REENTRY PLANNING FOR OFFENDERS WITH MENTAL DISORDERS

Policy and Practice

VOLUME II

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Library of Congress Cataloging in Publication Data
Reentry Planning for Offenders With Mental Disorders:
Policy and Practice, Volume II / Henry A. Dlugacz, M.S.W., J.D.

ISBN 978-1-887554-99-2

Library of Congress Control Number: 2014954368

To the memory and legacy of Dr. Lambert King, whose example taught so much to so many about combining academic rigor with compassionate care. And, as always, to Luisa, Isaac, and Noah.

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PART 3: ISSUES ARISING WITH SPECIAL POPULATIONS

Acknowledgements

I am extremely grateful to the impressive group of professionals who somehow found the time to contribute to this project. Thanks, too, to the top-notch team at Civic Research Institute, particularly Deborah Launer for her wisdom and guidance, and Maxine Idakus, whose keen eye and excellent judgment were invaluable. Last but not least, many thanks to Emily Brouwer for her excellent assistance with all aspects of this project.

Introduction

COPING WITH MASS INCARCERATION OF OFFENDERS WITH MENTAL DISORDERS

For decades, policy makers in the United States pursued a failed policy of mass incarceration in which millions of people, many with severe mental disorders, were incarcerated with little consideration for the human, social, or economic consequences. Seemingly, the abiding concern was only that our society incarcerate a lot of people for a long time. Policy makers rarely asked how much it cost to pursue this path and what return taxpayers were getting for this massive investment of human and fiscal capital.

The following were among the largely ignored questions:

- How did inmates, especially those with serious mental disorders, fare while incarcerated?
- Were they disproportionally victimized?
- Did they receive adequate mental health treatment?
- Were they segregated much more than other inmates?
- Were segregated inmates released directly from these isolating units into the community? And, if so, did any responsible professional believe that this practice facilitated successful reentry to society?
- Did custody staff and health care providers trying to cope with the inadequately treated mental disorders of inmates get injured unnecessarily?
- While incarcerated, did these inmates learn any new skills that would help them lead lawful lives upon release?
- Were they assisted with linkages to benefits, housing, and treatment that would improve clinical and social outcomes? If so, were these services adequate to the monumental task at hand?
- What effect did a steady flood of unprepared returning inmates with serious mental illness have on communities and families?

In short, "What about the way correctional systems were structured would make anyone think that they were designed to improve a returning inmate's chances of becoming a contributing member of society?" Unfortunately, the answer was "not much."

Remember in grade school when we were taught that the early explorers feared sailing off into the sunset because they thought that the world was flat and they would fall of the edge of the earth never to be seen again? During the latter part of the twentieth century, our view of prisoners was, in many respects, no less uninformed. Each piece of the criminal justice system acted as if the arrested person simply disappeared off the edge of a flat earth once its particular part of the process was complete. Overwhelmed by an onslaught of arrests to *process*, new admissions to *intake*, cases to *dispose of*,

and prisoners to *control*, with admirable exceptions, people working in such a system became vulnerable to simply seeing themselves as one, small cog in a perpetually spinning wheel, one that they had little or no ability to effect. Treatment providers must also guard against this myopic view of the problem; otherwise, their ability to conduct individualized assessments of the inmate's postrelease needs could be hampered.

INDIVIDUALIZED ASSESSMENTS

Individualized assessments require a focus on the person's uniqueness; but, they also require an integration of the person's history, his or her experience while incarcerated, and the environment to which the offender will return—keeping in mind that for longer incarcerations, that environment has changed in many respects: people die or move away, buildings are torn down, technology has advanced.

SOCIETY'S CONCERN

Writ large, our society also acts as if sentencing ends society's concern with an offender's future—ignoring the fact that the inmate who does not return to live among the rest of us in free society is rare indeed. Once the incarcerated person is to be released, the only factor we have any control over is how prepared he or she is to cope with life on the outside. That, in short, is the stuff of reentry planning.

