensitive times (e.g. showering, dressing and the collection of urine samples) to incorporate choice by the women as to who will be observing them during these procedures.

- Modify facilities and probation offices so they are inviting and promote a sense of calmness, safety, collaboration and openness. Display recovery supporting materials in the lobby that include self-regulation/relaxation skills. Identify spaces clearly, eliminating unmarked doors and creating ease of access to exits.

As a correctional professional, you have an increased risk of experiencing secondary traumatic stress, vicarious trauma and compassion fatigue. Recognize that staff may also have a history of trauma and provide education on the warning signs and symptoms such hypervigilance, hyperarousal, emotional numbing, being easily moved to tears, feelings of despair and hopelessness, reduced productivity and irritability. Instill and support strategies to manage personal and professional stress.

Additional resources available at https://cbhdp.asu.edu/content/trauma-informed-care.


This document was supported by Grant No, 2012-MI-BX-0023 awarded by the Bureau of Justice Assistance. The Bureau of Justice Assistance is a component of the Office of Justice Programs which also includes the Bureau of Justice Statistics, the National Institute of Justice, the Office of Juvenile Justice and Delinquency Prevention, the Office for Victims of Crime, the Community Capacity Development Office, and the Office of Sex Offender Sentencing, Monitoring, Apprehending, Registering, and Tracking. Points of view or opinions in this document are those of the author and do not necessarily represent the official position or policies of the U.S. Department of Justice.
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1 Harris and Elliot, 2001; Elliot D.E., Stephan, P., Elliot, R.D., Mardoff, L.S., and Reed, R.G. 2006.

This document was supported by Grant No. 2012-MO-BX-0023 awarded by the Bureau of Justice Assistance. The Bureau of Justice Assistance is a component of the Office of Justice Programs which also includes the Bureau of Justice Statistics, the National Institute of Justice, the Office of Juvenile Justice and Delinquency Prevention, the Office for Victims of Crime, the Community Capacity Development Office, and the Office of Sex Offender Sentencing, Monitoring, Apprehending, Registering, and Tracking. Points of view or opinions in this document are those of the author and do not necessarily represent the official position or policies of the U.S. Department of Justice.
APPENDIX G ROWBOATS Pocket Size Trauma-Informed Card

ROWBOATS
helping individuals with
cognitive impairments

Reduce amount of information
One instruction at a time
Written & verbal when possible
Breaks are helpful
Often is better, routines helps
Ask person to paraphrase/repeat
Take the time, go slowly
Simple & organized info best

Traumatic Brain Injury (TBI)

Every 23 seconds a TBI occurs in US
Symptoms worsen with multiple TBIs
High prevalence of TBI with co-occurring mental illness & substance abuse disorder
Convicted women are more likely to have sustained a pre-crime TBI and have been a victim of physical abuse

COMMON SYMPTOMS:
- easy overstimulated
- slowness in thinking
- difficulty grasping new information
- trouble following instructions
- difficulty with recall & new skills
- emotional, impulsive, or agitated
- interpersonal difficulties
- mental/physical fatigue

more information at cabhp.asu.edu
APPENDIX H AGREEMENT Mercy Maricopa

MARICOPA COUNTY ADULT PROBATION DEPARTMENT AND REGIONAL BEHAVIORAL HEALTH AUTHORITY COLLABORATIVE AGREEMENT

I. Background

The Maricopa County Superior Court’s Adult Probation Department (APD) enhances community safety by working in a collaborative partnership with the Maricopa County Regional Behavioral Health Authority (RBHA) and its contracted providers to provide research-based prevention and intervention services. Contracted providers deliver a range of behavioral health care services and treatment programs for adults with mental health and/or substance abuse disorders and children with serious emotional disturbance.

A critical component of managing and reducing offender risk in the community is a blended model of criminal justice and treatment affording the offender viable opportunities for change. By participating in services offered by the RBHA and APD, members can direct their own change.

Through this collaboration, APD and the RBHA will provide members with the behavioral health services they need, and in turn decrease recidivism and harm, thus avoiding further re-incarceration of these individuals.

