

# Process Measures at the Interface Between the Justice System and Behavioral Health: Advancing Practice and Outcomes

Faye S. Taxman, PhD

Sarah Wurzburg, MA

Kati Habert, MA



**BJA**  
Bureau of Justice Assistance  
U.S. Department of Justice

**JUSTICE★CENTER**  
THE COUNCIL OF STATE GOVERNMENTS  
*Collaborative Approaches to Public Safety*



**Center for Advancing Correctional Excellence!**

CRIMINOLOGY, LAW, & SOCIETY, GEORGE MASON UNIVERSITY

## Introduction

This paper proposes client and system-level process measures intended to gauge how well the justice and behavioral health treatment systems are collaboratively addressing individuals' behavioral health needs. Similar process measures within the behavioral health system have been found helpful in advancing access and retention in treatment services.

An estimated 9 million people with substance use disorders come into contact with the criminal justice system each year in the United States, making it the largest concentration of people with substance use disorders in the country.<sup>1</sup>

The prevalence of people who have a behavioral health disorder in the justice system is higher than in the general population,\* as approximately half have a known substance use disorder<sup>2</sup> and 17 percent have a serious mental disorder (SMD). Seventy-two percent of people in the justice system with SMDs also have a co-occurring substance use disorder.<sup>3</sup>

Both the justice and health systems have a role to play in identifying the needs of and accessing and providing care for people with behavioral health disorders. It is widely recognized that failure of both the justice and health systems to facilitate access to and provide appropriate behavioral health treatment contributes to both negative health and safety outcomes.<sup>4</sup>

---

\* According to SAMHSA's [2014 National Survey on Drug Use and Health \(NSDUH\)](#) an estimated 43.6 million (18.1 percent) Americans who are 18 or older have experienced some form of mental illness. In the past year, 20.2 million adults (8.4 percent) had a known substance use disorder. Of these, 7.9 million people had both a mental disorder and substance use disorder, also known as "[co-occurring mental and substance use disorders](#)." The Substance Abuse and Mental Health Services Administration, "Mental and Substance Use Disorders," retrieved from <http://www.samhsa.gov/disorders> (January 20, 2016).

## **A Distinct Challenge**

People with behavioral health disorders are arrested at disproportionately higher rates than the general population.<sup>5</sup> Despite the high rates of substance use and mental disorders among people who become involved with the criminal justice system, the system has historically been perceived as a referral source rather than a direct provider for behavioral health assessment, treatment services, and recovery management. For nearly 30 years, various efforts to advance its referral and treatment role with integrated care models have been developed, including drug and mental health treatment courts; intensive supervision and treatment; medication-assisted treatments and behavioral therapy; and in-prison treatment programs, such as therapeutic communities,<sup>\*</sup> with continued care after release.

More recently, the Affordable Care Act (ACA) has expanded access to behavioral health treatment for people who are involved with the criminal justice system, including for those who reside in the community, and has helped emphasize the importance of providing behavioral health services from a public safety and public health perspective. The expanded access to behavioral health care and insurance has coincided with the criminal justice systems' reform and reinvestment efforts. Fueling the need for collaborative, multi-system involvement in the provision of these services are the high rearrest, reconviction, and reincarceration rates faced by individuals who leave the criminal justice system. A U.S. Bureau of Justice Statistics study released in 2014 that

---

\* "In general, TCs are drug-free residential settings that use a hierarchical model with treatment stages that reflect increased levels of personal and social responsibility. Peer influence, mediated through a variety of group processes, is used to help individuals learn and assimilate social norms and develop more effective social skills." National Institute on Drug Abuse, *Therapeutic Community*, NIDA Research Report Series (2002): 1–12.  
<http://archives.drugabuse.gov/pdf/RRTherapeutic.pdf>

tracked the recidivism rate for individuals in 30 states following their incarceration in state prisons revealed that more than 70 percent were rearrested for a new crime in the 5 years following their release.<sup>6</sup> Other studies that have examined the post-release period also starkly highlight the health risks that may be involved: In a 2007 report from the New England Journal of Medicine, up to half of individuals who had substance use disorders and were released between 1999 and 2003 from the Washington State Department of Corrections relapsed shortly after release, and faced a much higher risk of death in the community than other state residents.<sup>7</sup>

### **About the Project**

Behavioral health treatment services for people with substance use disorders, mental disorders, and co-occurring substance use and mental disorders are still only available to a small percentage of those involved in the criminal justice system who need them. According to a 2007 study, approximately 10 percent of the daily prison or jail population—and even fewer of those involved with community corrections—have access to services.<sup>8</sup>

The long-standing need to provide appropriate and adequate services drives this publication.\* It is part of *Access to Treatment*, a larger CSG Justice Center project funded by the U.S. Department of Justice’s Bureau of Justice Assistance. The [first part of the project](#) focused on bringing the University of Wisconsin’s Center for Health Enhancement Systems Studies’ NIATx model for process improvement to criminal justice settings.<sup>9</sup> Three pilot sites (DeKalb County, Georgia; Durham County, North

---

\* In 2012, The CSG Justice Center report, [Adults with Behavioral Health Needs Under Correctional Supervision: A Shared Framework for Reducing Recidivism and Promoting Recovery](#) documented the consequence of failing to provide these behavioral health services across the spectrum of justice settings.

Carolina; and the state of Maryland) were selected to use the NIATx model as a guide to improve transitions between the criminal justice system and community substance use disorder treatment organizations. Specific process measures were then developed following lessons learned from the pilot sites to help guide the interaction between the behavioral health and criminal justice systems. These process measures are intended to help gauge how well criminal justice and behavioral health systems are working together to effectively screen, assess, refer, and treat individuals, while better facilitating access, initiation, and engagement in behavioral health services at the points where the criminal justice and behavioral health systems can and should interact. The goal is to advance the use of behavioral health services to reduce recidivism and reduce relapse rates.

## Guiding Principles

The identification of where in the criminal justice process behavioral health services can be integrated is one step toward creating a seamless system of care that addresses both public health and safety issues. The principles that follow are premised on the notion that both systems have a mutual responsibility to work together to maximize the opportunity for individuals to obtain care for their behavioral health needs:\*

1. **Collaboration.** The many different agencies that make up the criminal justice and behavioral health systems in each jurisdiction must work collaboratively to ensure that there is treatment available for people involved in the justice system who have substance use disorders, mental disorders, or co-occurring substance use and mental disorders.

---

\* These principles were developed by the Advisory Board for the *Access to Treatment* project. Please see Appendix B.

