Executive Summary

While the economy was booming through the 1990s, corrections was expanding unabated in the United States. This expansion has led to the 7 million adults under institutional and community supervision today, rates well beyond any other nation. Since the “great recession” that began roughly in 2008, the luxury of “building our way out of crime” is no longer a viable alternative; it is simply too costly at a time when many states must address budgetary deficits. Recidivism is high—it makes up a large proportion of the admittances to prisons or jails (in some jurisdictions over half of all incoming individuals). Further, many individuals released to the community possess a history of substance abuse and/or mental illness as well as other medical disorders and ailments which, left untreated, impedes their ability to find employment and demonstrate prosocial behaviors. Depending on the disorder or ailment, varying numbers will receive the in-custody treatment they need and even fewer will receive transitional treatment shown to be vital in long-term desistance.
A gap exists in the public health and public safety paradigms. The two are interrelated, with drug abusers 3–4 times more likely to commit a crime and individuals with a mental illness 2–3 times more likely to be incarcerated. Yet minimal communication exists between justice and health agencies. These two fields are distinct in terms of philosophy (e.g., poetic justice versus rehabilitation), policy, and practice. Nonetheless, support for more integration between the social sciences and criminal justice is growing—and information technology solutions are available today to allow these disparate communities to share information in a structured, formalized way. Sharing information can reduce delays (i.e., the timeliness of information), reduce data duplication, and improve overall coordination of a criminal population with specific health needs (Akers and Lanier, 2009; Potter and Akers, 2010). Solutions such as the National Information Exchange Model (NIEM) and Global Reference Architecture (GRA) provide a standards-based solution for sharing information. NIEM provides a universal data dictionary that allows disparate organizations to agree on key elements of data and their meaning. It serves as a translator to facilitate information exchange across domains. The GRA provides an architecture for information exchange that is designed to cut 80 percent of implementation time and costs for state and local agencies through the reuse of established practices in information technology architecture and design. The GRA uses a service-oriented approach. NIEM and GRA, used jointly, provide standards-based solutions for one or more communities to share information between divergent systems, often using an intermediary host, while simultaneously preserving the independence of each respective community and their unique data systems.

Despite the capabilities of this technology, the exchange of information is still contingent upon the willingness and ability of partners to participate, within policy requirements. A common barrier to justice-health exchange is the concern over litigation as the result of privacy laws such as HIPAA, the Health Insurance Portability and Accountability Act. In many cases, the fear associated with these laws is inflated, and a careful examination, with corresponding changes in practice (e.g., obtaining consent forms), can alleviate most concerns. Other common concerns include:

- past justice-health interrelations (i.e., absence of rapport between agencies, lack of trust, limited knowledge of each other’s capabilities),
- funding,
- data quality,
- the ability to redact sensitive information (i.e., do the information systems allow privilege management?), and
- technological capacity (i.e., does a given agency have the capacity or technology to participate in the exchange?).

Effective reentry management strategies require close collaboration, supported by information exchange, between criminal justice agencies (especially institutional and community corrections agencies) and their partners in the health and human services arena. Health and human services, like justice, are information-centric business areas, in which timely and accurate information are critical to effective decision-making.
What may result from increased sharing between justice and health/human services organizations of a justice-involved individual’s pertinent information (e.g., treatment plans, health and rehabilitation history, risk and needs assessments)? If this sharing occurs at—or ideally, prior to—the individual’s release to the community, it may result in:

- improved continuity of care,
- improved individual physical and behavioral health,
- improved public safety,
- enhancement of criminal justice and other agencies’ ability to implement evidence-based practices,
- long-term reductions in costs associated with reductions in recidivism, and
- The support of efforts to translate the research/literature on “what works” with offenders into more impactful policies and practices (which may reduce the likelihood of offender recidivism and promote community safety).

SEARCH, with funding provided by the U. S. Department of Justice (DOJ) Bureau of Justice Assistance (BJA) and support from the American Probation and Parole Association (APPA) and Association of State Correctional Administrators (ASCA), will provide support for two pilot sites to implement corrections-health/human services exchanges. Actual information to be shared will vary based on localized needs; however, risk/needs assessments and treatment-centric documentation will be the primary focus of these pilots. SEARCH and its partners will emphasize prerelease planning, as well as the ability of health/human services to communicate back to corrections to provide treatment updates in instances where an individual has recidivated (i.e., rearrest, reconviction, revocation). As a result, improvements in transitional success (i.e., desistance from crime) are expected. This project is expected to have an impact on public safety and public health, while also reducing the continuity of care costs (costs associated with the transition of care between corrections and service providers).

