

EVIDENCE-BASED RESOURCE GUIDE SERIES

Best Practices for Successful Reentry From Criminal Justice Settings for People Living With Mental Health Conditions and/or Substance Use Disorders



SAMHSA
Substance Abuse and Mental Health
Services Administration

Best Practices for Successful Reentry From Criminal Justice Settings for People Living With Mental Health Conditions and/or Substance Use Disorders

Acknowledgments

This report was prepared for the Substance Abuse and Mental Health Services Administration (SAMHSA) under contract number HHSS283201700001 / 75S20319F42002 with SAMHSA, U.S. Department of Health and Human Services (HHS). Donelle Johnson served as contracting officer representative.

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Recommended Citation

Substance Abuse and Mental Health Services Administration (SAMHSA). *Best Practices for Successful Reentry From Criminal Justice Settings for People Living With Mental Health Conditions and/or Substance Use Disorders*. SAMHSA Publication No. PEP23-06-06-001. Rockville, MD: National Mental Health and Substance Use Policy Laboratory. Substance Abuse and Mental Health Services Administration, 2023.

Originating Office

National Mental Health and Substance Use Policy Laboratory, Substance Abuse and Mental Health Services Administration, 5600 Fishers Lane, Rockville, MD 20857, Publication No. PEP23-06-06-001. Released 2023.

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Publication No. PEP23-06-06-001

Released 2023

Abstract

Individuals living with mental health conditions and/or substance use disorders reentering the community from jail or prison are at high risk for a recurrence of symptoms and reengagement with the criminal justice system. Therefore, there is a need to identify and assess the effectiveness of reentry programs for individuals living with health conditions who are incarcerated. With the necessary resources and evidence-based practices, criminal justice personnel, clinicians/practitioners, and community-based health and support staff can promote successful community reentry.

Individuals reentering the community may require support, such as treatment, recovery services, health insurance (including Medicaid/Medicare and other government benefits), housing, employment, and transportation. This guide examines interventions and models to support individuals living with mental health conditions and/or substance use disorders who are reentering the community from jail or prison. It identifies the types of interventions found to be the most successful in reducing recidivism, preventing a recurrence of symptoms, and improving overall well-being.



**MESSAGE FROM THE ASSISTANT SECRETARY
FOR MENTAL HEALTH AND SUBSTANCE USE,
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES**

As the Assistant Secretary for Mental Health and Substance Use in the U.S. Department of Health and Human Services and the leader of the Substance Abuse and Mental Health Services Administration (SAMHSA), I am pleased to present this new resource: *Best Practices for Successful Reentry From Criminal Justice Settings for People Living With Mental Health Conditions and/or Substance Use Disorders*.

SAMHSA is committed to improving prevention, treatment, and recovery support services for individuals with mental illnesses and substance use disorders. SAMHSA's National Mental Health and Substance Use Policy Lab developed the Evidence-Based Resource Guide Series to provide communities, clinicians, policymakers, and others with the information and tools to incorporate evidence-based practices in their communities or clinical settings. As part of the series, this guide highlights strategies for grantees, clinicians/practitioners, correctional facilities, recovery support organizations, and criminal justice system agencies to support individuals reentering the community from prison or jail who are living with mental health conditions and/or substance use disorders.

This guide and others in the series address SAMHSA's commitment to behavioral health equity, including providing equal access for all people to evidence-based prevention, treatment, and recovery services regardless of race, ethnicity, religion, income, geography, gender identity, sexual orientation, or disability. Each guide recognizes that substance use disorders and mental illnesses are often rooted in structural inequities and influenced by the social determinants of health. Behavioral health providers and community partners must give attention to health equity to improve individual and population health.

I encourage you to use this guide to implement interventions and programs that support individuals living with mental health conditions and/or substance use disorders as they reenter the community.

Miriam E. Delphin-Rittmon, PhD

Assistant Secretary for Mental Health and Substance Use
U.S. Department of Health and Human Services

Evidence-Based Resource Guide Series Overview

The Substance Abuse and Mental Health Services Administration (SAMHSA), specifically its National Mental Health and Substance Use Policy Laboratory (Policy Lab), is pleased to disseminate information on evidence-based practices and service delivery models.

The Evidence-Based Resource Guide Series is a comprehensive set of modules with resources to improve health outcomes for people at risk for, experiencing, or recovering from mental health conditions and/or substance use disorders. It is designed for providers, administrators, community leaders, health profession educators, and others considering an intervention for their organization or community.

Expert panels of federal, state, and non-governmental participants provide input for each guide. The

panels include accomplished researchers, educators, service providers, community members, community administrators, individuals with lived experience, and federal and state policymakers. Members provide input based on their knowledge of healthcare and criminal justice systems, implementation strategies, evidence-based practices, provision of services, and policies that foster change.

A priority for SAMHSA is providing programs for individuals with mental health conditions and/or substance use disorders. Implementing new programs and practices requires a comprehensive, multi-pronged strategy. This guide is one piece of an overall strategy to implement and sustain change. Readers are encouraged to review the [SAMHSA website](#) for additional tools and technical assistance opportunities.

***Behavioral health equity** is the right to access high-quality and affordable healthcare services and supports for all populations, including Black, Latino, and Indigenous and Native American persons, Asian Americans and Pacific Islanders and other persons of color; members of religious minorities; lesbian, gay, bisexual, transgender, and queer (LGBTQI+) persons; persons with disabilities; persons who live in rural areas; and persons otherwise adversely affected by persistent poverty or inequality.*

As population demographics continue to shift, behavioral healthcare systems will need to expand their ability to fluidly meet the growing needs of a diverse population. By improving access to behavioral health care, promoting quality behavioral health programs and practice, and reducing persistent disparities in mental health and substance use services for underserved populations and communities, recipients can ensure that everyone has a fair and just opportunity to be as healthy as possible. In conjunction with promoting access to high-quality services, behavioral health disparities can be further mitigated by addressing social determinants of health, such as social exclusion, unemployment, adverse childhood experiences, and food and housing insecurity. In all areas, including supporting individuals living with mental health conditions and/or substance use disorders, SAMHSA is committed to behavioral health equity.

Content of the Guide

This guide contains a foreword and five chapters. Each chapter is designed to be brief and accessible to SAMHSA grantees, practitioners, correctional facilities, recovery support organizations, criminal justice system agencies, and others interested in interventions for supporting individuals reentering the community from jail or prison who are living with mental health conditions and/or substance use disorders.

FW Evidence-Based Resource Guide Series Overview

Introduction to the series.

1 Issue Brief

Overview of the prevalence of mental health conditions, substance use, and co-occurring disorders among individuals who are incarcerated; outcomes used to measure successful reentry; challenges associated with reentry; and implications of incarceration for individuals living with mental health conditions and/or substance use disorders. .

9 What Research Tells Us

Current evidence on three interventions to improve reentry outcomes for individuals living with mental health conditions and/or substance use disorders.

23 Guidance for Identifying and Implementing Evidence-Based Practices to Support Reentry

Considerations and practical information for implementing interventions to address reentry among individuals living with mental health conditions and/or substance use disorders.

39 Examples of Organizations Implementing Evidence-Based Interventions

Descriptions of four organizations that have implemented the evidence-based practices from chapters 2 and 3 to provide interventions for people reentering the community from jail or prison.

48 Guidance and Resources for Evaluation

Guidance and resources for evaluating behavioral health interventions in the context of reentry from criminal justice settings.

FOCUS OF THE GUIDE

This guide provides an overview of the reentry and behavioral health service needs and opportunities for individuals leaving jail or prison.

It presents three evidence-based interventions and their associated behavioral health outcomes: 1) **medications for opioid use disorder and alcohol use disorder**; 2) **case management**; and 3) **peer and patient navigation**.

These approaches can assist providers in supporting individuals living with mental health conditions and/or substance use disorders who are reentering the community from jail or prison.

The guide provides examples of organizations implementing these strategies to address the reentry supports and behavioral health needs of people leaving jail or prison. It also describes evaluation approaches to assess behavioral health intervention implementation and quality improvement strategies, including whether interventions achieve desired outcomes.



Issue Brief

In 2021, 680 out of every 100,000 United States residents were in prison or jail, and approximately 3.7 million were under [community supervision](#).¹ Individuals living with mental health conditions and/or substance use disorders who reenter the community from jail and prison often encounter significant barriers to [behavioral health](#) treatment, stable and safe housing, meaningful employment, and other [recovery support services](#).² Best practices for successful [reentry](#), which is defined further in “[Outcomes Used to Measure Successful Reentry](#),” suggest that planning and support should begin during a term of incarceration and continue post-release.³ As a first step, comprehensive screening and assessment can inform a case plan that follows the individual from prison or jail into the community.

Appropriate support during reentry into the community can reduce risk for a [recurrence of symptoms](#), as well as risk of overdose, death by suicide, or risk for reincarceration. A North Carolina study found that during 2016–2018, the risk of death from overdose among formerly incarcerated people was 20.2 times higher than for the general population at one year post-release; the relative risk was even higher, at 50.3 during the two weeks after release.^{4,5}

Additionally, individuals released from prison are at greater risk of death by suicide post-release. They have high rates of death by suicide compared to the general population, especially during the first weeks following

Key Elements of Reentry

- Reentry planning (Collaborative Comprehensive Case Plans) across systems
- Warm hand-off to community providers to increase engagement
- Continuity of care; access to continuum of behavioral health services including harm reduction services
- Access to government identification (e.g., photo ID to obtain post-release treatment and government benefits)
- Medication, including Naloxone, and prescription access upon release
- Timely access to benefits, including Medicaid, Medicare, private health insurance, Supplemental Security Income/Social Security Disability Insurance (SSI/SSDI), Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), veteran’s benefits, etc.
- Peer support services
- Gainful employment; employment services
- Safe, secure, affordable, stable housing
- Other support services including transportation, childcare, legal services

Adapted from: SAMHSA, Criminal Justice System Intercept 4 - Transitioning back into the Community, 2022

release.⁶⁻⁸ Recidivism rates for people formerly incarcerated in United States prisons during 2005–2010 were 23, 36, and 55 percent within one, two, and five years after release, respectively.⁹ Rearrest rates are striking as well, with 42.9 percent of individuals arrested in the first year following release from state prison.¹⁰ A study evaluating the effectiveness of a cognitive-based drug treatment program revealed that 46 percent of individuals in a matched control group were sent back to prison or jail for more than 30 days, compared with 27 percent of those who completed treatment.^{11,12}

The consequences of incarceration are even more severe for individuals living with mental health conditions and/or [substance use disorders](#) (SUDs). For example, individuals living with [mental health disorders](#) who are incarcerated are more likely than other incarcerated individuals to incur disciplinary infractions and suffer punishment (such as restrictive housing) as a result, and they are more likely to be victimized, including sexual victimization, while incarcerated.⁶ The increased likelihood of punishment and traumatic events, such as sexual victimization, for people with mental health disorders can have long-term consequences that extend beyond incarceration into the reentry period.

Reentry planning and support should occur at multiple stages of the criminal justice process—pre-release, at-release, and post-release—to address the needs of each individual and promote continuity and linkages to care, as illustrated in the [Sequential Intercept Model](#). [Continuity of care](#) means that individuals who obtain services while in jail or prison continue to access these services in the community with no lapse, while [linkage to care](#) refers to connecting individuals to services upon reentry. These services should be evidence-based, readily accessible, and ideally accessed with help from a case manager or patient navigator.

A multi-disciplinary approach where correctional (jail or prison) and behavioral health personnel work as a team and engage in continuous knowledge sharing is critical for maximizing positive [outcomes](#) at both the individual and system levels.² Unfortunately, professionals in these roles often encounter barriers that prevent effective information sharing, such as laws related to disclosing patient information, and the incompatibility of electronic health records (EHRs), which limits access to patient information across health providers.¹³

In addition, the reentry experience may differ for individuals incarcerated in a jail setting versus a prison setting. Although the average length of stay in jails has been increasing, and in larger jails it now averages more than 30 days,¹⁴ jails are designed as shorter-term holding facilities; therefore, compared to prisons, there is less opportunity for long-term planning for reentry into the community¹⁵ and they often have smaller budgets for programming.¹⁶ While prisons, compared to jails, may have more resources to offer treatment programs and longer term planning, they are often located farther away from a person’s home community, making reentry connections more challenging.¹⁵

Distance and timing aside, prisons and jails are an opportunity to rehabilitate and address risks. One useful construct for understanding [risk factors](#) associated with probation/parole violations and revocations is [criminogenic risk](#), the likelihood that an individual will engage in future illegal behavior in the form of a new crime or because of failure to comply with probation/parole conditions. There are eight factors identified as strong predictors for criminal behavior (see graphic), and a risk-need-responsivity (RNR) model can help identify and prioritize individuals for appropriate treatment to reduce their likelihood of re-incarceration.¹⁷ When assessing the risks and needs of an individual, it is important to look at longer-term criminal histories than the most recent conviction offense because the severity of the original offense is not indicative of recidivism risk and criminal activity is not highly specialized.¹⁸ Although not mentioned in the figure below, lack of adequate housing and meaningful employment are also risk factors for future criminal behavior.^{19,20} They are both discussed in more detail below.

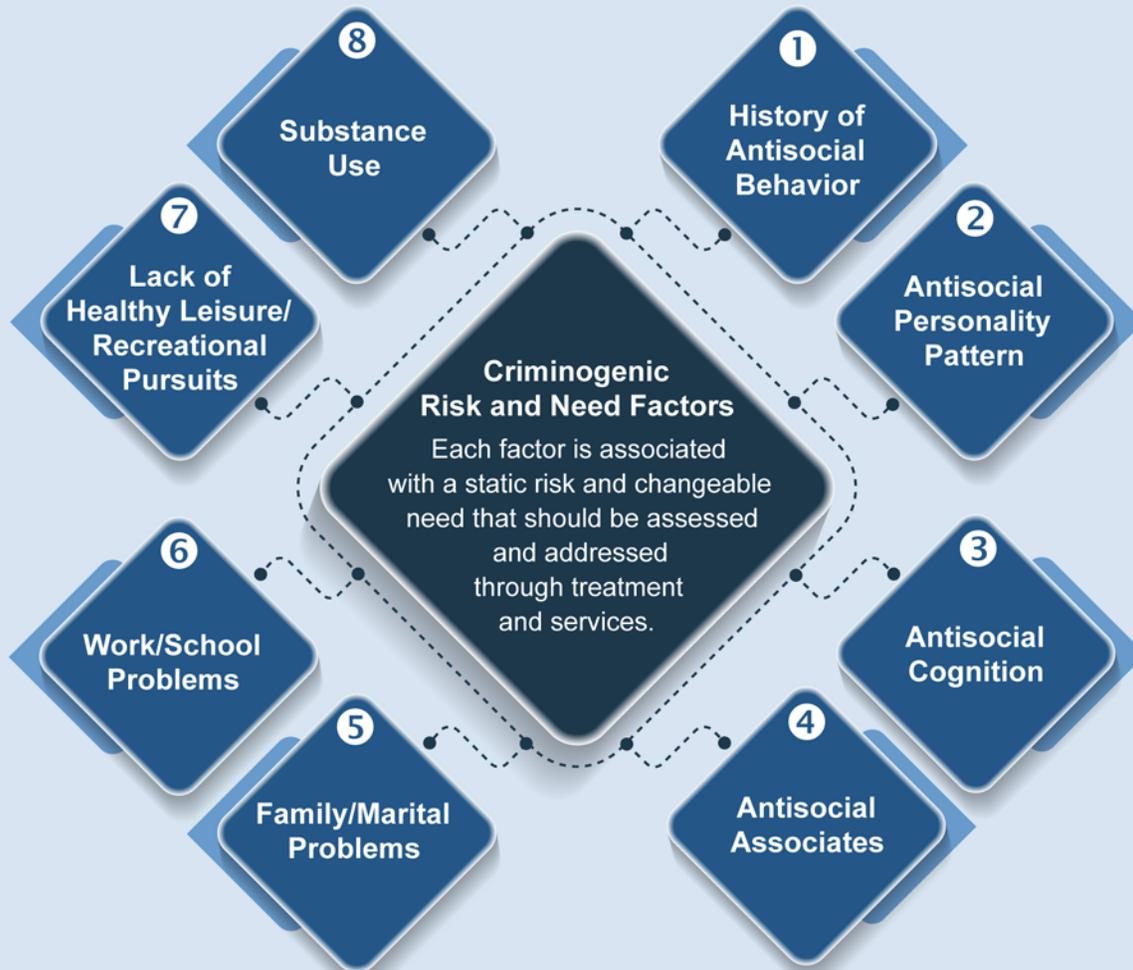


Criminogenic Risk and Need Factors

Criminogenic factors: Risks and needs that increase an individual's likelihood of re-offense.

Criminogenic risk: The likelihood that an individual will engage in future illegal behavior in the form of a new crime or failure to comply with probation/parole conditions.

Criminogenic needs: Dynamic or changeable factors that increase an individual's likelihood of re-offense but can be remedied or lessened through appropriate interventions or services.



The **Risk-Need-Responsivity (RNR)** model can help identify and prioritize individuals for appropriate treatment to reduce their likelihood of re-offense.

- Risk principle—match the level of service to the individual's risk to re-offend
- Need principle—assess each individual for known criminogenic needs and target treatment to most salient needs
- Responsivity principle—maximize the potential success of intervention by providing cognitive behavioral treatment and tailoring the intervention to the learning style, motivation, and strengths of the individual

Source:

Substance Abuse and Mental Health Services Administration (2019). *Principles of Community-based Behavioral Health Services for Justice-involved Individuals: A Research-based Guide*. HHS Publication No. SMA19-5097. Rockville, MD: Office of Policy, Planning, and Innovation. Substance Abuse and Mental Health Services Administration.

The Intersection of Mental Health, Substance Use, and Co-Occurring Disorders and Individuals in the Criminal Justice System

Prevalence of Mental Health Conditions and/or Substance Use Disorders Among Incarcerated Individuals

Individuals living with mental health conditions are overrepresented in criminal justice settings in the United States, including in jails and prisons and on probation/parole.²¹ In fact, nearly half of individuals incarcerated in state prisons have a history of a mental health disorder.²² Past available estimates suggest that approximately 16.0 and 17.0 percent of inmates in state prisons and jails, respectively, are living with a [serious mental illness](#) (SMI),² compared to the current estimate of 5.5 percent of all adults aged 18 or older.²³ For incarcerated women, the rates of bipolar disorder (and/or mania) and depressive disorders are double those of incarcerated men.²⁴

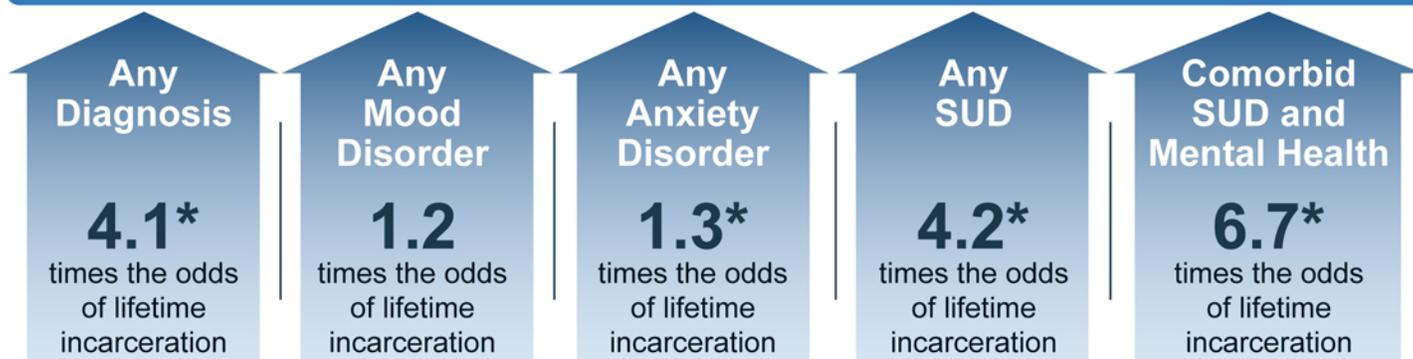
Rates of trauma are high among incarcerated individuals, and some populations are at particular risk of re-traumatization in jail and prison. [Lesbian, gay, bisexual, transgender, queer/questioning, and intersex \(LGBTQI+\)](#) individuals have higher rates of violent victimization,

including some forms of sexual assault and intimate partner violence, compared to heterosexual men and women.²⁵ In a national sample, women had approximately double the rate of [post-traumatic stress disorder \(PTSD\)](#) than men, and individuals with PTSD are at significantly higher risk for mental health conditions and/or substance use disorders.²⁶ Incarcerated women also have higher rates of [substance use](#) relative to the general population.^{27,28} In addition, women with criminal justice involvement report greater incidence of mental health problems than their male counterparts.²⁹

Compared to people living without a mental health condition, those with SMI are likely to spend more time in jail before adjudication, serve longer sentences, be re-arrested for the same crime, and have higher recidivism rates.³⁰ In addition, the presence of other mental health conditions and substance use disorders over the course of one's lifetime is associated with higher odds of lifetime incarceration (see graphic).³¹ For example, the odds of someone with comorbid SUD and mental health facing lifetime incarceration are 6.7 times the odds of someone without comorbid SUD and mental health.³¹

Past estimates of SUDs among incarcerated populations are 53.0 percent in state prisons and 68.0 percent in jails,² in stark contrast to the past-year prevalence of 16.5 percent among people aged 12 and older in the general public.³² Similarly, 33.0 to 60.0 percent of people in prison and jail have [co-occurring mental health conditions and substance use disorders](#), compared to 14.0 to 25.0 percent of people not incarcerated.² Adults with co-occurring mental health conditions

Association of Lifetime Mental Health Conditions and SUDs With Lifetime Incarceration; Odds Ratios Adjusted for Sociodemographic and Other Disorders



*p<.001

Source: Moore, K. E., Oberleitner, L. M., Zonana, H. V., Buchanan, A. W., Pittman, B. P., Verplaetse, T. L., Angarita, G.A., Roberts, W., McKee, S. A. (2019). Psychiatric disorders and crime in the US population: Results from the National Epidemiologic Survey on Alcohol and Related Conditions Wave III. *The Journal of Clinical Psychiatry*, 80(2), 15899. <https://doi.org/10.4088/JCP.18m12317>

and substance use disorders are at greater risk for incarceration (26.2 percent) compared to individuals living with mental health disorders only (7.5 percent) or substance use disorders only (23.0 percent).³¹ Over one-fifth of all individuals with PTSD use substances to manage their symptoms.³³ Those reentering the community need comprehensive integrated services to address mental health, substance use, and trauma.

Implications of Incarceration for Individuals Living With Mental Health Conditions and/or Substance Use Disorders

The negative health implications of incarceration disproportionately impact individuals living with mental health conditions and/or substance use disorders. While the impact of incarceration itself on mental health can be significant, it is compounded for individuals who have existing mental health conditions and/or substance use disorders.



Jail and prison settings involve increased risk of coercion, isolation, sexual and physical violence, and intimidation.^{17,34} Unfortunately, individuals living with mental health conditions and/or substance use disorders are more likely to experience victimization or exploitation while in jail or prison,² making their experience of incarceration worse. Compared to people without mental health conditions and/or substance use disorders, individuals living with mental health conditions and/or substance use disorders have longer jail stays,³⁵ are less likely to make bail,² and are disproportionately confined in restrictive housing (solitary confinement settings) with negative psychological effects.^{36,37} It is estimated that individuals living with SMI spend three times longer in solitary confinement compared to those with no history of mental health issues.³⁸

The long-lasting effects of trauma indicate the need for universal trauma screening and [trauma-informed approaches](#) to reentry that consider the well-being of all individuals. SAMHSA's [Trauma-Informed Care in Behavioral Health Services](#) provides tools and strategies for implementing a trauma-informed approach.