2. **Access and Retention.** Jointly facilitating access to and retention in behavioral health services by criminal justice and behavioral health partners is essential for achieving better behavioral health outcomes for people involved with the justice system.
3. **Options for Care.** Individuals in the justice system who have behavioral health needs should have access to the appropriate level of care.
4. **Process Measurement.** Process measures provide the means to assess whether partners (justice, behavior health, or both) have met their goals of providing access to, retaining, and completing the appropriate level of care for people who have behavioral health disorders.
5. **Quality and Joint Accountability.** Process measures can promote quality and joint accountability in the delivery of substance use and mental disorders services.

## History

Performance and quality measurement is a critical area that has been the focal point of many initiatives. Particular attention is currently being paid to creating access to treatment and making sure people receive the right services through appropriate level of treatment or care.\* The basis for these interface process measures are inspired and adapted from process measures that were developed for the substance use disorder treatment system.

In 2000, performance measures for treatment in both private and public health systems were developed by a group of scholars and practitioners funded by the Substance

---

\* Efforts such as the [Washington Circle](#), [NIATx](#), the [National Quality Forum](#), and the [National Outcomes Measures \(NOMS\)](#) have identified key components—access, initiation, engagement, and retention in treatment—that reflect the quality of service delivery.

Abuse and Mental Health Services Administration's (SAMSHA) Center for Substance Abuse Treatment (CSAT) to promote "quality and accountability in the delivery and management of alcohol and other drug (AOD) services by organized systems of care."<sup>10</sup>

Around that time, researchers at the University of Wisconsin's Center for Health Enhancement Systems Studies were developing the NIATx model. It advanced the use of process improvement methods\* by focusing on four aims to promote systems change and innovation for substance use and mental disorders treatment. These aims were to (1) reduce waiting time between first request for service and first treatment session; (2) reduce patient no-show rates; (3) increase admissions to treatment; and (4) increase patients' continuation in treatment from the first to the fourth treatment session.<sup>11</sup>

In 2007, the National Quality Forum (NQF) furthered the work of identifying areas where substance use treatment can be enhanced—ranging from screening to continuing care—in its development of *Standards of Care: Improving the Quality of Addiction Treatment*,<sup>12</sup> Two years later, in an effort to build upon the work of assessing how behavioral health services impact outcomes such as drug use, criminal justice involvement, and housing, SAMHSA collaborated with state substance abuse agencies and the National Association of State Alcohol and Drug Abuse Directors (NASADAD) to develop the National Outcomes Measures (NOMS).<sup>†</sup> SAMHSA has integrated these

---

\* Such as Plan-Do-Study-ACT, or PDSA. See <http://www.ihl.org/resources/pages/tools/plandostudyactworksheet.aspx>.

<sup>†</sup> NOMS are part of an effort to develop a reporting system that can create an accurate and current picture of substance use and mental health services across the country. The NOMS serve as performance targets for state- and federally funded programs around substance use prevention and mental health promotion, early intervention, and treatment services.

measures into their reporting systems, resulting in a more commonplace and frequently reported use of them.<sup>13</sup>

The interface process measures introduced in this paper take this work done by the substance use disorder treatment field a step further in order to examine the interface between the behavioral health and criminal justice system. For more on the history of performance measures for substance use treatment, please see Appendix C.

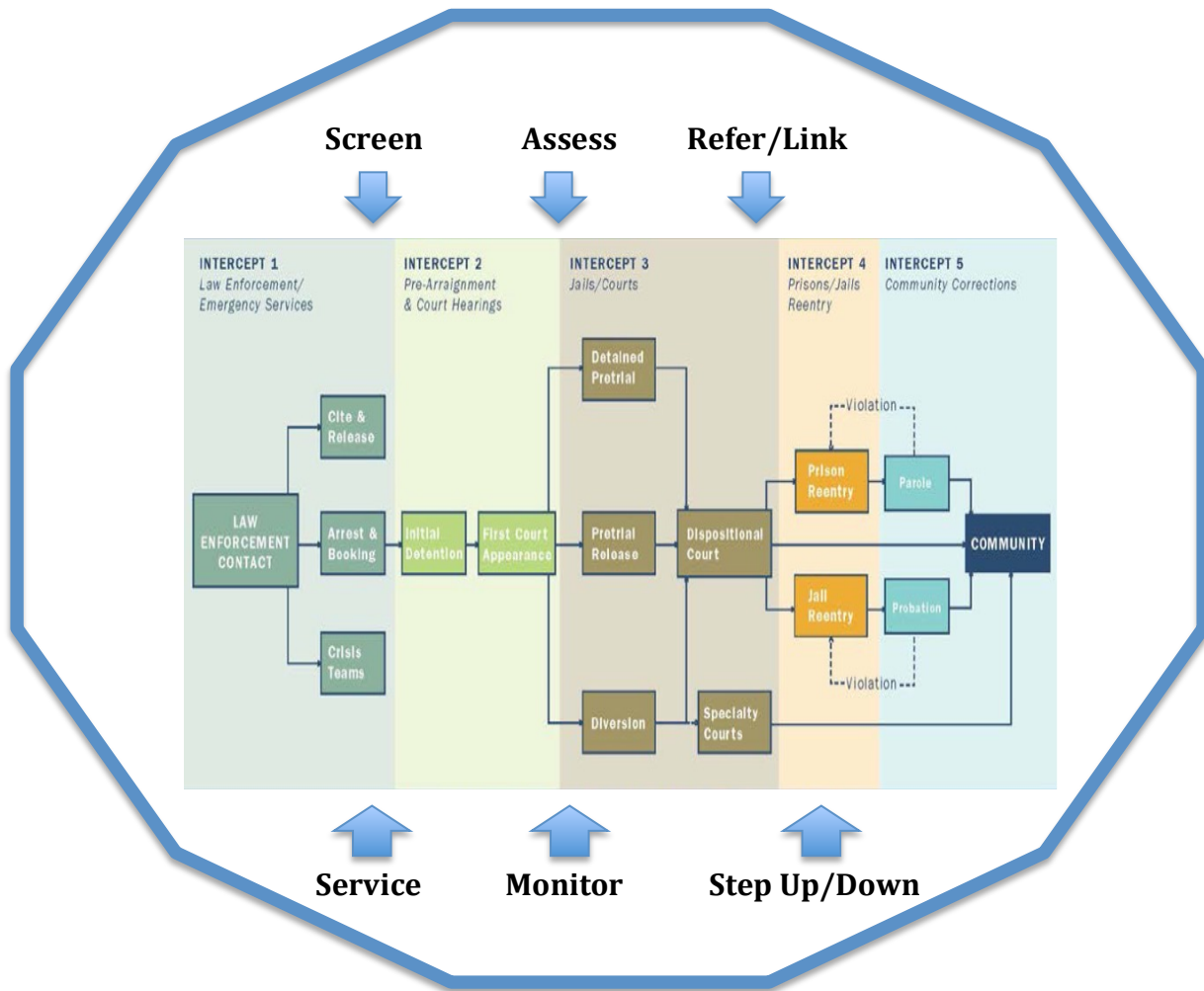
### **Conceptual Framework**

The [Sequential Intercept Model](#) (SIM) illustrates the different points in the criminal justice system where there can be an interception, or intervention, for people with behavioral health needs. [See Figure 1] In other words, the model shows the five major components of the criminal justice system and where, as people progress through the system, there are opportunities for practitioners to (1) identify the people in the system who have behavioral health disorders who would benefit from services; (2) provide those services; (3) work with treatment providers to link to appropriate services as well as work within the justice system to provide appropriate level and type of substance use and/or mental disorders treatment; (4) advance continuum of care practices; and (5) monitor progress with benchmarks to adjust the level of care.

