

Looking Ahead: Hillsborough's Reinvestment Model





How large is the re-entry issue in the United States?

- In 2007, 7.3+ million adults were under correctional supervision, on probation/parole, or in prison/jails. 70% (5.1 million) were supervised in the community, and 30% (2.3 million) were incarcerated.

Source: Prisoners in 2007 (NCJ-224280), was written by Heather C. West and William J. Sabol, Ph.D., and Probation and Parole in the United States, 2007 – Statistical Tables (NCJ- 224707) was prepared by Lauren E. Glaze and Thomas P. Bonczar. Following publication, Prisoners in 2007 can be found at <http://www.ojp.usdoj.gov/bjs/abstract/p07.htm> and Probation and Parole in the United States, 2007 – Statistical Tables can be found at <http://www.ojp.usdoj.gov/bjs/abstract/ppus07.htm>.

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How large is the re-entry issue in Hillsborough County?

In 2008, 8,306 ex-offenders returned to Hillsborough County from Florida's prisons.

- Approximately 70% were released without supervision to follow.
- About 30% were under some form of supervision following their release.



How large is the re-entry issue in Hillsborough County?

In 2008, 8,306 ex-offenders returned to Hillsborough County from Florida's prisons.

- 66% were released without supervision.
- 34% were under some form of supervision following their release.

Source: **Prisoner Reentry in Florida: Tampa & Hillsborough County** The data analysis and mapping were conducted by Nancy La Vigne and Diana Brazzell of The Urban Institute's Justice Policy Center.

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What obstacles are identified as barriers to successful re-entry?

Nationally

- Health Care
- Mental health services
- Sub. abuse treatment
- Housing
- Entitlements

Locally

- Housing
- Jobs
- Entitlements
- MH/SA services
- Health services

Source: "Reaching In to Help Out: Relationships between HCH Projects and Jail" by Nan McBride, PRA

Source: Hillsborough's Adult Re-entry Cross Training Project undertaken by Hillsborough County Criminal Justice in 2006

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What does that mean?

- The ex-offender may not have food or shelter.
- The ex-offender may not have adequate clothing or proper attire for an interview.
- The ex-offender is not likely to have learned job or life skills.
- The ex-offender has not had mental health or substance abuse treatment.



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What else does it mean?

- There is a lack of medication that permits higher functioning of the mentally ill.
- Transportation and other barriers such as lack of documents to prove their identity may prevent enrollment.
- Programs have various eligibility criteria, different enrollment processes, and delays in meeting immediate needs.