REDUCING RECIDIVISM

The purpose of this book, however, is not to recount a gloomy scenario or imply a future with no hope; many positive changes are afoot. With the groundwork laid by organizations, such as the Council of State Government's Consensus project, spurred on by the fiscal crises of 2009, policy makers of all political stripes are starting to ask some of these tough questions, and the answers are causing pause to reflect. In recent years, the phrase "reentry planning" has increasingly been on people's lips in the corrections world as we try to figure out just how we got into this mess, and, more importantly, how we can safely, effectively, and humanely find our way out of it. A recent report by the Vera Institute of Justice found that in 2013, thirty-five states passed at least eighty-five bills to modify some aspect of how they dealt with sentencing and corrections. The most common areas addressed were reduction of prison populations and costs, community-based corrections, risk and needs assessments, support for offender reentry, and promoting research to promote better criminal justice policy (Subramanian, Moreno, & Broomhead, 2014). Much work remains, but we are starting to study what works and what does not when it comes to reducing recidivism and improving clinical outcomes for offenders with serious mental disorders.

The varied and exciting chapters in this book attack this task from many different angles. This is what is needed; no service, no discipline, and no individual can fix this, strongly suggesting a role for professional organizations in promoting policies and practices that support reentry planning. It is no coincidence that the accomplished authors of the chapters in this volume include judges, social workers, physicians, psychologists, and could—and probably should—have included ex-offenders with mental disorders who have been through the experiences the authors address (in this regard, see Miller's [2010] work on peer counseling). It is likewise of note that an expert in law enforcement

responses to people with mental disorders is among these distinguished authors—as one of my first bosses in the field, Robert Cohen M.D. the former director of the Rikers Island Health Services, always reminds me, "entry precedes reentry." That is, once the person is incarcerated and stabilized, a critical focus of mental health treatment may become planning for successful reentry, but in many cases the better approach would have been to avoid the incarceration to begin with. It will take the wisdom of all these perspectives to address this difficult and complex problem.

Also necessary, is a research agenda that will continue to scientifically explore what approaches and interventions work best with which subgroup of offenders with serious mental disorders. Just like the rest of us, they are varied and multilayered. There is no reason to believe that they are a homogeneous group and that the same approach that will work with one will necessarily work with the other.

As I mention in Chapter 16, "Reentry and Coercion: Motivating Constructive Change," despite the need for more knowledge, there is one question we should be asking right now: why is it that we apply so little of what we know already about how people change their behaviors? Each offender is an individual with his or her own story, strengths, and disabilities. Viewing them as symbols or abstractions militates against the individualized, strength-based approach that success requires. Our political leanings matter little—whether inmates with mental disorders are seen as the ultimate disenfranchised group representing how our society oppresses those without a voice or as symbols of an overly permissive, out-of-control society; either way misses the mark. Each is someone's mother, father, son, or daughter; each has strengths that need to be ferreted out and supported; each has obstacles to prioritize and, with the right assistance, hopefully, overcome. They may, at once, have experienced overwhelming abuse and victimization and yet also have a lifestyle that involves taking advantage of or victimizing others. None of this is an abstraction. Reentry planning meets people where they are, not where we think they are, or where we think they should be!

How did we get into this situation? A detailed answer to this question is well beyond the scope of this book, let alone a brief introduction. But, the short answer is simple: we made a series of bad decisions across a diverse range of public policy areas over the course of decades. We reduced the number of beds in psychiatric hospitals without providing adequate community-based mental health services. We then declared deinstitutionalization a failure before it was ever really tried. We then proceeded to defund the existing public mental health system. Like community integration—a concept that may have new life under current approaches to the Americans With Disabilities Act as formulated by the Supreme Court in the *Olmstead*[1] decision—we also gave up on rehabilitation before it was ever properly tried.

In 1974, Robert Martinson published an influential article titled "What works? Questions and Answers About Prison Reform." The answer became widely understood as "nothing works," with the implication that rehabilitation was a fool's errand. Interestingly, the research group, of which Martinson was a part, came to a more nuanced conclusion: that corrections had not *as of yet* found satisfactory ways to reduce recidivism by significant amounts. Martinson, for his part, believed—perhaps naively—that because prisons promoted recidivism and impeded rehabilitation, it would come to be understood that they were beyond remediation and that our reliance on incarceration would be drastically reduced. Needless to say, this did not occur; rather, we decided that a vast number of people, not a broken corrections system, were beyond remediation.

[1] Olmstead v. L. C., 527 U.S. 581 (1999).

For decades this destructive notion that nothing works permeated public policy, promoting draconian sentencing statutes, sentencing guidelines, which eschewed the notion that rehabilitation was a worthy goal of incarceration, or that amenability to treatment was a sound consideration during sentencing, as well as sharp reductions in the use of parole. At the same time, in a series of important decisions, federal courts and accrediting organizations began to impose upon correctional systems a constitutional duty to provide minimally adequate health care. The result was that corrections had to provide a higher quality of care to more people (Dlugacz, 2014). As the public mental health system was deteriorating and incarceration of people with serious mental disorders increased along with the rest of the population, jails and prisons took on a primary health-care role, essentially becoming a fundamental part of the federal safety net for many people of limited means (Dlugacz, 2014). This prompted a reexamination of the role of correctional mental health providers and a move from a limited focus on crisis intervention and suicide prevention toward a robust sense of mission to include reentry planning (Dlugacz & Roskes, 2010).