While some people move through all five components of the criminal justice system, most are involved in at least three (e.g., law enforcement, court hearings, and at least one part of the correctional system).



**Figure 1. Sequential Intercept Model of Justice Processing**



The criminal justice system can facilitate the provision of behavioral health care through a relationship with a case management, treatment provider, or a behavioral health provider that operates with or within a justice agency. It is important to note that these components such as “case management” can be independent from the justice system, while also embedded in it.

## Interface Process Measures

When creating criminal justice and behavioral health systems process measures, three types of measures are important to consider: (1) action by systems staff; (2) participation by people involved in the justice system; and (3) recovery management efforts.

Regardless of the intercept, all systems staff, which includes various staff who come into play along the SIM such as law enforcement officials, court officials, probation, and treatment providers, should play a part in identifying people in need of behavioral health services, referring those people to treatment, and monitoring their progress. Staff at various points along the SIM need to have in place the ability to screen, assess, and/or refer for behavioral health disorders, including for both mental and substance use disorders. It should be noted that the identification of people in need of services is the first step, but that further processes are required to engage that person in services, retain them in appropriate care, and ensure that they complete relevant programs, regardless of whether the service is offered by the justice system or offered by external behavioral health providers.

In order for these process measures to be useful, the justice and/or behavioral health administrative management information systems must be able to track a person's involvement in both systems. Ideally, there would be an existing case management or other information system in place that follows the appropriate information sharing agreements and regulations, such as [HIPAA](#) or [42 CFR Part 2](#).

## Set 1: Identification and Referral (Systems Level)

This first set of measures focuses on how to measure the system's ability to identify people with behavioral health needs or disorders and refer them to behavioral health treatment. The goal is to determine if procedures have been developed for coordinating an individual's transfer from one system to another. Staff who implement screening and assessments should be trained in the administration of screening and assessment tools, and should have specialized knowledge and training that meets the agency, state, or local certification standards for behavioral health. Of the below process measures, those marked with an asterisk (\*) are prioritized. [For a full list, please see Appendix A.]

**\*Screening Rate:** Percentage of people (arrestees, defendants, inmates, probationers/parolees) who screened positive for behavioral health issues using a validated screening tool

**\*Clinical Assessment Rate:** Percentage of people (arrestees, defendants, inmates, probationers/parolees) clinically assessed using a validated assessment procedure as needing behavioral health services

**Referral Rate:** Percentage of people (arrestees, defendants, inmates, probationers/parolees) screened or assessed for behavioral health disorders who are referred to a treatment program or linked to services

**\*Initiation:** Percentage of people who had been referred to behavioral health services who start services within 14 days of the screening or clinical assessment<sup>14</sup>

### *Notes on Set 1*

Each measure is based on the number of individuals in the justice system in a given time

period from different points along the SIM,<sup>\*</sup> for example, it can refer to the number of people arrested; the number of people arraigned and therefore part of the formal justice processes; the number of people detained; the number of people on pretrial release; the number of people diverted to formal programming; the number of people incarcerated in jail; the number of people incarcerated in prison; the number of people on probation; the number of people on parole; and the number involved in other community corrections programming. The measures would report on the proportion of those people screened for behavioral health disorders, clinically assessed using a standardized instrument, referred to treatment programming (based on those who are screened or assessed with a need) or services, or those who start services in a timely fashion. “Individuals screened” identifies the population who is potentially in need of behavioral health services, while “individuals referred” to treatment identifies the actual action taken by the justice staff.<sup>†</sup>

It is recognized that there are validated screening and assessment tools that different agencies can use. The use of a validated tool enables the system to ensure that the identification of those in need is accurate. While the measures do not endorse a particular screening and assessment instrument, it recognizes that the presence of a validated tool enhances system performance. Screening for substance use, mental disorders, and criminogenic risk should be standard when justice and behavioral health systems collaborate.

Because the justice system has an influence on when an individual can initiate services—depending on whether the services are provided by the justice system, through

---

<sup>\*</sup> Please refer to Figure 1 for the corresponding intercept number.

<sup>†</sup> The referral/linkage measure does not differentiate between active or passive referral processes. Passive referrals involve providing the name and address of a treatment provider without taking any further steps to assist the individual in obtaining services. Active referral involves making appointments or providing transportation for the individuals to the treatment provider. Given that the goal is to use administrative data sets or to establish rates of processes occurring, a general measure of referral/linkage is recommended.

contractual services, or through a referral process—the initiation rate measure, which is often perceived as a step taken by an individual, is included in these system measures. The sooner services commence for people already engaged in care, the less likely there will be an interruption of services. For those not engaged in care, the greater the potential to improve positive outcomes.

## **Set 2: Engagement and Completion (Individual Level)**

The measures below address participation in and completion of treatment services.

**\*Engagement:** The individual participates in at least two treatment sessions within a 30-day period of initiation<sup>15</sup>

**Retention:** Length of stay in treatment for different levels of care including outpatient treatment, intensive outpatient treatment, therapeutic community, and counseling services<sup>16</sup>

**\*Successful Completion Rate:** Percentage of individuals (arrestees, defendants, inmates, probationers/parolees) who successfully complete treatment

**Medication-Assisted Treatment (MAT) Rate:** Percentage of individuals (arrestees, defendants, inmates, probationers/parolees) screened or assessed for behavioral health disorders who require medication and who are provided medication in a justice setting

**Compliance with Treatment Plan:** Percentage of individuals who are in compliance with their treatment plans developed by the behavioral health specialist and the individual

### *Notes on Set 2*

Engagement in treatment is an important variable<sup>17</sup> and is an indicator of early commitment to making changes in drug use behaviors or addressing mental health

challenges.