II. Target Population

A person becomes engaged with APD at Pretrial or the Presentence processes and can be granted probation, with or without a term of jail, or sentenced to Department of Corrections (DOC) with a consecutive probation grant. Consequently, APD is engaged in re-entry when DOC and Maricopa County Sheriff’s Office (MCSO) release inmates to the community contingent on the terms of probation.

In FY2013, on a monthly basis, APD supervised 2,274 defendants on Pretrial supervision, 20,186 standard probationers (including specialized caseloads) and 709 intensive supervision probationers. Three critical specialized caseloads are the seriously mentally ill (SMI) caseloads, which averaged 610 probationers, the sex offender caseloads, which averaged 1,976 probationers and the Transferred Youth population, which averaged 220 adolescent and young adult probationers. The entire average monthly population was 51,764.

APD uses a standardized statewide risk/needs assessment tool, known as the Offender Screening Tool (OST) or Field Re-Assessment Offender Screening Tool (FROST) that has been validated to identify risk to re-offend and areas of crinmo-genic need. The risk categories are high, medium-high, medium- low and low. The areas of crinmo-genic need are mental health, vocational/financial, education, family and social relationships, residence and neighborhood, alcohol and/or drug abuse, attitude and criminal behavior. First-time and repeat offenders in need
of mental health or substance abuse services will be referred to the RBHA for eligibility screening and to ensure the appropriate services and level of care are assigned to them.

As of February 2014, APD identified, through OST and FROST assessments, 33% of probationers needing to address mental health factors, 27% needing to address alcohol abuse issues and 55% needing to address drug abuse issues.

A very small percentage of critical populations experience homelessness and will need housing services. Those populations are SMI, sex offenders, SMI sex offenders, Transferred Youth and higher risk substance abusers engaged in treatment but in need of a sober living environment.

The RBHA is available to provide integrated health care to individuals eligible under the Arizona Health Care Cost Containment System (AHCCCS) who are in the pretrial process, or sentenced to probation and who are designated as SMI or who meet the criteria to receive general mental health/substance abuse (GMH/SA) services. Upon receipt of referral, the RBHA and their contracted providers will assist eligible probationers in need of services by assessing and engaging them in targeted services.

III. Programmatic Basis of Agreement

The RBHA will work with APD in coordinating the delivery of mental health and substance abuse services to persons served by both organizations (known hereafter as “members”), provide mechanisms for resolving problems, develop a standardized automated information sharing process, address the resources each contributes to the care and support of persons mutually served, arrange for co-location of services, if applicable, and identify and address joint training needs.

Additionally, the Affordable Care Act and the Arizona restoration of Medicaid provides a much needed opportunity to increase access to services by enrolling all eligible members into AHCCCS. Both agencies shall jointly share this responsibility.

Agreement Goals

1. Coordinate the delivery of behavioral health services to persons served by both organizations

   APD will engage, assist and enroll in healthcare as many members as feasible, who are processed through the Assessment Center, which generally occurs when an offender is in the Pre-Sentence stage or is new to probation. APD will support and reinforce efforts by the RBHA and its contracted providers to enroll eligible probationers and defendants in AHCCCS. Given the dynamic and transient nature of probationers, APD will continue to inquire about probationers’ healthcare needs and refer the uninsured to AHCCCS.

   The RBHA will require its contracted providers to engage, assist and enroll eligible probationers in behavioral health services.
The RBHA, in cooperation with APD pursuant to Administrative Order 2014-092 dated 07-08-2014, will identify, screen and engage all individuals who are eligible for SMI and children's services. In addition, the RBHA and APD will work together to screen and engage GMH/SA eligible individuals.

A. IDENTIFY:

Per Administrative Order 2014-092 dated 07-08-2014, the RBHA will provide APD with the following data:

- First, Middle and Last Name, and known aliases of the individual
- Last four digits of SSN
- Date of birth, gender and the ethnicity of the individual
- Whether the subject individual is, or has been previously, enrolled as a client of the RBHA in Maricopa County and has been designated as SMI
- Whether the subject individual is enrolled or previously enrolled as a client of the RBHA in Maricopa County as a youth involved in children's services
- Name of clinic or provider, name of case manager and telephone number

The RBHA-contracted crisis intervention provider will contact APD Specialized SMI Officers/Specialized Sex Offender SMI Officers on all APD identified cases when a crisis mobile team has been dispatched to a shared client, or the crisis team member needs assistance from a Specialized SMI Officer to help a shared client.