Additional outcomes that could be measured objectively include enhancements in the ability to initiate offender case planning prior to release, use the results of an empirically-based offender evaluation tool to guide case planning, and ensure treatment continuity by building upon progress made in the jail/prison setting, rather than “starting over” in the community.

Using NIEM and the GRA, several deliverables—including technical reports, documentation of exchange models, service specifications, and implementation technology—will be made publicly available by SEARCH for use in future justice-health exchange efforts nationally. This will allow other jurisdictions that have the technological capacity to leverage these deliverables to create similar exchanges and assume the benefits at a fraction of the costs.
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Introduction

Recovery from the economic recession continues to lag, with many government agencies continuing to struggle to address their budgetary woes. Some correctional institutions have been forced to make unexpected reductions to their inmate populations to address overcrowding, an inability to meet individual medical needs, and/or to ameliorate budgetary constraints (Wright and Rosky, 2011). Programs involving early release or good time credits have been devised to quickly remove low-risk inmates from the population. Often, however, these short-term gains in reduced prison population pale in comparison to the long-term failures in recidivism. A large proportion of institutional admissions are returning inmates who were unsuccessful in reintegrating back to society. Many of these individuals enter or leave with a variety of substance abuse, mental health, and medical problems and little in the way of transitional programming (Hammett, Roberts, and Kennedy, 2001). Over 40 percent of adult prisoners are likely to recidivate (i.e., commit a new crime or get revoked on a technical violation) within 3 years of release (Pew, 2011). Therefore, addressing inmate reentry needs—especially epidemiological criminogenic needs such as substance abuse, mental health, and co-occurring disorders (Akers and Lanier, 2009; Lanier, Luken, and Akers, 2010; Potter and Akers, 2010)—prior to and during their transition into the community will result in larger gains over the long-term.

With funding from the Bureau of Justice Assistance (BJA), SEARCH and partner agencies, including the American Probation and Parole Association (APPA) and Association of State Correctional Administrators (ASCA), have begun work on a Justice-Health Collaboration project. The goal of this project is to promote more efficient business processes, through the exchange of information, which will provide complete/more timely medical, mental health, substance abuse, and treatment records to improve the individual’s treatment and continuity of care, whether in prison, under supervision, or released from the justice system. Specifically, the project seeks organizations treating individuals with substance abuse, mental health, co-occurring, and other medical disorders. To reach this goal, the project’s primary objective is to implement justice-health information exchanges in two pilot sites using the National Information Exchange Model (NIEM) and Global Reference Architecture (GRA).

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1 *Epidemiological criminology* is a term coined in reference to the need to develop new, integrated theories across the sciences and disciplines of criminology, criminal justice, epidemiology, and public health in order to better coordinate and integrate scientific theories (Akers and Lanier, 2009; Lanier, Luken, and Akers, 2010; Potter and Akers, 2010).

2 *Co-occurring disorders* is the intersection of psychological, biological, and social factors on crime.

3 [https://www.niem.gov/](https://www.niem.gov/)

Driving the Call for Change: Why the Current System Doesn’t Work Well

The Justice Dilemma: Keeping up with Corrections

It is no secret that the United States has long led all nations in the use of incarceration as a means of just deserts for its criminals (Reichel, 2005; Tonry, 1999). Today the U.S. incarcerates about 1 out of every 100 adults (Pew, 2008). Specifically, on any given day there are 1.6 million adults incarcerated in state or federal prisons (West, Sabol, and Greenman, 2010) and another 750,000 adults incarcerated in local and county jails (Minton, 2011). More than 700,000 prisoners return to the community each year (Petersilia, 2003). Nearly 80 percent of these individuals are placed on probation or parole supervision annually (Glaze and Palla, 2005; Sabol, Minton, and Harrison, 2007). About 1 in 47 adults is under some form of community supervision (i.e., probation and/or parole) (Glaze, Bonczar, and Zhang, 2010). Specifically, there are 4.2 million adults under probation supervision and another 800,000 under parole supervision. In sum, whether it is jail, prison, probation, or parole, about 7.3 million—or 1 in 31 adults—are under some form of correctional supervision (Glaze and Bonczar, 2009; Pew, 2009). About 40 percent of adult prisoners will recidivate within 3 years for a new crime or technical violation (Pew, 2011). In addition, about 200,000 juveniles will return home annually from a juvenile facility or a state or federal prison (Mears and Travis, 2004).

The cost of corrections is substantial. The Pew Research Institute estimates that states spend in excess of $49 billion annually on correctional institutions (Pew, 2008). The average annual operating cost per inmate is estimated at about $24,000. Prior to the recession, growth in correctional costs had outpaced both education and Medicaid. Five states (Vermont, Michigan, Oregon, Connecticut, and Delaware) spent as much or more on institutional corrections than they did for higher education.