Research from treatment studies have found that individuals who participate in treatment services for at least 90 days have better outcomes than those that do not participate for such a duration in treatment services.<sup>18</sup>

“Completion” of treatment varies widely and often refers to time spent in a program. In some programs, it refers to making clinical progress or improved functionality. Regardless, the completion of a program is a positive indicator that the person has been committed to the treatment regime for a specific period of time.

The provision of medication-assisted treatment is another measure for those with behavioral health disorders, and includes treatment for opioid, alcohol, or psychiatric disorders. The justice system should provide medication—based on the screening or assessment of behavioral health disorders that require or respond to medications—to people with specific disorders or ensure that the individual can continue the use of the medication(s) during their engagement with the justice system. The provision of medications is designed to stabilize individuals with substance use or mental health disorders, to reduce recidivism for people who are opioid dependent, and to provide evidence-based treatments.

Compliance with a treatment plan is an important measure of how well systems and individuals are working together to achieve positive individual outcomes. Adherence to the treatment plans is a means to advance positive outcomes.

### Set 3: Recovery Management (Individual Level)

The other set of individual-level measures refer to the continuum of care concept and indicate the rate at which individuals initiate services or are involved in behavioral health services.

- **\*Continuum of Care:** Percentage of individuals who transitioned from one program to another (step up or step down) within 30 days
- **Continuity of Care:** Percentage of individuals who transitioned from one phase of programming to another within 30 days
- **Transitioning of Care:** Percentage of individuals who moved from one type of programming (i.e. substance use or mental disorder) to another, such as vocational or educational services

#### *Notes on Set 3*

Continuum of care in this context refers to individuals who have transitioned from one program to another within a 12-month period of time. This transition rate is important because it signifies progress at the client level and that individuals can benefit from other services as they stabilize in the community.\* The continuum of care measure also indicates that the systems are able to refer to other services either at the same agency or a different agency; for example, an individual might transition from a prison-based therapeutic community to a community-based intensive outpatient treatment program. Continuity of care also refers to phases within programs. For example, if a person were involved in a mental health court that had three different phases of treatment, this

---

\* Continuum of care is different than continuity of care. Continuum refers to movement across programs whereas continuity of care refers to movement within programs.

measure would track the person's progression from one phase of treatment to another.

Transitioning of care refers to tracking an individual's referrals to programming outside of behavioral health care, such as into a vocational training program.

#### **Set 4: Access Measures and Systematic Responsivity (Systems Level)**

While individual-level process measures are focused on facilitating better individual outcomes, other factors can have an impact on an individual's ability to access and retain services. These factors are often outside of the parameters of the justice system or even an individual treatment program. Instead they refer to whether the jurisdiction has the appropriate programming available to address the need profile(s) of an individual.<sup>19</sup>

- **\*Uniform Screening Protocols:** A core set of screening processes and criteria accepted by justice and treatment agencies to identify individuals with substance use and mental disorders.
- **Insurance Enrollment:** Percentage of individuals involved in the justice system who are enrolled in health insurance
- **Enrolled in Insurance at Time of Release:** Percentage of individuals released from prison or jail who are enrolled in health insurance
- **Responsivity Rate:** Percentage of individuals involved in the justice system who can access appropriate services for their specific needs
- **Availability of Programming:** Capacity of the system to provide appropriate levels of care for individuals (in prisons, probation/parole, jail, or community settings) who have specific needs



- **Access Rate:** Percentage of individuals who can access a given program
- **Participation Rate:** Percentage of individuals who partake in programs during their period of incarceration or supervision

*Notes on Set 4*

A uniform screening protocols (USP) specifies the criteria used to identify behavioral health conditions. This ensures the ability of justice and health organizations to determine that a certain type of behavioral health condition warrants treatment. It also affects the funding and resources available to provide behavioral health services. By having a USP, it is possible to develop rates of behavioral health needs at the jurisdictional level.

Another system measure is the percentage of individuals in the justice system who are covered by health insurance. As changes occur in behavioral health services, individuals may have greater access to care through health insurance coverage than through publically funded programs. Including this measure allows for the assessment of how financial barriers to health care can affect access to and retention in treatment.

Systemic responsivity exists when the services available in a jurisdiction or system are appropriate to the behavioral health needs of an individual. It facilitates an emphasis on issues such as dosage (amount of treatment provided), appropriateness of treatment available, and integrated care. There is typically an overabundance of low-intensive treatment services (e.g., counseling, group therapy) for individuals involved with the justice system when there is actually a need for more intensive services, such as residential treatment, intensive outpatient services, and other medication-assisted therapies.<sup>20</sup> This can result in individuals being placed in inappropriate services or

receiving no services, which contributes to negative outcomes. Systemic responsiveness ensures that the distribution of behavioral health services matches the specific behavioral health and criminal justice risk of individuals. It also provides for the ability to conduct gap analyses to identify where services are needed or where surpluses exist.

The three subsequent measures are subsets of systemic responsiveness: the availability rate, access rate, and participation rate. The availability rate at the system level indicates the percentage of justice settings (e.g., prison, jails, probation/parole, pretrial agencies, etc.) that offer different types of behavioral health programs. Access rates refer to system's capacity to serve individuals with specific needs who could enter a given program. Finally, the participation rate refers to the percentage of individuals who participate in programs during their period of incarceration or supervision.

Through the use of the set 4 measures a jurisdiction can begin to consider if there is equal access to behavioral health services. Equal access refers to the ability to provide appropriate behavioral health services that meet the needs of individuals regardless of race, ethnicity, gender, or sexual orientation. The system should have the capacity to provide for specific responsiveness (tailored to the need of individuals) to promote better outcomes. In some systems, for example, there are higher access rates for individuals by gender or racial background. These higher rates should be monitored to ensure that the system is flexible and culturally competent to meet the needs of different types of individuals who are in need of behavioral health services.

## Using the Process Measures: A County Example

The following example of a county with an overpopulated jail is designed to illustrate how the measures can be used to understand the impact of behavioral health services on client-level outcomes.

The county has case managers who assess people who are detained in jail. The jail has an average daily population of 10,000 individuals. Their rates are as follows:

- **Screening:** The jail, on average, screens 1,000 people a year (a rate of 10 percent of the daily population).
- **Assessment:** The local county health department conducts an assessment for 500 people a year who have been in screened in jail (a rate of 5 percent of the daily population).
- **Referral:** The case managers refer approximately 500 people a year for behavioral health services (a rate of 5 percent of the daily population).
- **Initiation:** 100 people a year begin post-release behavioral health services (an initiation rate of 20 percent of those who are referred).
- **Engagement:** Of those who initiate services, 15 people participate in two services within 30 days of release from jail (a rate of 15 percent of those referred).
- **Completion:** Of those who initiate services, 10 people complete services (a rate of 10 percent of those starting services).