In addition to disproportionate negative health implications, individuals living with mental health conditions and/or substance use disorders do not always have access to appropriate behavioral health services while in jail or prison. Individuals with chronic medical conditions often go without appropriate health care. Only two-thirds of prison inmates and less than half of jail inmates who previously took a psychiatric medication received any medication for a mental health condition during their incarceration.³⁹ The consequences of incarceration on health, coupled with insufficient services, further highlights how strong connections to comprehensive behavioral health services are needed for incarcerated people reentering the community.

Challenges Associated With Reentry

The health implications of incarceration can be devastating. Many people living with mental health conditions and/or substance use disorders who are reentering the community face challenges accessing treatment and services (e.g., health care, medication), as well as housing, employment, food, and social supports, which increases their risk for future justice system involvement.²

At the most basic level, public benefits can be compromised: a criminal record can render an individual ineligible for public housing, though many myths persist regarding these limitations.⁴⁰ Supplemental Nutrition Assistance Program (SNAP, previously known as the Food Stamp Program), Temporary Assistance for Needy Families (TANF), and other social supports may be compromised.⁴¹ Furthermore, lack of a valid government-issued photo identification can limit an individual's ability to access employment and vocational and educational resources.¹⁷

Continuity of Treatment

One of the greatest challenges for individuals living with mental health conditions and/or substance use disorders is related to continuity in treatment (from incarceration to post-release), assuming facilities even offer treatment. Individuals in prisons and jails have traditionally lacked adequate health care due to lack of funding and/or monitoring of and compliance with quality standards.^{42,43} Long-term [recovery](#) and successful reentry outcomes hinge on minimizing an individual's time from release to engagement in community-based [substance use services](#).⁴⁴ For example, if an individual has received [medication for opioid use disorder \(MOUD\)](#) while incarcerated, access to MOUD should be uninterrupted throughout the reentry process.⁴⁵

Relatedly, a lapse in or inability to obtain or qualify for benefits, such as health insurance,² Supplemental Security Income (SSI), Social Security Disability Insurance (SSDI), and veteran's benefits,⁴¹ upon

release can result in delayed behavioral health services. Individuals reentering the community may be uninsured because their Medicaid was suspended or terminated during incarceration, or they may be unable to afford private health insurance.¹⁷ See [Chapter 3](#) for a more detailed discussion of Medicaid and reentry.

Housing

Compared to the general public, formerly incarcerated individuals are almost 10 times more likely to experience homelessness.⁴⁶ [Stigma](#) also contributes to higher rates of homelessness among individuals living with mental health conditions and/or substance use disorders compared with the general population.⁴⁷

Safe, affordable housing is critical to an individual's well-being and their successful reentry, and it reduces recidivism.^{19,48} Barriers to stable housing can increase the risk for future justice system involvement. In this respect, housing is prevention. However, individuals often do not have adequate housing supports,⁴¹ or if needed, access to recovery housing. Additionally, although public housing authorities have discretion in determining who can be denied housing,⁴⁰ certain housing programs (e.g., Section 8) may be unavailable to those with a violent offense on their record.⁴¹ In addition, the federal definition of chronic homelessness stipulates that an individual who has been residing in an institutional care facility, including jail, for more than 90 days is not considered homeless during this time, effectively restarting the 12 months necessary to qualify for benefits upon release.⁴⁹



[Structural racism](#) in the housing market further limits access to safe, affordable housing for people of color,⁴⁷ and decades of research have documented racial discrimination throughout the rental market.⁵⁰ People of color also are more likely to live in [under-resourced communities](#), where the risk of homelessness is much greater (e.g., due to a lack of social supports, barriers to health care, and overcrowding).⁵¹ These factors, coupled with policies that may exclude formerly incarcerated individuals from public housing,⁵² disproportionately impact people of color, limiting their housing options.⁵³ In addition, higher rates of policing take place in communities of color. Disproportionately high arrest rates that affect Black people who use drugs, regardless of their neighborhoods,⁵⁴ can create a cycle of criminal justice system involvement that perpetuates reentry challenges. Landlords may also be concerned that a formerly incarcerated individual will have a recurrence of symptoms or be a difficult tenant.⁴⁷ This further compounds the issues people of color face, as they are incarcerated at higher rates than White people.

Employment

The ability to find meaningful employment is another significant and well-established challenge for formerly incarcerated individuals reentering the community. There is evidence that people who are released from prison or jail and are employed are less likely to recidivate.⁵⁵ Yet, unemployment rates are almost five times higher for formerly incarcerated individuals than for the general population.²⁰ Even brief incarceration can lead to unemployment and negatively impact future opportunities.¹⁷ Disclosure of a criminal justice record, even a minor felony conviction, can negatively impact employer callbacks for job applications,⁵⁶ which is why expungement is seen as an important avenue to increase employment opportunities for those with criminal records.⁵⁷

Almost a quarter of jobs in the United States require a government-issued license, but individuals with a criminal record are often discouraged or prohibited from receiving occupational licenses or jobs in licensed fields.⁵⁸

Notably, many of the challenges (e.g., housing discrimination, stigma associated with reentry populations) discussed above are extrinsic social factors beyond the individual. Best practices for reentry may be successful in offsetting some of these external barriers rather than treating some intrinsic disorder in the individual.

Outcomes Used to Measure Successful Reentry

Successful reentry can mean different things to different people; however, it is most commonly measured using outcomes related to reducing recidivism. While there is no single definition of recidivism, it is broadly understood to mean a return to criminal activity,⁶⁰ and has been operationalized as a re-arrest,⁶¹⁻⁶³ a probation/parole violation,⁶⁴ or a new conviction.^{64,65}

Defining Recidivism⁵⁹

While there is no single definition of recidivism, all definitions share three common traits.

1. A starting event, such as release from custody, program completion, or placed on probation/parole.
2. A measure of failure following the starting event, such as a subsequent arrest, a conviction resulting from a subsequent arrest, or a new episode of incarceration resulting from a subsequent arrest.
3. A recidivism window (e.g., six months, one year, two years, three years, etc.) beginning with the date of the starting event.

In one study,⁶⁶ recidivism outcomes were 1) a probation violation; 2) a charge for a new crime; 3) either a new crime or probation violation; and 4) the amount of time from the release date to the recidivism event. Two other studies evaluating program effectiveness defined recidivism as a conviction of any new offense or the conviction of a felony offense,⁶⁷ and looked at the average time to recidivate.⁶⁸ Each of these two studies found their respective programs were effective at reducing recidivism.

Although most studies examining the effectiveness of reentry programs use recidivism as a primary outcome for success, some experts argue that recidivism alone is an inadequate measure. First, individuals often “age out” of crime,⁶⁹ with older people returning to prison at lower rates.⁷⁰ Second, most individuals are rearrested for public order offenses (e.g., driving under the influence).⁷⁰ Third, different measures have strengths and weaknesses, and it is important to compare “apples to apples,” as rearrest



Preview of Approaches to Reentry for Incarcerated Individuals Living With Mental Health Conditions and/or Substance Use Disorders

This guide examines the evidence base of [interventions](#) that target all phases of reentry (pre-release, at-release, and post-release) for incarcerated adults with mental health conditions and/or substance use disorders who are returning to the community from jail or prison. The purpose of the guide is to share information about the types of interventions that are most successful in reducing recurrence of symptoms, overdose, and recidivism, based on a review of evidence-based approaches. Although reducing recidivism and preventing recurrence of symptoms and overdose are the primary outcomes reported in the literature, experts argue that successful reentry also needs to be measured by outcomes related to an individual’s overall well-being, such as stable housing and social support.⁷¹ Therefore, these outcomes are also discussed throughout the guide.

The chapters that follow describe the evidence for interventions that promote successful reentry ([Chapter 2](#)), strategies to support implementation ([Chapter 3](#)), case studies highlighting organizations that have implemented reentry programs for incarcerated adults with mental health conditions and/or substance use disorders ([Chapter 4](#)), and recommendations for ongoing evaluation ([Chapter 5](#)).

rates can look a lot different from re-incarceration rates and both vary depending on the follow-up period.⁷⁰ Finally, success can also be conceptualized as an improved personal sense of well-being, which can be measured by assessing current life satisfaction and future life optimism and focusing on post-release outcomes, such as stable housing, income/financial security, meaningful employment, and access to social support.⁷¹ Improved well-being may be achieved by reducing substance use and the negative impact of other higher risk behaviors through [harm reduction](#) services.⁷²

Other outcomes used to examine the effectiveness of reentry programs focus on substance use, mental health symptoms, and treatment engagement. These outcomes include:

- Reduction in substance use and recurrence of symptoms^{73,74}
- Improved mental health or quality of life^{75,76}
- Treatment engagement and adherence, related to mental health, substance use, and co-occurring disorders^{77,78}



What Research Tells Us

Individuals reentering the community from prison and jail have multiple needs, which include treatment and recovery services; safe, stable, and affordable housing; gainful employment; timely access to health insurance; and prescription access upon release. Additionally, continuity of care and linkage to care are critical for increasing the likelihood of successful reentry back into the community.⁷⁹ The interventions highlighted in this chapter have demonstrated evidence of success. This chapter summarizes the results of a targeted literature search to identify interventions, or models used to support successful reentry of individuals living with mental health conditions and/or substance use disorders.

Intervention or Model Selection

The first step of the literature review process was a scan of systematic reviews of interventions for individuals with behavioral health disorders (substance use, mental health, and co-occurring disorders) returning to the community from criminal justice settings (prison and jail). This assessment identified interventions for potential inclusion in the guide based on the rigor of a study's research design and the evidence presented.

The second step involved a more rigorous evidence review process for each of the interventions identified. The review included different types of studies. Randomized controlled trials (RCTs) are often considered the “gold standard” of experimental clinical research design because they have the potential to reveal causation between interventions and observed outcomes.

Successful Reentry: Key Resources

The following resources are used by practitioners, community leaders, policymakers, and justice system representatives to improve reentry policy, practices, and outcomes.

- SAMHSA's GAINS Center and Policy Research Associates' (PRA) Sequential Intercept Model, [Intercept 4: Reentry](#)
- National Institute of Justice (NIJ), [CrimeSolutions](#), Evidence Review Database
- Bureau of Justice Assistance (BJA), [Building Second Chances: Tools for Local Reentry](#)
- BJA, [Comprehensive Opioid, Stimulant, and Substance Abuse Program \(COSSAP\)](#)
- [Columbia Justice Lab](#)
- National Institute on Drug Abuse (NIDA) and Justice Community Opioid Innovation Network (JCOIN) Coordination and Translation Center, [Reentry Research and Resources](#)

Quasi-experimental designs (QEDs), including controlled comparisons, can also identify strong correlational trends between intervention implementation and observed outcomes. Given the practical limitations of implementing experimental study designs with this population, the review also included study designs that may not have the same level of rigor as RCTs but are strong nonetheless (e.g., pre-post, retrospective or

case-control, cohort) if they included a comparison group. Similarly, the review included qualitative and/or descriptive studies if the study referenced a parent study with a more rigorous study design.

To ensure use of rigorous methodology in each study, the following questions were asked:

- Are experimental and comparison groups demographically equivalent, with the only difference being that participants in the experimental group received the intervention and those in the comparison group received treatment as usual or no or minimal intervention?
- Was baseline equivalence on outcome measures established between the treatment and comparison groups?
- Were missing [data](#) addressed appropriately and adequately?
- Were outcome measures reliable, valid, and collected consistently from all participants?

In addition to assessing the overall study design and methodological components (described above), reviewers identified statistical significance ($p < .05$) and direction of the relationship (positive or negative) for study outcomes. Reviewers then synthesized these study characteristics to determine the overall strength of the study designs and outcomes for each intervention. For an intervention or model to be considered for inclusion, at least one study needed to demonstrate a statistically significant positive outcome related to behavioral health or recidivism that was clinically meaningful (with the exception of [peer navigation](#), discussed in detail below). [Appendix 3](#) provides additional details on the evidence review process. [Appendix 4](#) details the interventions and outcomes for the studies included in the evidence review.

Although other interventions or models may be just as effective, this review, in conjunction with consultation of a panel of experts, identified three interventions that demonstrated a strong evidence base of effectiveness for individuals with mental health conditions and/or substance use disorders reentering the community from jail or prison:

- Medication for Opioid Use Disorder (MOUD) / [Medication for Alcohol Use Disorder](#) (MAUD)
- [Case Management](#)
- Peer and [Patient Navigation](#)



MOUD and MAUD are approaches for treating opioid and [alcohol use disorders](#) and sustaining recovery using medications approved by the Food and Drug Administration (FDA), including buprenorphine, methadone, and naltrexone for MOUD and acamprosate, disulfiram, and naltrexone for MAUD.⁸⁰ Case management and peer and patient navigation involve reducing barriers to care and addressing competing priorities, all with a positive, harm reduction approach. While patient navigators are often healthcare workers helping individuals navigate complex healthcare and social service systems, [peers](#) have [lived experience](#) and provide support through shared understanding and mentorship. These interventions can be used in tandem to provide a holistic approach to recovery.

As noted in [Chapter 1](#), some experts in the reentry field have questioned the use of recidivism as a primary outcome of interest, as well as how the outcome is measured. They assert that successful reentry should be measured by outcomes that reflect multiple life domains, including well-being, education, employment, and housing.⁷¹ Since most studies that examine the effectiveness of reentry programs use recidivism as a primary outcome of interest, it was included as a measure of success for each of the above three interventions. Wherever appropriate, we include additional outcomes.

The purpose of this chapter is to present these three interventions, including a description of each intervention and any positive outcomes achieved for individuals with mental health conditions and/or substance use disorders who are reentering communities from criminal justice settings. Strategies to support their implementation are included in [Chapter 3](#).

Medications for Opioid Use Disorder and Medications for Alcohol Use Disorder

Overview

According to data from the 2007 and 2008–09 National Inmate Surveys, approximately 58 percent of individuals in state prisons and 63 percent of sentenced individuals in jails met the criteria for drug dependence or abuse. By comparison, only 5 percent of the total general population aged 18 or older met these criteria, as measured by the National Survey of Drug Use and Health (NSDUH) collected from 2007–2009.⁸² For individuals reentering the community from criminal justice settings who have certain SUDs, MOUD and MAUD are key components of recovery.

More than two decades of research have shown that these interventions lower rates of opioid misuse, decrease fatal and non-fatal overdoses, increase treatment retention, and lower rates of reincarceration. These medications are clinically effective, but they are still underused.⁸³

MOUD and MAUD in the Context of Reentry

For individuals transitioning from criminal justice settings, MOUD and MAUD are often considered a core aspect of treatment.

- **Medications for Opioid Use Disorder (MOUD)** is an approach for treating opioid use disorders, preventing overdose, and sustaining recovery. As described on the [SAMHSA website](#), the FDA has approved three medications for opioid use disorders: buprenorphine, methadone, and naltrexone. Combining MOUD with counseling and behavioral therapies can provide a comprehensive approach.⁸¹
- **Medications for Alcohol Use Disorder (MAUD)** is an approach for treating alcohol use disorders, reducing alcohol use, and sustaining recovery. The most common FDA-approved medications used to treat alcohol use disorders are acamprosate, disulfiram, and naltrexone.

While MOUD and MAUD can be used in combination with counseling and other behavioral health interventions to provide a more comprehensive and effective approach to recovery,⁷⁶ medications alone are proven to be beneficial without counseling services.^{83–85} The provision of medication should not be made contingent upon participating in counseling or other services.^{86–88}

Medications to treat [opioid use disorder](#) and alcohol use disorder can be provided in various settings, including SAMHSA-accredited and certified opioid treatment programs (OTPs). While methadone must be dispensed by a SAMHSA-certified OTP, other medications can be provided in outpatient treatment programs, physician offices, clinics, and residential treatment programs by a practitioner who has a current Drug Enforcement Administration (DEA) registration that includes Schedule III authority and is permitted by state law.^{91,94–96}

Unfortunately, prisons and jails encounter unique barriers to MOUD, including security concerns, liability, lack of qualified medical staffs, and state or local regulations that prohibit prescribing medications.⁹⁷

MOUD and MAUD Medications

MOUD

- **Buprenorphine** is an opioid partial agonist. Its maximal effect is less than that of full agonists, such as heroin, and reaches a ceiling where higher doses do not increase the effect.⁸⁹ This medication lowers physical dependency to opioids, increases safety in case of overdose, and lowers the potential for misuse. It can be prescribed or dispensed in physician offices.⁹⁰
- **Methadone** is a long-acting full opioid agonist that reduces opioid craving and withdrawal and blocks the effects of opioids. Methadone must be dispensed by SAMHSA-certified opioid treatment programs (OTPs).⁹¹
- **Naltrexone** for opioid use disorder lowers opioid cravings by binding and blocking opioid receptors. Naltrexone can be prescribed by any practitioner who is licensed to prescribe medications and can be administered as an extended-release intramuscular injectable.⁹²

MAUD

- **Disulfiram** is an oral medication used to prevent and limit alcohol use for individuals with alcohol use disorder. When consumed with alcohol, disulfiram causes negative physical symptoms, such as nausea and vomiting, that can deter alcohol use.⁹³
- **Acamprosate** is an oral medication that is used to maintain recovery among individuals with a history of alcohol use disorder who are no longer using alcohol at the time of treatment initiation. Acamprosate works by reducing the negative symptoms related to alcohol withdrawal.⁹³
- **Naltrexone** for alcohol use disorder lowers alcohol cravings by binding to endorphin receptors and blocking the effects of alcohol. Naltrexone can be prescribed by any practitioner who is licensed to prescribe medications and can be administered in pill form or as an extended-release intramuscular injectable.⁹²

Findings From the Evidence Review

Studies focused on MOUD and MAUD included RCTs,^{73,77,84,98-110} QEDs^{a, 111-119} and single-sample pre-post studies.^{74,120} Most studies in the evidence review were conducted in the United States (including one in Puerto Rico⁷⁴), two were conducted in Canada,^{114,117} and one was conducted in Australia.¹²⁰

Study on MAUD

The one MAUD study in the evidence review used naltrexone to treat alcohol use disorder.⁷³ Although it had a strong study design, it did not demonstrate a main effect of treatment. However, findings showing an [association](#) between extended-release naltrexone at higher doses and decreased alcohol use were statistically significant.

Studies on MOUD

Some MOUD studies focused on more than one type of medication. Five studies focused on buprenorphine,^{74,102,103,110,119} sixteen on methadone,^{77,84,98-101,105,108,111-114,116-118,120} and five on

naltrexone.^{104,106,107,109,115} One study provided patient navigation in combination with naltrexone,¹⁰⁹ and another provided patient navigation in combination with methadone.⁹⁸

Expanded Access to Opioid Disorder Treatment¹²¹

During the COVID-19 Public Health Emergency (PHE), SAMHSA updated regulations to expand access to treatment, which were made permanent in December 2022. These updates:

- Broadened the definition of an OTP treatment practitioner to align with wider definitions of practitioners, nurse practitioners, physician assistants, etc.
- Provided flexibilities for the provision of take-home doses of methadone and the use of telehealth in initiating buprenorphine in OTPs.

^a QEDs include prospective, longitudinal, observational, and case-control studies and retrospective quasi-experimental trials.

Studies from the evidence review largely assessed MOUD's impact on recidivism, substance use, and treatment engagement and retention. All studies had strong designs. They included statistically significant, positive findings for several outcomes, which demonstrated that MOUD treatment^b is effective at decreasing recidivism rates. MOUD treatment^c was also shown to decrease rates of recurrence of symptoms and fatal and non-fatal overdose and was effective at reducing substance use. MOUD treatment,^d when provided while incarcerated, is effective at increasing the likelihood of its initiation in the community, along with adherence to and retention in treatment, post-release. For individuals leaving jail or prison, continuity of MOUD treatment should be prioritized. Both methadone and buprenorphine reduce risk of overdose.¹²²

Typical Settings

MOUD/MAUD studies took place in prisons,^{73,74,84,99-104,107,110,114,117,120} jails,^{77,98,106,109,111-113,115,116,118} or both,^{105,108,119} across geographically diverse regions. Studies typically recruited individuals while they were incarcerated and started providing MOUD/MAUD pre-release in jails and prisons.^{73,74,77,84,98-120} The majority of studies indicated clients continued MOUD/MAUD treatment in the community post-release, although length of engagement varied.^{73,74,77,84,98-108,110-112,115,116,119,120}

Demographic Groups

MOUD/MAUD interventions were provided to individuals of varying ages, to both adult women^{103,104,114,115} and adult men^{84,99,100,102-104,106,112,115} in prison and/or jail. Individuals had an opioid use disorder or a history of opioid use disorder or dependence,^{84,99-102,104,106,107,111,115} including a history of heroin use and dependence, and alcohol use disorder.⁷³ In some cases, participants were receiving methadone treatment at an OTP in the community prior to entering jail or prison^{105,112,113,118} and treatment was continued during incarceration or they were required to undergo medical withdrawal.

Provider Types

Methadone programs were provided by certified OTP providers, as required by law, and often connected with a community treatment provider.^{84,98,99} Community

treatment providers¹¹⁵ or physicians¹⁰⁶ provided naltrexone injections in the studies reviewed and were often accompanied by nurses and other medical staff.^{104,107} In one of these studies, participants also met with physicians during medical management visits to discuss adverse events and medication side effects.¹⁰⁹ In the studies on buprenorphine, physicians provided the medication to participants, often supervising the initial dose and any adjustments, and nursing staff assisted with the treatment.^{74,110,119} In one study, the prison physician collaborated with psychosocial staff to coordinate transition to community care by primary care and substance use treatment specialists.⁷⁴

Intensity and Duration of Treatment

The intensity and duration of MOUD/MAUD treatment varied based on individuals' history of opioid and alcohol use and the medication prescribed. In several studies, methadone dosing was determined based on individual needs and was gradually increased, if needed, up to a specified target dose.^{84,98-100} Methadone was provided for up to 12 months post-release.^{84,100,101,108} Typically, the treatment group received methadone while they were incarcerated and were provided a referral to a community MOUD provider upon release.^{77,84,98-100,108,115} In a study on combined methadone treatment plus patient navigation, individuals had a pre-release planning session with a patient navigator, and then had the option of meeting with the patient navigator post-release for eight or more sessions over three months.⁹⁸ This is one example of a study that combined interventions to create a more comprehensive treatment plan. However, medication alone is shown to be effective and counseling or other services should never be mandated to receive medication.

While some studies in the evidence review provided counseling in addition to medication, study designs differed regarding timing, frequency, and type of counseling provided. Thirteen studies specifically mentioned providing pre- or post-release counseling in addition to MOUD.^{77,84,98-104,110,115,116,118} Several studies comparing outcomes for those receiving counseling only versus MOUD and counseling at different points in the reentry process found MOUD and counseling participants were more likely to attend treatment in the community upon release^{84,99,101} and spend more days in treatment,^{100,101} were less likely to be reincarcerated;⁹⁹

^b These studies used methadone and naltrexone, specifically.

^c These studies used methadone, buprenorphine, and naltrexone, specifically.

^d These studies used methadone, buprenorphine, and naltrexone, specifically.

Outcomes Associated With MOUD and MAUD

The studies included in this evidence review demonstrated that for individuals reentering communities from criminal justice settings, MOUD and MAUD were significantly associated with outcomes in three domains: recidivism, substance use, and treatment engagement and retention. All outcomes were statistically significant ($p \leq 0.05$). This evidence review included the following study designs: RCTs, QEDs, pre-post, and epidemiological studies. This table includes all statistically significant findings, including both positive and negative outcomes. [Appendix 4](#) details each study, medication type, and statistically significant outcomes.