Inmate healthcare costs represent a core driver of correctional expenditures for all states. “…[M]edical care is one of the principal cost drivers in corrections budgets today. From 1998 to 2001, healthcare spending in state prisons grew 10 percent annually, a 2004 report by the Council of State Governments found. At the time of the study, medical care costs totaled $3.7 billion annually and accounted for about 10 percent of correctional spending.” (Pew, 2008). Special needs populations (e.g., HIV positive, elderly) further contribute to the ballooning healthcare costs within adult institutions. Further

5 “Probation is a court-ordered period of correctional supervision in the community, generally as an alternative to incarceration. In some cases, probation can be a combined sentence of incarceration followed by a period of community supervision” (Glaze and Bonczar, 2011, p. 2).

6 “Parole is a period of conditional supervised release in the community following a prison term. It includes parolees released through discretionary or mandatory supervised release from prison, those released through other types of post-custody conditional supervision, and those sentenced to a term of supervised release” (Glaze and Bonczar, 2011, p. 2).

7 To put this in perspective, the federal minimum wage is $7.25 an hour, or about $15,000 per year.

8 As dictated by the 1976 U.S. Supreme Court ruling in Estelle v. Gamble, states are required to offer comparable medical care (Pew, 2008, p. 12).
complicating matters is the potential for communicable diseases to spread rapidly within such a confined space. Hepatitis C, for example, is both life-threatening and expensive, with treatments costing upwards of $30,000 per inmate per year.

The recent growth of community corrections (i.e., probation and parole) has far surpassed institutional corrections, but without the corresponding rise in financial support (Pew, 2009). Nine out of every 10 correctional dollars go to institutional corrections. The difference in costs between supervising individuals in the community, as opposed to maintaining them in an institution, is dramatic: The cost is an average of $3.42 per day per probationer versus $78.95 per day per inmate. That said, community corrections agencies suffer from numerous managerial ailments, including high caseloads, burgeoning workloads, outdated equipment, and limited mobility (i.e., office-based supervision) (DeMichele, Payne, and Matz, 2011).

Despite these limitations, community corrections has served as the one of the primary conduits of prisoner reentry. Risk/needs assessments that probation/parole officers conduct are key to getting probationers/parolees referred to the appropriate services in the community, as well as discerning the appropriate level of surveillance (high, moderate, low) (Andrews, Bonta, and Hoge, 1990). It is clearly tempting for policy- and lawmakers to engage community corrections as the cost-reducing alternative to incarceration. However, the approach taken by states has frequently been haphazard. Often, they neglect to increase probation and parole resources and manpower to accommodate the shift of inmates from correctional facilities to community supervision. Researchers have made it clear there is a need to improve effectiveness in community supervision. In 2008, 400,000 probationers and 200,000 parolees were readmitted to a prison or jail due to technical violations or new offenses (recidivism) (Glaze and Bonczar, 2009). Reducing the failure rates of community supervision alone could result in a decrease in crime, victimization, and prison or jail admissions, thereby resulting in a substantive cost savings (Durlauf and Nagin, 2011).

The poor economy has led states to take aggressive measures to reduce their burgeoning correctional institutions’ populations. The Montana Department of Corrections (DOC), for example, instituted an early release program to reduce overcrowding and meet budgetary constraints. An evaluation conducted by Wright and Rosky (2011), however, found that the early release program came at the expense of adequate prerelease planning. As a result, the early release participants were more likely to recidivate, and to recidivate sooner than traditional releases. Though the most common argument against early release is the threat to public safety, Wright and Rosky found that returns were mostly due to parolee technical violations (e.g., missed appointments, failed urinalysis). Those granted early release were more likely to have their supervision revoked for technical violations but were no more likely to commit violent crimes than those who were released on a

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9 The Justice Reinvestment Initiative is making considerable strides, however, in addressing this issue (for more information, see [http://justicereinvestment.org/](http://justicereinvestment.org/)).

10 Specifically, the Montana DOC had a $9 million budget deficit to overcome (Wright and Rosky, 2011).
traditional time schedule. As a result of the institutional “revolving door” from parole violations, the early release program was believed to have contributed further to Montana’s financial problems. Therefore, improved effectiveness in community corrections, in combination with improved prerelease planning beginning in the correctional institution, benefits not just one organization but the justice system at large. It is therefore essential that parole boards and releasing authorities have comprehensive inmate information prior to contemplating and designing release conditions and plans.