At the system level, the following measures depict the system's ability to be responsive to individuals' unique needs:

- **Uniformed Screening Protocol:** The jurisdiction has a core set of screening

criteria accepted by justice agencies to screen for health coverage and behavioral health disorders, which means that the screening and assessment procedures use different foundations. The goal is to facilitate universal screening in all intercepts and areas of care.

- **Enrolled in Insurance:** Percentage of individuals in the jail who are enrolled in health insurance (20 percent)
- **Responsivity Rate:** Based on the risk-need profile of the individuals involved in the justice system, 25 percent are placed in a level of care appropriate for their needs.
- **Availability of Programming:** The jail has the capacity, given their formal programming and volunteer services, to provide treatment to 30 people a day or about 480 people each year, which is a rate of 10 percent (assuming half need behavioral health services).
- **Access Rate:** Given the operations of the jail, approximately 20 individuals participate in programming (an access rate of 4 percent).
- **Participation Rate:** Given the operations of the jail, in a given year 100 people have participated in programming (a 25-percent participation rate).

Based upon the data collected by the interface process measures, the county system has information that will help them assess their system and how to provide better referrals and care for individuals with behavioral health disorders. For example, the county now knows the assessment rate in their jail is 5 percent. The county can use 5 percent as its target and work to improve the rate to 10 percent over the next year. The initiation rate of 20 percent into treatment in the community indicates that there may be a

need to create stronger ties to community-based treatment providers to do outreach into the jail or to discuss how the jail, the treatment provider, and community supervision agency (if applicable) can help to increase the amount of individuals who get treatment in the community. The jail is able to provide programming to 10 percent of individuals in their system per year. How is it decided which people will receive programming? The county jail has the opportunity to review their protocols and make sure that the individuals with highest risk of recidivism and highest needs have access to it. It also might be possible for the county to reallocate resources or increase funding in order to provide additional programming. These are just a few examples of how the interface process measures could be used by the county to improve their efforts to provide behavioral health services for people involved in the justice system. Overall, the rates can be used to gauge improvements in the delivery of services over time, as well as in dashboards to assess the performance of the behavioral health and justice systems.

## **Next Steps and Implications for Future Work**

Federal and state officials, researchers, executives of associations and treatment organizations, and other stakeholders met twice over the course of a year to discuss these interface process measures. While no consensus has been reached yet on specific measures—since they need to be tested by jurisdictions to ensure their utility—the group has agreed that working toward the development of such measures between the criminal justice and behavioral health systems is an important step forward to improve systems of care. Systems coordination is critically needed at a time when people involved with the justice system have more access to health insurance and the range of behavioral health

services is expected to increase. More attention should be given to tracking whether or not these goals are being achieved. These process measures can provide indicators as to whether an individual is partaking in services in a manner that should facilitate positive outcomes and whether the justice-behavioral health system is capable of delivering the appropriate services. Thus, building on the logic of “what gets measured gets done,” the proposed measures can facilitate improvements in the interface between the systems to increase positive outcomes at individual and systems levels.

Now that the process measures have been articulated, the next step would be to conduct a pilot study for the interface process measures that would allow the measures to be tested in several jurisdictions. Since the process measures are designed to use existing administrative database or multiple administrative databases, part of the work of a pilot could be to develop the linking algorithms that will produce measures from justice and/or health databases. The creation of these measures is likely to require a link between court databases (e.g., dates of arrests, court hearings, etc.) or correctional databases and behavioral health databases, which include key dates regarding treatment initiation and completion. These linked databases could then be used as the basis for the various measures. Working with several jurisdictions to construct these measures would allow for the opportunity to determine the core minimum data requirements that a jurisdiction may need to construct and maintain the interface process measures. If jurisdictions were to take up these measures, they could be used as benchmarks within a jurisdiction for target goals for systems improvements.

## ENDNOTES

1. Taxman, Faye S., Matthew L. Perdoni, and Lana D. Harrison. "Drug Treatment Services For Adult Offenders: The State Of The State," *Journal of Substance Abuse Treatment* 32, no. 3 (Mar 2008): 239-254. DOI: [10.1016/j.jsat.2006.12.019](https://doi.org/10.1016/j.jsat.2006.12.019); Substance Abuse and Mental Health Services Administration, *Results from the 2012 National Survey on Drug Use and Health: Summary of National Findings*, NSDUH Series H-48, HHS Publication No. (SMA) (2014): 14-4863. <http://www.samhsa.gov/data/sites/default/files/NSDUHresultsPDFWHTML2013/Web/NSDUHresults2013.pdf>.
2. Compton, Wilson M., Deborah Dawson, Sarah Q. Duffy, and Bridget F. Grant, "The Effect Of Inmate Populations On Estimates Of DSM-IV Alcohol And Drug Use Disorders In The United States," *American Journal of Psychiatry* 167, no. 4 (Apr 2010): 473-4. DOI: [10.1176/appi.ajp.2009.09081087](https://doi.org/10.1176/appi.ajp.2009.09081087).
3. Kessler, R.C., W.T. Chiu, O. Demler, E.E. Walters, "Prevalence, Severity, And Comorbidity Of Twelve-Month DSM-IV Disorders In The National Comorbidity Survey Replicatio," *Archives of General Psychiatry* 62, no. 6 (Jun 2005): 612-27. <http://www.ncbi.nlm.nih.gov/pubmed/15939839>; Steadman, Henry, Fred C. Osher, Pamela C. Robbins, Brian Case, and Steven Samuels, "Prevalence of Serious Mental Illness Among Jail Inmates," *Psychiatric Services* 60, no. 6 (Jun 2009): 761-65. DOI: <http://dx.doi.org/10.1176/ps.2009.60.6.761>; Abram, K. M. and L.A. Teplin, "Co-Occurring Disorders Among Mentally Ill Jail Detainees," *American Psychologist* 46, no. 10 (Oct 1991): 1036-1045. <http://www.ncbi.nlm.nih.gov/pubmed/1746771>.
4. Kamala Mallik-Kane and Christy A. Visher, *Health and Prisoner Reentry: How Physical, Mental, and Substance Abuse Conditions Shape the Process of Reintegration*, Washington: The Urban Institute (Feb 2008) <http://www.urban.org/sites/default/files/alfresco/publication-pdfs/411617-Health-and-Prisoner-Reentry.PDF>.
5. Dan Aufderheide, "Mental Illness in America's Jails and Prisons: Toward a Public Safety/Public Health Model," Health Affairs Blog (April 1, 2014) <http://healthaffairs.org/blog/2014/04/01/mental-illness-in-americas-jails-and-prisons-toward-a-public-safetypublic-health-model/>.
6. U.S Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, *Recidivism of Prisoners Released in 30 States in 2005: Patterns from 2005 to 2010*, by Matthew R. Durose, Alexia D. Cooper, and Howard N. Snyder, Special Report NCJ 244205 (Washington, DC, 2014). DOI: <http://www.bjs.gov/index.cfm?ty=pbdetail&iid=4987>