PREPARATION FOR SUCCESSFUL REENTRY

Increasingly, preparation for successful reentry is seen as a primary function of corrections. It is fast moving from a best practice to a standard of care (Dlugacz & Roskes, 2010). The standards of most professional organizations require some attention to reentry planning, but the contours and extent of these requirements are still evolving. As attention to this function increases, so does an investigation of what approaches work best with different subgroups of the population. Of course, prevention of incarceration through adequate supervision and services or through diversion for appropriate offenders who come into contact with the police is a far less costly and more humane solution than is reentry planning, which at best attempts to minimize the damage. But, the reality is that many offenders, including those with serious mental disorders, cycle in and out of our nation's jails and prisons. The care and interventions they received while in jail are really just one stop in a cycle of treatment that happens to take place during incarceration. Seen in this way, good reentry planning during one incarceration is really a step toward prevention of the next.

PERSONAL EXPERIENCES

My own experience has tracked this progression and also provides some cautionary tales.

In the early 1980s, I was privileged to be part of a group at Montefiore Hospital retained by the City of New York to develop a model correctional mental health program for part of the New York City jail system. I described this briefly in the introduction to the first volume of this work (Dlugacz, 2010). We were proud of the work we did, which vastly improved the short-term treatment crisis intervention and suicide prevention in that jail. As a result, many lives were saved. As our initial program focused on the busiest intake jail in New York City, where all new admissions from Manhattan were processed, we sadly saw that in many instances, the good clinical work we did in identifying, stabilizing, and treating inmates with mental disorders had little effect on what happened once they were released. After many hours of intensive and hopeful treatment, we would, all too often, see released inmates return to the jail all too quickly. At the time,

the fatal flaw in our approach appeared to be that we did not make arrangements for continued care upon release. This certainly would have improved clinical outcomes and may have had some positive effect on recidivism, but as too-often happens, the intuitive answer does not fully address the vicissitudes of stubborn problems.

RECENT SCHOLARSHIP AND THE CHAPTERS IN THIS BOOK

Recent scholarship, which is so well described in Chapter 1 by Rotter, Carr, and Frischer, calls into question the criminalization theory—that untreated mental illness is the proximate cause of recidivism for most offenders with serious mental disorders. A growing body of literature indicates that this is the case for only a relatively small subgroup of the population. Mental illness does not protect against having a criminal lifestyle; nor does having a criminal lifestyle protect against having a mental disorder. The two can, and do, coexist. Increasingly, we have come to understand as described in Chapter 1, that it appears what reduces recidivism in many offenders with serious mental disorders is the same type of cognitive-behavioral and psychosocial interventions that work with other offenders. In this respect, we are reminded that people with serious mental disorders are not a diagnosis; they are people. This recent scholarship will also have to be reconciled with other studies, again arguing against oversimplification: other recent research suggests that standard mental health treatment may moderate recidivism. Another study found that routine outpatient treatment reduced the likelihood of arrest and that medication possession in the ninety-day period following hospitalization appeared to provide further protection (Van Dorn, Desmarais, Petrila, Haynes, & Singh, 2013). One study of those leaving the Texas prison system found that inmates with major psychiatric disorders had a substantially increased risk of multiple incarcerations over a six-year period (Baillargeon Binswanger, Penn, Williams, & Murray, 2009a). It is also noted that because people with mental disorders remain incarcerated longer than others, they may have a reduced opportunities to commit new crimes (Baillargeon et al., 2009b). Additionally, the episodic nature of mental illness may serve to mask the connection between symptoms and arrest, and we may underestimate the effects mental disorders have on social functioning. Of course, all of this may simply be a manifestation of what we already know—that offenders with serious mental disorders have more than their fair share of risk factors and vulnerabilities in multiple areas of life, which increase the likelihood of many bad outcomes, including arrest.