B. SCREEN:

The RBHA will require its contracted providers, in collaboration with APD to screen APD members referred for mental health and/or substance abuse treatment services and/or housing according to guidelines outlined in the RBHA Provider Manual.

C. ENGAGE:

The RBHA will provide necessary medical services to enrolled children, GMH/SA, and SMI individuals in accordance with their eligibility. Services may include but are not limited to:

- Medical Care
- Behavioral Health Care
- Case Management
- Supportive Housing
- Supportive Employment
- Transportation
- Crisis Response
h. Additional services as covered by the Arizona Health Care Cost Containment Services (AHCCCS)

The RBHA will require its contracted providers, in collaboration with APD, to attend multi-disciplinary team meetings and/or mental health court.

The RBHA will require its contracted providers to make available Peer Support persons to assist SMI recipients. Support personnel will attend mental health court sessions, be available to co-locate at designated probation offices in Maricopa County if needed, provide behavioral health screenings and transition and support services for identified APD members transitioning from incarceration.

2. Provide mechanisms for communication and resolving problems

APD and RBHA management will have quarterly meetings to build and strengthen relationships and address any problems or conflicts. Additionally, the RBHA will identify provider level meetings, appropriate for APD participation.

Meetings shall include opportunities for agency cross-training to increase understanding and knowledge of each other’s mission, goals and how they are achieved.

The RBHA and APD will work together to ensure processes from both agencies are being practiced and remain up to date within the RBHA Provider Manual, including its annual review. APD will be notified of any changes in the Provider Manual that could impact shared members.

The RBHA and APD will identify key staff who have the authority to assist with disputes and find resolutions based on the agreements and best interest of the populations both jointly serve. If necessary this may include the Chief Clinical Officer and the Deputy Chief Probation Officer.

Meetings shall include opportunities to report identified gaps in services (types of services, accessibility and frequency) and discuss solutions.

3. Develop standardized information sharing processes

The Arizona Department of Health Services, the APD and the RBHA maintain a formal agreement (Administrative Order 2014-092) authorizing information sharing between agencies on defendants and probationers processed through the criminal justice system in order to provide continuity of care, supervision, and appropriate sentencing and treatment recommendations to the Court.

The APD and the RBHA shall continue to collaborate and work towards adopting a systemized, electronic and secure method to exchange relevant, accurate and real-time member case information necessary to provide Court recommendations and improve continuity of care.
The APD and the RBHA shall each maintain the confidentiality of information exchanged and shall not disseminate information to any person or entity not under each agency’s supervision or control except as permitted by applicable law, rule, regulation or Administrative Order.

4. **Address the resources each contributes to the care and support of persons mutually served**

The APD will provide current assessment results, case plans and probation status and probation officer contact information to the RBHA.

The RBHA will require its contracted providers in collaboration with the Specialized SMI Unit Officers to determine which probationers are eligible for the Morten Housing Project. The RBHA and its contracted providers will support eligible probationers/recipient in this housing project with wrap-around and supportive services as outlined in the RBHA Provider Manual.

With the member’s consent, the RBHA’s contracted providers will invite APD to staffings, ISP updates and other service planning meetings at clinics or other locations when APD or the contracted provider indicates a need to make joint decisions on a probationer/offender facing challenges in the community or in jail.

The RBHA and its contracted providers will provide court liaisons and peer-support specialists in mental health court and be part of the multi-disciplinary team with the Superior Court Judge. RBHA contracted provider staff may also need to be present to staff cases in mental health court and other courts in addition to the RBHA court liaison.

The RBHA and the APD will continue participating in designing, development, submission, implementation and evaluation of grant projects.