7. Binswanger Ingrid A., Marc F. Stern, Richard A. Deyo, Patrick J. Heagerty, Allen Cheadle, Joann G. Elmore, Thomas D. Koepsell, "Release From Prison: A High Risk Time For Death," *New England Journal of Medicine* 365, no. 2 (Jan 2007): 157-65. DOI: [10.1056/NEJMs064115](https://doi.org/10.1056/NEJMs064115); author reply 2007 Apr.; 356:1785-1787.
8. Faye S. Taxman, Matthew L. Perdoni, and Lana D. Harrison, "Drug Treatment Services For Adult Offenders: The State Of The State," *Journal of Substance Abuse Treatment* 32, no. 3: 239-254. DOI: [10.1016/j.jsat.2006.12.019](https://doi.org/10.1016/j.jsat.2006.12.019).
9. "The NIATx Model." *NIATx*. Accessed January 11, 2016. <http://www.niatx.net/Content/ContentPage.aspx?PNID=1&NID=8>.
10. "Mission of the Washington Circle." *The Washington Circle*. Accessed January 11, 2016. <http://www.washingtoncircle.org/mission.html>.
11. "The NIATx Model: The Four Aims." *NIATx*. Accessed January 11, 2016, <http://www.niatx.net/Content/ContentPage.aspx?NID=130>.
12. National Quality Forum, *National Standards for the Treatment of Substance Use Conditions* (Philadelphia: Treatment Research Institute, 2007), [http://www.tresearch.org/download/policy\\_briefs/NQF\\_Standards\\_Summary.pdf](http://www.tresearch.org/download/policy_briefs/NQF_Standards_Summary.pdf).
13. "NOMS 101: National Outcomes Measures." *Substance Abuse and Mental Health Services Administration*. Accessed January 11, 2016. <http://media.samhsa.gov/co-occurring/topics/data/nom.aspx>.
14. Garnick, Deborah W., Margaret T. Lee, Constance M. Horgan, Andrea Acevedo, and the Washington Circle Public Sector Workgroup, "Adapting Washington Circle Performance Measures for Public Sector Substance Abuse Treatment Systems," *Journal of Substance Abuse Treatment* 36, no. 3 (Apr 2009): 265-277. DOI: [10.1016/j.jsat.2008.06.008](https://doi.org/10.1016/j.jsat.2008.06.008).
15. Garnick, Deborah W., Margaret T. Lee, Constance M. Horgan, Andrea Acevedo, and the Washington Circle Public Sector Workgroup, "Adapting Washington Circle Performance Measures," 265-277.
16. "NOMS 101: National Outcomes Measures," *Substance Abuse and Mental Health Services Administration*. Accessed January 11, 2016. Retrieved from: <http://media.samhsa.gov/co-occurring/topics/data/nom.aspx>.
17. Garnick, Deborah W., Constance M. Horgan, Andrea Acevedo, Margaret T. Lee, Lee Panas, Grant A. Ritter, Robert Dunigan, Alfred Bidorini, Kevin Campbell, Karin Haberlin, Alice Huber, Dawn Lambert-Wacey, Tracey Leeper, Mark Reynolds, David Wright, "Criminal Justice Outcomes After Engagement In Outpatient Substance Abuse Treatment," *Journal of Substance Abuse Treatment* 46, no. 3 (Mar 2014): 295-305. DOI: [10.1016/j.jsat.2013.10.005](https://doi.org/10.1016/j.jsat.2013.10.005).



18. Hubbard, Robert L., Mary Ellen Marsden, J. Valley Rachal, Henrick J. Harwood, Elizabeth R. Cavanaugh, E. R., and Harold M. Ginzburg, "Drug Abuse Treatment: A National Study Of Effectiveness," *The New England Journal of Medicine* 322 (1990): 1676-1677. DOI: 10.1056/NEJM199006073222319
19. Taxman, Faye S., "Second Generation of RNR: The Importance of Systemic Responsivity in Expanding Core Principles of Responsivity," *Federal Probation* 78, no. 2 (2014): 79. <http://www.uscourts.gov/statistics-reports/publications/federal-probation-journal/federal-probation-journal-september-2014>; Taxman, Faye S., Matthew Perdoni, and Michael Caudy, "The Plight Of Providing Appropriate Substance Abuse Treatment Services To Offenders: Modeling The Gaps In Service Delivery," *Victims & Offenders* 8, no. 1 (2013): 70-93. DOI: 10.1080/15564886.2012.747459
20. Taxman, Perdoni, and Caudy, "The Plight Of Providing Appropriate Substance Abuse Treatment," 70–93.

# Appendix A

## Process Measures at the Interface Between Justice Systems and Behavioral Health: Advancing Practice and Outcomes

*Access to Treatment: Bringing NIATx to Corrections*

### *Guiding Principles*

6. **Collaboration.** The many different agencies that make up the criminal justice and behavioral health systems in each jurisdiction must work collaboratively to ensure that there is treatment available for people involved in the justice system who have substance use disorders, mental disorders, or co-occurring substance use and mental disorders.
7. **Access and Retention.** Jointly facilitating access to and retention in behavioral health services by criminal justice and behavioral health partners is essential for achieving better behavioral health outcomes for people involved with the justice system.
8. **Options for Care.** Individuals in the justice system who have behavioral health needs should have access to the appropriate level of care.
9. **Process Measurement.** Process measures provide the means to assess whether partners (justice, behavior health, or both) have met their goals of providing access to, retaining, and completing the appropriate level of care for people who have behavioral health disorders.
10. **Quality and Joint Accountability.** Process measures can promote quality and joint accountability in the delivery of substance use and mental disorders services.

### *Interface Process Measures*

#### **Set 1: Identification and Referral (Systems Level)**

- **\*Screening Rate:** Percentage of people (arrestees, defendants, inmates, probationers/parolees) who screened positive for behavioral health issues using a validated screening tool\*
- **\*Clinical Assessment Rate:** Percentage of people (arrestees, defendants, inmates, probationers/parolees) clinically assessed using a validated assessment procedure as needing behavioral health services
- **Referral Rate:** Percentage of people (arrestees, defendants, inmates, probationers/parolees) screened or assessed for behavioral health disorders who are referred to a treatment program or linked to services
- **\*Initiation:** Percentage of people who had been referred to behavioral health services who start services within 14 days of the screening or clinical assessment†

#### **Set 2: Engagement and Completion (Individual Level)**

- **\*Engagement:** The individual participates in at least two treatment sessions within a 30-day period of initiation‡

---

\* Of the below process measures, those marked with an asterisk (\*) are prioritized

† Garnick, Lee, Horgan, and Acevedo, "Adapting Washington Circle Performance Measures," 265–77.