One size does not fit all. We know that drug use, particularly stimulants and alcohol increase the risk for violent offending, but some people are only violent in certain situations and with particular people. We know that treatment, such as assertive community treatment (ACT) and integrated treatment for mental illness and substance abuse, works to improve clinical outcomes. ACT is associated with increased time in stable housing and a reduction in hospitalizations—tremendously beneficial outcomes for the individual and important indicators as a matter of public health. Unfortunately, in and of itself, this is not enough to keep many offenders with mental disorders from reoffending. Holding mental health treatment up as a panacea to combat the effects of poverty, lack of education, and limited employment opportunities will unrealistically raise expectations and increase the chances that, like the concept of rehabilitation in earlier times, we will declare treatment unworthy of funding and consideration instead of recognizing its critical importance and limitations. What is needed is an individualized approach to aftercare

planning for treatment and risk assessment. These issues are thoroughly addressed in Chapter 2 by Trestman and Barry and in Chapter 3 by Barber-Rioja and Rotter.

The other excellent chapters in this book deal with the varied aspects of the reentry endeavor.

Just as an unused piece of gym equipment does not improve cardiovascular health, a risk assessment—no matter how comprehensive, which is simply filed away in the back of a medical record, does nothing to reduce violence. Likewise, a great assessment that does not lead to a harm-reduction plan, which helps the person acquire the skills needed to put the plan into effect, does little good (see Chapter 3). As I attempt to discuss in Chapter 16, the best-crafted discharge plan means little if it is not followed. Motivation can come from many sources, but it must be attended to. I originally planned on writing two separate chapters, one on coercion and one on motivational interviewing, but ultimately I came to see them as two ends of a continuum, not separate issues.

Just as a plan not followed is not useful, no plan that cannot be afforded by the person will be of any utility. Perret's treatment of strategies for assisting with successful benefits applications, in Chapter 14, is invaluable. Similarly, the Affordable Care Act provides a newfound opportunity to connect reentering inmates with the means to pay for needed treatment. Many states are starting to avail themselves of this opportunity by setting up units to ease Medicaid applications for soon-to-be-released inmates. In Chapter 6, Moskovitz outlines the evolving state of implementation of this groundbreaking law. That the population is multiproblem has become cliché, but that makes it no less true. In Chapter 9, Copenhaver, Baldwin, Springer, Muoto, and Altice, describe one aspect of this by elucidating strategies to improve HIV prevention and care for former inmates.

Women are a small but important subgroup of the correctional population. While successful reentry planning for women shares many of the same attributes as does planning for men, there are unique issues as well. Kubiak and Fedock's Chapter 10 addresses some of these critical issues with a particular emphasis on the role of trauma. Trauma-informed reentry planning is no less critical than is trauma-informed care. In Chapter 11, Willging, Lilliott, and Kellett also address gender issues in reentry planning and remind us that reentry also takes place in a rural not just urban context.

Likewise, Goss, in Chapter 5, brings the judicial perspective to the question of reentry planning in a rural community where resources are scarce, making ingenuity all the more important. Also bringing a judicial perspective, in Chapter 4, is D'Emic, who provides a view from the bench as he describes lessons learned from his experience presiding over a problem-solving mental health court in an urban setting.

As with women, reentry planning for incarcerated juveniles has its own unique aspects. These, along with strategies for addressing them, are presented by Altschuler in Chapter 12. Of course, released offenders return to live in our communities. The attitudes of people living in these communities toward their formerly incarcerated neighbors have important practical consequences for many aspects of reentry. Seward, in Chapter 8, provides a description of her look at this critical area. While attitudes are important, so are programs that work. Mann, Wright, and Chen, in Chapter 13, describe a model interagency approach to reentry planning, which is achieving success on the ground. MacDonald, in Chapter 15, provides a comprehensive description of international perspectives on successful programs.

As important as reentry is, prevention is better. That is, law enforcement strategies that promote diversion are a critical aspect of success in addressing the problem

of overrepresentation of people with mental disorders in our criminal justice system. Reuland, in Chapter 7, describes important ways that law enforcement can improve its response to these citizens.

All of these authors have different but entirely complementary perspectives. Once again, I thank them for their contributions and hope that their important work continues. They have taken on no easy task, but worthwhile endeavors are not usually the easy ones.

—Henry A. Dlugacz
May 2014

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Mr. Dlugacz teaches, writes, and lectures on related topics nationally and internationally. He is active as a court-appointed monitor and mediator of class action lawsuits involving correctional mental health care, forensic hospital care, and reentry planning for inmates with mental disorders.