Recidivism:

- Lower rate of being reincarcerated (for individuals in treatment for eight months or longer)^{*120} compared to counseling-only group and counseling + referral participants^{*99}
- Higher rate of being reincarcerated for those receiving extended-release naltrexone pre-release compared to those receiving extended-release naltrexone post-release^{*104}
- Lower rate of engaging in criminal activity^{*99,101}
- Lower rate of return to custody post-release^{*114,117}
- Longer time to follow-up (number of days between release and return to custody)^{*117} or number of days to rebooking^{*118}
- Fewer disciplinary tickets during incarceration^{*116}
- Fewer reincarceration days^{*113}

Substance Use:

- Lower self-reported heroin use,^{*74,84,99,101,108} other opiate use,¹⁰⁸ cocaine use,^{*74} and injection drug use^{*105,108,119}
- Lower rate of positive opioid urine screen^{*84,100,101,106} or cocaine urine screen^{*100}
- Lower rate of opioid recurrence^{*106,108}
- Decrease in non-fatal overdose^{*112}
- Lower self-reported opioid use^{*105,109}
- Increased injection drug use and risk behaviors for those receiving extended release naltrexone post-release compared to those receiving extended release naltrexone pre-release^{*104}
- Lower rates of alcohol consumption among participants who received four or more injections of naltrexone compared to those who received four or more injections of placebo^{*73}

Treatment Engagement and Retention:

- Increased rate of entering any substance use treatment or MOUD treatment in the community^{*84,99,110}
- Higher rate of being enrolled in opioid use disorder treatment 30 days post-release^{*77} and at six months (but not later)^{*98}
- Higher mean number of days of community MOUD treatment^{*100,103}
- More days enrolled in community substance use treatment^{*101}
- Higher rate of attending community MOUD treatment^{*105,108,115}
- Fewer days to engagement with methadone maintenance treatment post-release^{*105,108}
- Greater retention in MOUD treatment post-release^{*101,103,115,119}
- Higher rate of entering treatment while incarcerated^{*110}
- Higher rate of resuming methadone in the community post-release,^{*112} within one day of release^{*116} and within 30 days of release^{*116}

General Health and Well-Being:

- Lower self-reported health quality for those receiving extended-release naltrexone pre-release compared to post-release^{*104}

*Denotes a significant outcome ($p \leq 0.05$)



reported fewer days of criminal activity or criminal involvement,^{99,101} and were less likely to use [opioids](#) or cocaine compared to counseling-only participants.⁹⁹⁻¹⁰¹

Naltrexone injections were typically provided once every four weeks, for three to six months (i.e., three to six injections).^{73,104,107,115} With regard to pre-release dosing, studies started providing monthly injections to participants up to six months¹⁰⁴ pre-release or started providing injections within days or weeks prior to release.^{73,106,107,109,115} In one study, participants were randomized to a naltrexone intervention one week before their release from jail.¹⁰⁶ Depending on when dosing started prior to release, studies either provided a referral to community MOUD treatment upon release or 4 to 6 monthly doses in the community post-release.^{73,106,107,115}

Case Management

Overview

Case management involves providers making referrals and linkages to community-based services, including mental health and substance use disorder (SUD) treatment, often providing comprehensive wraparound services for individuals preparing to return to the community from criminal justice settings. For individuals returning from prisons and jails, case management is most effective when it includes a strong community

handoff that ensures continuity of care between criminal justice settings and community-based services.¹²³

Jail or prison “[in-reach](#),” a strategy through which providers from community-based organizations meet with individuals in the jail or prison before release, is particularly effective for establishing continuity of care and can be used as an element in conjunction with case management approaches.^{123,124} Developing a single case plan with input from jail, probation, and community-based providers also bolsters continuity of care.^{123,125} As a best practice, these plans should include creating [SMART goals](#) with the client^e and identifying steps they can take to achieve these goals (case plans are discussed in more detail in [Chapter 3](#)).

The types of case management in these studies are [strengths-based](#) case management,¹²⁶ intensive case management (ICM),⁶⁴ probation case management,^{127,128} and a jail “in-reach” case management program.⁷⁸ Given the myriad needs of individuals returning from criminal justice settings, case management can be combined with other behavioral health interventions to be most responsive to individual needs. For example, one study in this evidence review combined [motivational interviewing](#) with case management.¹²⁹

Transition From Jail to Community Case Management Principles¹²³

1. Case management services are provided to individuals who have been screened as at medium or high risk to reoffend.
2. Individuals receive a comprehensive case plan that builds upon a needs assessment and specifies interventions that address the individual’s identified criminogenic needs.
3. All agencies interacting with the individual use a single case plan—including jail, probation, and community-based service providers—and the case plan follows the individual into the community upon release.
4. Jail staff coordinate with staff from community-based organizations to ensure that individuals are referred to appropriate programs and services.

^e “Client” is used throughout this guide to refer to individuals receiving behavioral health services. The authors recognize that while some professional roles or settings may use this term exclusively, other organizations, professional roles, or settings may use other terms, such as patient.

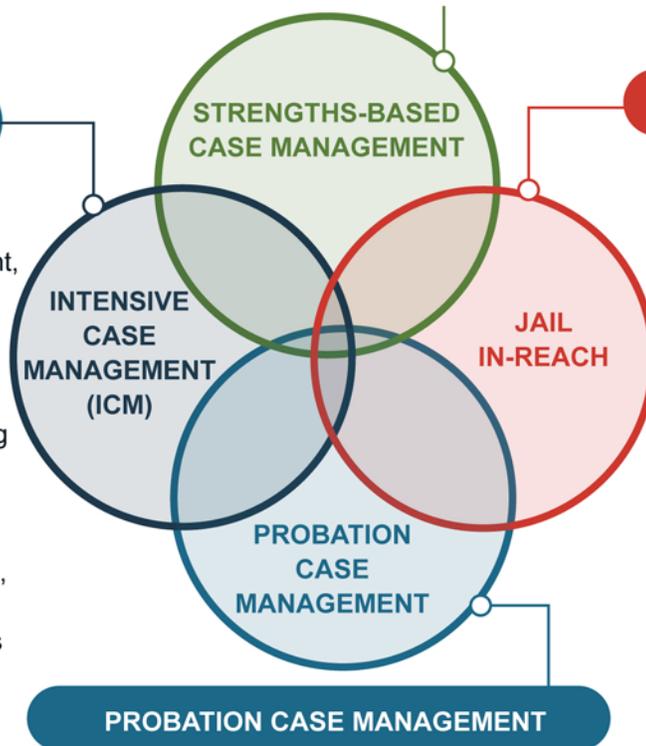
Types of Case Management in the Context of Reentry

STRENGTHS-BASED CASE MANAGEMENT

Focuses on the **inherent strengths of an individual** and leverages these strengths to help individuals achieve their goals and meet their needs. Strengths-based case management is largely client-directed but subject to parole and treatment requirements, and participants typically complete a Strengths Assessment and Goal Plan, which guides the services provided. It often involves aggressive outreach and seeks to increase engagement in community substance use treatment and access to social services while also improving substance use and recidivism outcomes.

INTENSIVE CASE MANAGEMENT (ICM)

An intensive care model that focuses on smaller caseloads than standard case management, frequent individual contact, and coordinated care. Intensive case management utilizes a wraparound services approach that prioritizes outreach, bringing services to the individual's location, continual availability of staff, and providing services including mental health services, substance use treatment, housing, employment, and crisis intervention.



JAIL IN-REACH

A strategy where **community-based organizations meet with an individual prior to release**, to begin service planning and establish continuity of care. Specific activities may include rapport development, education about post-release services, interviews or assessments for post-release programming, and the provision of other services or programming prior to release.

PROBATION CASE MANAGEMENT

Combines elements of **intensive supervision program (ISP), case management, and substance use treatment**. Probation officers are trained and supervised in therapeutic case management. Alongside the individual, these officers attend treatment planning meetings and medical appointments and make referrals to other health and social services including childcare and child reunification services, employment and educational counseling, and housing assistance.

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Findings From the Evidence Review

The review identified seven studies^f focused on case management for reentry. The study designs included RCTs,^{126,128-130} quasi-experimental,^{65,127} pre-post,⁷⁸ and retrospective studies.⁶⁴ All studies used strong study designs and were conducted in the United States.

The studies assessed the impact of case management on recidivism, mental health and general well-being, substance use, treatment engagement and retention, employment, education, and housing. They produced significant, positive findings, demonstrating that case management is effective in decreasing individuals' rates of recidivism, specifically arrests for serious charges and rates of conviction.

Case management was also associated with increased access to mental health and substance use treatment, higher levels of social support, reduction in substance use, increased rate of employment, and increased educational attainment (e.g., receiving GED in prison,

attending a college or vocational program upon release). Outcomes are positive and statistically significant and extend beyond recidivism as a measure of successful reentry (see box below). While two studies had positive outcomes related to housing, the findings were not statistically significant.^{64,129}

Typical Settings

Case management is implemented in a wide range of settings and is most effective when initiated in correctional settings prior to release. Three studies, all providing case management to individuals leaving prisons, met with individuals at least once prior to release.^{64,65,126} Studies provided services to individuals entering the community from prisons (northern Kentucky; Los Angeles, California; and Missouri),^{64,65,126,129} jails (New York City, Los Angeles, a midwestern metropolitan county),^{78,129,130} and to individuals on probation¹²⁸ or parole¹²⁷ (both San Francisco County, California), some of whom entered sober living houses.¹²⁹

Outcomes Associated With Case Management

Case management for individuals reentering communities from criminal justice settings was associated with statistically significant outcomes ($p \leq 0.05$) in the following domains: recidivism, substance use, treatment adherence and engagement, employment, and education.

Recidivism:

- Lower rates of arrest^{*129}
- Lower rates of arrest for serious charges^{*130}
- Lower rates of a new conviction^{*65,129}
- Lower rates of incarceration over six months^{*129}
- Improved outcomes on the Addiction Severity Index (ASI) legal scale^{^129}

Treatment Engagement and Retention:

- Increased rate of engaging in any community mental health treatment, low-intensity mental health services, and medium-intensity mental health services (case management intervention focused on mental health)^{*78}
- Greater rate of participating in at least one substance use treatment program (case management intervention focused on substance use and HIV risk)^{*130}
- Fewer mental health service visits (case management intervention focused on substance use)^{*126}

Employment and Education:

- Greater number of employment and education services received three months following release^{*126}

*Denotes a significant outcome ($p \leq 0.05$)

^The [legal scale](#) includes items on probation or parole, charges, convictions, incarcerations or detainments, and illegal activities.

^f Findings are from a small set of studies and may not be generalizable.

Demographic Groups

Case management was provided to both adult women^{64,78,127,128,130} and men^{78,130} and across different racial/ethnic groups,⁸ including to participants who identified as White, African American, Hispanic or Latino/a, Asian/Pacific Islander, and Native American.^{65,126-129} One study focused on women reentering the community from prison with reentry barriers related to substance use and/or mental health;⁶⁴ another included men and women reporting high rates of SMI and co-occurring SUDs.⁷⁸ More than 90 percent of men and women in a study had substance use treatment needs, with most classified as having mild or moderate dependence or [substance misuse](#).⁶⁵ Another study also included individuals living with HIV or with at least one HIV risk behavior, such as injection drug use.¹²⁹

Professional and Academic Experience

Case managers often have experience as social workers, therapists, probation officers, or have behavioral health degrees (such as psychology or social work). In the reviewed studies, case managers had prior experience as a case manager before the study started,¹²⁶ had a bachelor's degree or master's degree,¹²⁶ or were a trained social worker.⁷⁸ In the combined case management and motivational interviewing intervention, providers were master's-level therapists trained in motivational interviewing.¹²⁹ In the study providing probation case management, case managers were current probation officers who received weekly clinical supervision from a consultant during the first two years of the study, bi-weekly in the third year, and then monthly in the fourth year.^{127,128}

Intensity and Duration of Treatment

The intensity and duration of case management can be tailored to fit individuals' needs. In the studies included in this evidence review, case management was delivered for three months,¹²⁶ six months,⁶⁵ or up to 12 months (including for the intervention delivered with motivational interviewing).^{129,130} In some studies, case management was implemented in criminal justice settings prior to an individual's release.^{64,65,126}



Case managers typically interacted with individuals more frequently at the beginning and then at a lower intensity as the intervention continued. For example, in the study that combined case management with motivational interviewing, case managers met with individuals one month prior to release, then for three sessions within the first month, and monthly for the remaining 11 months.¹²⁹ In another study, case managers met with individuals pre-release and then weekly for three months followed by the option for three monthly follow-up contacts based on needs.¹²⁶ Case managers in other studies contacted the individual at least twice per month through field visits, office visits, or by phone.^{127,128}

⁸ The United States Census Bureau defines race and ethnicity as a person's self-identification with one or more social groups based on ancestral region of origin. Information on race is collected to make funding decisions and understand disparities in housing, education, employment, health care, and other sectors. While there are no biologically distinct "races," there are biological traits that are more common in certain races than others.

Peer and Patient Navigation

Overview

Peer and patient navigation refer to the practice of providing recovery support for individuals living with mental health conditions and/or substance use disorders. Peer navigators (also referred to as peer recovery coaches and [peer support](#) workers) are individuals who have been successful in the recovery process who help others experiencing similar situations. Through shared understanding, respect, and mutual empowerment, they help individuals enter and stay engaged in the recovery process and reduce the likelihood of a recurrence of symptoms.¹³¹ Peer navigators provide recovery-oriented treatment planning and non-clinical services, such as housing support, employment services, mentoring, and support groups.⁷⁵ Patient navigators help individuals leaving jail or prison overcome barriers to treatment services,¹³² such as assisting with transportation¹⁰⁹ and healthcare enrollment.^{76,109}

There are several similarities between peer and patient navigation; however, the main difference is that the former involves individuals with lived experience. Peer navigation is included in this evidence review because of its promising outcomes. There is strong evidence that peer support is effective, but research on peer navigation within the reentry context is in the early stages and only one study met the methodological criteria to be included in this guide.

For individuals returning from jail or prison, peer and patient navigation is often combined with other interventions, such as MOUD/MAUD. One study examined the effectiveness of combining interim methadone treatment (methadone provided in jail with continued methadone treatment post-release) with patient navigation compared to interim methadone treatment alone and treatment as usual. Those receiving interim methadone (alone or with patient navigation) were more likely to engage in treatment 30 days post-release, compared to the treatment as usual group.⁷⁷ Another study assessed the effectiveness of combined extended-release naltrexone with patient navigation and showed that the combined intervention led to lower rates of self-reported opioid use compared to enhanced treatment as usual.¹⁰⁹

The most successful peer and patient navigation interventions begin pre-release and have the same person supporting the individual in the jail or prison and post-release.^{45,123} Both of the studies that combined MOUD/MAUD and patient navigation included meetings with patient navigators pre-release.^{77,109} In one study, the combined interim methadone and patient navigation intervention included a pre-release assessment and planning session before individuals left jail.⁷⁷ In another study, individuals who received combined extended-release naltrexone and patient navigation met with a patient navigator before release.¹⁰⁹

Findings From the Evidence Review

The review identified four studies^h with peer and patient navigation, all of which were RCTs and included strong study designs. One of the studies focused on peer navigation,⁷⁵ and three studies focused on patient navigation.^{76,77,109} One patient navigation study combined elements of peer support and patient navigation since the patient navigator had family members with incarceration

Peer and Patient Navigation in the Context of Reentry

- **Peer navigation** refers to various reentry supports provided by individuals with lived experience of mental health conditions and/or substance use disorders, and in some cases, criminal justice involvement.¹³³ Peers share their lived experience with individuals as they help improve access to mental health services, substance use treatment, and other social services, including harm reduction services, housing and shelter, transportation, food assistance, training and education programs, and employment.¹³³
- **Patient navigation** refers to the use of trained healthcare workers to reduce barriers to care for individuals returning from criminal justice settings. Trained healthcare workers help individuals navigate complex healthcare and social services systems to improve access to care and treatment. Navigators help connect individuals with services, schedule appointments, and communicate with providers.^{76,109}

^h Findings are from a small set of studies and may not be generalizable.

experience and was therefore considered a “near-peer navigator.”⁷⁶ All four of the studies were conducted in the United States.

The studies assessed the impact of peer and patient navigation on mental health and general well-being, substance use, and treatment utilization and engagement. Patient navigation studies included significant, positive findings for several outcomes, which showed the intervention is effective in reducing individuals’ substance use, including alcohol use and opioid use. Patient navigation is also effective in increasing MOUD treatment engagement and decreasing the rate of emergency department visits, urgent care visits, and hospitalizations.

Though the peer navigation study did not have significant findings, peer support is a well-established, effective intervention,^{131,133} and the study had positive outcomes showing that the intervention is associated with improvements in mental health outcomes, self-efficacy, and treatment motivation and reductions in alcohol and illicit substance use. In consultation with an expert panel, we deemed these outcomes important to reentry research that seeks to move beyond recidivism as its primary outcome of interest. While these outcomes are more difficult to measure and often require ongoing assessment by qualified staff—which is not possible for all study designs and budgets—they are no less important.

Outcomes Associated With Peer and Patient Navigation

Four RCTs demonstrated that for individuals reentering communities from criminal justice settings, peer and patient navigation were positively associated with mental health and general well-being, substance use, and treatment utilization and engagement. Findings are statistically significant ($p \leq 0.05$) except when noted as not statistically significant (NS). Non-statistically significant findings are positive, which may suggest promising trends.

Mental Health and General Well-Being:

- Improved self-reported quality of life (number of days that usual activities are prevented due to poor physical or mental health) at 6 and 12 months⁷⁵ (NS)
- Reduced number of physically and mentally unhealthy days at 6 and 12 months⁷⁵ (NS)
- Increased self-efficacy at 6 and 12 months⁷⁵ (NS)
- Reduced number of physically and mentally unhealthy days at three months (NS) and mentally unhealthy days at six months⁷⁶ (NS)

Substance Use:

- Decreased self-reported opioid use^{*109}
- Reductions in alcohol use at 6 and 12 months, compared to baseline⁷⁵ (NS)
- Reductions in use of illicit substances at 6 and 12 months, compared to baseline⁷⁵ (NS)

Treatment Engagement and Retention:

- Increased treatment motivation at 6 and 12 months⁷⁵ (NS)
- Increased rate of being enrolled in opioid use disorder treatment 30 days after release,^{*77} but not after 12 months
- Increased emergency department/urgent care visits at six months,^{*} likely due to ongoing three-month waitlist at nearest safety net primary care clinic and encouragement by navigator to seek chronic care medications from emergency department to avoid treatment gaps during wait^{*76}
- Decreased rate of hospitalization at three months^{*76} and six months^{*76}

*Denotes a significant outcome ($p \leq 0.05$)

NS = not statistically significant

Recidivism, measured in several ways (discussed in [Chapter 1](#)), can be operationalized and measured more easily from administrative data on arrests, violations, and bookings. As a result, recidivism is a more common outcome reported in reentry studies. With research on peer navigation and reentry in its early stages, some outcomes in the text box below are not statistically significant but are included to draw attention to positive outcomes of successful reentry that extend beyond recidivism as the main measure. More research is needed to fully establish the impact of peer navigation on a broad range of reentry outcomes.

Typical Settings

Peer and patient navigation can be provided in any setting. One study provided services to individuals leaving state prisons,⁷⁶ two served individuals returning from jail,^{77,109} and another included those returning from both jails and prisons.⁷⁵ Clients met with patient navigators once prior to release from jail in two studies, one in Baltimore, Maryland, and the other in Albuquerque, New Mexico.^{77,109} Among the studies with jail populations, individuals were expected to be released within one year, either because of the nature of their charges⁷⁷ or because they had an expected release day.¹⁰⁹

Demographic Groups

In the context of reentry, peer and patient navigation have been implemented with individuals from different demographic backgrounds, including age, gender, race, and ethnicity. In the studies included in this evidence review, individuals had a history of SUD or drug involvement^{75,76} or met the DSM criteria for opioid use disorder.^{77,109} Peer and patient navigation are also effective across different criminal justice settings.

Professional and Academic Experience

Peer navigation is delivered by an individual with lived experience with incarceration, a mental health condition, and/or substance use disorder. In three studies, patient navigators delivered the intervention,^{76,77,109} and in one study, peer recovery coaches delivered the intervention.⁷⁵ The peer recovery coaches were individuals with lived experience who were state-certified and provided non-clinical services, such as mentoring, support groups, employment assistance, and housing services, as well as recovery-oriented treatment planning.⁷⁵ In a patient navigation study, the patient navigator had prior experience working in a jail

and had family members with incarceration experience, so the study considered them a “near-peer navigator.”⁷⁶ The patient navigator participated in a formal patient navigator training program and was supervised by an expert in patient navigation and a physician.⁷⁶

Intensity and Duration of Treatment

The intensity and duration of peer and patient navigation can vary, based on individual needs. In the studies included in this evidence review, patient navigation services lasted for three months^{76,77,109} and two demonstrated some improved outcomes over time. The peer navigation intervention lasted for 12 months, and peer recovery coaches tailored the frequency and length of meetings based on individual needs and preferences.⁷⁵

In the two studies that combined patient navigation with MOUD/MAUD, planning sessions with patient navigators started before individuals were released from jail.^{77,109} They met weekly with a patient navigator during the first month post-release, and then biweekly during the following two months.¹⁰⁹

Brief Summary of Outcomes

MOUD prior to release from jail or prison, in addition to a strong referral to community-based MOUD treatment upon release, is effective and results in significant positive outcomes for individuals with opioid use disorders. Several studies compared starting MOUD pre-release with MOUD post-release and found that participants starting MOUD pre-release were more likely to enter into drug treatment in the community,^{84,99,101} less likely to be reincarcerated,⁹⁹ and less likely to have an opioid or cocaine positive urine screen.¹⁰⁰

Several studies in this evidence review provided pre- or post-release counseling in addition to MOUD,^{77,84,98-104,107,110,115,116,118} but the study designs differed with regard to timing, frequency, and type of counseling provided. Several found that participants who received MOUD and counseling, compared to those who received counseling only, had better outcomes with respect to treatment engagement and retention, reduced recidivism, and reduced substance use. Together, these findings illustrate the effectiveness of medication for opioid use disorder.



Four studies provided one or more [evidence-based practice](#), including three studies on patient navigation and MOUD^{77,98,109} and one study on case management and motivational interviewing.¹²⁹ Combining methadone and patient navigation found significantly higher rates of being enrolled in opioid use disorder treatment 30 days post-release (but not at 12 months)⁷⁷ and at six months post-release.⁹⁸ The study that combined naltrexone and patient navigation found a significant decrease in opioid use.¹⁰⁹ The combined case management and motivational interviewing study yielded significant outcomes related to lower rates of arrest, lower rates of incarceration over the past six months, lower rates of a new conviction, and improved legal outcomes.¹²⁹ Together these findings demonstrate the effectiveness of combining evidence-based practices to provide a more holistic approach to reentry services.

Limitations of Research and Future Directions

While this evidence review identified RCTs of interventions to support successful reentry for individuals living with mental health conditions and/or substance use disorders upon release from jail or prison, it also included less rigorous study designs, such as observational studies and retrospective reviews. In these cases, the outcomes can only be interpreted as correlational. In some studies, small sample sizes also pose limitations for generalizability.⁷⁵

Two additional limitations are that many studies exclude individuals experiencing SMI, and studies for some

programs largely focus on recidivism outcomes. While there is a lot of variation in how SMI is defined across systems, it is prevalent among incarcerated individuals, and reentry programs may want to examine what would be necessary to treat and support this population. Co-occurring disorders are prevalent among incarcerated individuals as well, and programs should provide comprehensive screening, assessment, and treatment to support individuals with these conditions.