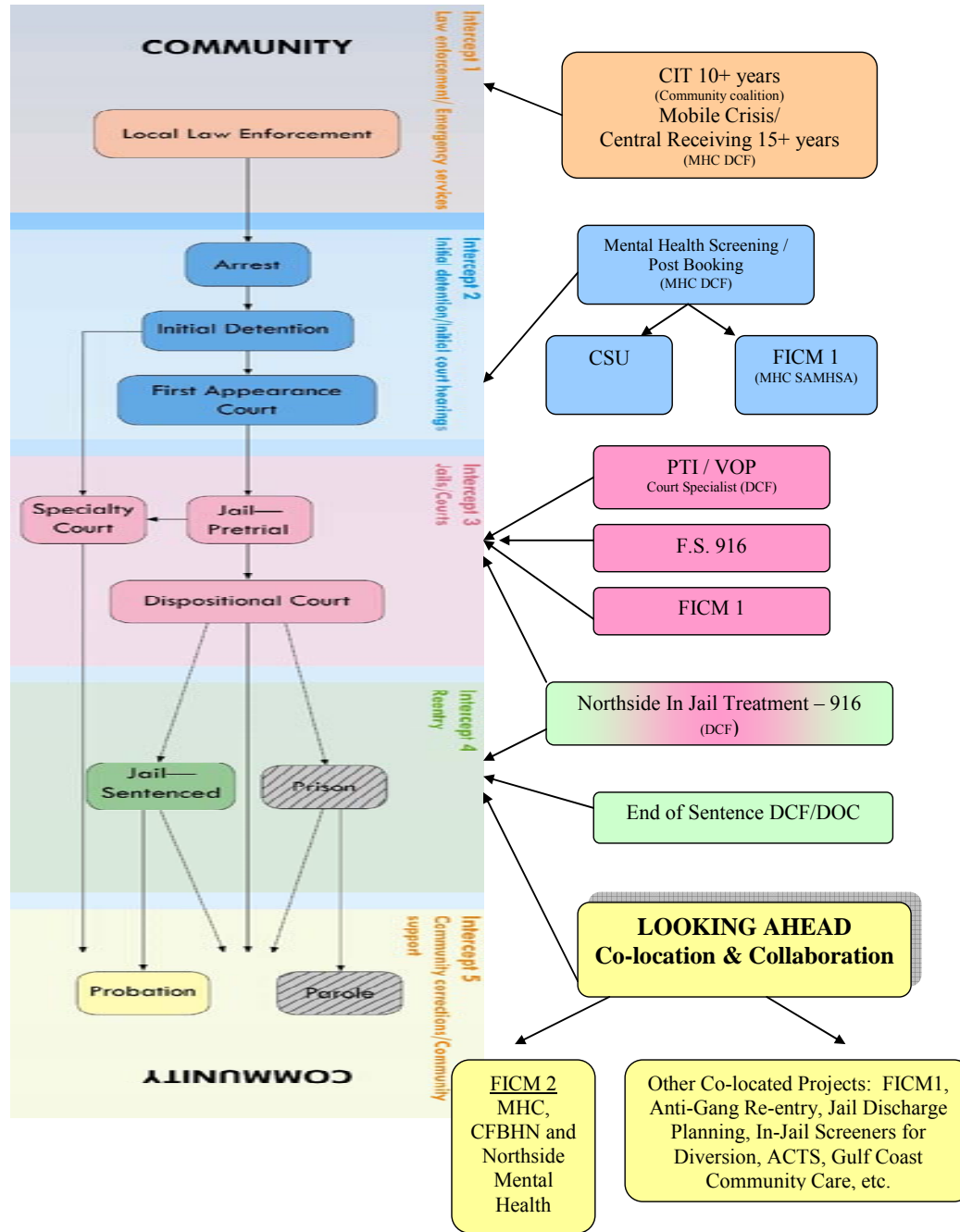
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Local Solution: Looking Ahead

Create a public/private partnership with a multi-service design at the "community" intercept.

Note: Program components and related projects are indicated in yellow on the sequential intercept chart on the following page.





Reinvestment Grant Model



Target persons with significant behavioral health issues who are returning from prison/jail.

Provide three levels of service based on need/eligibility.

Deliver voucher services and related case management.



Approach

Involve and retain ex-offenders in meaningful services by providing early engagement and voluntary, post release services that are client directed, stage appropriate, timely, continuous, comprehensive and integrated.

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3 Tiers of Service

(1) Screening/Simple Referral

Immediate, face-to-face contact with mental health staff to clarify individual risk and needs (approximately 100 ex-offenders per mo.)

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Tiers of Service

(2) Engagement/Linkage

Immediate, short-term (up to 29 days) assistance to individuals with significant mental illness to facilitate community re-integration. (approximately 25 clients at a time)



Tiers of Service

(3) Intensive Case Management

Longer-term assistance and support if needs are not successfully met within the first 30 days.
(approximately 50 clients at a time)