Frederick L. Altice, M.A., M.D., is a professor of medicine and professor of epidemiology and public health at Yale University in New Haven, Connecticut, where he also serves as the director of clinical and community research and the director of the HIV in Prisons Program at the Yale University AIDS Program. Dr. Altice is currently conducting research at the interface of infectious diseases and substance abuse. He is a clinical epidemiologist and intervention researcher who has created novel programs for the treatment of HIV, HCV, and tuberculosis among vulnerable populations, including injection drug users, criminal justice populations, and men who have sex with men. In addition to advancing the science of adherence through development of directly administered antiretroviral therapy for HIV+ drug users and for released prisoners, he has been at the forefront of integrating medication-assisted therapies such as methadone, buprenorphine, and extended-release naltrexone into treatments for individuals with HIV, HCV, tuberculosis, and mental illness—including the first implementation of buprenorphine in correctional settings. His work has been extended globally to address the issues of integration of HIV care, substance abuse treatment, and management of tuberculosis.

Dr. Altice's commitment to improving care of incarcerated individuals is reflected in his research. He has been involved as a principal investigator in numerous clinical studies examining issues ranging from organizing HIV care for incarcerated persons to improving health outcomes among HIV-infected individuals who are substance abusers. He is currently leading studies in Ukraine, Russia, Central Asia, Malaysia, Peru, and the United States that bridge the correctional to the community setting, including the use of Directly Observed Antiretroviral Therapy and Opiate Substitution Therapy such as methadone, buprenorphine, and naltrexone. He served as a leading member of the World Health Organization's *Policy Guidelines for Collaborative Tuberculosis and HIV Services for Injecting and Other Drug Users: An Integrated Approach.* He is also

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Jin-Song Chen, Ph.D., has been with the Oklahoma Department of Mental Health and Substance Abuse Services since 2007 as a senior data analyst in the Decision Support Services Division, conducting data quality assurance, data analysis, data matching, and program evaluation in the Co-Occurring Treatment Team Specialist and Re-Entry Intensive Care Coordination Programs. Prior to this position, Dr. Chen worked as a research hydrologist with the U.S. Department of Agriculture in data assimilation, as a scientist/modeler with Dynamac Inc. for technical/modeling support to the Environmental Protection Agency, as a research associate with Oklahoma State University to develop decision support tools in groundwater research. Dr. Chen received his Ph.D. in agronomy from Purdue University, a master of science degree in environmental sciences from the University of Oklahoma, and a bachelor of science degree in soil science from National Chung-Hsing University.

Michael Copenhaver, Ph.D., is a tenured associate professor of health promotion in the Department of Allied Health Sciences at the University of Connecticut (UCONN) and is a licensed clinical psychologist in Connecticut. Over the past decade, he has been a federally funded principal investigator at the Center for Health Intervention and Prevention at UCONN. His research has focused on developing and adapting evidence-based behavioral HIV prevention interventions for optimal use with priority populations within clinical care or criminal justice settings regionally, nationally, and internationally. He teaches research methods for health professionals at the undergraduate level, a health intervention seminar at the graduate level, and actively mentors a variety of undergraduate, graduate, and postdoctoral students at UCONN and at Yale. He is among the leading experts in HIV prevention targeting high-risk and HIV-infected drug-involved individuals.

Honorable Matthew J. D'Emic, J.D., is a graduate of Fordham University and Brooklyn Law School. He was appointed to the Court of Claims in 1996 and is assigned to Kings County Supreme Court. Since 1998, he has presided over the Brooklyn Domestic Violence Court, a specialized felony domestic violence part. In March 2002, he was selected to open and preside over the first mental health court in New York State, the Brooklyn Mental Health Court. In March 2014, he was appointed Administrative Judge for Criminal Matters in Supreme Court, Kings County, in addition to his other duties.

Judge D'Emic is past chair of the Supreme Court Gender Fairness Committee and is a member of the New York State Judicial Committee on Women in the Courts as well as the NYC Mayor's Steering Committee of the Citywide Justice and Mental Health Initiative. He is also cochair of the alternatives to incarceration and diversion committee of the Criminal Justice Section of the American Bar Association and was a member of the Domestic Violence Committee of the New York City Bar Association. Judge D'Emic has been recognized for his work in domestic violence by the Brooklyn Women's Bar Association and the Lawyers Committee Against Domestic Violence, and for his work in mental health by the New York State Chapter of the National Alliance for the Mentally Ill, Brooklyn Psychiatric Center, the American Association for Psychosocial Rehabilitation, and the New York State Psychiatric Association.