Future research may want to consider a more comprehensive approach to reentry that measures general well-being. Well-being involves people’s perception of the quality of their lives by their living and employment conditions, including “the quality of their relationships, their emotions and resilience, their realization of their potential, and their overall satisfaction with life.”⁷¹

Evidence-based interventions are developed using research protocols that may be difficult to implement in the real world. For example, the use of incentives for participation in data collection or services provided in some research studies may not be within the budget limitations of programs.

While not a limitation, it is also important to remember that there is ample evidence supporting the use of MOUD/MAUD, case management, peer support, and patient navigation with individuals living with mental health conditions and/or substance use disorders; this evidence review was limited to MOUD/MAUD, case management, and peer and patient navigation within the context of reentry.

Guidance for Identifying and Implementing Evidence-Based Practices to Support Reentry



Overview

This chapter provides an overview of how to plan effectively for and implement reentry programs for individuals living with mental health conditions and/or substance use disorders. It begins with a discussion of the relevant systems-level considerations and strategies. It then presents key considerations and strategies for implementing treatment and support services with a focus on case management, peer and patient navigation, and medication for opioid use disorder and medication for alcohol use disorder (MOUD/MAUD) at each phase of reentry: pre-release, at-release, and post-release. Finally, the chapter provides tools and resources for organizations and agencies implementing reentry programs. The guide includes implementation resources for case management, peer and patient navigation, and MOUD/MAUD.

Systems-Level Planning and Implementation Considerations for Reentry Programs

Treatment service providers, recovery support organizations, correctional facilities, [criminal justice personnel](#), and other community partners need to collaborate in planning, implementation, and evaluation of reentry programs. Systems-level implementation can promote [sustainability](#) of effective reentry programs for individuals living with mental health conditions and/or substance use disorders.

Establish a Community Coalition and Determine Reentry Needs, Service Gaps, and Reentry Program Components

Consideration: A local agency, existing community group, or behavioral health or social service organization may be the impetus for beginning a planning process for new reentry initiatives. Communities and/or organizations initiating or expanding existing reentry programs and services need to understand both the populations they want to serve and the resources already available within their community. While a community may already provide some behavioral health and other services to individuals released from incarceration, there may be a need for a more comprehensive approach.

When planning, implementing, and evaluating services for populations reentering the community with specific behavioral health needs, it is important to bring together a mix of community members from the criminal justice system, the behavioral health system, social services and support systems, people with lived experience reentering the community, business leaders, and others who can provide diverse perspectives and interests during needs assessments and throughout program implementation. Depending on the organization(s) leading the work, the funding available, and the exact undertaking, several of the components discussed below could be done in a different order or parallel to one another. SAMHSA's [Evidence-Based Resource Guide on Community Engagement](#) discusses several of the strategies below, and provides examples from communities successfully employing them in a variety of programs.

Strategies:

- **Create a community reentry coalition.** One potential first step in building a community reentry initiative may be to develop a local reentry coalition. Developing a clear purpose with shared goals and a vision or mission is key. Resources, such as the [Building Second Chances: Tools for Local Reentry Coalitions Toolkit](#) from the National Reentry Resource Center, provide guidance on how to undertake this task.¹³⁴ Tools include a sample member list and guiding questions to ask when building a coalition. Although these resources are not focused solely on populations with behavioral health needs, coalition leaders can easily adapt the resources and mapping tools to the needs of people with mental health conditions and/or substance use disorders.

Using evidence-based community engagement strategies can help ensure the coalition is representative of the affected populations and community sectors. See [Community Engagement: An Essential Component of An Effective and Equitable Substance Use Prevention System](#) for more information.

- **Ensure the coalition reflects the diversity of the community and those who are reentering.** When building a coalition, it is important to consider the diversity of the reentering population and how individuals may experience incarceration or their transition back into the community differently. This includes consideration of peoples' lived experiences with mental health conditions, substance use disorders (SUDs), and/or incarceration; the sector they represent; their age, race or ethnicity, primary language, immigration status, sexual orientation, gender, disability status, or tribal affiliation; and many other characteristics.

People of color, particularly those who are Black or Hispanic or Latino/a, are overrepresented in the criminal justice system and face many barriers to accessing treatment services.⁶ As discussed in [Chapter 1](#), LGBTQI+ individuals are more likely to enter prison or jail with a history of trauma and can have worse outcomes once incarcerated. In communities with large tribal populations, it is important that tribal authorities or representatives are on coalitions to help integrate aspects of tribal-specific history,

values, and strengths in reentry programs.¹³⁵

See the Office of the Assistant Secretary for Planning and Evaluation's (ASPE) [Methods and Emerging Strategies to Engage People with Lived Experience](#).

- **Get to know the local jail and/or prison context.** Understanding the potential reentry population is a critical first step to designing a reentry program that will meet their needs. This can include gathering information on whether a prison, jail, or both are in the service area; the average daily incarcerated population; typical turnover of the population; the percent of the population who is sentenced versus awaiting trial; the prevalence of mental health conditions and/or substance use disorders and physical comorbidities in the population; and what kind of access incarcerated populations have to treatments, such as MOUD. For both corrections and community-based agencies and organizations, this will also include understanding the [cultures](#) and organizational structures of their counterparts. Using as much information as available will help inform program components.
- **Conduct a community service needs assessment.** A community needs assessment for reentry planning identifies existing behavioral health programs and other relevant services, as well as service gaps or insufficient service capacity. Needs assessments may be done by a local agency, such as a health department, to begin the planning process prior to convening a coalition, or it may be done by the coalition itself. This will depend on the impetus, funding availability, and skills of those involved in beginning to build or expand a reentry program.

The assessment should review community providers' receptiveness to work with people who were recently incarcerated. Understanding service provision within the jail or prison is also key, as public or private health providers that serve individuals who are incarcerated may have different requirements for how they can coordinate with community-based entities. A needs assessment should also include questions related to existing data systems and extant data sharing agreements or processes to better inform cross-sector and cross-organization collaboration. More information and resources are listed below.

Community Service Needs Assessment Resources

Assessing existing service capacity in a community can focus specifically on whether the community or individual programs have sufficient and appropriate staffing with an openness to work with a reentry population; available financial resources; capacity in terms of hours, available providers, and accessible locations; and community and organizational buy-in to implement programs. Federal resources listed below may help communities complete needs assessments or community health assessments that can be tailored to a reentry context.

- [The Centers for Disease Control and Prevention \(CDC\) Community Health Assessments & Health Improvement Plans.](#)
- [CDC's Community Health Improvement Navigator](#) for providers and other community members involved in community health initiatives.
- [Agency for Healthcare Research and Quality's Planning Culturally and Linguistically Appropriate Services: Guide for Managed Care Plans.](#)
- [The Health Resources and Services Administration's Readiness Assessment and Developing Project Aims module.](#)
- The [Sequential Intercept Model \(SIM\)](#) provides a framework for understanding the needs of individuals living with mental health conditions and/or substance use disorders as they move through the criminal justice system, including at reentry (Intercept Four). SAMHSA's GAINS Center for Behavioral Health and Justice Transformation offers [training opportunities](#) for communities interested in implementing this planning process.
- [SAMHSA's Guidelines for Successful Transition of People With Mental or Substance Use Disorders From Jail and Prison: Implementation Guide](#) promotes jurisdictional implementation of the APIC Guidelines through the identification and description of various strategies that were adopted to facilitate successful community reentry for [justice-involved](#) individuals with mental health conditions and/or substance use disorders.



- **Consider a multi-pronged approach to reentry.** A multi-pronged approach ensures a community can meet individuals' complex needs as they reenter from jail or prison by leveraging various aspects of reentry programs. For instance, a reentry coalition serving an area with robust behavioral health services and treatment capacity may want to focus resources on building a patient or peer navigation program that ensures smooth connections to services. The assessment and expansion of reentry services may be accomplished by a reentry coalition or organization that provides reentry services. Individuals' experiences of incarceration will vary based on multiple factors, including their own history, identity, and where they were incarcerated (see textbox below), thus requiring options to serve all individuals. Needs assessment data can inform service offerings most applicable to the typical population programs will serve.

Create a Sustainable Infrastructure for Reentry Programs

Consideration: Program sustainability is critical in both reentry and behavioral health contexts, as continuity of mental health and substance use services is key for successful reentry from jail or prison to the community. Program sustainability can mean consistency of funding, staffing, community partnerships, and other resources. It can mean establishing policies and practices that are well-documented, adaptable, and allow for continued program function well into the future.

Strategies:

- **Leverage, establish, and maintain cross-system collaboration.** Successful reentry initiatives require collaboration between corrections agencies, corrections-based mental health and substance use providers, community organizations, and other community members. Historically, this collaboration has been challenging for multiple reasons, including hesitance of corrections to collaborate with outside agencies and of community organizations to work with people with criminal justice involvement.¹³⁷ Community organizations that serve individuals with criminal justice histories may be reluctant to create formal collaborations with corrections or public safety because of a desire to protect their clients. Being aware of these dynamics will help establish the most effective collaborations. Reentry programs may be able to leverage existing relationships, such as those supported via federal investments in public safety and public health partnerships related to overdose prevention.¹³⁸
- **Create data sharing systems and protocols.** A key component of cross-system collaboration is developing systems, policies, and practices for data sharing between criminal justice agencies and community organizations. Data sharing practices should take a realistic cost and systems approach and prioritize client privacy and well-being. Linking data systems across agencies may

The Context of Prisons vs. Jails

The length of someone's incarceration, the services provided at the jail or prison, and location of services for individuals reentering the community all have important ramifications for reentry programs.

- While the typically longer length of incarceration in prisons provides custody and prison health team staff and community providers sufficient time to plan and coordinate reentry activities, prisons are often geographically isolated and not located in the community a person is reentering.¹⁵ Video visits and telehealth appointments are more common since the COVID-19 pandemic, but challenges, such as finding a private and secure place with internet connectivity in a facility, still exist and should be addressed when implementing video visits and telehealth appointments.¹³⁶
- Jails are local facilities, and individuals may be exiting after only a few hours or up to a year, limiting time to coordinate services. The proximity of jails to an individual's own community means social support ties are less likely to be severed by distance and time, and these individuals can be part of the reentry planning process.¹⁵
- The length of time an individual is incarcerated can impact the types of services they have access to while incarcerated, and therefore the support needed to reenter the community successfully.³⁹ Prisons and larger jails may have more access to onsite services than smaller jails, and past research has shown that individuals in jails are less likely to receive medical and behavioral health care than those in prisons.³⁹

be unrealistic, so understanding existing systems and planning for any data sharing practices should occur before implementing a program.¹³⁹ There are often complicated legal requirements for protecting client data, since information related to mental health or substance use, as well as incarceration history, may be regulated by law. Resources exist to help understand [legal frameworks](#)¹⁴⁰ that can be adapted to individual programs.

- **Diversify funding sources.** Initial funding for establishing or expanding reentry programs, such as [reentry grants from SAMHSA](#), can provide access to much-needed planning and implementation capital. While some services may be reimbursable under public or private health insurance or coverage programs, a mix of public and private funding will be needed to serve this population. The [Re-Entry Policy Council’s policy statement](#) on funding reentry programs discusses how to coordinate and leverage diverse funding streams to best support reentering populations.¹³⁹
- **Provide technical assistance support and policy development.** States and local jurisdictions can develop policies so reentry populations can access safety net programs (e.g., unemployment insurance, Supplemental Nutrition Assistance Program [SNAP], Medicaid, etc.) and reduce barriers to housing, employment, and financial stability. For example, clean slate laws, such as [Connecticut’s](#), facilitate criminal record expungement for individuals with misdemeanors and lower-level felony records who remain crime-free for a period of time. States and/or philanthropic organizations may be able to actively support technical assistance needs through solicited requests for support or grantmaking, particularly in small or under-resourced communities. Some justice-related technical assistance and training resources are listed in the [Resources](#) section of this chapter, including ones available through the [Bureau of Justice Assistance’s \(BJA\) National Training and Technical Assistance Center](#).
- **Monitor the changing enrollment, eligibility, and coverage policy landscape to optimize access to needed treatments for individuals reentering the community.** During the COVID-19 public health emergency (PHE), the United States government provided more

flexibilities and encouraged states to consider existing flexibilities related to [telehealth](#) treatment of mental health conditions and substance use disorders.¹⁴¹ Flexibilities around expanded access to telehealth, covered providers who could use telehealth services, and ability to conduct audio-only visits, among others, were created at the federal and state levels across public insurance payers.¹⁴² States have additional flexibilities for telehealth reimbursements in their state Medicaid programs through State Plan Amendments¹⁴³ and even greater flexibility for programmatic changes related to eligibility, benefits, and other coverage requirements through Medicaid 1115 waivers.¹⁴⁴

In April 2023, HHS released [guidance](#) encouraging states to apply for new Medicaid Reentry Section 1115 waivers, allowing states to cover a package of services related to mental health and substance use treatment for 90 days prior to someone’s release from a carceral facility.¹⁴⁵ Additionally, the Consolidated Appropriations Act of 2023 reduced training and registration requirements for clinicians to be eligible to prescribe buprenorphine for opioid use disorder treatment, potentially expanding the provider pool for individuals seeking it.⁹⁵ The [Center for Connected Health Policy](#) provides detailed information on telehealth policies at the federal and state levels across payer types.

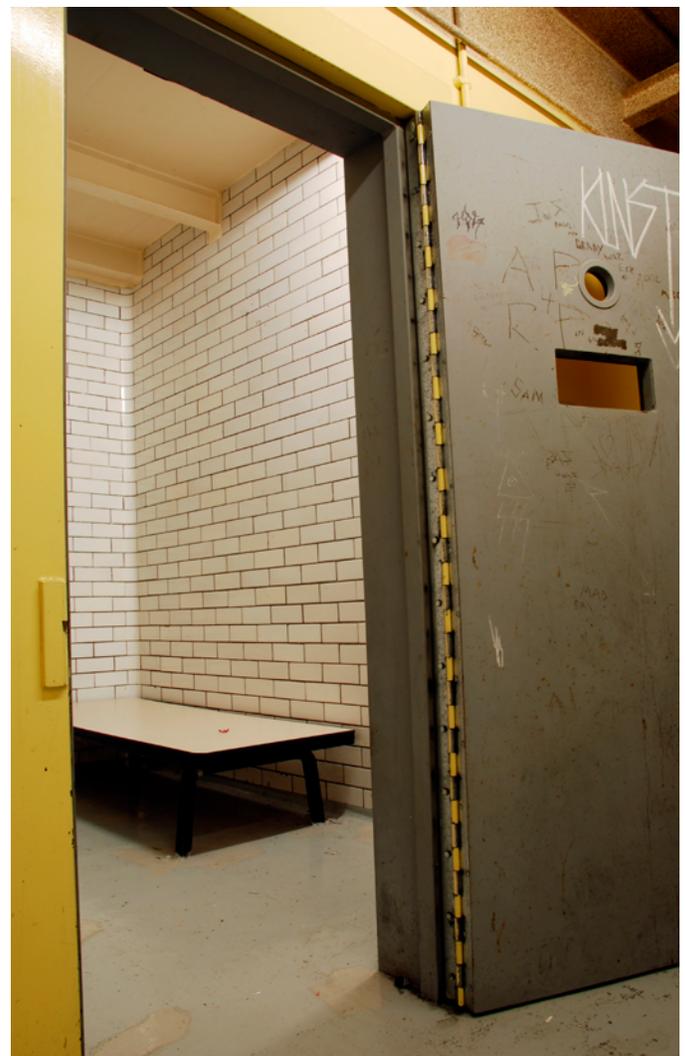
- **Leverage community support and organizational partnerships.** As discussed above, leveraging partnerships is critical, including at the treatment or service delivery level. Beyond planning stages, organizations will need to partner with other service delivery providers to give clients ongoing access to multi-pronged reentry programs. Organizations with a focus on case management or patient navigation can establish partnerships with community MOUD/MAUD programs or peer services organizations for mental health conditions and/or substance use disorders to better meet client needs. In communities where MOUD/MAUD and other services have limited availability, either due to lack of available providers or existing provider capacity, tapping into existing [hub and spoke models](#) is one way to expand client access to critical medications.

- **Provide trauma-informed training and stigma reduction training to providers working with reentry populations.** Staff interacting with clients during the reentry process should be properly trained in [trauma-informed approaches](#) (TIA), which prioritize that neither clients nor staff are retraumatized and that people in the organization know how to identify the signs of trauma.¹⁴⁶ In this context, it may also mean ensuring there are systems in place to screen for and provide direct care or referrals for individuals showing symptoms of trauma or [post-traumatic stress disorder](#) (PTSD).¹⁴⁶ Training client-facing and non-client facing staff at all levels and across all service areas (e.g., corrections, health and social services, peer workers) will ensure they are aware of the potential sources and effects of trauma for clients and staff.²
- SAMHSA’s Gains Center offers [trauma-informed response training](#) for criminal justice professionals, as well as train-the-trainer models for organizations. Stigma can exist both within and outside organizations and agencies and even among providers who serve reentry populations with mental health conditions and/or substance use disorders. Anti-stigma trainings, such as ones from the [National Alliance on Mental Illness \(NAMI\)](#)¹⁴⁷ or [JCOIN Coordination and Translation Center](#), for staff and community partners, can increase understanding and empathy towards the reentry population. Ensuring staff are appropriately trained and supported to work with a population of individuals reentering the community, and ensuring clients are provided non-stigmatizing services with TIA, will support retention of a sustainable workforce.¹⁴⁸ See also [SAMHSA’s Guidance for a Trauma-Informed Approach](#).

context, implementation quality, unmet and addressed needs, and program effectiveness. For more evaluation-related strategies, see [Chapter 5](#).

Strategies:

- **Establish a process for ongoing program monitoring with input from clients and other community members and organizations.** People who are reentering the community have complex needs that can change over time. Services for this population may also change, and it will be important to track service availability and fit. Monitoring in this context may need to include data on client satisfaction, staff feedback, and client participation in services. In addition, data collection should include information on implementation fidelity, substance use and mental health treatment services provided and received, and availability of and participation in other social services.



Ensure Ongoing Monitoring and Evaluation

Consideration: Implementing evidence-based reentry practices requires [fidelity](#) to the intervention’s core components, as well as responsiveness to client needs and feedback. Organizations will need to create systems that support ongoing data collection for program monitoring and evaluation. Input from affected communities and individuals implementing and participating in the interventions can help guide data collection and ensure evaluations are culturally responsive, appropriate, and adequate for understanding

- **Evaluate program effectiveness and disseminate findings.** When evaluating any intervention, particularly one that is newly implemented, it is critical to determine if it is meeting program objectives and desired outcomes. Programs may want to measure a variety of outcomes, including those related to criminal justice involvement, substance use, mental health, housing, employment, education, and overall well-being. Organizations should disseminate evaluation findings to community partners, other interested organizations, and relevant government agencies to be transparent about program outcomes, increase buy-in from the broader community, provide ongoing review and support for program adaptations, and encourage continued support and funding.

Make Equity Explicit in Program Planning and Implementation

Consideration: Historical inequities in both the behavioral health and criminal justice systems can adversely affect individuals who are returning to communities from jail and prison settings. Understanding and explicitly addressing disparities and inequities in program planning and implementation ensures the culture, history (including trauma history), values, experiences, and needs of individuals reentering the community are central to reentry programs and services.

Strategies:

- **Ensure that equity is an explicit component of the planning process.** Principles of equity should run throughout the planning stages and be embodied in the practices of organizations or agencies to ensure that both clients and staff experience fair and equitable treatment. Equitable hiring, pay, and promotion policies will ensure staff and peers feel supported and increase staff retention.
- **Use data to inform an equitable approach to program implementation.** As part of the initial needs assessment, communities should determine what community-level data are available to identify populations of greatest need. Investigating health, access,

and engagement disparities through these data will help ensure the program appropriately serves particular communities or subsets of the community. Data should be disaggregated by race, ethnicity, and other identity characteristics to examine disparities in service access and engagement (e.g., Who has access to peer navigators? MOUD/MAUD? Other treatment services? Who accesses supportive housing? Who returns to jail within 30 days?) and intended outcomes across subpopulations. It should also seek to understand the cost associated with not investing in comprehensive reentry programming that supports all individuals equitably.

For example, many communities are engaging in [overdose fatality reviews](#) (OFRs), a multidisciplinary, in-depth review of local overdose deaths to identify existing service gaps and community-specific interventions to address overdose prevention. In this context, OFRs identify information about people who die of an overdose, including their race/ethnicity, age, gender, and sexual orientation, as well as their interactions with the carceral, health, and social services systems.

- **Adapt materials and services to equitably meet the needs of all individuals a program serves.** Services should support and be respectful of clients' race, ethnicity, culture, sexual orientation, gender identity, age, different abilities, incarceration history, and other individual characteristics or experiences. Individuals with lived experience promote shared understanding and valuable support. Equitably engaging people with lived experience involves trust building; providing proper orientation, background, and accessibility; and acknowledging power dynamics.¹⁴⁹ Evidence-based practices can be adapted, as necessary, to meet the varying needs of the populations an organization serves.¹⁵⁰ Considering individuals' intersecting identities and experiences will be key to ensuring equitable access to programs for all participants.

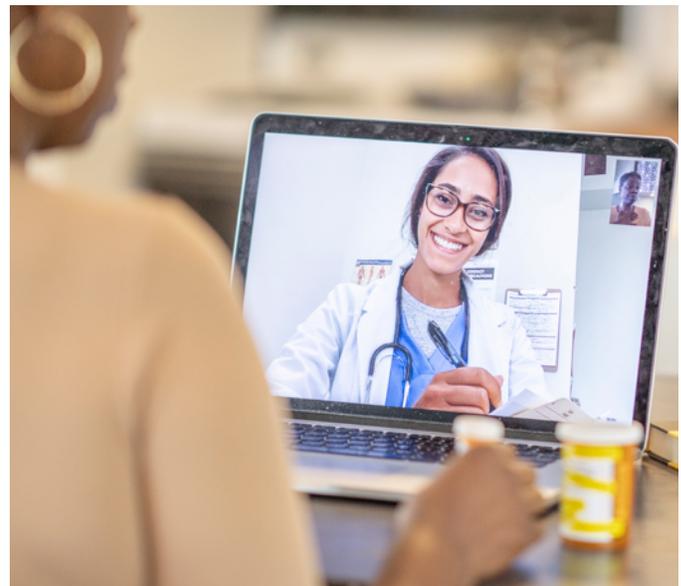
Key Considerations for Implementing Case Management, Peer and Patient Navigation, and MOUD/MAUD Across Phases of Reentry

As discussed in [Chapter 2](#), organizations can implement case management, peer and patient navigation, and MOUD/MAUD alone or in combination with another evidence-based practice. For example, MOUD may be combined with peer navigation,¹⁰⁹ or case management with motivational interviewing,¹²⁹ to provide robust reentry services. Any case management or patient or peer navigation program should have strong connections to MOUD/MAUD and other behavioral and physical health treatment programs to ensure individuals have access to all necessary services.

Linkage to care and continuity of care from correctional to community settings is critical.² It requires that all sector personnel, from correctional to behavioral health to support services, work together as a team across all phases of reentry—pre-release, at-release, and post-release—engaging in coordination, information and knowledge sharing, and a seamless continuum of services.¹⁵¹ Below are considerations and strategies for implementing case management, peer and patient navigation, and MOUD/MAUD relevant to different phases of reentry.