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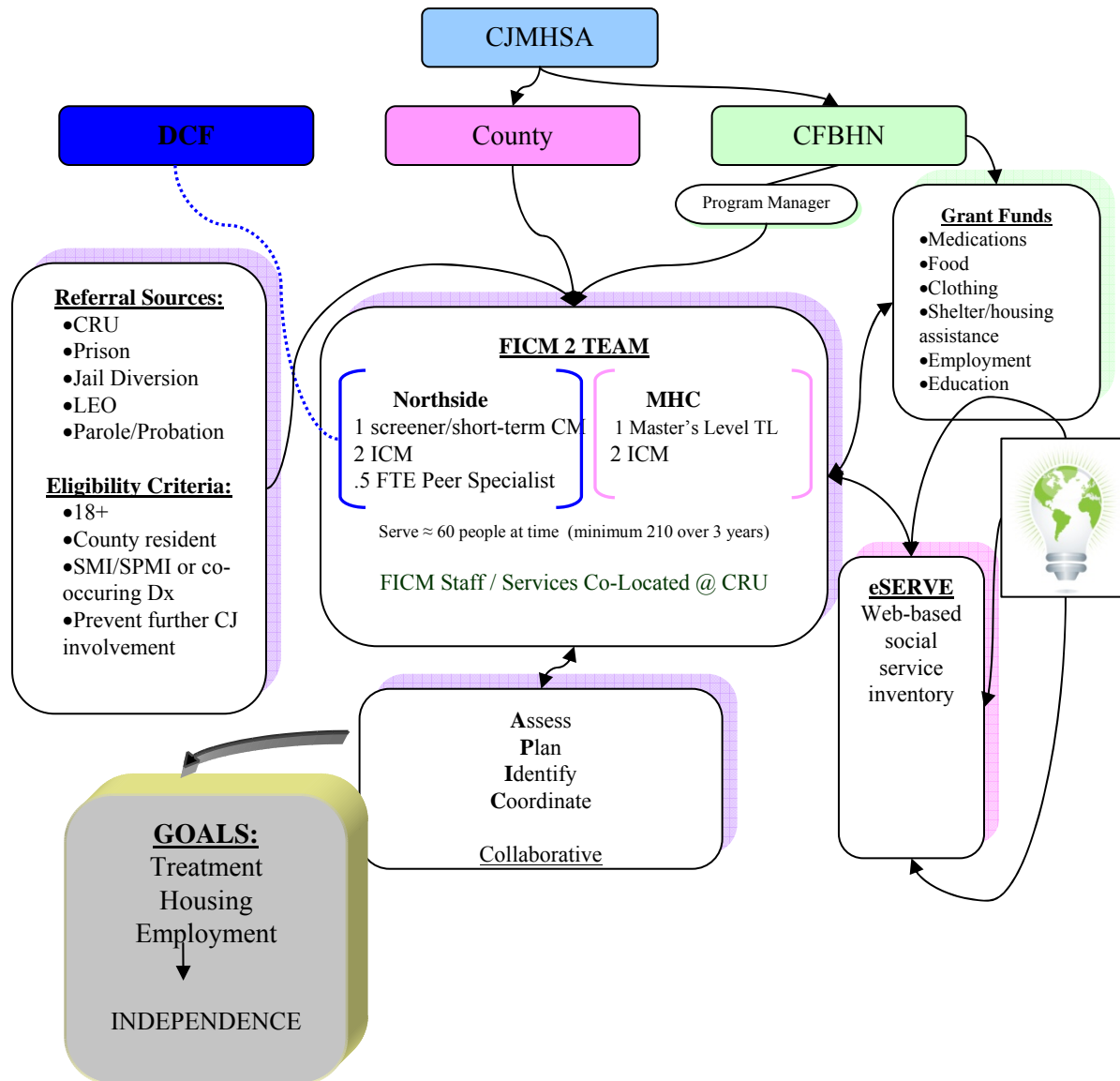
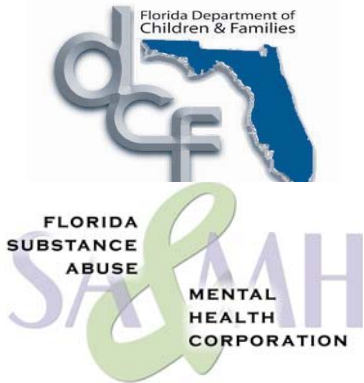


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How does this approach differ from traditional services?

- Provides a variety of related services and resources, which are conveniently located and easy to navigate.
- Considers individual need and help the ex-offender address their immediate and interim needs.
- Creates a plan for the ex-offender to meet their own long-term needs.