The Interrelation between Crime, Drugs, and Mental Health

There is also a well-known relationship between substance abuse and criminal behavior. As found in a meta-analysis of 30 different studies on the drug-crime connection, drug abusers are 3–4 times more likely to commit a crime than non-drug-abusers (Bennett, Holloway, and Farrington, 2008). Substance abuse involvement has been implicated in 78 percent of those incarcerated for violent crimes and 83 percent of those incarcerated for property crimes. Further, 85 percent of jail detainees and 65 percent of prisoners (7 times the rate of the general population) are believed to be substance-involved (National Center on Addiction and Substance Abuse, 2010). Despite these stark findings, less than 20 percent of inmates will receive any formal treatment for their addictions while incarcerated (Treatment Research Institute [TRI], 2011).

Individuals suffering from mental illness are also disproportionately represented within the criminal justice system. The prevalence of mental illness within the institutional setting is 2–3 times higher than that of the general population (Hammett et al., 2001). According to the Bureau of Justice Statistics (BJS), in midyear 2005 nearly half of all inmates (federal, state, and local) reported having some mental health problem (James and Glaze, 2006). These individuals are often the poorest, often homeless, and most severely challenged in all aspects of community life.

What happens to those who suffer mental illness within the confines of a correctional institution? Unfortunately, as Slate (2003) emphasizes, the criminal justice system often exacerbates the illness, potentially increasing the likelihood of mental health complications, all while continuing to accrue the inevitable cost associated with maintaining inmate custody. Similar to substance abuse, correctional personnel may fail to refer those suffering from mental illness to the appropriate medical personnel or to appropriate treatment (Slate, 2003). Many correctional officers, probation/parole officers,

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11 The most commonly associated drugs with crime were found to be heroin, crack, and cocaine (Bennett et al., 2008). Heroin use was associated with odds of 3–3½ times the likelihood of offending as compared to nonheroin users. Crack users were 6 times more likely to offend than noncrack users and cocaine users were about 2½ times more likely to offend than noncocaine users. Marijuana use was associated with a 1½ times higher likelihood of offending and amphetamine users were associated with odds of 1.9 higher compared to nonusers. In terms of likelihood of offending, crack users ranked highest, followed by users of heroin, cocaine, amphetamine, and marijuana. In terms of crime, drug users were 4–6 times more likely to be involved in shoplifting, 3 times more likely to be involved in prostitution, 2½ times more likely to be involved in burglaries, and 1.7 times more likely to be involved in robberies.

12 Note substance involvement does not necessarily equate to addiction or treatment.
and even police officers on the street are poorly equipped with the ability, training, or the means to deal effectively with individuals suffering from mental illness (Chandler, Peters, and Juliano-Bult, 2004; Slate, 2003). Many of the mentally ill will be exposed to treatment only upon arrest, due to a variety of factors: the deinstitutionalization movement of state mental hospitals, selective admittance by private hospitals, and poor insurance coverage of the mentally ill (Slate, 2003). Such a predicament holds many negative implications for public safety, and can cause heightened levels of illness, potential for hospitalization, opportunities for substance abuse, suicide, homelessness, and future recidivism (Osher, Steadman, and Barr, 2003).

The justice literature can give the erroneous perception that substance abusers are distinct from the mentally ill. This division can be artificial and misleading. Many substance abusers also suffer from mental health issues. Co-occurring disorders have been found to range from a low of 13 percent to a high of 74 percent of inmates (TRI, 2011). Up to 80 percent of probationers convicted of a drug-related offense also need mental health services (Chandler et al., 2004). The prevalence of justice-involved individuals suffering from substance abuse and mental health issues is believed to be on the rise. Individuals with co-occurring disorders are particularly challenging for justice agencies. These individuals can be difficult to supervise, as they are often impulsive and unpredictable. Inmates with mental disorders are more vulnerable to stressors associated with overcrowding and noise, which may exacerbate their symptoms (Sun, 2010). As their needs vary, it requires the coordination of multiple service providers to address mental health, drug abuse treatment, and supervision needs. Further complicating matters, the availability of mental health services may be limited in a given jurisdiction. For those jurisdictions in which services are available, justice-health relationships may or may not be established (or if established, they may not be very strong). Finally, the combination of services for co-occurring disorders can drive up costs exponentially for a given inmate/probationer/parolee.