Begin the Reentry Planning Process as Early as Possible

Consideration: To maximize success, reentry planning should begin on the first day a person enters jail or prison.¹⁵² Reentry planning involves jail/prison medical staff or reentry staff, probation/parole personnel, and community-based service providers (e.g., case managers, clinicians, physicians, peers, patient navigators, housing providers). Not all jails/prisons provide the screening, assessment, and pre-release planning services described below. In these cases, reentry programs are encouraged to work with the appropriate jail/prison staff to provide pre-release assessment and planning for individuals prior to release.



Strategies:

- **Start with comprehensive screening and assessment.** Best practices indicate that the jail/prison medical team or other appropriate staff should screen individuals for substance use, mental health disorders, and criminogenic risk using standardized, validated instruments at entry and again prior to release. Individuals who screen positive on any screening tool then receive a comprehensive assessment.² Reentry staff, including case managers and peer and patient navigators, should be trained to administer screening tools, and those with specialized training should administer assessments (as necessary).
- **Develop an individualized case plan for reentry.** The jail/prison medical team or other corrections-based reentry staff can use the screening and assessment results to develop a case plan^{2,153} for reentry and inform the services an individual receives upon release. The case plan includes goals, timelines, the individual's responsibility to meet them, their risk level and needs, services they are receiving, and any information on probation/parole requirements, outstanding warrants in other jurisdictions, child support orders, or other information relevant to the conditions of an individual's release. The client should also provide input on their case plan to establish their commitment to meeting its goals.¹⁵¹ The more collaborative the process is of creating the case plan and setting goals, the more likely a client

will be committed to achieving them. All agencies and organizations should use the same case plan, including in the community, upon release.^{123,125} This requires interagency collaboration and ongoing sharing to ensure information is current and everyone is working toward the same goals.

- **Develop an SUD relapse prevention plan prior to release.** Reentry staff should develop a relapse prevention plan in the weeks or months prior to release for those with positive SUD assessments.¹⁵⁴ For individuals with opioid use disorder, this plan identifies an individual’s triggers for a recurrence of symptoms, how to best avoid these triggers, and how to manage impulses.⁴⁵ The plan is made with the individual and their case manager, peer or patient navigator, or both, if applicable. Connecting the newly reentering individual to treatment and/or recovery and other social supports is critical, as is equipping the individual and their family or friends with [naloxone](#) to reduce the risk of fatal overdose.¹⁵⁵

Collaborative Comprehensive Case Plans Incorporate 10 Priorities & Components¹²⁵

- Interagency collaboration and information sharing
 - Staff training
 - Screening and assessment
 - Case conference procedures
 - Participant engagement
 - Prioritized needs and goals
 - Responsivity
 - Legal information
 - Participant strengths
 - Gender considerations
- **Prioritize reinstatement of benefits.** Medicaid, Supplemental Security Income/Social Security Disability Insurance (SSI/SSDI), SNAP, Temporary Assistance for Needy Families (TANF), and Veteran’s Affairs (VA) benefits are essential to obtain vital services, prevent a lapse in needed medication, and avoid delays in physical health care and behavioral health treatment.²

- Analyses suggest that most incarcerated adults would be eligible for Medicaid upon their release, particularly in states that expanded Medicaid eligibility under the Affordable Care Act.^{156,157} While Medicaid is a critical component for ensuring individuals have access to necessary health care upon release,¹⁵⁶ in most states, Medicaid is suspended or terminated when someone is incarcerated, even if their jail stay is minimal.^{158,159} As of early 2023, California became the first state to receive federal waiver approval to allow Medicaid coverage of incarcerated individuals, providing some benefits to individuals 90 days prior to their discharge. Newly released guidance was intended to encourage more states to take advantage of this flexibility.¹⁴⁵ Several additional states have waivers pending to provide such coverage in the future.
- In the meantime, some states may suspend rather than terminate coverage,¹⁶⁰ yet there is variability in when states initiate Medicaid suspension during an incarceration.¹⁶¹ Additionally, data sharing processes between state Medicaid and corrections agencies can be manual and complicated, and the full range of disruptions to benefits is not well understood.¹⁶¹ Evidence suggests that the sooner incarcerated individuals are enrolled in Medicaid (either pre-release¹⁶² or post-release¹⁶³), the sooner they will access critical services during reentry related to mental health conditions and/or substance use disorders. A [2023 report to Congress](#) outlines promising practices for connecting individuals to Medicaid upon reentry.
- The SSI/SSDI Outreach, Access, and Recovery (SOAR) model, designed to increase access to disability benefits, is one program that can help those returning to the community access vital benefits. Furthermore, pre-release agreements between the Federal Bureau of Prisons (BOP) and the Social Security Administration (SSA) help expedite benefit determinations for those released from federal custody and facilitate continuity of care.¹⁶⁴

Prioritize Building Rapport With Individuals Reentering the Community

Consideration: Case managers and peer and patient navigators who engage with an individual before release need to build rapport and facilitate continuity of care as individuals move from jail or prison to the community.⁴⁵

Strategy:

- Conduct in-reach—a strategy that involves meeting with individuals in jail or prison before release—to facilitate continuity of care. Depending on reentry program staffing, case managers, peer or patient navigators, or treatment providers can conduct in-reach when feasible. In some cases, in-reach may consist of multiple visits a few months prior to release and is especially effective if conducted by the same provider who will work with the individual post-release. In-reach meetings can focus on rapport building,¹²³ re-screening/assessing the individual, and reviewing and updating an existing case plan. If prison/jail reentry staff did not create a case plan, the case manager, peer or patient navigator, or treatment provider should create one as part of their in-reach activities.

Provide Individuals With Supplies Needed Immediately for Successful Reentry

Consideration: Individuals leaving prisons and jails, especially those living with mental health conditions and/or substance use disorders, are at heightened vulnerability in the initial period following release.⁵ It is important that individuals reentering the community have what they need to support their physical and mental health immediately upon leaving the facility.

Strategies:

- **Provide individuals with a bridging prescription and at least a four-week supply of needed medications.** At release, individuals should receive both prescribed medications and an active prescription that will last them at least until their first appointment with a provider. If the appointment cannot be scheduled until after release, the prescription may need to be for longer. This includes medications for any mental health conditions, chronic illnesses (e.g., blood pressure, diabetes, asthma, Hepatitis C Virus, HIV), and SUDs. Providing

individuals with needed medications, in addition to a prescription, reduces challenges around accessing necessary medications when difficulties related to transit, benefits, or other issues may limit their immediate access to a pharmacy upon release.

- **Provide individuals with necessary paperwork and documentation.** Upon release, an individual should have an appropriate government-issued photo identification to obtain vital post-release treatment, support services, and government benefits.¹⁶⁵ Reentry staff should also ensure the individual has legal paperwork as proof of their release and inform them of any outstanding legal issues that have implications for them post-release, including any conditions of their probation or parole. Finally, proof of certifications, licensing, apprenticeship certificates, and other credentials attained while in prison or jail should be included with discharge paperwork.¹⁶⁵

Provide an In-Person Connection to Reentry Services

Consideration: Case managers and peer and patient navigators can play an important role at release by physically meeting individuals, providing access to transportation to ensure they get to their first behavioral health treatment appointment and residence, and ensuring they have what they need when they leave. They can ensure individuals are engaged with treatment services and have access to a continuum of behavioral health services.

Strategies:

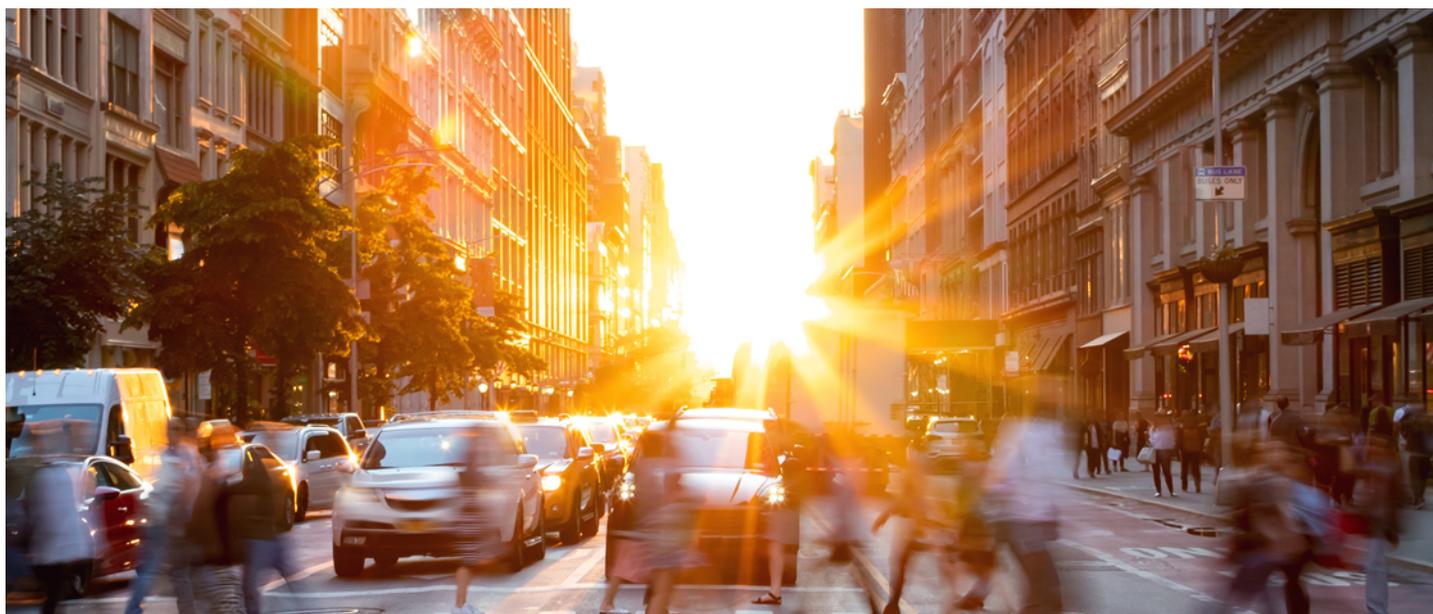
- **Create a “welcome to the community” experience.** A “welcome to the community” experience is structured, supportive, and proactive in avoiding risks for reincarceration.¹⁶⁵ A case manager or peer or patient navigator is best suited for these guided experiences, which may involve picking up the individual at the facility and “walking with them” through the first hours (and even days) after release. Ideally, this individual already provided in-reach services pre-release and became a trusted partner. This reentry practice can include ensuring the individual has clothes that fit and do not look like they were issued by the prison, providing cash the individual had in their

account at the facility (so they do not have to cash a check or pay fees to use a debit card), and supplying hygiene items and food to meet immediate basic needs.

- **Provide a [warm hand-off](#) to community-based behavioral health and chronic health treatment.** Linkages to the appropriate level of treatment (e.g., outpatient, intensive outpatient, inpatient, residential) based on an individual's assessments and case plan are critical. With the appropriate permissions and information waivers, case managers and peer and patient navigators can make the initial connection with a treatment provider on behalf of a client (making the appointment or informing the provider someone is coming in), provide transportation to the appointment, and even attend the appointment to be an advocate and hear information. Understanding conditions of an individual's probation or parole that may affect access to services, such as the distance from home they are allowed to travel, is imperative to providing individuals with access to care that will not violate conditions of their release.
- **Provide proactive follow-up on missed appointments.** Timely reengagement is critical and case managers or peer or patient navigators should conduct home, shelter, or residential treatment visits whenever possible to help the individual reengage in services. For those who are unstably housed, this may mean seeking individuals out where they stay most often. To provide this level of follow-up, appropriate

releases must be in place authorizing treatment providers to contact case managers or peer or patient navigators if an individual misses an appointment.

- **Incorporate peer navigators or case managers with lived behavioral health and criminal justice experience on the team supporting individuals reentering the community.** The role of the peer is unique in that it is based on sharing similar experiences. Peers model recovery, promote shared understanding, focus on strengths, offer positive coping strategies, and provide valuable information and resources.¹⁶⁶ Peers, therefore, are in an important position to reduce barriers to treatment engagement and help individuals reentering the community address and cope with the stigma associated with MOUD/MAUD and past involvement in the criminal justice system. In addition to connecting individuals to evidence-based treatment, peers can help them address their psychosocial needs and develop skills to support long-term wellness.¹⁶⁷
- Incorporating peers into the workforce requires well-defined roles and strong support and supervision from staff who understand the unique peer role.¹⁶⁸ In most states, peer services may also be covered under Medicaid for people with SUDs, ensuring these services can be reimbursed, at least in conjunction with a clinical care team.¹⁶⁹ However, different state authorities and requirements for covering such services¹⁶⁹



and different certifications, or lack thereof, across states for peer workers¹⁷⁰ means that not all Medicaid programs cover peer services in the same way, or at all. In 2023, SAMHSA published the [national model standards for peer support](#) to accelerate integration of the peer workforce across the healthcare system. Programs described in [Chapter 4](#) highlight the importance of hiring staff with lived experience to support clients' reentry.

Establish Connections to a Broad Range of Support Services

Consideration: At post-release, recovery support services, including housing, employment, medical care for chronic health conditions, peer support, and family reunification, are critical to successful reentry. These services should be part of an individual's case plan to ensure immediate access upon entering the community.

Strategies:

- **Provide a warm hand-off to community social service providers.** Case managers should contact housing, income, employment, benefit, and other recovery support providers to give preliminary information about the individual who is reentering the community and, whenever possible, schedule an intake or initial appointment. Warm hand-offs or referrals remove barriers for the individual entering the community and increase the likelihood of their access to and engagement in needed services.
- **Provide connections to safe, stable, affordable housing.** Housing is one of the most significant needs for individuals reentering the community.^{171,172} For individuals living with SUD, housing should meet the recovery and support needs of the individual, whether that means living with friends or family, living alone, in a halfway house, or in supportive housing. Case managers should be aware of community housing or shelters that do not accept individuals who are currently or may begin receiving MOUD/MAUD. Federal policy prevents recovery housing from discriminating against individuals on MOUD/MAUD;¹⁷³ however, acceptance of MOUD/MAUD in these contexts may be variable.¹⁷⁴ Furthermore, a history of substance use or any recurrence of use could endanger someone's access to publicly

funded housing in certain circumstances.¹⁷⁵ For some individuals, reentry involves community placement while they are still serving sentences, such as with mandated reentry services provided at halfway houses during the end of their incarceration.¹⁷⁶ For this population, services and access may need to be coordinated with the carceral system in a community setting.

- **Provide help securing employment with a livable wage.** Many individuals reentering the community from jail or prison face barriers and stigma associated with their involvement with the criminal justice system. Case managers can connect individuals to supported employment and community-based employment programs. Supported employment, an evidence-based intervention, provides job development and placement, job coaching and training, and problem-solving skills development to individuals with disabilities and behavioral health conditions¹⁷⁷ (see SAMHSA's [Supported Employment Toolkit](#)). Community-based employment programs provide job training, employment supports, job resources, and job placement services.¹⁶⁵ Reentry programs can also create explicit pathways to hire former or existing clients as peers, or help connect them to other reentry or recovery programs who hire peers with lived experience of incarceration, mental health conditions, or SUDs.

Approaches to Incorporating Supported Employment in Reentry Planning and Existing Programs

- **Identify local supported employment providers** through the local Department of Vocational or Rehabilitation Services database, the Veterans Health Administration, the state mental health agency, and the [Social Security Administration's Ticket to Work program](#).
- **Encourage work through ongoing conversations about employment.** Use the [SOAR Employment Conversation Guide](#) to help with these conversations.
- **Include employment goals and progress in regular check-ins** by asking proactive questions to help maintain momentum and address any barriers to prevent job loss.

- **Facilitate reunification with family members, including children, to assist with community reintegration and ongoing support.** Individuals leaving prison or jail have stated the importance of family to successful reentry.¹⁷⁸ Given the importance of positive family connections, case managers and peer navigators should connect the individual with the necessary family reunification resources, when appropriate. This may include family or reunification counseling, parenting assistance, childcare, and other reunification services when restraining orders are not present. Case managers and peer navigators should assist individuals in identifying family members with whom it is safe to reconnect. Individuals without safe, supportive family members should foster positive healthy connections with friends, peers, and mentors.¹⁶⁵

Reduce Immediate Risks for Individuals Living With Substance Use Disorders

Consideration: For individuals living with SUDs and other health conditions, correctional and community health providers can mitigate risks for those reentering the community by ensuring they have needed medications and information that enables them to avoid any gaps in treatment. The risk of overdose death is significantly higher for individuals who were recently incarcerated, likely due to loss of substance tolerance, limited access to MOUD/MAUD, and lack of access to naloxone while incarcerated.¹⁷⁹ Medication management and connections to or provision of MOUD/MAUD and naloxone are necessary when individuals who have SUDs are released from jail or prison.

Strategies:

- **Provide MOUD/MAUD during incarceration and ensure continuity of treatment in the community.** Jails and prisons play a critical role in ensuring appropriate treatment for people living with SUDs and mitigating increased overdose risk post-release.¹⁷⁹ Substance use treatment services in correctional settings can reduce deaths^{180,181} and non-fatal overdoses,¹⁸¹ promote continuity of treatment post-release,^{105,116,180,181} and reduce recidivism.¹¹⁶ Methadone and buprenorphine reliably increase treatment initiation and retention during incarceration and post-release.^{179,182-184} Some

facilities offer injectable extended-release naltrexone as a preventive measure pre-release.¹⁸⁵

- **Consider providing contingency management or other behavioral health treatment in combination with MOUD/MAUD to enhance retention in treatment and decrease substance use.**¹⁸⁶ Use of behavioral health therapies in combination with medication provides a “whole patient” approach to treating SUD.⁸⁰ Contingency management, an example of a behavioral intervention for treating substance use, is based on rewards or reinforcement of positive behavior change through vouchers for goods, services, or other incentives. Use of contingency management in methadone treatment settings is associated with higher rates of [stimulant](#) and alcohol negative urine samples and longer periods without substance use among individuals who received both methadone and contingency management compared to those receiving only methadone.¹⁸⁷ Programs may have limited resources, or only have incentives to provide during initial treatment engagement. Planning for other ways to maintain a supportive and engaging treatment program for clients is important.
- **Provide intensive services, such as Forensic Assertive Community Treatment (FACT), as appropriate.** The FACT model provides 24-hour access to comprehensive services delivered by an integrated, multidisciplinary team of cross-trained mental health and criminal justice team members. Individualized psychiatric treatment and social and recovery support services address the immediate needs of individuals living with SMI. The team also provides forensic services that address criminogenic risks and needs.¹⁸⁸
- **Implement rapid response teams (RRTs) to stay in touch with those with OUD/AUD.** RRTs are interdisciplinary teams that provide daily well-being checks in the hours and first two weeks following release when individuals reentering the community experience heightened vulnerability for substance use and other risk behaviors.⁴⁵
- **Develop and support programs that provide individuals with information on harm reduction, overdose prevention, and**

naloxone kits. Individuals, as well as their family and friends, should be trained in overdose prevention, provided with naloxone kits, and given information on local harm reduction programs. Overdose prevention information and naloxone kits are especially critical for the first two weeks following release when individuals are most vulnerable to recurrence of symptoms and fatal and non-fatal overdoses.⁴⁵ Reentry programs can also provide clients with information on where to obtain additional naloxone kits or other harm reduction supplies. In some jurisdictions, naloxone is available for free from community programs,¹⁸⁹ available from pharmacies without individual prescriptions,¹⁹⁰ and available by mail.¹⁸⁹ Since March 2023, Narcan, a name brand nasal-spray version of naloxone, has been available over-the-counter.¹⁹¹



Reincarceration Is a Reality Programs Need to Prepare For

Consideration: In the immediate period post-release, individuals have an increased risk of re-arrest and re-incarceration, with the highest rates of re-arrest occurring in the first year post-release.⁷⁰ This is particularly true for both men and women with substance use issues.¹⁹²

Strategies:

- **Provide ongoing support to the client during reincarceration.** If possible, conducting in-reach or providing additional information to medical or case management staff in the jail or prison can help ensure the individual maintains some level of treatment or support while incarcerated. If the incarceration is for an extended duration, a closure session should be provided and a plan for how to reengage the client upon their next release.
- **Reengage the client at their next release.** In cases where the duration of incarceration is short, such as a brief jail stay, reentry staff may be able to reengage the same client at their next release. Providing a reconnection to the same staff and treatment providers will help smooth their transition into the community again.

Implementation Resources

Below are several tools and resources to help providers and community agencies and organizations implement the interventions described in [Chapter 2](#). Implementation guides specific to those interventions are listed when available.

General Reentry

- SAMHSA’s 2017 [APIC Implementation Guide](#) discusses several components of reentry programs, from screening to individualized treatment plans.²
- Funded and administered by the United States Department of Justice’s Office of Justice Programs, Bureau of Justice Assistance (BJA), the [National Reentry Resource Center](#) is a national source of information and guidance on reentry. Resources include:
 - Several clearinghouse resources to support the reentry field: [Clean Slate Clearinghouse](#), [National Inventory of Collateral Consequences of Conviction](#), and [Public Safety Risk Assessment Clearinghouse](#).

- A list of [Second Chance Act grantees](#) around the country.
- [Building Second Chances: Tools for Local Reentry Coalitions](#), a comprehensive toolkit for reentry coalition leaders and local city, county, and community leaders who want to play an active role in improving reentry.
- [A Second Chance Resource Center Network United, Inc.](#) provides parenting education, case management, job readiness/career planning, tutoring and mentoring, financial literacy, education on arts and culture/historic preservation, and various workshops and seminars to support people previously incarcerated and their families (of both former and currently incarcerated family members), individuals living with SUDs, and low-income individuals and families.
- [Bridging the Gap: Improving the Health of Justice-Involved People Through Information Technology](#) provides proceedings from a two-day conference convened by SAMHSA in 2014 to address the problems of disconnected justice and health systems and to develop solutions using health information technology (HIT).

Case Management and Peer or Patient Navigation

- The National Institute of Corrections (NIC) and the Urban Institute partnered to develop the [Transition from Jail to Community \(TJC\) initiative](#) with the goal of improving reentry outcomes and public safety.
- The Council of State Governments Justice Center’s [Collaborative Comprehensive Case Plans](#) has key priorities for implementing case plans. Additional resources for developing case plans include several webinars available through the National Reentry Resource Center.
- The Office of the Assistant Secretary for Planning and Evaluation’s (ASPE) brief identified [methods and emerging strategies to engage individuals with lived experience in federal research, programming, and policymaking](#).

Substance Use, MOUD/MAUD, Mental Health

- SAMHSA’s [Use of Medication-Assisted Treatment for Opioid Use Disorder in Criminal Justice Settings](#) focuses on using MOUD in jails and prisons and during the reentry process to reduce the risk of overdose and a recurrence of symptoms.
- JCOIN Training & Engagement Center’s [Medications for Opioid Use Disorder in Corrections](#) contains resources to learn about medications for opioid use disorder and hear from practitioners and researchers about the benefits of providing these medications. Also available is the CLA and JCOIN Course [Implementing Medications for Addiction Treatment \(MAT\) in Correctional Settings](#).
- [The Quick Guide for Clinicians: Continuity of Offender Treatment for Substance Use Disorder from Institution to Community](#) is designed to help clinicians and case managers support individuals reentering the community from jail or prison. It discusses assessment, transition/reentry plans, important services, special populations, and confidentiality.
- SAMHSA’s [Guidelines for Successful Transition of People with Mental or Substance Use Disorders from Jail and Prison: Implementation Guide](#) provides behavioral health, correctional, and community organizations with examples of strategies for transitioning individuals living with mental health conditions and/or substance use disorders from correctional settings.
- SAMHSA’s [Principles of Community-Based Behavioral Health Services for Justice-Involved Individuals: A Research-Based Guide](#) provides [behavioral health providers](#) with guidelines for assisting individuals reentering the community from institutional settings (jail, prison, or hospital).
- The Council of State Governments Justice Center’s [FY2020 Planning and Implementation Guide for Second Chance Act Programs Improving Reentry for Adults with Substance Use Disorders](#) is intended to support BJA’s Second Chance Act grantees by fostering discussion on best practices, collaboration, and implementation challenges.