5. **Arrange for co-locations of services, if applicable**

APD and the RBHA will continue to explore and implement co-location of services as appropriate.

6. **Identify and address joint training needs**

The RBHA, its contracted providers and APD will provide cross training opportunities as needs are identified which includes: specialized training for Specialized SMI Officers, overview of the BH system, overview of APD and other topics as mutually identified.

APD will provide T4C Facilitator training to the RBHA and any provider that will be working with APD members. “Thinking For A Change” is a public-domain evidence based program. Probation will partner with the RBHA to provide train-the-trainer and a
co-facilitator for providers that elect to offer this program for members who are or have been medium-high or high-risk offenders.

IV. Review
This collaborative protocol shall be reviewed annually and updated as mutually agreeable by both parties.

Signatures

Eddy Broadway, Mercy Maricopa Chief Executive Officer

Date

Barbara Broderick, Chief Probation Officer

Date

09-09-14

9-12-14
APPENDIX I Working with Inmates

**Working with Inmates: Behavioral Health & Cognitive Impairments**

**COURSE DESCRIPTION**

The purpose of this bi-annual refresher course is to build upon the information that participants received in prior trainings. Trainings will be co-facilitated by the Maricopa County Sheriff's Office-Training Division and Maricopa County Correctional Health Services. The training will support detention officers in recognizing individuals who have a behavioral health (i.e. mental health & substance abuse) or other cognitive disorder(s) so they can intervene early and reduce the use of force.

**LEARNING OBJECTIVES**

Upon course completion participants will be able to:
- describe the prevalence of inmates with behavioral health needs and cognitive impairments;
- discuss how trauma survivors can be triggered in a jail environment, understand trauma-related responses, and list the benefits of being trauma-informed;
- identify the signs and symptoms of these inmate populations;
- give examples of professional interactions and early interventions that can reduce use of force;
- explain when to refer an inmate to Correctional Health Services; and
- give examples of self-care and/or strategies to manage correctional staff fatigue.

**PARTICIPANTS / TARGET AUDIENCE**

Detention Staff at the Maricopa County Sheriff's Office

**TIME REQUIRED**

2.5 – 3.0 hours

**ADVANCED PREPARATION NEEDED FOR DELIVERY**

1. Review trainer guide, PowerPoint presentation and relevant policies and procedures.
2. A meeting should to review and determine how the training will be divided between the co-presenters should occur prior to the scheduled training date.
3. Identify any necessary classroom set-up, equipment or software system needs.
4. Print copies of PowerPoint presentation, ROWBOAT TIP Card (if you do not laminate TIP cards available), Professional Quality of Life (ProQoL) Self-Test, Compassion Fatigue Self-Test: An Assessment and the Life Stress Self-Test.
<table>
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<tr>
<th>MATERIALS</th>
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<tbody>
<tr>
<td>Working with Inmates: Behavioral Health &amp; Cognitive Impairments</td>
<td>Trainer’s Guide &amp; PowerPoint</td>
</tr>
<tr>
<td>ROWBOATS helping individuals with cognitive impairments</td>
<td>ROWBOATS TIP Card</td>
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<tr>
<td>Compass Fatigue Awareness Project</td>
<td>Exercise</td>
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<tr>
<td><a href="http://www.compassionfatigue.org/pages/selftest.html">http://www.compassionfatigue.org/pages/selftest.html</a></td>
<td>Homework</td>
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<tr>
<td>Professional Quality of Life Compassion Satisfaction,</td>
<td>Post Test &amp; Post Test Key</td>
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<td>Compass Fatigue and Secondary Traumatic Stress;</td>
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<td><a href="http://www.proqol.org/uploads/ProQOL_5_English.pdf">http://www.proqol.org/uploads/ProQOL_5_English.pdf</a></td>
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<tr>
<td>Evaluation Tool(S)</td>
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<td>Working with Inmates: Behavioral Health &amp; Cognitive Impairments Post</td>
<td></td>
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<tr>
<td>Test which is comprised of 20 questions with True/False, Multiple</td>
<td></td>
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<tr>
<td>Choice or Short Answer Items.</td>
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