‡ Garnick, Lee, Horgan, and Acevedo, "Adapting Washington Circle Performance Measures," 265–77.

- **Retention:** Length of stay in treatment for different levels of care including outpatient treatment, intensive outpatient treatment, therapeutic community, and counseling services\*
- **\*Successful Completion Rate:** Percentage of individuals (arrestees, defendants, inmates, probationers/parolees) who successfully complete treatment
- **Medication-Assisted Treatment (MAT) Rate:** Percentage of individuals (arrestees, defendants, inmates, probationers/parolees) screened or assessed for behavioral health disorders who require medication and who are provided medication in a justice setting
- **Compliance with Treatment Plan:** Percentage of individuals who are in compliance with their treatment plans developed by the behavioral health specialist and the individual

### Set 3: Recovery Management (Individual Level)

- **\*Continuum of Care:** Percentage of individuals who transitioned from one program to another (step up or step down) within 30 days
- **Continuity of Care:** Percentage of individuals who transitioned from one phase of programming to another within 30 days
- **Transitioning of Care:** Percentage of individuals who moved from one type of programming (i.e. substance use or mental disorder) to another, such as vocational or educational services

### Set 4: Access Measures and Systematic Responsivity (Systems Level)

- **\*Uniform Screening Protocols:** A core set of screening processes and criteria accepted by justice and treatment agencies to identify individuals with substance use and mental disorders.
- **Insurance Enrollment:** Percentage of individuals involved in the justice system who are enrolled in health insurance
- **Enrolled in Insurance at Time of Release:** Percentage of individuals released from prison or jail who are enrolled in health insurance
- **Responsivity Rate:** Percentage of individuals involved in the justice system who can access appropriate services for their specific needs
- **Availability of Programming:** Capacity of the system to provide appropriate levels of care for individuals (in prisons, probation/parole, jail, or community settings) who have specific needs
- **Access Rate:** Percentage of individuals who can access a given program
- **Participation Rate:** Percentage of individuals who partake in programs during their period of incarceration or supervision

---

\* “NOMS 101: National Outcomes Measures,” *Substance Abuse and Mental Health Services Administration*, Accessed January 11, 2016. <http://media.samhsa.gov/co-occurring/topics/data/nom.aspx>.

## Appendix B

**Participant List for Access to Treatment: Bringing NIATx to Corrections Project  
Interface Process Measures Meeting  
January 29, 2015  
Washington, DC**

**Steve Allen\***

Director, Behavioral Health Services  
Minnesota Department of Corrections  
[Steven.allen@state.mn.us](mailto:Steven.allen@state.mn.us)

**Danica Binkley, JD**

Senior Policy Advisor for Criminal Justice and  
Health Policy  
Bureau of Justice Assistance, Office of Justice  
Programs  
U.S. Department of Justice  
[Danica.Binkley@usdoj.gov](mailto:Danica.Binkley@usdoj.gov)

**Emily Buckler**

Publications Editor  
Communications Division  
The Council of State Governments Justice  
Center  
[ebuckler@csg.org](mailto:ebuckler@csg.org)

**Cynthia Caporizzo**

Senior Policy Advisor for Criminal Justice  
Executive Office of the President  
Office of National Drug Control Policy  
Washington, D.C.  
[ccaporizzo@ondcp.eop.gov](mailto:ccaporizzo@ondcp.eop.gov)

**Jac A. Charlier**

Director of Consulting and Training  
TASC, Inc.  
Chicago, IL  
[jcharlier@tasc.org](mailto:jcharlier@tasc.org)

**David A. D'Amora**

Director of Special Projects  
The Council of State Governments Justice  
Center  
New York  
[ddamora@csg.org](mailto:ddamora@csg.org)

**Tony Folland**

Clinical Services Manager  
Division of Alcohol & Drug Abuse Programs  
Vermont Department of Health  
[Anthony.Folland@state.vt.us](mailto:Anthony.Folland@state.vt.us)

**Kati Habert**

Deputy Director, County Program  
The Council of State Governments Justice  
Center  
[khbert@csg.org](mailto:khbert@csg.org)

**Rick Harwood**

Deputy Executive Director/Director of Research  
and Program Applications  
National Association of State Alcohol and Drug  
Abuse Directors (NASADAD)  
Washington, DC  
[Rharwood@nasadad.org](mailto:Rharwood@nasadad.org)

**Kim Johnson**

Co-Deputy Director, NIATx  
Center for Health Enhancement Systems Studies  
University of Wisconsin-Madison  
[kimberly.johnson@chess.wisc.edu](mailto:kimberly.johnson@chess.wisc.edu)

**Ron Manderscheid, PhD**

Executive Director  
The National Association of County  
Behavioral Health and Developmental  
Disability Directors  
Washington, DC  
[rmanderscheid@nacbhd.org](mailto:rmanderscheid@nacbhd.org)

**Amy Murphy**

Project Director  
Center for Advancing Correctional Excellence  
George Mason University  
[amurph10@gmu.edu](mailto:amurph10@gmu.edu)

---

\* Became a senior policy advisor for state initiatives at the  
CSG Justice Center in March 10, 2015.

**Kamala Mallik-Kane**

Justice Policy Center  
Urban Institute  
Washington, DC  
[KKane@urban.org](mailto:KKane@urban.org)

**Kenneth Robertson**

Lead Public Health Advisor  
Substance Abuse and Mental Health Services  
Administration (SAMHSA)  
U.S. Department of Health and Human Services  
Rockville, MD  
[kenneth.robertson@samhsa.hhs.gov](mailto:kenneth.robertson@samhsa.hhs.gov)

**Faye S. Taxman, PhD**

Professor, Criminology, Law & Society  
Department  
Director, Center for Advancing Correctional  
Excellence  
George Mason University  
[ftaxman@gmu.edu](mailto:ftaxman@gmu.edu)

**Becky Vaughn**

Vice President of Addictions  
The National Council for Behavioral Health  
Washington, DC  
[beckyv@thenationalcouncil.org](mailto:beckyv@thenationalcouncil.org)

**Nastassia Walsh**

Program Manager  
National Association of Counties  
Washington, DC  
[NWalsh@naco.org](mailto:NWalsh@naco.org)

**Greg Warren**

Behavioral Health Consultant  
Former Director  
Baltimore Substance Abuse Systems  
Baltimore, MD  
[gregcwarren@yahoo.com](mailto:gregcwarren@yahoo.com)

**Sarah Wurzburg**

Grantee Technical Assistance Manager  
Behavioral Health Program  
The Council of State Governments Justice  
Center  
[swurzburg@csg.org](mailto:swurzburg@csg.org)

## Appendix C

### Substance Use Treatment Performance Measures Timeline and Criminal Justice Research Update

#### Substance Use Treatment Performance Measures Timeline

Several larger systematic developments that have occurred in the substance use field have shaped perceptions of the quality of services. Initiatives that have advanced the field to improve service delivery include (a) the Washington Circle, (b) the National Outcomes Measures, (c) the National Quality Forum, and (d) NIATx. Regrettably, fewer infrastructure and systems are in place for mental health agencies, and none exist for the interface between the justice and behavioral health systems.