Public Benefits

- [The SSI/SSDI Outreach, Access, and Recovery \(SOAR\) Technical Assistance Center](#) provides resources to connect individuals to SSI/SSDI income supports. The website contains products and services, including webinars, issue briefs, toolkits, and infographics; case worker resources, such as information on employment and work incentives; resources for SSA appeals; and resources to assist specific populations, such as children, veterans, youth, and American Indian/Alaska Native (AI/AN) populations.
- SAMHSA's [Medicaid Coverage and Financing of Medications to Treat Alcohol and Opioid Use Disorders](#) presents information about Medicaid coverage of medication-assisted treatment for opioid and alcohol dependence. It covers treatment and cost effectiveness, as well as examples of innovative approaches in Vermont, Massachusetts, and Maryland.
- [The Council on Criminal Justice's The Health and Reentry Project](#) promotes continuity of care between correction and community settings. [Issue Brief 2](#) proposes a new reentry care model and identifies essential elements for successful implementation of potential Medicaid reentry policies critical to address during a needs assessment.

Screening and Assessment

- SAMHSA's [Screening and Assessment of Co-Occurring Disorders in the Justice System](#) provides evidence-based practices for screening and assessing for mental health conditions, SUDs, and co-occurring disorders. It includes comprehensive descriptions of screening and assessment tools for mental health, risk of death by suicide, trauma, PTSD, motivation for treatment, substance use, and co-occurring mental health conditions and/or substance use disorders.

Special Populations

- SAMHSA's [After Incarceration: A Guide to Helping Women Reenter the Community](#) contains resources for service providers and practitioners who provide or coordinate reentry services for women.
- The Legal Action Center's [ATI/Reentry Services and the LGBTQI Community](#) PowerPoint slides include reentry resources for the LGBTQI+ community.
- The Office of Human Services Policy, Office of the Assistant Secretary for Planning and Evaluation, and the Administration for Native Americans, Administration for Children and Families, both within the United States Department of Health and Human Services, published [Improving Outcomes for American Indian/Alaska Native People Returning to the Community From Incarceration](#), a resource guide for service providers. The document includes a link to the Bureau of Justice Assistance's [Planning a Reentry Program: A Toolkit for Tribal Communities](#).

Examples of Organizations Implementing Evidence-Based Interventions



This chapter highlights four programs serving individuals living with mental health conditions and/or substance use disorders who are reentering the community from a correctional setting. Each program implements at least one of the three practices described in [Chapter 2](#) and provides services pre- and post-release. The programs included in this chapter were identified through a review of the practice literature and consultation with experts.

- The *Border Reentry and Community Integration Program*, operated by Serving Children and Adults in Need, supports individuals returning to Webb County, Texas, following incarceration in state and local facilities. Participants have a substance use disorder (SUD), or co-occurring substance use disorder and mental health condition.
- The Felton Institute’s *Success: Movement From Incarceration* program serves individuals returning from jail to Alameda County, California, who are experiencing severe and persistent behavioral health challenges.
- The *MISSION Re-Entry* program in Plymouth County, Massachusetts, is implemented by Gándara Mental Health Center. The program serves men living with a SUD or co-occurring substance use disorder and mental health condition who are returning to Plymouth County from any correctional facility in the state.

- The *Living-Free* program, run by the Forensic Drug Diversion Clinic in New Haven, Connecticut, focuses on individuals living with a SUD or co-occurring substance use disorder and mental health condition who are reentering their community following jail or prison.

The program summaries include information gathered through interviews with each program’s staff and review of program materials. Though the specific population of focus and the type of interventions vary across programs, they all had the common goal of successfully integrating people back into the community using a holistic and multidisciplinary approach. This approach sought to address participants’ behavioral health needs as well as their needs for physical health care, housing, food assistance, employment, and transportation.

The following themes were common across programs:

- Communication and relationship building with prospective participants prior to release motivated them to enroll and stay engaged in the program.
- Case management and peer navigation were crucial in helping participants obtain key documents (e.g., social security cards, birth certificates), acquire food, find a job, locate housing, and access transportation.
- Employing staff with lived experience or similar backgrounds builds trust and helps program participants feel comfortable in sharing their own experiences.

Serving Children and Adults in Need – *Border Reentry and Community Integration Program*

Laredo, Texas

Background and Context

Serving Children and Adults in Need (SCAN), a Certified Community Behavioral Health Clinic, provides “step up” or “step down” care and crisis services to program participants. The Border Reentry and Community Integration Program, established in 2018, supports individuals returning to Webb County, Texas, following incarceration in state and local facilities. Program participants are adult men and women aged 18 and older who meet DSM-5 criteria for a SUD or co-occurring substance use disorder and mental health condition.

Situated on the border between Texas and Mexico, Webb County has a population of 267,114 ([United States Census, 2020](#)). Nearly 23 percent of families live below the poverty line, double the national average. Program staff report that residents are exposed to adverse environmental factors, such as easy access to cheap drugs, severe poverty, border militarization, historical patterns of discrimination, and limited social resources, which place them at higher risk of criminal behaviors and incarceration.

Program Overview

The Border Reentry and Community Integration Program provides outpatient, intensive outpatient, and intensive and supportive residential treatment services. Program practices include **case management**, **medication for opioid use disorder (MOUD)**, and **medication for alcohol use disorder (MAUD)**. Counselors provide case management as an integrated component of the program. SCAN’s programs and community relationships enable it to support program participants’ diverse needs. Its Rapid Rehousing and Homeless Program, for example, collaborates with two shelters in Laredo and works with the local Housing Authority to find housing for participants. It also has a longstanding relationship with a local employment agency to help participants find jobs.

The program provides suboxone for opioid use disorder in-house, and an in-house psychiatrist prescribes other medications approved by the Food and Drug Administration (FDA), as needed. SCAN has a memorandum of agreement with a local clinic, where clients go for methadone treatment. The Border Reentry and Community Integration Program also implements other evidence-based practices that address treatment engagement and retention (e.g., [Motivational Interviewing](#)), substance use (following a [Matrix Model for Criminal Justice Settings](#) approach), trauma and substance use (Seeking Safety), and co-occurring substance use disorders and mental health conditions (Acceptance and Commitment Therapy).

The program served 343 participants between September 2018 and December 2022. Ninety-five percent were White, and ninety-nine percent were Hispanic or Latino/a, primarily Mexican American; 86 percent were male. Substances that participants commonly use include cocaine, marijuana, opioids, and alcohol. Participants often need employment and housing in addition to immediate medical attention.

The Approach

The Public Defender’s and Sheriff’s Office refer individuals to SCAN. Program staff meet with each individual prior to release. At this time, they confirm eligibility, assess the individual’s service needs, introduce them to their counselor, and provide them with information about release, including their treatment plan, linkage to job sites, and other services. At release, program staff pick up the participant; if they need services that SCAN does not provide, such as detoxification, the program will transport them to the relevant facility.

When the participant arrives at SCAN, a counselor conducts another needs assessment and then provides or refers participants to services. Participants may receive individual behavioral health treatment and family integrated services (including psychoeducation on overdose prevention and needed services, such as rapid HIV/HCV testing, food assistance, mental health services, and utility fees assistance). Counselors help participants obtain key documents (e.g., social security cards, birth certificates), find a job, locate housing, and access transportation. Participants meet with their counselor at least once a week. They typically remain in the program for four to six months.

Counselors must be licensed or certified within the state and complete training on evidence-based practices. Treatment teams meet weekly, and counselors receive feedback from the clinical supervisor and peers, as well as ongoing training and supervision. A grant awarded in 2018 under SAMHSA’s Offender Reentry program supports SCAN.

Serving Children and Adults in Need – *Border Reentry and Community Integration Program*

Laredo, Texas

Outcomes and Other Benefits

Participant outcomes include:

- Fewer arrests in the past 30 days (20 percent at intake compared to 1 percent at discharge), fewer incarcerations for at least one night (57 percent at intake and 9 percent at discharge), and less likely to have committed a crime (28 percent at intake and 7 percent at discharge).
- Increased abstinence from both alcohol and drugs between intake (73 percent) and discharge (89 percent).
- Fewer symptoms of depression, anxiety, and traumatic stress.
- Increased housing stability (83 percent in stable housing at discharge).
- Greater social connectedness.

Program staff report that many participants have reunited with their families.

Lessons Learned

The program has struggled with staffing and limited community resources. To attract and retain staff, they have increased salaries and created flexible schedules. Program staff have developed relationships with local organizations (e.g., soup kitchens, homeless shelters, local housing authority) to increase access for participants. Specific lessons learned include:

- **Develop and sustain community partnerships.** Especially in communities with limited resources, relationships with other organizations are crucial to meeting the diverse needs of a reentry population.
- **Focus on trauma both with program participants and among staff.** Staff receive training that enables them to provide services with a trauma-informed approach. This is critical because of the high level of past trauma in this population, and it helps staff manage secondary trauma.
- **Establish connections with local universities.** SCAN meets with graduate students in counseling psychology and other disciplines for staff recruitment. During these meetings, staff share the benefits of working at the organization, the training provided, and the SCAN job application process. SCAN has successfully recruited recent graduates from local universities.

Related Resources

- [SCAN website](#)
- [Border Reentry and Community Integration Program](#)

Felton Institute – *Success: Movement From Incarceration*

Alameda County, California

Background and Context

The Felton Institute operates several programs for individuals with justice involvement in San Francisco and Alameda County, California. One program, *Success: Movement From Incarceration*, supports individuals returning from jail to Alameda County who are experiencing severe and persistent behavioral health challenges.

In 2011, California passed [Public Safety Realignment legislation](#) (AB 109), which shifted responsibility for people with non-violent, non-serious, and non-sex offenses from the state to the counties. Specifically, individuals who are incarcerated began reporting to county probation officers rather than state parole officers upon release. In addition, any individuals sentenced to non-serious, non-violent, or non-sex offenses began serving their sentences in county jails instead of state prison. In addition to an increased population in county jails, there has been an increase in the number of people with mental health conditions upon release. In response, the Felton Institute created the *Success: Movement From Incarceration* program to provide intensive clinical case management to support individuals as they reentered the Alameda County community.

Program Overview

The program uses wraparound services and **case management** to support approximately 160 participants a year through three program phases: stabilization, transition, and sustainability. During stabilization, staff assess a participant's mental health and immediate needs, such as housing, food, vital documents, and transportation. During the transition phase, participants receive mental health and/or substance use treatment and case management services. When participants are ready to be self-sufficient and transition into long-term or short-term community support, they are in the sustainability phase.

The program primarily employs cognitive behavioral therapy, harm reduction, and motivational interviewing to support participants' behavioral health needs. At the same time, program staff, including **peer support specialists**, help participants locate housing, access transportation, acquire food, secure employment, and connect to other social services. The program also helps participants with family reunification.

The Santa Rita jail or local public defenders refer most program participants. Participants are typically on probation for a felony and are experiencing post-traumatic stress disorder (PTSD), schizophrenia, bipolar disorder, depression, anxiety, and/or SUD. Among participants with both mental health conditions and/or substance use disorders, use of methamphetamine, heroin, and/or alcohol is most common. As of April 2023, 68 percent of participants were male. Half (55 percent) were Black or African American, 16 percent were White, and 8 percent were Asian.ⁱ

The Approach

Program staff (case managers, peer support specialists, clinical case managers, and the program manager) visit the Santa Rita jail weekly to meet with potential program participants and provide information about the program. The program manager monitors referrals daily. Once the program accepts an individual and sends a confirmation to the referral source, a case manager reaches out to the individual within 48 hours. If the individual is experiencing homelessness upon release, the case manager will go into the community to locate the individual and meet them wherever they are. Upon enrollment, program staff conduct a needs assessment and connect participants to needed services.

A multidisciplinary team supports participants. The clinical case manager conducts a mental health assessment and provides counseling. Medical staff provide a medical evaluation, and a nurse practitioner provides medication, if needed. The peer support specialist helps participants gain social security benefits and acquire a driver's license or other documentation. The case manager works with participants to obtain Medicaid, secure housing, enroll in education or training, and prepare their resume.

ⁱ Data on ethnicity were not available.

Felton Institute – *Success: Movement From Incarceration*

Alameda County, California

Participants typically remain in the program for one year. The frequency of visits varies depending on the program phase. Participants in the stabilization phase need more support, but as they become more independent during the transition phase, require less support and fewer visits. When participants reach the sustainability phase, they are independent and connected with external services, as needed.

Case managers must have a bachelor's degree, and clinical case managers must have a master's degree. All program staff are trained in motivational interviewing, cognitive behavioral therapy, trauma-informed care, stages of change, a [Wellness Recovery Action Plan \(WRAP\)](#), harm reduction, cultural sensitivity, and de-escalation. The program offers trainings several times each month, and collaborators from the Alameda County Probation Department provide regular trainings on probation and compliance.

The program receives funding from the California Board of State and Community Corrections through AB 109 and from Alameda County Behavioral Health Care Services. The Felton Institute supports additional programming through private contributions.

Outcomes and Other Benefits

The program measures treatment engagement, service utilization, Medicaid enrollment, and linkage to primary care. Program staff report that participants have been able to advance their education, remain employed for longer periods of time, and reunify with family members. By the end of the program, participants report they have gained self-agency and feel empowered.

Lessons Learned

The program encountered several challenges related to the COVID-19 public health emergency. Many individuals were released from jail after a short period of time and often without notice, which made it difficult to engage them. Program staff conducted outreach to try to locate these individuals, and peers were particularly important in this effort. Once the program connected with an individual, there was concern about whether they were positive for COVID-19. The Felton Institute arranged for participants to quarantine in a hotel for 14 days, providing food delivery and hygiene kits. Additional lessons learned include:

- **Operate from a participant-centered lens.** Allow participants to share their needs and stay focused on their readiness for change. What worked for one participant may not work for another participant.
- **Be physically present.** Working with individuals who are reentering the community from jail and experiencing homelessness requires outreach on the ground, and this cannot be accomplished from a distance. To engage individuals in treatment, program staff must be willing to go to homeless encampments, parks, and other locations in the community.
- **Hire staff that mirror the participant population.** It is important that staff reflect participants' race, ethnicity, gender, language, and experience. Staff with lived experience can mitigate some of the stigma associated with being incarcerated and help participants feel comfortable sharing their own lived experience and trauma.

Related Resources

- [Felton Institute](#)
- [Success: Movement From Incarceration](#)

Gándara Mental Health Center – *MISSION Re-entry*

Plymouth County, Massachusetts

Background and Context

Gándara Mental Health Center provides reentry services through its *MISSION Re-entry* program in Plymouth County, Massachusetts. The program serves men with SUD or a co-occurring substance use disorders and mental health condition at two recovery center sites: Brockton, Massachusetts, and Plymouth, Massachusetts.

MISSION Re-entry began in January 2019 in response to the high number of incarcerated individuals returning to the Brockton and Plymouth communities upon release from correctional settings. Initially, the program accepted participants with SUD or a co-occurring substance use disorder and mental condition who had at least three-month sentences and were returning from the Plymouth House of Corrections (HOC). However, during the COVID-19 public health emergency, the program was unable to enroll its projected number of participants and, in 2020, began accepting participants returning to Plymouth and Brockton from any correctional facility in the state, including those on probation and parole.

Program Overview

The program aims to increase access to substance use and mental health treatment and recovery services upon reentry, as well as to improve housing and economic stability; reduce substance use, crime, and violence; and prevent recidivism. Using a wraparound team approach, *MISSION Re-entry* provides substance use and mental health treatment, case management, and peer support. Program staff help participants access benefits, obtain employment, and find housing.

The program provides services to an average of 60 men a year. As of September 2022, 59 percent of participants were White, 39 percent were Black/African American, and 12 percent were Hispanic or Latino/a. Seventy percent were on probation or parole. Most reported using alcohol (70 percent), and 22 percent used both alcohol and other drugs. Program participants most commonly reported using cocaine/crack, marijuana, and/or heroin. Forty-four percent of participants had a co-occurring mental health condition and substance use disorders. Anxiety (83 percent) and depression (60 percent) were the most frequent mental health diagnoses, and participants reported their symptoms interfered with their day-to-day abilities. The main challenges participants face is obtaining documentation, housing, and employment.

The Approach

Program staff regularly visit the Plymouth HOC and work with HOC staff to identify eligible individuals prior to release. *MISSION Re-entry* occasionally offers presentations for potential participants where individuals can learn if they are eligible and ask questions. Staff get to know prospective participants and then follow-up with them closer to their release.

MISSION Re-entry staff aim to meet with everyone being released to Plymouth or Brockton at least once before release. This initial meeting occurs 3 to 4 months before release. Program staff will ask individuals about their needs for treatment, housing, transportation, and other services. Staff then follow-up with these individuals periodically during the time before their release to continue to build rapport and see if any of their needs have changed. At release, the program provides transportation to one of their recovery centers. There, the case manager completes a needs assessment and makes needed referrals.

Case managers and peer support specialists help participants obtain vital documents (e.g., birth certificate, driver's license), gain health insurance, receive services from the Massachusetts Department of Transitional Assistance (e.g., cash assistance, SNAP benefits), and secure employment. Through the program's relationships with community organizations and businesses, participants may be connected with a temporary staffing agency, construction or landscaping company, or a local restaurant. In addition, the program helps participants with resume building and interviewing, sealing their records, and character references. The peer support specialist may also take participants to food pantries and introduce them to relevant support groups in the area (e.g., Narcotics Anonymous, Alcoholics Anonymous) and those offered by Gándara (e.g., Men's Support Group, Learn to Cope).

Gándara Mental Health Center – *MISSION Re-entry*

Plymouth County, Massachusetts

Individuals participate in the program for nine months. Typically, they meet with their therapist and recovery coach weekly and also meet with case managers and peer support specialists to discuss needs such as education or employment.

Case managers, peer support specialists, and recovery coaches must have a bachelor's degree and complete the agency's training to work with a reentry population. Staff are trained on multiple topics, including [cultural competence](#), crisis management, harm reduction in substance use, and motivational interviewing. Staff may also complete trainings offered by [SAMHSA's GAINS Center for Behavioral Health and Justice Transformation](#).

A 2019 grant under SAMHSA's Offender Reentry program supports *MISSION Re-entry*.

Outcomes and Other Benefits

Between enrolling in the program and six-month follow-up, the:

- Percentage of those reporting abstinence increased (i.e., did not use alcohol or illegal drugs; 68 percent at follow-up compared with 19 percent at baseline)
- Percentage of those reporting current employment or school attendance increased (65 percent at follow-up compared with 16 percent at baseline)
- Percentage of those with a permanent place to live in the community increased (25 percent at follow-up compared with 1 percent at baseline)

MISSION Re-entry has built relationships with local entities to address participants' primary needs. For example, program staff worked with the Brockton Mayor's Office to help participants obtain identification and birth certificates with fewer hurdles.

Many program participants become interested in working with individuals like themselves who are reentering the community and dealing with substance use. One who had begun to pursue a master's degree in substance use counseling, and another who had completed the program, became volunteers and were then employed full-time by the program as case managers.

Lessons Learned

MISSION Re-entry's biggest challenges have been helping participants obtain housing and secure employment. The program can support participants in sober living for three months, during which time they must begin working to save money for rent. However, many have trouble finding employment due to their criminal record. Program staff provide character references, write letters, and go to court to advocate for participants and help them get hired. Specific lessons learned include:

- **Meet participants where they are.** Focus not only on recovery, but also on the root cause of the issues contributing to their substance use.
- **Be an active listener.** Be attentive and allow participants to be themselves; this is essential for relationship building and encourages participants to keep coming back.
- **Employ staff with lived experience.** Staff who are in recovery can be supportive to program participants even without incarceration experience; for participants, knowing that staff come from the same or a similar background is powerful and helps them relate to and trust one another.

Related Resources

- [Gándara](#)

Forensic Drug Diversion Clinic – *Living-Free*

New Haven, Connecticut

Background and Context

The Forensic Drug Diversion (ForDD) Clinic, a satellite of the Connecticut Mental Health Center (CMHC), provides outpatient substance use treatment through a program called Living-Free to individuals reentering the New Haven community following jail or prison. Eligible individuals are those who have been sentenced for at least three months; they may be on probation or parole.

Despite Connecticut being one of the wealthiest states,¹⁹³ New Haven has fallen into economic decline over the past three decades, leaving an inner city with high rates of poverty, homelessness, and substance use. Connecticut has disproportionately high rates of [drug overdose](#) deaths (ranked 10th in the United States in 2020),¹⁹⁴ with New Haven County having the highest rate of drug overdose deaths in Connecticut.¹⁹⁵ Prior to 2016, there were no services in the New Haven community that focused on SUDs for those returning from jails or prisons. Living-Free was established to address this service gap and decrease substance use and recidivism rates while promoting pro-social behaviors and increasing the overall health of substance-dependent populations with criminal justice involvement.

Program Overview

Living-Free uses a collaborative care model, pairing addiction and mental health care with primary care and peer mentorship. Addiction and mental health treatment involves individualized treatment plans and focuses on the delivery of trauma-informed, evidence-based behavioral and pharmacological treatments. The program provides medication for opioid use disorder (MOUD) and medication for alcohol use disorder (MAUD) (buprenorphine, suboxone, and naltrexone), as well as medications to manage psychiatric symptoms. Methadone is available from a provider co-located at the same address. All participants receive naloxone kits.

Peer mentors provide wraparound case management services focused on housing stability, employment, and education. They support program participants in accessing and engaging in treatment, navigating barriers, obtaining needed social and community supports, and engaging in the community. All participants are referred to a primary care partner with expertise in treating those returning to their communities from incarceration.

Over the first three years, 57 percent of Living-Free participants identified as Black, 43 percent White, 16 percent Hispanic or Latino/a, and 48 percent female. Most had been incarcerated multiple times. The most common SUDs were alcohol and opioid use disorders. Psychiatric comorbidity was common; depression, anxiety, bipolar disorder, and PTSD were the most commonly reported mental health conditions. Thirty-five percent of participants had serious and chronic healthcare issues and needed immediate medical care. In addition to behavioral health treatment, participants primarily needed support with housing, employment, and navigating other systems, such as parole, probation, and child welfare.

The Approach

Living-Free provides extensive pre-release services. Program staff work with the Department of Corrections (DOC) Coordinator to identify eligible individuals four months prior to release and recruit them into the program. Two months prior to release, the addiction clinician and peer mentor meet with the participant to understand their treatment needs, develop an individualized treatment plan, and encourage participants to engage in treatment. One month prior to release, participants go on an escorted visit to the ForDD Clinic. On this half-day visit, they see the physical location of the clinic and meet with the treatment team to continue to build therapeutic relationships, develop their individualized treatment plan, and identify case management needs. Treatment continues the day of release. The DOC has the capacity to start MOUD or MAUD in their facilities, and continuation of any medications is managed at ForDD. Overdose prevention begins at the first recruitment meeting and continues throughout treatment. The primary mode of treatment is individual counseling, with group therapy used as a supplement. Behavioral treatment occurs through individual weekly sessions with a clinician and meetings with other treatment team members, such as addiction psychiatrists.