As a result of poor preventive health care prior to incarceration (TRI, 2011), 40 percent of inmates are also likely to suffer from other medical disorders (as estimated by Maruschak, 2008). For example, inmates are more likely to suffer from hypertension, arthritis, cervical cancer, and hepatitis (Binswanger, Krueger, and Steiner, 2009; Sun, 2010). AIDS is a particularly sensitive issue within prisons, with prevalence rates hovering around 3.5 times that of the normal population (Lanier and Potter, 2010); specifically 13.5 percent of inmates have been diagnosed with hepatitis and 1.5 percent with HIV/AIDS (Maruschak and Beavers, 2009). In addition, inmates released to the community are twice as likely to die from cardiovascular disease and cancer (Binswanger, et al., 2007).
Gap in Services: The Need for Improved Continuity of Care

As was the case in Montana’s early release program (Wright and Rosky, 2011), inmates may be hastily released into the community with little prerelease preparation when institutions are under budgetary duress. Over the long run, unprepared releases have the potential to be more costly to the institution as a result of increased returns, largely in part due to probation or parole revocations for technical violations (e.g., inability to locate employment, unsatisfactory housing arrangements, missed appointments with the supervision officer, and failed urinalysis). This shifting of institutional overcrowding down the road to community supervision (known as “criminal justice thermodynamics”) has the potential to backfire.13 The end result is a more costly correctional system and an inefficient attempt to reintegrate former offenders or provide the right level of healthcare without exacerbating their addictions or medical problems.

Research has shown, however, that transitional treatment does increase positive outcomes for drug-abusing individuals returning to the community (Butzin, Martin, and Inciardi, 2005 and 2002; Wexler, Melnick, Lowe, and Peters, 1999). Butzin et al.’s (2005) study of Delaware’s work-release treatment program using a therapeutic community (TC) approach found prisoners were more likely to maintain abstinence, to have a lengthier time remaining drug-free even with failure, and had greater likelihood of obtaining employment as compared to a group of prisoners receiving standard postrelease supervision.14 Treatment was most beneficial during an inmate’s transition back to the community, as opposed to treatment within the institution. The reasoning for this finding is likely due to the similarity in transitional treatment to the actual community inmates will be returning to, as well as the potential of treatment to help inmates stave off risks associated with prior criminogenic behaviors. Obtaining employment was associated with desistence from both criminality and substance use, while at the same time abstinence was associated with increased likelihood of employment (i.e., a dynamic interplay exists between abstinence and employability). Consistent with views expressed in the life-course perspective theory of criminology (Cullen and Agnew, 2006; Laub and Sampson, 2001; Warr, 1998), programs aimed at assisting inmates with employment and treatment for substance abuse enable individuals to reintegrate into society by reestablishing social ties (e.g., job stability, family) and removing significant barriers to success (e.g., substance abuse, mental illness).

Similarly, inmates returning to the community with mental health needs must overcome a variety of obstacles. These include functional impairments, delay or loss of federal benefits, socioeconomic disadvantage, inability to access treatment, and a criminal record (Prins and Osher, 2009). Treatment needs may include medication, counseling, behavioral therapy, substance abuse treatment, housing, crisis intervention, vocational

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13 For further discussion and viewpoints on the concept of criminal justice thermodynamics, see Walker, 2006; Wright and Rosky, 2011, pp. 896–897.

14 The Delaware work-release treatment program occurred during the last 6 months of a prisoner’s sentence and allowed the prisoners to work for pay in the community while spending all other hours within the institution or community-based work-release facility and in treatment.
training, and family counseling. It is imperative for justice and local mental health agencies to coordinate their efforts in order to overcome these barriers and address related needs. The APIC model (Assess, Plan, Identify, and Coordinate) represents a practical tool for jail case-planning that can be applied to individuals with mental illnesses, as well as those with co-occurring disorders. (The APIC model is potentially useful for prisons as well.) Assessments conducted at intake will set the foundation for how inmates are received by post-incarceration agencies (e.g., probation, mental health agencies). Justice and health agencies can collaboratively reduce recidivism of mentally ill inmates within a jurisdiction if services are coordinated based on the risk/needs/responsivity principles, and if the programs being used are based on evidence-based practices.

However, as Petersilia (2003) explains, many institutions have been reducing prison treatment programs, with less than 30 percent of inmates receiving drug or alcohol treatment and less than 12 percent receiving prerelease services (Kurlychek, 2011). Further, more than 20 percent of jails lack any mental health services and many correctional officers—estimates are up to 80 percent—lack training on mental health issues (Chandler et al., 2004). Despite the promise of transitional programming (discharge planning, prerelease planning), support remains lacking at a time when efficiency is paramount to costs savings. Initiatives such as the Transition from Prison to the Community (TPCI) (see figure 1 on page 8) and Transition from Jail to the Community (TJC), however, provide the impetus for conveying this need to practitioners, policy-makers, executive personnel, and others (Parent and Barnett, 2004). As these models highlight, individuals entering the justice system must go through a variety of stages, hosted by a variety of agencies, from intake to reintegration. The continuity of this process is contingent largely on the ability of the involved agencies to transfer and share pertinent information. Without sharing information, each step of the process must repeat an initial assessment and evaluate individuals independent of the information available from formerly involved organizations. Each duplicative assessment may introduce error while also neglecting vital information needed for appropriate classification and treatment.
Transition from Prison to Community Initiative (TPCI)

The Transition from Prison to Community Initiative (TPCI) model represents a holistic approach to offender reentry. Though specifically targeted at incarcerated offenders, the principle remains unchanged for probationers (Parent & Barnett, 2004). Planning for reentry must occur from the outset of the offender’s entry to prison, and while this is not always possible, pre-release reentry planning is paramount for successful reintegration. The top bars of the model demonstrates the primary agencies likely to be involved at a given point and time during this process. Note the overlap that exists. At the bottom of the model we see three distinct phases. These phases-institutional, reentry, and community—represent the different orientations for which the system and the inmate/probationer/parolee must prepare.