Direct Services

- Medication Management by a licensed clinician
- Stage Appropriate, Recovery Oriented Treatment/Goals
- Dual Recovery Group
- Life Skills Training
- Aggressive Supervision/Monitoring
- Brokering access to appropriate levels of care

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Wrap Around Services

- Transportation
- Housing via contingency funds
- Navigating SSI/SSDI
- Representative Payee
- Residential treatment, if appropriate

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Local Stories

Don (54) is a Bipolar client with a strong work history while on medication. Due to a lack of services he discontinued his medication about a year ago and was unable to maintain employment. He fell behind on all his payments and pawned many items to survive. Then he was arrested for assault. He was in someone's yard and they told him to get off the property. He doesn't recall clearly what happened next and remembers being arrested. When he was incarcerated he expressed remorse. Now he sees the repercussions of discontinuing his medication.

Looking Ahead assisted him by helping him to get back into his apartment instead of being homeless. He is back on medication and is getting health care. He is stable and seeking employment. He has worked several day labor jobs and is hopeful that this will lead to full time employment.



Wanda (50) is diagnosed with co-occurring depression/ anxiety and substance abuse. Prior to the program Wanda self medicated by using crack cocaine. Wanda was unable to hold a steady job or home, prior to incarceration for theft.

Since she has been in the Looking Ahead program, Wanda is residing with her son. She has been clean since her incarceration and is on the proper medication. She has received transportation assistance, applied for SSD, and is looking for employment. For the first time, Wanda loves herself.



Ester (52) is Bipolar and discontinued her medication due to extended periods of homelessness. Ester attended a university, but was unable to graduate because she started getting "confused".

Since she has been in Looking Ahead she is residing with her brother and on medication. She has received transportation assistance, applied for food stamps and healthcare, and obtained a pair of shoes. She has had several day jobs and is currently seeking full time employment. Her family says she is much better.



Goal

To reduce recidivism and increase public safety with innovative, effective, and sustainable programs.



Re-arrest Data

1,000 ex-offenders screened during this period. 417 ex-offenders from the target population were offered some level of service. 11.5% (48 people from the 417 screened) were re-arrested after 120 days.

According to the FDOC data 29% of DOC inmates commit a new crime within 120 days of release. Looking Ahead's post-release services results are 17.5% lower than the average.



Level of Service Provided to Arrestees



38 arrestees received referrals only.



10 arrestees received on-going support/case management services.



The most common charges for all 48 arrests were drug related (5) and petit theft (3).





Goal

To reduce recidivism and increase public safety with innovative, effective, and sustainable programs.



Objective

Develop efficiencies between programs, align practices, re-deploy resources, expand capacity, and deliver quality services.



Preliminary Results

85% of the 8,306 ex-offenders released from FDOC identified a need for mental health follow-up at intake

- 70% were failing to keep an initial appointment elsewhere
- 90% of engaged clients kept that community appointment

55% of individuals screened (8,306 ex-offenders) had a history or need for psychotropic medications.

- 84% of participants received medications within 48 hours of the request.

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Preliminary Results

80% of our 417 clients identified a lack of benefits or employment
-44% obtained income or had made application for Social Security benefits at the end of engagement.

30% of our 417 clients were homeless upon arrival or desired supportive housing.
100% of clients were in housing at the end of engagement.



Local Solution: Looking Ahead

Eliminated artificial barriers by co-locating services, sharing resources, and improving service delivery.

Used vouchers to insure that clients receive immediate, highly individualized services.

Recognized that each ex-offender has needs and deliver timely, highly-individualized services to meet that need.

Stimulated a hopeful environment using intensive case management and create a plan for self-sufficiency.

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Looking Ahead Accomplishments

- Created a Re-entry Strategic Plan – Memorandum of Understanding - signed by 18 partners
- Implemented a Unified Consent form for HIPAA release of information
- Modified the GAINS Brief Mental Health Screen
- Incorporated Advanced Directives for Psychiatric Care
- Standardized court orders
- Reduced referrals to the Crisis Response Unit
- Co-located five agencies and six programs into Looking Ahead



Next Steps

- Re-map adult Diversion and Re-entry System (Feb)
- Scheduling juvenile system mapping

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