Peer mentors who have prior lived experience of substance use and incarceration are members of the treatment team. Notably, the **peer mentor meets with the participant daily** during the first week post-release and provides ongoing support, which may continue daily throughout treatment. Peer mentors also facilitate weekly groups. Treatment lasts a minimum of three months and continues as long as needed, sometimes up to two years.

Forensic Drug Diversion Clinic – *Living-Free*

New Haven, Connecticut

The treatment team consists of psychologists, social workers, nurses, licensed drug and alcohol counselors, peer mentors, employment specialists, and addiction psychiatrists. All clinicians are trained in evidence-based addiction care. All staff are trained in opioid overdose prevention, and naloxone is on site. Peer mentors receive 40 hours of training.

CMHC is a facility of the State of Connecticut Department of Mental Health and Addiction Services (DMHAS) and is operated in collaboration with Yale University. The ForDD Clinic is a cooperative endeavor between DMHAS and the Law and Psychiatry Division of CMHC and the Department of Psychiatry at the Yale School of Medicine. Living-Free has been supported by SAMHSA grants since its inception in 2016. Because it is state-funded, the ForDD Clinic can provide treatment to individuals who do not have the ability to pay.

Outcomes and Other Benefits

Outcomes from the first 200 Living-Free participants include:

- Almost 80 percent of participants completed a minimum of 12 sessions and were abstinent from substances.
- By the end of treatment, 96 percent of participants were housed, and 48 percent obtained employment.
- Six-month recidivism outcomes were 4.6 percent for a new arrest, and 0 percent for a new incarceration, which were lower than state averages¹⁹⁶ (19 percent and 21 percent, respectively).

Lessons Learned

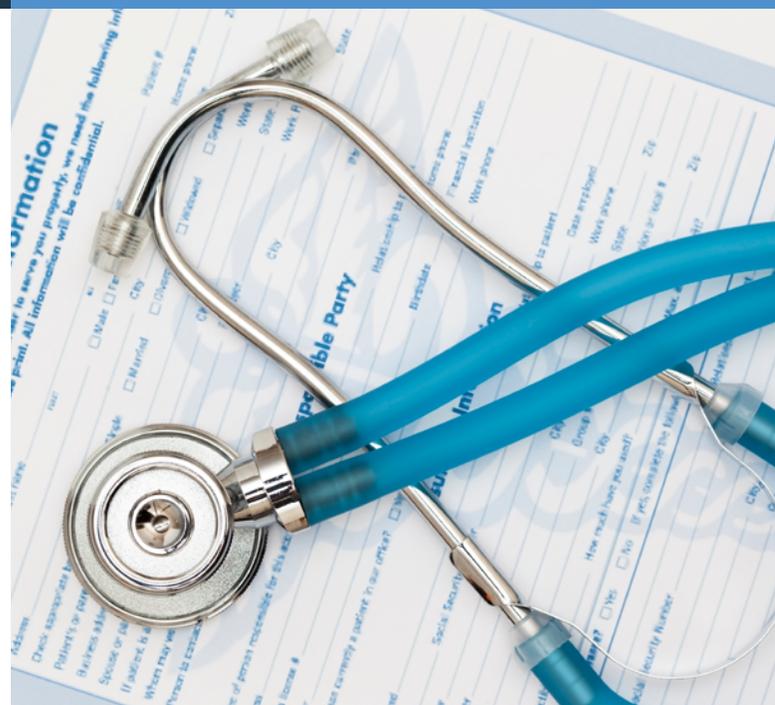
During the COVID-19 public health emergency, program staff were unable to visit potential participants while they were still incarcerated, and the entire program was transitioned to a telehealth format. Once they were able to see participants in person again, they maintained a hybrid format, allowing participants the flexibility of telehealth visits when needed. Specific lessons learned include:

- **Recognize that the first few weeks after release can be an overwhelming time for individuals.** Program staff need to support participants during this transition.
- **The treatment team must be committed to working with this population.** Providing an open and welcoming environment helps participants feel understood and positively impacts treatment outcomes.

Related Resources

- [Interview with NPR about Living-Free](#)
- [The ForDD Clinic](#)

Guidance and Resources for Evaluation



Program evaluation can occur at varying levels of depth and rigor, through multiple approaches, and for different purposes. Evaluations can answer important questions about the extent to which an intervention is delivered as planned (fidelity), which aspects of a program are working, and which aspects may require modifications for improvement. Evaluation can also show how clients benefit from the program or practice and provides data that can be helpful in adjusting the program, if necessary. Findings from an evaluation can demonstrate the value of a program to justify its continuation and secure additional funding.

Organizations should evaluate both the process of implementing the intervention and its outcomes. Ideally, evaluations of reentry programs will document significant outcomes related to behavioral health, well-being, and/or recidivism, as well as trust in the implementation process. Staff who manage and implement the intervention and program participants should be engaged in the generation of evaluation plans and data collection tools to ensure they are appropriate for the evaluated programs and program participants. Sharing findings with staff and program participants is a priority and promotes transparency and program improvement.

In contrast to evaluation, [continuous quality improvement](#) (CQI) is the process of assessing program or practice implementation and short-term outcomes, and then involving program staff to identify and implement

improvements in service delivery and organizational systems to improve outcomes. The data collected as part of CQI can overlap with data that might be collected as part of a more structured evaluation plan. Ideally, evaluation findings are also used to improve the implementation and quality of programs, but this feedback process typically takes much longer because it relies on a more involved process of data collection, cleaning, analysis, and reporting.

This chapter provides an overview of approaches to assess implementation and outcomes of interventions for reentry of incarcerated individuals living with mental health conditions and/or substance use disorders.

Types of Evaluations

Evaluation is an integral part of the planning and implementation process. Evaluations can be [formative](#) (conducted prior to or during implementation) or summative (conducted once the organization has implemented the program/intervention). Summative evaluations can encompass fidelity, processes, outcomes, or impact. Evaluations can have different purposes, as described below. They can inform organizations about needed modifications to the current intervention or identify whether additional interventions may be required to meet an organization's ultimate goals. Both qualitative and quantitative methods, as well as participatory approaches, are important when evaluating interventions to address reentry. When evaluating reentry

Types of Evaluations



FORMATIVE EVALUATIONS assess the readiness of an organization to implement a program/intervention, articulate a theory of change (often illustrated in a logic model), and determine the extent to which evaluators will be able to obtain data to assess a program's implementation and outcomes. Staff can also use what is learned during formative evaluations to make mid-course corrections to the program so that it reaches the intended audience or achieves desired results.



FIDELITY EVALUATIONS measure the extent to which the delivery of an intervention adheres to the protocols and program model originally developed. Fidelity evaluations identify and measure the core components, activities, and processes of the intervention to identify discrepancies. This can be particularly useful when making sense of unsuccessful outcomes, to assess whether the result truly reflects the intervention or was due to not implementing the intervention with fidelity.



PROCESS EVALUATIONS collect and analyze data about the implementation of a program. Process evaluations enable leaders and/or program managers to assess whether they have implemented the program as planned and if (and to what extent) the program reached the intended audience. Process evaluation, namely continuous quality improvement (CQI), also documents factors that support implementation and implementation challenges or barriers (e.g., Is programming trauma-informed?). Organizations may conduct a process evaluation concurrently with an outcome or impact evaluation.



OUTCOME EVALUATIONS collect baseline data and data at defined intervals (e.g., monthly, quarterly, yearly) during and after full implementation of the program to assess short- and long-term outcomes. These outcome data provide leaders and/or program managers with information to assess changes or improvements in attitudes and behaviors that can be associated with the program.



IMPACT EVALUATIONS assess whether outcomes can be attributed to the program. Impact evaluations seek to establish a causal relationship between a program and the observed outcomes. However, impact evaluations often can be challenging, time-consuming, and expensive to implement.

programs, it is important to remember that outcomes may not be observable immediately. Therefore, evaluation should be continuous and longitudinal in scope.

Evaluation Considerations

Conducting Culturally Responsive and Equitable Evaluation

As highlighted earlier in this guide, people of color, particularly those who are Black, Hispanic or Latino/a, and Native American,¹⁹⁷ are overrepresented in the criminal justice system and face many barriers to accessing treatment and other social services.⁶ It is important for the evaluation of reentry programs and reentry practices to examine whether the intervention is equitably implemented to benefit all individuals and whether it has differential effects.

A [culturally responsive and equitable evaluation](#) does not consider culture as a subjective factor that needs to

be controlled; instead, it explicitly acknowledges culture and context when assessing program effectiveness. Equitable evaluation relies heavily on engaging with the program participants for whom the evidence-based program or practice is being implemented and from whom evaluation data are collected. According to the [Equitable Evaluation Initiative](#) (EEI), evaluation efforts should be in service of equity, and evaluators should consider the following aspects while developing their evaluation approach:

- Diversity of their evaluation teams, including cultural backgrounds, disciplines, beliefs, and lived experiences
- Cultural appropriateness and validity of evaluation methods
- Ability of the evaluation design to reveal structural and systems-level drivers of inequity (present-day and historical)
- Degree to which communities have the power to shape and own how evaluation happens

The EEI also states that evaluative work can and should answer critical questions. Given the diverse racial composition of individuals reentering the community from prisons and jails, programs may also wish to collect data to understand the effects racial differences have on:

- Referral patterns for services
- Retention in programs
- Engagement with services
- Reasons people exit programs or discontinue services

These types of questions, through an equitable evaluation lens, will help identify structural issues or other biases that may affect service systems and help sustain equitable service delivery.

Continuous Quality Improvement

CQI can address some of the considerations above and be used with the help of program staff to systematically identify, document, and analyze barriers and facilitators to implementation. It's an important tool for improving outcomes. See next page for more information about CQI.

Developing an Evaluation Plan

The Centers for Disease Control and Prevention (CDC) has identified [six key steps to program evaluation](#):

1. **Engage community members.** The program planning, implementation, and evaluation of a reentry intervention will require involvement of multiple partners with diverse backgrounds. As discussed in [Chapter 3](#), it is important to engage state and community organizations and agencies representing the criminal justice system, the behavioral health system, and social services and supports, as well as people with lived experience reentering the community, business leaders, and others who can provide diverse perspectives.
2. **Describe the intervention.** The implementation team needs to reach a common understanding of what the intervention is, its goals, and its intended outcomes. This includes agreeing on the theoretical approach (e.g., abstinence or harm reduction). It can be helpful for providers and community members to develop a logic

Types of Data

Qualitative and quantitative data are complementary. Each provides critical insight into if and how the intervention is operating and achieving the intended objectives.

- **Qualitative data** include any non-numeric, text-based information, such as verbal, visual, or written data. Qualitative data collection methods include interviews, focus groups, clinical observations, gathering data from documents and images, and open-ended survey questions and polling responses.
- **Quantitative data** are any numeric data that can be processed by mathematical or statistical analysis. Quantitative data collection includes close-ended survey questions and polling responses, services and utilization data, and claims and encounter data.

model that articulates the components of the program they are evaluating, what the intended outcomes are, and how they hypothesize the program will achieve the intended impact. Organizations should also consider potential unintended consequences of the program and how it may affect different groups because of their social identities (e.g., race/ethnicity, age, sexual orientation, ability).

3. **Focus the evaluation design.** As described above, organizations can conduct several types of evaluations. It may be necessary to conduct multiple evaluations to fully understand the intervention's implementation and what its outcomes and impact were. Once the organization has selected which evaluations to conduct, it must identify evaluation questions and determine meaningful [indicators](#) (as described below).
4. **Gather credible evidence.** Six questions can help guide a data collection plan:
 - a. What do you need to know to answer the evaluation questions?
 - b. In what timeframe will you collect data, and how often?
 - c. What is the evaluation budget? What is the staff capacity and ability to do data collection?

Continuous Quality Improvement

WHAT IS CQI?

CQI involves a systematic process of assessing program or practice implementation and short-term outcomes and then involving program staff to identify and implement improvements in service delivery and organizational systems to achieve better outcomes. CQI helps assess practice fidelity (the degree to which a program delivers a practice as intended).

CQI differs from process evaluation in that it involves quick assessments of program performance, timely identification of problems and potential solutions, and implementation of small improvements to enhance treatment quality. CQI is usually conducted by internal staff. Process evaluation involves longer-term assessments and is best conducted by an external evaluator.

WHY USE CQI?

CQI takes a broad look at the systems in which programs or practices operate. Because of the pivotal role it plays in performance management, agencies and communities beginning to implement reentry services such as case management, MOUD/MAUD, and peer and patient navigation for those returning from jail or prison may benefit from CQI procedures.

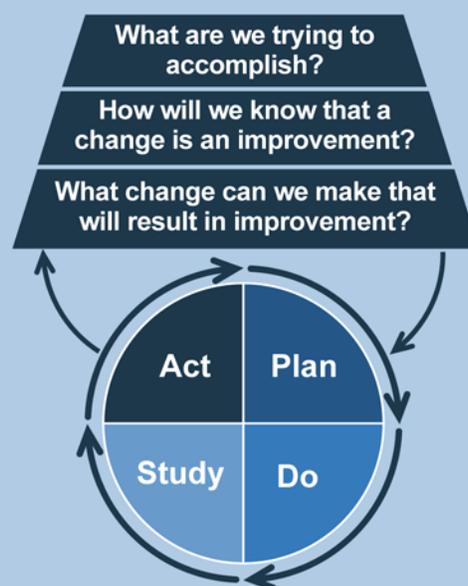
WHAT ARE THE STEPS INVOLVED IN CQI?

Although steps in the CQI process may vary based on objectives, typical CQI steps include:

- 1 Identify a program or practice issue needing improvement and a target improvement goal
- 2 Analyze the issue and its root causes
- 3 Develop a plan to correct the root causes of the problem, including specific actions to be taken
- 4 Implement the actions in the plan
- 5 Review the results to confirm that the issue and its root causes have been addressed and short- and long-term outcomes have improved
- 6 Repeat these steps to identify and address other issues as they arise

Another way to think about the stages are in an action-oriented, cyclical manner, with stages of: planning it (PLAN), trying it (DO), observing the results (STUDY), and acting on what is learned (ACT).

MODEL FOR IMPROVEMENT



Sources:

Institute for Healthcare Improvement. (n.d.). *Science of improvement: Testing changes.*

<http://www.ihl.org/resources/Pages/HowtoImprove/ScienceofImprovementTestingChanges.aspx>

Associates in Process Improvements. (n.d.). <http://www.apiweb.org/>

U.S. Department of Health and Human Services Office of Adolescent Health. (n.d.). *Continuous quality improvement, part 1: Basics for pregnancy assistance fund programs.* <https://www.hhs.gov/ash/oah/sites/default/files/cqi-intro.pdf>

New Jersey Department of Children and Families. (n.d.). *Five stages of continuous quality improvement.* <https://www.nj.gov/dcf/about/divisions/opma/CQI%20framework.pdf>

- d. Are there ethical considerations, such as anonymity or privacy, which affect data collection?
- e. Are the data reliable and valid?
- f. Who owns the data? Are the data accessible?

5. Justify conclusions. Once data collection is complete, the evaluation team should present the data in a way that is meaningful and understandable to community members, including staff and leaders within the organization. Interested organizations, agencies, and individuals identified earlier in the evaluation process should have an opportunity to provide guidance and input on data interpretation. Program staff and evaluators also should consider using this opportunity to look at and present the data through an equity lens, analyzing outcomes by different subpopulations (e.g., different roles within the organization, different racial/ethnic groups, populations with different socioeconomic characteristics).

6. Ensure use and share lessons learned. Organizations can use evaluation results both internally (for continuous feedback on an intervention’s implementation) and externally (to provide information on the effectiveness of the program, increase the evidence base, and/or increase awareness about the program). For each audience, consider detailing what the communication objectives are, what the best format is to communicate the results, and what the key focus is. Then, look at other considerations specific to each target audience, such as what their priorities are, whether background information is needed, and how much time they have to review results.

should educate program staff about the importance of data collection to make it a priority in their work.

Program leaders and staff, on the other hand, play an important role in guiding the evaluation.¹⁹⁸ They provide a “real-world” understanding of the issues evaluators should integrate into an evaluation to make it relevant to the individuals receiving services. Program staff looking for evaluation partners can connect with local universities to identify researchers who focus on criminal justice or reentry and have experience with program evaluation. Additionally, online evaluation tools are available, such as [CONNECT](#), a researcher and practitioner collaboration and discovery tool developed by the Justice Community Opioid Innovation Network (JCOIN).

Tips for Effective Partnerships Between Reentry Program and Evaluation Staff¹⁹⁸

- Roles and responsibilities for evaluation and program staff are clear
- Associated tasks have clear objectives, designated staff, and deadlines
- Evaluators familiarize themselves with the corrections system in their jurisdiction
- Evaluation staff co-locate with program staff to conduct the evaluation
- Communication between evaluators and program staff is regular and consistent
- High-level program leaders are engaged early on, and informational sessions occur with both program and evaluation staff

Evaluation and Program Staff Collaboration

Funding agencies may require projects to conduct an evaluation as part of their grant project.¹⁹⁹ To meet this requirement, reentry programs are increasingly partnering with evaluators who bring the skillset required to conduct a rigorous evaluation. Collecting and analyzing evaluation data is critical to monitor progress toward program goals, determine whether program components have the intended effect, and make midcourse corrections in implementation. Evaluators

Outcomes

An important but often challenging step in the process of implementing reentry programs and practices is determining whether they have produced desired outcomes. An outcome is the actual change resulting from an intervention’s implementation. Program leaders and staff may see short-term outcomes of an intervention quickly, such as enrollment in job training programs or participation in specific substance use or mental health treatment services. Long-term outcomes may take longer to measure, such as reduction in substance use,

reduction in recidivism, and acquisition of meaningful employment and/or stable housing.

The table below provides a list of potential process and outcome measures, illustrative indicators, and qualitative and quantitative data sources that evaluation teams may use to review evidence-based programs and practices identified in [Chapter 2](#). It is important to establish program goals early and the outcome types necessary for program success. It is also imperative that data exist to inform measures and a plan is developed to collect,

manage, and analyze evaluation data to determine program effectiveness.

Evaluations do not need to use all of these measures. Choosing which measures to use will depend on the program goals and evaluation, the population, available data sources, and the time and resources for and feasibility of collecting the data. Further, it is important to pilot measures to ensure they are understood and interpreted as intended.

Measures, Indicators, and Data Sources		
Measure	Illustrative Indicators	Illustrative Data Sources
Process Measures		
Drug or Alcohol Testing	<ul style="list-style-type: none"> Percentage of program participants who receive drug or alcohol testing to help monitor substance use and treatment progress Percentage of program participants who received at least one random drug or alcohol test 	<ul style="list-style-type: none"> Administrative data
Other Services Provided	<ul style="list-style-type: none"> Percentage of program participants who received the following services: <ol style="list-style-type: none"> Cognitive behavioral therapies SUD treatment Mental health treatment Education Employment Housing Other 	<ul style="list-style-type: none"> Administrative data
Program Participants Served	<ul style="list-style-type: none"> Percentage of individuals eligible for program services who were served since implementation of the program 	<ul style="list-style-type: none"> Administrative data
Screening and Assessment	<ul style="list-style-type: none"> Are criminogenic risk and/or needs-assessment tools used to inform the services provided to participants? If so, how are they used? How are tool results used to determine who is admitted as program participant? How are tool results used to inform individualized case planning done within the program? 	<ul style="list-style-type: none"> Administrative data collected through validated screening assessment tools,ⁱ selected based on the treatment population. Examples include: <ul style="list-style-type: none"> Texas Christian University Drug Screen Addiction Severity Instrument Level of Service Inventory-Revised Level of Service/Case Management Inventory Ohio Risk Assessment System PTSD Checklist Patient Health Questionnaire Brief Addiction Monitor Five Facet Mindfulness Questionnaire

ⁱ Tools vary in cost; before selecting a tool, ensure the cost for use fits within budget constraints.

Measures, Indicators, and Data Sources		
Measure	Illustrative Indicators	Illustrative Data Sources
Process Measures		
Training	<ul style="list-style-type: none"> • Number of trainings completed since the start of the program • Number of staff trained • Percentage of staff trained • Increased knowledge, skills 	<ul style="list-style-type: none"> • Administrative data • Pre-and-post training survey
Treatment Services Provided	<ul style="list-style-type: none"> • Percentage of participants, since the beginning of the program, who received treatment services for different types of substance use (e.g., stimulants, opioids, alcohol) • Percentage of individuals living with alcohol and/or opioid use disorders who have been identified as eligible for Medications for Opioid Use Disorder (MOUD) and Medications for Alcohol Use Disorder (MAUD) (since the start of the program) • Percentage of participants identified as eligible for MOUD/MAUD who received different medications (e.g., methadone, buprenorphine, naltrexone) • Percentage of individuals, since the start of the program, who received specific treatment: <ol style="list-style-type: none"> A. Outpatient services B. Intensive outpatient or partial hospitalization services C. Residential or inpatient services D. Medically managed intensive inpatient services E. Inpatient withdrawal management (detoxification), MOUD/MAUD F. Co-occurring mental health and substance use disorder treatment services G. Mental health treatment services H. Family therapy I. Trauma treatment 	<ul style="list-style-type: none"> • Administrative data

Measures, Indicators, and Data Sources		
Measure	Illustrative Indicators	Illustrative Data Sources
Outcome Measures		
Housing, Employment, and Education	<ul style="list-style-type: none"> Percentage of participants, since the beginning of the program, who: <ul style="list-style-type: none"> Obtained housing, by housing type (e.g., emergency housing, residential treatment facility, own house or apartment) Obtained permanent/stable housing (i.e., for six months or longer) Obtained high school diploma or equivalent Obtained vocational, professional, or occupational certifications or licenses Obtained higher education degree Obtained employment Obtained and retained employment for six months or longer 	<ul style="list-style-type: none"> Administrative data Survey instruments (develop own measures, quantitative or qualitative)
Engagement in Reentry Intervention	<ul style="list-style-type: none"> Percentage of individuals still engaged with the program (out of the total number of participants served since the start of the program) Percentage of individuals who completed program requirements (out of the total number of participants no longer engaged with the program) Percentage of individuals who report being satisfied with the program 	<ul style="list-style-type: none"> Administrative data Survey instruments (develop own measures, quantitative or qualitative) Qualitative interviews with program participants
Mental Health and General Well-Being	<ul style="list-style-type: none"> Self-reported perceptions of overall satisfaction with: <ul style="list-style-type: none"> Vocation Finances Health Social Relationships Self-reported hospitalization for mental health relapse 	<ul style="list-style-type: none"> Survey instruments (develop own measures, quantitative or qualitative) Qualitative interviews with program participants Structured quantitative scales and assessments (e.g., Well-Being Inventory, Mental Health Inventory, BMJ Open Review of 99 self-report measures for assessing well-being in adults)
Recidivism	<ul style="list-style-type: none"> Rearrest rate Reconviction rate Reincarceration rate Revocation that led to reincarceration 	<ul style="list-style-type: none"> Arrest/conviction data from a criminal justice agency (e.g., local police department or sheriff's office, state police, department of corrections, probation, or parole) Public record jail/prison data Survey instruments (develop own measures, quantitative or qualitative) Qualitative interviews with program participants

Measures, Indicators, and Data Sources		
Measure	Illustrative Indicators	Illustrative Data Sources
Outcome Measures		
Substance Use	<ul style="list-style-type: none"> Percentage of program participants testing positive at least once from a random drug or alcohol test Percentage of program participants reporting engaging in substance use following program completion Percentage of program participants reporting reduced drug use Percentage of program participants reporting receipt of naloxone Percentage of program participants experiencing an overdose Percentage of program participants reporting using less severe or risky modes of administration (e.g., oral vs. injection administration) 	<ul style="list-style-type: none"> Administrative data Survey instruments (develop own measures, quantitative or qualitative) Qualitative interviews with program participants

General Program Evaluation and Continuous Quality Improvement Resources

- A [Framework for Program Evaluation](#) from the Program Performance and Evaluation Office at the Centers for Disease Control and Prevention summarizes essential elements of program evaluation.
- The National Institutes of Health has a [webpage](#) with tools and guidance for evaluation.
- The [Rainbow Framework](#) provides tools that organizations can use in program monitoring and evaluation.
- The Administration for Children and Families (ACF) provides [several resources](#) to assist in evaluating programs. While originally intended for pregnancy prevention programs, the resources are applicable to reentry as well.
- [The Institute for Healthcare Improvement’s Quality Improvement Essentials Toolkit](#) includes the tools and templates to launch a quality improvement project and manage performance improvement.