**Assessment and Classification**
Using empirically validated instruments, static and dynamic risk factors are identified. Additional assessments should be conducted on a periodic basis.

**Behavior and Programming**
A transition accountability plan is created. This plan outlines the specific programs and the service providers to be utilized throughout the offender’s criminal justice experience. Specific conditions and behavioral expectations will be laid out for the offender.

**Release Preparation**
At roughly six months preceding release, a reentry plan is developed. This plan will address issues such as housing, employment, treatment, and conditions of release.

**Release and responses to violations**
A review of the offender’s behavior and time served is used to determine the target release date. Responses to violations of conditions of release will be outlined along a continuum of force.

**Supervision and Services**
Risk assessment is used to determine appropriate services for the offender and the level of required surveillance.

**Discharge**
The point at which supervision of the offender is terminated should be clearly established and communicated to the offender.

**Aftercare**
Offenders may continue to frequent community services. In addition, legal barriers should not impede offender’s ability to partake in local community activities.

Figure 1: Transition from Prison to Community Initiative (TPCI)
A Cost-effective Solution: Improve Information Sharing Between Corrections and Health

As the previous sections have outlined, a gap exists between intra-institution treatment and transitional treatment associated with reentry into the community and beyond. In many instances, institutional and community corrections agencies could overcome some of these shortcomings by increasing their level of communication with mental and physical health services providers in the community through the exchange of information. Improved information exchange reduces the duplication and/or regeneration of required information and provides service providers with the information they need to do their job, which can lead to improved continuity of services, improved individual health records, improved public safety, improved business process for criminal justice and health, better care, improved recidivism outcomes, and a substantial costs savings.

Both correctional agencies and human services organizations are aware of the need to better coordinate offender reentry efforts. However, the technical nature of communicating sensitive information and reaching beyond organizational boundaries presents barriers to the exchange of information. In addition, separate funding streams and program objectives can be obstacles.

Within the workgroup of justice and health/human services professionals that assembled for this project, it became clear that the exchange of offender profile information—whether it occurred upon release, prior to release, or at referral of probation or parole—could achieve two goals: (1) expedite the process of providing treatment in the community and (2) improve the continuity and consistency of that treatment (from what was offered within the institution). Likewise, the exchange of information from health/human services back to institutional corrections upon re-arrest or revocation could similarly ensure continuity even with failure (i.e., recidivism), thereby improving the likelihood of future treatment success. Sharing information can also reduce duplicative assessments and procedures (e.g., risk/needs, medication, medical tests), saving both time and money. As the research shows, drug users and individuals with mental illness are more likely to be criminally involved than others in the general population (Bennett et al., 2008; Hammett et al., 2001). Improving coordination between justice and mental health agencies has direct implications for improving public safety and health.

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15 SEARCH, APPA, and ASCA convened a workgroup of justice and health professionals on November 1, 2011, in Arlington, Virginia, for 1½ days to discuss the prospect and potential issues associated with exchanging information. Representatives came from various organizations, including the American Public Human Services Association (APHSA), National Association of State Alcohol and Drug Abuse Directors (NASADAD), North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse Services, National Association of Community Health Centers (NACHC), University of Central Florida’s Department of Criminal Justice, and the Centers for Disease Control and Prevention (U.S. Public Health Service).
As a result, effective and lasting reentry management strategies will require close collaboration, supported by information exchange between criminal justice agencies (especially institutional and community corrections agencies) and their partners in the health and human services arena. Health and human services, like justice, are information-centric business areas, in which timely and accurate information are critical to effective decision-making. Much of the information that health and human services agencies require (i.e., medical, mental health, and substance abuse history, risk and needs assessments, treatment plans, programming completed while incarcerated, conditions of supervision, and financial status) are essential for community-based service providers to provide continuity of care and achieve positive long-term reentry results.