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In 2002, Judge Goss founded and continues to preside over the Dougherty Superior Court Mental Health/Substance Abuse treatment program for felony offenders dealing with co-occurring disorders. This program has served since 2006 as one of five national learning sites for mental health court programs as designated by CSG and the Bureau of Justice Assistance. He has served on the teaching faculty of the National Judicial College since 2003 and serves on the teaching faculty for the National Drug Court Institute. He is a senior consultant to the U.S. Substance Abuse Mental Health Services Administration GAINS Center for persons with co-occurring disorders. He serves on the advisory board of the Judges Leadership

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Sheryl Pimlott Kubiak, M.S.W., Ph.D., is a professor of social work and core faculty member in the Consortium on Gender-Based Violence at Michigan State University. She has worked at the intersections of mental health and substance abuse with justice involved women for over twenty-five years.

Elizabeth Lilliott, Ph.D., is an evaluator at the Pacific Institute for Research and Evaluation. As an anthropologist, she has conducted ethnographic research in the Southwest United States with youth and adults living with substance use problems, incarcerated women and their families, as well as criminal justice professionals, behavioral health providers, and policy makers. Dr. Lilliott has also served as a statewide and local evaluator for New Mexico substance abuse prevention programs focused on Native American and Latino communities and rural populations.

Morag MacDonald, Ph.D., is director of the Social Research and Evaluation Unit at Birmingham City University in the United Kingdom. Professor MacDonald is an acknowledged expert in the fields of prisoner health, drugs and related health issues, and domestic violence and abuse; she is also well known as a social research methodologist.

She has been successful in obtaining funding for many European research grants in her field. She is currently researching the lack of an integrated approach to housing and ongoing social support for women at highest risk of being victims of violence funded by the EU Daphne program. She has recently completed a toolkit for throughcare services for prisoners with problematic drug use and training materials for professionals in the criminal justice system regarding imprisoned women with a history of violence and abuse. She has also completed a training manual to assist criminal justice professionals in providing harm-reduction services for vulnerable groups and a health promotion toolkit for young prisoners.

Dr. MacDonald is also the joint editor of *The International Journal of Prisoner Health.* The journal is intended to facilitate an exchange of information among experts in the field of prisoner health care from different cultural interpretations and perspectives.

Bob Mann, R.N., L.S.W., is the administrator of mental health operations for the Oklahoma Department of Corrections. Mr. Mann comanages the Oklahoma Collaborative Mental Health Reentry Program for incarcerated individuals with serious mental illness and coordinates reentry initiatives for offenders who are veterans of military service. Mann is a frequent national speaker on topics such as federal benefits for soon-to-be released offenders, collaboration between mental health and criminal justice entities, and mental health prison reentry. He became a registered nurse in 1992 and earned his master's degree in administrative social work from the University of Oklahoma in 1997. In 2011, Mr. Mann was inducted into the Oklahoma Social Work Hall of Fame.

Joshua S. Moskovitz, J.D., is an attorney at Beldock Levine & Hoffman LLP where his practice focuses on civil rights and constitutional law, including police and prosecutorial misconduct and employment discrimination cases. He has argued novel issues of federal civil procedure in the U.S. Court of Appeals for the Second Circuit and has written on procedural complexities raised in litigation under the Prison Litigation Reform Act.

Ifeoma Muoto, M.S., is a doctoral student of health policy at Oregon State University where she also teaches a course on HIV/AIDS and sexually transmitted infections in modern society. Prior to this, her research focused on improving antiretroviral medication adherence and reducing HIV-related risk behaviors among marginalized groups, including injection drug users and prisoners.

Yvonne M. Perret, M.A., M.S.W., L.C.S.W.-C., is a psychiatric social worker with roughly forty years of experience, including thirty years in mental health. She also has a master's degree in journalism and is the coauthor of *Children With Disabilities: A Medical Primer,* 3rd edition. In 2010, she coauthored a chapter entitled "Accessing Public Benefits: More Advocacy Than Entitlement" in Henry A. Dlugacz ed., *Reentry Planning for Offenders With Mental Disorders: Policy and Practice.* Ms. Perret has also authored several articles on SSI/SSDI and related mental health topics.