- The National Learning Consortium offers a primer called [Continuous Quality Improvement \(CQI\) Strategies to Optimize Your Practice](#) that focuses on electronic health record implementation, which could be applied to any type of outcome, regardless of the sophistication of the data collection mechanisms available.
- The CDC provides information on [logic models](#) and the [key steps for developing a useful logic model](#).



Evaluating Programs That Focus on Re-entry

- The National Reentry Resources Center developed a brief entitled [Improving Evaluation Readiness for Reentry Programs](#) that focuses on improving evaluation readiness for reentry programs.
- The National Reentry Resource Center's [Resource Brief: Using Evaluation Results to Improve Service Delivery in Reentry Programs](#) describes strategies for using formative and [process evaluation](#) data to inform and improve implementation.
- [Best Practices for Collecting Primary Data From Reentry Populations for Program Evaluation](#), published by the Evaluation and Sustainability Training and Technical Assistance (ES TTA) Project, provides guidance on designing and implementing primary data collection protocols for reentry programs.

Resources on Culturally Responsive and Equitable Evaluation

- The Handbook of Practical Program Evaluation's [Culturally Responsive Evaluation: Theory, Practice, and Future Implications](#) provides a foundation for culturally responsive evaluation, from preparation for evaluation to disseminating and utilizing results.
- The [Equitable Evaluation Framework™](#) provides a set of principles upon which to understand why and how to conduct culturally responsive evaluation.
- The National Reentry Resource Center's [Assessing and Enhancing Cultural Responsiveness in Reentry Programs Through Research and Evaluation](#) is a resource brief on identifying strategies for improving a reentry program's cultural responsiveness.

Evaluating Program Sustainability

- The Center for Public Health Systems Science at the Brown School at Washington University in St. Louis has developed a [Program Sustainability Assessment Tool \(PSAT\)](#) and a [Clinical Sustainability Assessment Tool \(CSAT\)](#) to measure progress toward sustaining new implementation efforts.
- JCOIN Coordination and Translation Center's customizable [Budget Impact Tool](#) can be used to estimate the costs of starting and maintaining methadone, buprenorphine, and/or naltrexone prescribing services.



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APPENDIX 1: Glossary

Alcohol use disorder: A medical condition characterized by an impaired ability to stop or control alcohol use, despite adverse social, occupational, or health consequences.

Association: Evidence demonstrating a statistical relationship, either positive or negative, between an intervention and outcomes measured in the study's sample population. Association is not causation.

Behavioral health: The promotion of mental health, resilience, and well-being; the treatment of mental health conditions and substance use disorders; and the support of those who experience and/or are in recovery from these conditions, along with their families and communities.

Behavioral health provider: A professional who helps individuals address mental health conditions and/or substance use disorders. Professionals include psychologists, psychiatrists, nurses, peers, patient navigators, therapists, addiction and mental health counselors, recovery coaches, case workers, social workers, psychiatric aides and technicians, psychiatrists, and paraprofessionals working in psychiatric rehabilitation and addiction recovery fields, as well as other medical and non-medical professionals who manage and support behavioral health issues.

Case management: A coordinated approach to delivering and linking clients to health, substance use, mental health, and social services, however appropriate to address clients' specific needs and achieve stated goals.

Causality: Evidence demonstrating that an intervention causes or is responsible for the positive or negative outcomes measured in the study's sample population.

Community supervision: The supervision of criminal offenders in the resident population, as opposed to confining offenders in secure correctional facilities. The two main types of community supervision are probation and parole.

Continuity of care: Ability to access uninterrupted medical and mental healthcare and substance use services during a setting transition. Ideally, transitions are as seamless as possible and involve timely access to effective, evidence-based treatment to avoid a service lapse.

Continuous quality improvement (CQI): A systematic process of assessing program or practice implementation and short-term outcomes and then involving program staff to identify and implement improvements in service delivery and organizational systems to achieve better outcomes. CQI helps assess practice fidelity.

Co-occurring mental health conditions and substance use disorders: The coexistence of both a mental health condition and a substance use disorder.

Criminal justice personnel: Individuals who work in law enforcement, the court system, or corrections.

Criminogenic risk: The characteristics, traits, problems, or issues of an individual that directly relate to the individual's likelihood to re-offend and commit another crime.

Cultural competence: A set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enable that system, agency, or those professions to work effectively in cross-cultural situations.

Culturally responsive and equitable evaluation (CREE): Evaluation that incorporates cultural, structural, and contextual factors (e.g., historical, social, economic, racial, ethnic, gender) using a participatory process that shifts power to the individuals most impacted.

Culture: A broad, multi-dimensional construct that refers to integrated patterns of human behavior, including language, spirituality, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups.

Data: Any information that has been collected, observed, generated, or created by an individual, grantee, program, organization, state, or federal agency. Some data can be used to identify a specific individual, and in such cases, it is protected. Data is used to describe activities in an objective manner, and it can be used to validate research findings. Patient-level data created by specialty addiction treatment programs is protected under 42 C.F.R. Part 2.

Drug overdose: When an individual uses a high quantity of a drug or other substance, or combination of drugs or other substances, which results in toxicity that can cause harmful symptoms. A drug overdose can be accidental or intentional and fatal or nonfatal.

Evidence-based practice (EBP): Interventions that are guided by the best research evidence with practice-based expertise, cultural competence, and the values of the persons receiving the services, which promote individual-level or population-level outcomes.

Fidelity: The extent to which an intervention is delivered as conceived and planned.

Formative evaluation: An evaluation that assesses the readiness of an organization or community to implement the intervention, articulates a theory of change, and determines the extent to which evaluators can assess an intervention in a reliable and credible fashion.

Harm reduction: A practical and transformative approach that incorporates public health strategies, including prevention, risk reduction, and health promotion, to people who use drugs so they can live healthy and purpose-filled lives.

Indicators: Quantitative or qualitative metrics that provide information to monitor performance, achievement, and accountability.

In-Reach: A strategy where providers from community-based organizations meet with an individual prior to release to begin service planning and establish continuity of care. Specific activities may include rapport development, education about post-release services, interviews or assessments for post-release programming, and the provision of other services or programming prior to release.

Intervention: A program, initiative, service, or policy related to reentry.

Justice-involved: This descriptor indicates past or current involvement in the criminal justice system, typically indicating the person has experienced one or more of the following: an arrest, prosecution, incarceration in a jail or prison, and/or community supervision.

Lesbian, gay, bisexual, transgender, queer/questioning, and intersex + (LGBTQI+): People who are questioning their sexual orientation or gender identity, and others who are not cisgender or straight/heterosexual. LGBTQI+ is used interchangeably with “sexual and gender minority.”

Linkage to care: Connecting individuals to services.

Lived experience: Personal knowledge gained through direct, first-hand involvement. In the context of this report, lived experience refers to individuals who have experienced mental illness, substance use or substance use disorder, or criminal justice involvement.

Medications for alcohol use disorder (MAUD): An approach for treating alcohol use disorders, reducing alcohol use, and sustaining recovery. The most common FDA-approved medications used to treat alcohol use disorders are acamprosate, disulfiram, and naltrexone.

Medications for opioid use disorder (MOUD): An approach for treating opioid use disorders, preventing overdose, and sustaining recovery. The FDA has approved three medications for opioid use disorders: buprenorphine, methadone, and naltrexone.

Mental health disorder: A health condition characterized by changes in thinking, mood, and/or behavior. Mental health disorders include anxiety, depression, seasonal affective disorder, or more serious illnesses as bipolar disorder, major depression, schizophrenia, post-traumatic stress disorder (PTSD), and more.

Motivational interviewing: A collaborative, person-centered style of communication that is designed to initiate and/or strengthen motivation to change and that acknowledges how hard it is to change learned behaviors. It provides a framework for interacting with people who are experiencing homelessness, mental health conditions and/or substance use disorders, or trauma.

Naloxone: An opioid antagonist medication that rapidly reverses an opioid overdose.

Opioid use disorder: A type of substance use disorder involving opioid drugs, such as heroin, fentanyl, or prescription opioids (e.g., OxyContin).

Opioids: A class of drugs that includes legal and illegal substances, such as heroin, fentanyl, and prescription pain relievers like oxycodone (OxyContin®), hydrocodone (Vicodin®), codeine, morphine, and others. Some opioids, like morphine, are naturally derived, while others are synthetic (e.g., methadone) or semi-synthetic (e.g., oxycodone).

Outcomes: Variables that are monitored during a study to document the impact a given intervention or exposure has on the health of a given population.

Patient navigation: The use of trained healthcare workers to reduce barriers to care for individuals returning from criminal justice settings. Patient navigators help individuals navigate complex healthcare and social services systems to improve access to care and treatment.

Peer navigation: The practice of peer navigators providing recovery support for individuals living with mental health conditions and/or substance use disorders. Through shared understanding, respect, and mutual empowerment, they help individuals enter and stay engaged in the recovery process and reduce the likelihood of a recurrence of symptoms. Peer navigators provide recovery-oriented treatment planning and non-clinical services, such as housing support, employment services, mentoring, and support groups.

Peer support: A range of activities and interactions between people who share similar experiences of being diagnosed with mental health conditions, substance use disorders, or both.

Peers: People with lived experience who have been successful in the recovery process who help others experiencing similar situations. Through shared understanding, respect, and mutual empowerment, peers help people enter and stay engaged in the recovery process and reduce the likelihood of relapse. Peers may be referred to as peer support workers, peer specialists, peer recovery coaches, peer advocates, or peer recovery support specialists. Peers are trained as recovery coaches or peer specialists and may include family peer supporters.

Post-traumatic stress disorder (PTSD): PTSD is a mental health condition that is triggered by a traumatic event—either experiencing it or witnessing it in person. Symptoms may include flashbacks, nightmares, and severe anxiety, as well as uncontrollable thoughts about the event.

Process (implementation) evaluation: An evaluation that assesses the quality of an intervention's implementation and conditions that facilitate or create barriers to successful implementation. Process evaluation enables program managers and policymakers to assess whether they have implemented the intervention as planned, and whether and to what extent it reached the intended audience.

Recovery: Recovery is a process of change through which people improve their health and wellness, live self-directed lives, and strive to reach their full potential. There are four major dimensions that support recovery:

1. **Health:** overcoming or managing one’s disease(s) or symptoms and making informed, healthy choices that support physical and emotional well-being.
2. **Home:** having a stable and safe place to live.
3. **Purpose:** conducting meaningful daily activities and having the independence, income, and resources to participate in society.
4. **Community:** having relationships and social networks that provide support, friendship, love, and hope.

Recovery support services: A range of non-clinical support services designed to help people with mental health conditions and/or substance use disorders manage their conditions successfully.

Reentry: The point at which people who have been incarcerated are released into the community.

Recurrence of symptoms: A phase of recovery where a person’s symptoms have returned, and their functioning has decreased. This may be more commonly referred to as “relapse,” “lapse,” or “return to use.”

Risk factors: Factors that increase the likelihood of beginning substance use, of regular and harmful use, and of other behavioral health problems.

Serious mental illness (SMI): A diagnosable mental, behavioral, or emotional disorder that causes serious functional impairment that substantially interferes with or limits one or more major life activities. SMI includes disorders such as bipolar disorder, major depressive disorder, schizophrenia, and schizoaffective disorder.

SMART goals: SMART is an acronym that stands for specific, measurable, achievable, relevant, and time-bound. SMART goals incorporate all of these elements and are clear statements about the specific results to be achieved, or what should happen as a result of a program.

Stigma: Stigma arises from the negative feelings many individuals harbor against people struggling with mental health conditions and/or substance use disorders, and their beliefs that poor personal choices, “moral failing,” and defects of character are to blame for the disease. Stigma can reduce willingness of policymakers to allocate resources, reduce willingness of providers in non-specialty settings to screen for and address mental health conditions and substance use disorders, impact a person’s standing in their community, limit access to employment or housing, and may limit willingness of individuals with these conditions to seek treatment. Some people object to this term as it may perpetuate a negative connotation. Others favor “prejudice and discrimination” as the societal attitudes and actions that reinforce negative stereotypes and policies.

Stimulants: A class of drugs that includes legal and illegal drugs, such as cocaine, methamphetamine, and prescription stimulants like dextroamphetamine/amphetamine (Adderall®), methylphenidate (Ritalin®, Concerta®), and dextroamphetamine (Dexedrine).

Strengths-based: An approach to assessment and care that emphasizes the strengths of the individual.

Structural racism: A system in which public policies, institutional practices, cultural representations, and other norms work in various, often reinforcing, ways to perpetuate racial group inequity.

Substance misuse: Use of any substance in a manner, situation, amount, or frequency that can cause harm to the person using the substance or those around them. For some substances or individuals, any use would constitute misuse (e.g., underage drinking, injection drug use).

Substance use: Use—even one time—of alcohol or other drugs.

Substance use disorder: A health condition characterized by a cluster of cognitive, behavioral, and physiological symptoms that describe an individual’s compulsive use of a substance despite significant adverse problems associated with the use.

Substance use services: A service or set of services that may include medication, counseling, harm reduction, and other supportive services designed to enable an individual to reduce or eliminate alcohol and/or other drug use, address associated physical or mental health problems, and restore the patient to maximum functional ability. May also be referred to as “substance use treatment.”

Sustainability: The process of building an adaptive and effective prevention system that achieves and maintains desired long-term results.

Telehealth: Telehealth is usually used as a broader term than “telemedicine.” Telehealth typically includes not only telemedicine but also other forms of telecommunication, including asynchronous or “store and forward” systems, which transfer a patient’s data or images for a physician or practitioner at another site to access at a later time. With these systems, the patient and provider do not have to be present at the same time.

Trauma-informed care or 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; responds by fully integrating knowledge about trauma into policies, procedures, and practices; and seeks to actively resist re-traumatization. Referred to variably as “trauma-informed care” or “trauma-informed approach” this framework is regarded as essential for care.

Under-resourced communities: Population groups or geographic areas that experience greater obstacles to health based on characteristics such as, but not limited to, race/ethnicity, socioeconomic status, age, gender, disability status, historical traumas, sexual orientation/gender identity, and/or location.

Warm hand-off: A warm transfer of care between parties (be it correctional health or other reentry staff, a case manager or patient/peer navigator, or community-based social and health services staff), including directly introducing the client to the receiving provider, providing the client with all necessary materials and information to continue services, and if appropriate, providing transportation to the receiving service provider to ensure continuation of care upon release.

Withdrawal management: The provision of progressively lower and lower doses of medications to individuals experiencing characteristic physiological symptoms upon the abrupt cessation or significant reduction in use of a substance to which they had developed tolerance.

APPENDIX 2: Acknowledgments

This guide is based on the thoughtful input of SAMHSA staff and the Technical Expert Panel on Best Practices for Successful Reentry From Criminal Justice Settings for People With Substance Use and Mental Health Disorders from November 2022 through August 2023. Two expert panel meetings were convened during this time. A series of guide development meetings were also held virtually over a period of several months.

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APPENDIX 3: Literature Review Process

The authors followed a rigorous, systematic evidence review process in developing this guide. This appendix provides an overview of the evidence review methodology used to identify the strength of the behavioral health interventions and approaches included.

STEP 1: Environmental Scan – The search strategy used for this guide began with a broad scan of systematic reviews on populations returning from criminal justice settings (prisons and jails) with behavioral health disorders (substance use, mental illness, co-occurring disorders). Searches were conducted in seven databases: CINAHL, PsycInfo, EBSCO, PubMed, Science Direct, SSCI, and MedLine.

STEP 2: Study Identification – The team conducted an abstract review of every citation captured from the database searches of systematic reviews (n=62). We systematically reviewed abstracts (or in rare cases, the entire article if an abstract was not available) according to the following criteria:

- Articles published between 2003 and December 2022, written in English, and published in the United States, United Kingdom, Canada, Australia, or New Zealand

Articles described an intervention, program, or model focused on improving behavioral health service engagement and use among individuals returning from criminal justice settings (prisons and jails). In conjunction with the Technical Expert Panel, we identified three behavioral health interventions or approaches as part of this search process. For each of these interventions, we conducted a separate evidence review focused on journal articles, research, or technical reports. We excluded systematic reviews and meta-analyses from this second stage of the evidence review. We then screened abstracts for each identified behavioral health intervention/approach and application of the approach with individuals returning from criminal justice settings.

1. Medication for opioid use disorder and medication for alcohol use disorder (344 abstracts)
2. Case management (120 abstracts)
3. Peer navigation and patient navigation (212 abstracts)

STEP 3: Full-Text Study Review – The studies identified in the abstract review varied in type and rigor, so reviewers assessed them further for inclusion in the evidence review. To be eligible for full-text review, research studies had to:

- Employ a randomized or quasi-experimental design, or
- Be a single sample pre-post design or an epidemiological study with a strong counterfactual (a study that analyzes what would have happened in the absence of the intervention)

Additionally, to be eligible for further review, studies had to:

- Include at least one eligible outcome related to recidivism, substance use, treatment adherence or engagement, general well-being, education, employment, housing, etc.
- Have a comparison or control group that is treatment as usual or no/minimal intervention if using a randomized experimental or quasi-experimental design

Next, trained reviewers assessed each study to ensure the methodology was rigorous, and therefore, could demonstrate [causality](#) between the treatment practice and the identified outcomes. Reviewers analyzed and documented each study to ensure:

1. Experimental and comparison groups were statistically equivalent, with the only difference being that participants in the experimental group received the intervention and those in the comparison group received treatment as usual or no/minimal intervention.
2. For randomized experiments with high attrition and for quasi-experimental designs, baseline equivalence had been established between the treatment and comparison groups.
3. For randomized experiments, randomization was not compromised. For example, reassignment of treatment status (usually made to balance the distribution of background variables between treatment and control groups) did not occur.
4. Study did not have any confounding factors (i.e., those that affect the outcome but are not accounted for in the study).
5. Missing data were addressed appropriately, including:
 - Imputation based on surrounding cases was considered valid.
 - Complete case analysis was considered valid and accounted for as attrition.
 - Using model with dummy for missing as a covariate was considered valid.
 - Assuming all missing data points are either positive or negative was not considered valid.
 - Regression-based imputation was considered valid and mean imputation was not considered valid.
6. Outcome measures were reliable, valid, and collected consistently from all participants.
7. Valid statistical models were used to estimate impacts.
8. Treatment demonstrated improved outcomes related to substance use, SUD, or treatment engagement.

Based on these study characteristics, reviewers determined if studies had a strong design that provided support for causal evidence and if they included significant, positive outcomes.

We also systematically reviewed and extracted information, such as type(s) of services (treatment and recovery, housing, employment, etc.), the population served (prisons, jails), setting, study design, outcomes of focus, findings, and lessons learned.

Most studies included outcomes related to recidivism, substance use, and treatment adherence or engagement.

STEP 4: Study Synthesis – We synthesized findings for each of the three approaches and programs included in this evidence review. We included interventions if at least one study had a strong study design and demonstrated significant, positive behavioral health outcomes (behavioral service engagement and use) or recidivism outcomes for individuals reentering communities from criminal justice settings.

APPENDIX 4: Study Interventions and Outcomes

Summary table of statistically significant outcomes for studies included in [Chapter 2](#). Where studies looked at peer or patient navigation interventions, non-statistically significant but positive outcomes are also included in the table, consistent with findings in [Chapter 2](#). All other non-statistically significant findings are not included.

Study	Setting (J=Jail; P=Prison, S=Supervision or probation)	Type of Intervention			Outcomes								
		MOUD/MAUD (M=methadone, N=naltrexone, B=buprenorphine)	Case management	Peer and patient navigation	Recidivism	Urine screen	Self-reported substance use	Overdose or drug risk	Treatment engagement or retention	Hospitalization and emergency department use	Mental health and general well-being	Employment and education	
Binswanger, et al., 2015	P			✓						✓	✓		
Chan, et al., 2005	S		✓		NS								
Dolan, et al., 2005	P	✓	M		✓								
Farabee, et al., 2020	J	✓	N	✓			✓						
Farrell-MacDonald, et al., 2014	P	✓	M		✓								
Friedman, et al., 2018	P	✓	N		NS								
Garcia, et al., 2007	P	✓	B				✓						
Gordon, et al., 2018	P	✓	B		NS								
Gordon, et al., 2008	P	✓	M		✓	✓	✓		✓				
Gordon, et al., 2014	P	✓	B						✓				
Gordon, et al., 2017	P	✓	B						✓				
Guydish, et al., 2011	S			✓	NS								
Haas, et al., 2021	J	✓	M					✓	✓				
Hicks, et al., 2022	J			✓					✓				
Horn, et al., 2020	J	✓	M		✓								
Kinlock, et al., 2009	P	✓	M			✓			✓				
Kinlock, et al., 2008	P	✓	M		✓		✓		✓				
Kinlock, et al., 2007	P	✓	M			✓	✓		✓				
Lee, et al., 2015	J	✓	N			✓	✓						
Lincoln, et al., 2018	J	✓	N						✓				
MacSwain, et al., 2014	P	✓	M		✓								
McDonald and Arlinghaus, 2014	P			✓	NS								
McKenzie, et al., 2012	J&P	✓	M				✓		✓				
McMillan, et al., 2008	J	✓	M		NS								
Moore, et al., 2018	J	✓	M		✓				✓				
Needels, et al., 2005	J			✓	✓				✓				
Prendergast, et al., 2011	P			✓					✓			✓	

Study	Setting (J=Jail; P=Prison, S=Supervision or probation)	Type of Intervention			Outcomes							
		MOUD/MAUD (M=methadone, N=naltrexone, B=buprenorphine)	Case management	Peer and patient navigation	Recidivism	Urine screen	Self-reported substance use	Overdose or drug risk	Treatment engagement or retention	Hospitalization and emergency department use	Mental health and general well-being	Employment and education
Polcin, et al., 2018	J&P		✓		✓							
Ray, et al., 2021	J&P			✓			✓		✓		✓	
Rich, et al., 2015	J&P	✓	M				✓		✓			
Schwartz, et al., 2021	J	✓	M						✓			
Schwartz, et al., 2020	J	✓	M	✓					✓			
Springer, et al., 2017	P	✓	N				✓					
Westerberg, et al., 2016	J	✓	M		✓							
Wikoff and Morani, 2012	P			✓	✓							
Woody, et al., 2021	P	✓	N		✓		✓				✓	
Zaller, et al., 2013	P	✓	B				✓		✓			

Photos are for illustrative purposes only.
Any person depicted in a photo is a model.

Publication No. PEP23-06-06-001

SAMHSA
Substance Abuse and Mental Health
Services Administration

SAMHSA's mission is to lead public health and service delivery efforts that promote mental health, prevent substance misuse, and provide treatments and supports to foster recovery while ensuring equitable access and better outcomes.
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