The aforementioned types of information being readily available to service providers can make services more effective and fiscally responsible. The information that correctional institutions and community corrections agencies collect (e.g., treatment plans, health and rehabilitation history, risk and needs assessments) is valuable to health and human services provider agencies when assessing an individual’s fitness for specific programs. This information exists in the corrections databases, yet is not currently being shared—primarily because of a lack of guidance at the business process, information exchange, and policy/governance levels, as well as a lack of existing standards-based implementations. As such, recidivism could be reduced if corrections and health/human services communities were provided a cost-effective and flexible means to communicate inmate/probationer/parolee transitional needs.

Current Justice-Health Information Sharing Programs

**SMART.** Created in 2003 and built on the national Web Infrastructure for Treatment Services Platform (WTS), the Statewide Maryland Automated Record Tracking System (SMART) provides clinical records of individuals involved in the substance abuse treatment system to collaborative partners, including drug treatment facilities and drug courts (TRI, 2011). As a web-based exchange using a centralized database, SMART allows service providers to report case data online through a web browser that is shared among collaborative partners. SMART utilizes various modules (e.g., drug court module) to meet the data entry needs of each partner while maintaining continuity between services. The SMART system also conducts automatic validation checks and produces a monthly report to alert agencies of missing data. Finally, given client consent through an electronic consent agreement known as eConsent, collaborative partners can view the collective information and provide referrals as well as foster improved treatment continuity across agencies while still complying with 42 C.F.R. § 28 and HIPAA rules (TRI, 2011).

**BHIPS.** Similar to SMART, the Behavioral Health Integrated Provider System (BHIPS) is a centralized online database (TRI, 2011). The web-based clinical information system originated in Texas and exists in five other states and contains information applicable to substance abuse and mental health service providers. In Texas, the system is being replaced by the Clinical Management for Behavioral Healthcare System (CMBHHS), which, once fully implemented, will include the Department of Public Safety, drug
courts, and the Office of Court Administration in its collaboration. BHIPS and CMBHS, which are also 42 CFR- and HIPAA-compliant, require signed consent forms from clients prior to sharing identifying information across organizations (TRI, 2011).

Both BHIPS/CMBHS and SMART are centralized online databases—or “warehouses”—of identifiable client information from which collaborators submit and query data in real time via a web-based application. Centralized databases have traditionally proved to be costly, with a high-level of administrative and governance overhead required to build, host, and manage a centralized store of information. The information exchange pilot project discussed in this document will use a “federated” model, based on Global standards, where information is exchanged between existing systems using standard system interface(s). It is expected that the use of Global standards and a federated model for exchanging information will significantly reduce implementation costs and promote reuse.

Leveraging Existing Standards and Resources for Information Exchange

The goal of the pilot projects discussed in this document is to leverage existing industry standards to allow for the flow of information across domains. To the extent possible, this approach will successfully bring together the disparate systems of corrections and health communities. To keep costs low, agencies will need to leverage existing information sharing frameworks and associated standards. Currently, the health care industry relies on what is known as the Health Information Exchanges (HIEs),16 a framework using HL717 standards, whereas the justice domain utilizes Global standards such as the Global Reference Architecture (GRA) and the National Information Exchange Model (NIEM). The GRA, specifically, offers the following:

1. It implements a layer of messaging infrastructure, based on open standards, between the partnering agencies. This layer effectively isolates the two systems so that each agency’s system continues to operate independently from the others (eliminating any potential dependencies that may otherwise occur as a by-product of information exchange). In other words, a change or upgrade in one partner agency’s system will not impact the operation of another agency’s system(s).

2. It follows proven open-industry standards (as opposed to proprietary approaches), which allow for maximum flexibility in agency participation, independence, and the potential for reuse.

3. It is governed by a formal structure that promotes a common approach to information sharing, as opposed to project-by-project solutions that can become costly and disparate.

16 http://searchhealthit.techtarget.com/definition/Health-information-exchange-HIE
17 www.hl7.org/
Information exchange is greatly facilitated through the use of industry standards. Using standards allows both the sending and receiving partners to clearly understand the business and technical nexus between the exchanges. Information exchange standards also allow the information systems themselves to remain autonomous and reduce costs through reuse.

**Privacy Concerns**

Some agencies have shied away from information exchange due to an overarching fear of litigation, and a misunderstanding of what and how information can be shared between health and justice agencies. Regulations that protect sensitive health information are necessary to ensure personal stigmatizing information remains confidential (TRI, 2011). In general, HIPAA\(^{18}\) and 42 C.F.R. require protected health information not be disclosed without written permission from the individual of interest. However, for those who consent to share their information, the barrier between justice and health information exchange is largely removed through the implementation of security and privacy policies using technological means. The Treatment Research Institute also explains,

“…while 42 C.F.R. § 2.1 (c), prohibits the use of treatment information for the initiation of criminal charges by law enforcement, it does not preclude the use of this information to initiate revocation of parole or probation or, in context of post-plea diversionary programs (e.g., a drug court), to reinstate charges. Policy makers, with input from treatment specialists and law enforcement, should deliberate the public health and safety consequences of extending the provisions of 42 C.F.R. § (c) to community corrections.” (2011, p. vii)