Ms. Perret is the founder of SOAR (SSI/SSDI Outreach, Access and Recovery), a national program that includes a SOAR TA Center based in Albany, New York, which is funded by SAMHSA. SOAR focuses on assisting adults who are homeless with accessing SSI/SSDI and beginning their recovery both from homelessness and mental illness and/or co-occurring disorders. SOAR is based on the SSI Outreach Project in Baltimore, which Ms. Perret directed from 1993 to 2002. In 2001, this program was named a Best Practice Program by the National Alliance to End Homelessness and, in 2005, an Exemplary Practice Program by SAMHSA. She continues her advocacy work, her SOAR training, and other work on SOAR-related advocacy and planning, with a particular current focus on veterans.

She also is the lead author of *Stepping Stones to Recovery* (funded by SAMHSA) and *Stepping Stones to SSI/SSDI* (funded by HUD), two curricula that focus on assisting individuals with accessing SSI/SSDI and beginning recovery. The first curriculum centers on individuals with serious mental illness and/or co-occurring disorders who are homeless or at risk of homelessness. The second focuses on people with HIV/AIDS. The emphasis in both is on using benefits as tools in recovery.

Ms. Perret has also trained and worked extensively in co-occurring disorders, mental illness, and other mental health–related topics. She has presented at numerous mental health and other national conferences and is the recipient of several awards for mental health advocacy. She is actively involved in ongoing advocacy and systems change for people who have serious mental illness, co-occurring disorders, and other disabling conditions. Recent work includes facilitating access to benefits for individuals being released from prison and jails in several states as well as assisting veterans who are homeless.

Since January, 2011, Ms. Perret has been the part-time interim executive director of seven peer-staffed wellness and recovery programs in three counties in rural Western Maryland.

Melissa Reuland, M.A., consults on research and technical assistance projects related to law enforcement responses to people with mental illness. She is currently working with the Council of State Governments (CSG) Justice Center and the Police Executive Research Forum (PERF) on the Bureau of Justice Assistance–funded Law Enforcement/Mental Health Partnership Project. For this project, Ms. Reuland has developed several products designed to support expansion of specialized responses to people with mental illnesses, including *Improving Responses to People with Mental Illnesses: Tailoring Law Enforcement Initiatives to Individual Jurisdictions, The Essential Elements of a Specialized Law Enforcement Program, Strategies for Effective Law Enforcement Training,* and *Law Enforcement Responses to People with Mental Illnesses: A Guide to Research-Informed Policy and Practice*. Ms. Reuland worked at PERF from 1994 through 2004, after ten years of social science research. While at PERF, she was a senior research associate and directed two GAINS/TAPA Center projects on models for law enforcement diversion of people with mental illness, which resulted in two monographs describing keys to program implementation. Ms. Reuland directed the law enforcement track of CSG's Criminal Justice/Mental Health Consensus Project and PERF's prior project on the police response to people with mental illnesses, coauthoring the publication of the same name. In addition, she has published several community policing curricula, edited books on crime analysis and problem solving, and written articles for peer-reviewed journals. Ms. Reuland holds an M.A. in criminal justice from the University of Baltimore.

Merrill Rotter, M.D., is a forensic psychiatrist working at Albert Einstein College of Medicine where he is associate clinical professor of psychiatry and director of the Division of Law and Psychiatry for the Department of Psychiatry. Dr. Rotter received his B.A./M.D. from the Boston University Six-Year Combined Liberal Arts Medical Education Program. Trained in clinical psychiatry at Columbia and in forensic psychiatry at Yale, Dr. Rotter leads a program of teaching, research, and clinical service for Einstein as well as the New York State Office of Mental Health. In his Office of

Mental Health role, Dr. Rotter is director of the Division of Forensic Services at Bronx Psychiatric Center and senior consultant to the Division of Forensic Services. In addition, Dr. Rotter is the medical director of the EAC and its NYC TASC Mental Health Programs, which provide the clinical arm of the Queens and Bronx Mental Health Courts, as well as the Brooklyn TASC Mental Health Diversion and Reentry Programs. Dr. Rotter is project director of SPECTRM, a nationally recognized research, training, and treatment program aimed at helping to meet the needs individuals with mental illness who have a history of incarceration. Dr. Rotter has presented and published in areas related to forensic training, risk assessment, treatment, and management of mentally ill offenders, the insanity defense, and mental health diversion. In 2009, Dr. Rotter received the Award for Outstanding Teacher in a Forensic Fellowship Program from the American Academy of Psychiatry and the Law

Vanda Seward, M.S., Ph.D., is the statewide director of reentry services for the New York State Department of Corrections and Community Supervision. In this capacity she is responsible for ensuring that there are resources and services readily available for persons under parole supervision in the state of New York. She is the former executive director of the Kings County District Attorney's Office ComALERT program, which is the first full service reentry program run under the guidance of a prosecutor's office. Dr. Seward has been serving high-risk populations that are criminal justice involved for well over twenty-five years. Her extensive experience expands to providing services and linkages to men, women, and adolescents suffering from mental illness, substance abuse, homelessness, unemployment, literacy, and HIV and AIDS.