Initiative	Date Began	Brief Summary	Link to Additional Information
The Washington Circle	2000	A group of scholars and practitioners funded by the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Treatment (CSAT) developed performance measures for treatment systems in both private and public health systems to "promote quality and accountability in the delivery and management of alcohol and other drug (AOD) services by organized systems of care." <sup>*</sup>	<a href="http://washingtoncircle.org/mission.htm">http://washingtoncircle.org/mission.htm</a>
NIATx	2003	NIATx advanced the use of process improvement methods (such as Plan-Do-Study-ACT, or PDSA) by focusing on four aims to promote systems change and innovation. These aims are (1) reducing waiting time between first request for service and first treatment session; (2) reducing patient no-show rates; (3) increasing admissions to treatment; and (4) increasing patients' continuation in treatment from the first to the fourth treatment session. <sup>†</sup>	<a href="http://www.niatx.net/Content/ContentPage.aspx?PNID=1&amp;NID=8">http://www.niatx.net/Content/ContentPage.aspx?PNID=1&amp;NID=8</a>

<sup>\*</sup> "Mission of the Washington Circle," *The Washington Circle*, Accessed January 11, 2016. <http://www.washingtoncircle.org/mission.html>.

<sup>†</sup> "The NIATx Model: The Four Aims," *NIATx*, accessed January 11, 2016.

The National Quality Forum (NQF)	2007	NQF Standards of Care: Improving the Quality of Addiction Treatment (2007) furthered work on the identification of various areas where treatment can be enhanced, ranging from screening to continuing care.	<a href="http://www.tresearch.org/download/policy_briefs/NQF_Standards_Summary.pdf">http://www.tresearch.org/download/policy_briefs/NQF_Standards_Summary.pdf</a>
The National Outcomes Measures (NOMS)	2008	NOMS builds on efforts to assess how behavioral health services impact outcomes such as drug use, criminal justice involvement, and housing stability. SAMSHA has integrated these measures into their reporting systems, resulting in a more commonplace and frequent reported use of NOMS.	<a href="http://media.samhsa.gov/co-occurring/topics/data/nom.aspx">http://media.samhsa.gov/co-occurring/topics/data/nom.aspx</a>

### Criminal Justice Research Update

In 1990 the Bureau of Justice Statistics (BJS) spearheaded an effort to define performance measures for each part of the justice system as a means to outline a foundation for determining the quality of justice.\* Its subsequent collection of white papers outlined key measures that can be used to assess how well different justice subsystems were functioning. Lawrence A. Greenfeld, then acting director of BJS, noted:

Unanimous agreement exists that the justice system ought to be efficient, effective, and fair. Less accord, however, exists about how best to secure these essential qualities or how to measure whether they have been achieved. Apart from the obvious problem of determining the measurement criteria for a particular performance expectation, there is a more difficult subsequent problem of determining what weight to give to the findings and what changes need to be made to resolve the gap between expectation and performance. Unlike marks on a ruler, criminal justice measures are not neutral standards but are factors that enter into the processes being analyzed—identifying relative degrees of improvement in fairness in sentencing, for example, would still indicate that the sentencing process was giving weight to information not legally relevant (1993: v).

Several demonstration projects are underway or have been completed to test out the use of quality improvement processes and improve service delivery for individuals involved with the criminal justice system who have behavioral health disorders. Most notable is the work that the Criminal Justice Drug Abuse Treatment Studies (CJ-DATS2) undertook to advance the use of contingency management in probation agencies<sup>†</sup> in an effort to increase the uptake of HIV

---

\* U.S Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, *Performance Measures for the Criminal Justice System*, by John J. DiIulio, Jr., Geoffrey P. Alpert, Mark H. Moore, George F. Cole, Joan Petersilia, Charles H. Logan, and James Q. Wilson, Special Report NCJ 143505. Washington, DC, October 1993.  
<http://www.bjs.gov/content/pub/pdf/pmcjs.pdf>.

<sup>†</sup> Rudes, Danielle S., “Getting Technical: Parole Officers’ Continued Use of Technical Violations Under California’s Parole Reform Agenda,” *Journal of Crime & Justice* 35, no. 2 (April 2012): 249-268. DOI: 10.1080/0735648X.2012.677572

testing and treatment and prevention efforts,<sup>\*</sup> in addition to advancing the use of medication-assisted treatments by criminal justice organizations.<sup>†</sup> These efforts were typically done to examine what features of process improvement are important to improve service delivery for specific problem areas.

---

<sup>\*</sup> Pearson, Frank S., Michael S. Shafer, Richard Dembo, Graciela del Mar Vega-Debién, Jennifer Pankow, Jamieson L. Duvall, Steven Belenko, Linda K. Frisman, Christy A. Visher, Michele Pich, Yvonne Patterson, “Efficacy of a Process Improvement Intervention on Delivery of HIV Services: A Multi-Site Trial,” *American Journal of Public Health* 104, no. 12 (April 2014): 2385-2391. DOI: 10.2105/AJPH.2014.302035

<sup>†</sup> Friedmann, Peter D., Donna Wilson, Hannah K. Knudsen, Lori J. Ducharme, Wayne N. Welsh, Linda Frisman, Kevin Knight, Hsiu-Ju Lin, Amy James, Carmen E. Albizu-Garcia, Jennifer Pankow, Elizabeth A. Hall, Terry F. Urbine, Sami Abdel-Salam, Jamieson L. Duvall, and Frank J. Vocci, “Effect of an Organizational Linkage Intervention on Staff Perceptions of Medication-Assisted Treatment and Referral Intentions in Community Corrections,” *Journal of Substance Abuse Treatment* 50, (Oct 2014): 50 – 58. DOI: <http://dx.doi.org/10.1016/j.jsat.2014.10.001>