While care must be taken to protect individual offender information, it should not stop agencies from sharing pertinent information when appropriate and legal to do so. In addition to HIPAA, agencies should also be mindful of privacy laws specific to their state or locality.\(^{19}\) For instances in which privacy and security challenges associated with the exchange of information are a concern, the Office of the National Coordinator for Health Information Technology (ONC), U.S. Department of Health and Human Services (HHS) has developed a Nationwide Privacy and Security Framework to provide a consistent and coordinated approach to privacy and security.\(^{20}\)

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\(^{18}\) Health Insurance Portability and Accountability Act (HIPAA), Pub.L. 104-191.

\(^{19}\) For further guidance, see [www.samhsa.gov/healthPrivacy/docs/EHR-FAQs.pdf](http://www.samhsa.gov/healthPrivacy/docs/EHR-FAQs.pdf).

Other Concerns and Limitations

In addition to privacy, issues of data quality, appropriate use, technological capacity, funding, mission creep, and justice-health interrelations also pose some risk to a justice-health information exchange. Data quality is a common concern when working with any outside agency. The exchange itself has the potential to improve data quality on both ends as the data become more utilized and more eyes become reliant on its accuracy. That said, guidance is available to further examine these issues using the Information Quality program guide.\textsuperscript{21}

Appropriate use is tied to privacy in some respects. When sensitive information is shared across domains, there is the potential for misuse if proper controls are not put in place to restrict access to specific individuals for specific purposes. One concern with sharing information between justice and health agencies is the danger of increased offender monitoring, which could lead to increased probation or parole revocations in lieu of improved treatment outcomes (TRI, 2011). Alternatively, mission creep and/or mission distortion concerns the tendency of one agency to take on the role of another, often cited in the police-probation partnership literature (Corbett, 1998; Kim, Gerber, and Beto, 2010; Murphy and Lutze, 2009; Murphy and Worrall, 2007). In other words, institutional or community corrections agencies begin to place treatment and rehabilitation goals above surveillance and compliance as a direct result of their relationship with human services agencies. On the other hand, it’s possible for human services agencies to sway toward monitoring and detection as a result of their association with justice entities.

Finally, two particularly important issues that can stop an exchange from materializing at the outset of a project are the current relationships shared between justice and health agencies, and the technological capacity of each agency to participate in an information exchange. If relationships between justice and health are strained due to prior disagreements, a general distrust, or unwillingness to compromise, little progress can be made until the respective agencies can mend their broken relationship. Even in those cases where relationships are strong or neutral, agencies must possess some technological capacity to share information. Some justice and health agencies, particularly small rural jurisdictions, continue to utilize classic paper-based procedures. Until these agencies are capable of advancing to electronic files, their participation in larger information exchanges will be severely limited.

Justice-Health Pilot Project Implementation

As previously noted, two pilot projects will be implemented to exchange Justice-Health information. The pilot sites will be chosen through a Request for Proposals (RFP) evaluation process. The project workgroup will review proposal responses. Selection of the pilot sites will place an emphasis on the partners’ willingness and need to share information, technical readiness, and governance/support for information sharing between justice and health. In addition, the project workgroup will concentrate on pilots that have a need to convert information between healthcare data standards (e.g., HL7, CCD) and NIEM.

Conclusion

Although a plethora of information exists on inmates, probationers, and parolees collected from various points through the justice and health/human services systems, the information is currently disjointed, duplicative, and uncoordinated.

Reimagining the depth and timing of information exchange between the justice and health/human services systems can serve two purposes: (1) reduce many of these inefficiencies while (2) simultaneously impacting the quality of services provided upon reentry of the inmate/parolee/probationer into the community. Of particular concern is the presence of medical disorders (e.g., substance abuse, mental illness), which complicate community reintegration and can serve as barriers to desistance-enabling behaviors and ties such as employment and positive peer relations (i.e., epidemiological criminology). As prior research has demonstrated (Butzin et al., 2005), improved transitions lead to better inmate, probationer, and parolee outcomes, thereby resulting in lower recidivism (i.e., rearrest, probation/parole revocation), fewer jail/prison admittances (i.e., returns), and subsequently reduced crowding and institutional costs.

Improving interagency information exchange is the first step to making inmate, probationer, and parolee transitions more successful. These exchanges can be implemented using industry standards to preserve existing systems (system autonomy), reduce costs, and promote consistency and reuse across domains.
References


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<td>Acquired Immune Deficiency Syndrome</td>
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<td>APHSA</td>
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