Dr. Seward has worked for numerous community-based organizations and government agencies including the New York State Department of Correctional Services prior to the merge, where she has worked in a number of prisons at various security levels as a counselor. She has an extensive history working with the forensic population while working at FEGS where she was the director. She has headed several pilot projects and committees to assist the needs of the formerly incarcerated and communities at large.

Dr. Seward received her Ph.D. in criminal justice from Capella University. She is a graduate of Iona College, where she holds a master's of science in criminal justice and is also a graduate of the College of New Rochelle, where she holds a B.A. degree. She also has twelve years as an adjunct professor at the College of New Rochelle. Dr. Seward has received many rewards and accolades for her work within the criminal justice arena.

Sandra A. Springer, M.D., is an associate professor of medicine in the Department of Internal Medicine and Infectious Diseases at the Yale School of Medicine. She is board certified in internal medicine, infectious diseases, and addiction medicine. Dr. Springer has significant clinical and research experience with persons living with HIV (PLH) with comorbid mental illness, drug and alcohol dependence, and in particular with those involved in the criminal justice system. She is the director of the Infectious Disease Clinic in the Newington site of the Veterans Administration Healthcare system West Haven, Connecticut, where she cares for HIV-infected patients. She is a core research scientist with the Center for Interdisciplinary Research on AIDS at the Yale School of Medicine. She was a recipient of a National Institute Drug Abuse–funded K23 mentored career development award, where she evaluated the use of medication-assisted treatment to prevent

relapse to opioid use as a conduit to care among HIV-infected opioid-dependent released prisoners. She developed the first protocol to use buprenorphine as relapse prevention for opioid-dependent HIV+ prisoners on day of release. She also has considerable clinical and research experience with the use of extended-release naltrexone and has been awarded National Institutes of Health–funded grants to improve HIV treatment outcomes among criminal justice–involved PLH who have alcohol use disorders and who are transitioning to the community and among opioid dependent released criminal justice populations. She has published her findings in several peer-reviewed journals and books and has presented her work nationally and internationally. She currently also holds an Independent Scientist K02 award from the National Institute on Drug Abuse, which allows her to mentor young investigators who are interested in research involving the intersection of HIV, substance use disorders, mental illness, and the criminal justice system.

Robert L. Trestman Ph.D., M.D., is a professor of Medicine, Psychiatry, and Nursing at the University of Connecticut and heads the University of Connecticut Health Center Correctional Managed Health Care. He received his Ph.D. in psychology and M.D. from the University of Tennessee, and trained in psychiatry and neurobiology at the Mt. Sinai School of Medicine. Dr. Trestman has studied the neurobiology and treatment of people with severe mood and personality disorders, and conducts translational research on correctional health. He has published widely, consults to the National Institute of Mental Health, SAMHSA, Department of Justice, and the Vera Institute of Justice, and he is board chairman of the Connecticut Child Health and Development Institute.

Cathleen E. Willging, Ph.D., is a senior research scientist at the Pacific Institute for Research and Evaluation. She is a medical anthropologist whose research focuses on health policy, public sector mental health and substance abuse services, institutional ethnography, incarceration, and rural populations. Dr. Willging has spearheaded several large research projects that employ qualitative data collection techniques to understand the impacts of new interventions and policy reforms on service organizations, in addition to professional providers and the clients they serve.

David Wright, Ph.D., serves as the evaluation projects manager in Decision Support Services for the Oklahoma Department of Mental Health and Substance Abuse Services. The responsibilities of this position involve performing evaluation, statistical analysis, and research supporting treatment programs for justice-involved individuals. Dr. Wright oversees the evaluation of adult and juvenile drug courts, driving under the influence courts, family drug courts, mental health courts, diversion programs, and prison reentry programs. Prior to this position, Dr. Wright served as the director of the Oklahoma Statistical Analysis Center and director of research at the Oklahoma Criminal Justice Resource Center. He has received numerous awards and honors for his research publications. Dr. Wright received his Ph.D. in political science from the University of Houston, after receiving his master's degree at Oklahoma State University and his bachelor's degree at Southwestern Oklahoma State University.