Issue 4 March 2009

COCHS Connection

A Message from the Editor

Connectivity is the key guiding principal to the COCHS approach: By linking with their communities, local correctional facilities have an opportunity to improve both public safety and public health while supporting offender re-entry.

Fortunately, connectivity can take many forms. I say "fortunately" because if there's one thing we've all learned it's that no two local correctional facilities are the same. In addition, the communities they serve all have different problems and needs, as well as different capacities to serve returning offenders. So there is no one-size-fits-all, cookie-cutter approach to building a solid program of developing connectivity.

That's why we have a COCHS "approach" – not a COCHS "model." We recognize the need for a diversity of approaches to implementing community-based correctional care.

And therein lies the beauty of connectivity.

We started our program working to foster partnerships between local jails and community health providers in an effort to replicate the success of the Hampden County (MA) Jail. To date, that work has led to the creation of two highly successful collaborations in Washington, DC, and Marion County, FL.

The diversity of the systems we work with is taking COCHS in exciting new directions: juvenile health and community-based treatment of opiate addiction. In both cases, connectivity is the linchpin.

Our new partner program, Juvenile Offenders Community Health Services (JOCHS), will work to create stable connections between juvenile corrections and community health services. JOCHS applies the same concepts for juveniles in detention that COCHS does for adults in corrections.

In addition, COCHS is developing partnerships centered on the use of buprenorphrine in creating continuity of care for opiate addicts between the correctional and community settings. This type of connectivity is an excellent example of how community/correctional relationships can be built to create a continuum of care and how public safety dollars can be refocused on community health care to keep offenders living and working within their communities.

You'll find more information on these initiatives in this issue of *COCHS Connection*. Also, check out the new website for JOCHS, www.jochs.org.

In the complex world of inmate re-entry, one program does not fit all, but connectivity fits everywhere.

Paul Sheehan
Chief Operating Officer
Community Oriented Correctional Health Services

COCHS
COMMUNITY ORIENTED CORRECTIONAL HEALTH SERVICES

To subscribe to *COCHS Connection,* please send an email to newsletter@cochs.org and indicate if you would like to recieve the newsletter by email or in hard copy through the mail. In addition, we welcome your comments, feedback, and questions. COCHS is supported in part by the Robert Wood Johnson Foundation.

New Initiatives

The movement to create connectivity between local correctional and community health care is picking up steam. COCHS is excited to announce the following new initiatives:

- Juvenile Offenders Community Health Services (JOCHS), COCHS' new partner program, is designed to foster connections between local juvenile justice systems and community providers of health care and other supportive services. The goal is to build an uninterrupted continuum of high-quality community health and mental health services for youth as they enter and leave detention. The Juvenile Justice Center in Alameda County, CA, pioneered the integrated approach to juvenile health and support services that serves as the prototype for JOCHS.

JOCHS is supported by the California Endowment and by the Robert Wood Johnson Foundation.

- COCHS is working with several partners in New Mexico to expand access to opiate addiction treatment using buprenorphine, which can be prescribed by doctors in the community and dispensed at a pharmacy. Bernalillo County have earmarked $500,000 this year to treat 1,000 opiate addicts with buprenorphine. Also, the New Mexico Department of Health has started offering buprenorphine in the Doña Ana County Detention Center. And in Albuqerque, Project ECHO, an innovative telemedicine learning program, has trained doctors to prescribe buprenorphine and monitor its use in the community.

- The COCHS Mapping Arrestee Population Tool (COCHS MAPTool), a new web-based program designed by COCHS to support offender re-entry planning, is now available for free at www.cochsmaptool.org .

- Our new manual describing the legal relationships possible between health care centers and local correctional facilities is now available for free download at www.cochs.org. We hope that this tool, created for COCHS by Feldesman Tucker Leifer Fidell LP, legal counsel for the National Association of Community Health Centers, will help foster new partnerships and support innovative approaches around the provision of community-based inmate care.

To stay on top of new developments, visit our website, www.cochs.org.

Alex Briscoe: Connecting Juvenile Justice to Public Health through JOCHS

Alex Briscoe is the project director of Juvenile Offenders Community Health Services (JOCHS), the new partner program to COCHS. He is also the deputy director of the Health Services Agency in Alameda County, CA, which pioneered the JOCHS approach for linking juveniles with community health services at its Juvenile Justice Center (JJC). Here, Briscoe discusses why coordinated, ongoing medical and behavioral health care is critical for juveniles and how jurisdictions can go about replicating Alameda County's approach.

How will JOCHS work to improve health care for juveniles?

JOCHS will foster partnerships between local juvenile justice systems and community providers of health care and other supportive services. The goal is to build an uninterrupted continuum of high-quality community health and mental health services for youth as they enter and leave detention. We view juvenile detention not just as a crisis but as a window of opportunity to help young people and their families establish an enduring medical home that they wouldn't have otherwise.

Most youth entering detention do not have a regular doctor or other health care provider. When they leave detention, they generally stop receiving health care. Their problems and conditions worsen – increasing the odds that they will get into trouble again, and contributing to recidivism rates of or above 60 percent for most juvenile offenders. JOCHS works to ensure that youth get the care they need not only in detention – but after they leave it, in the community.

What makes health care for juveniles different from health care for adult jail inmates?

Both populations are at high risk for a wide range of health and mental health problems, but juveniles have an especially complex mix of developmental, medical, and behavioral needs. While adults have serious behavioral health needs, the acuity, seriousness and pervasiveness of mental health disorders in the juvenile population is significant higher. So, when it comes to treating juveniles, in addition to chronic disease, there must be an emphasis on behavioral health. The three leading causes of death for juveniles in detention are homicide, suicide, and unintentional injury. These are not traditional medical diagnoses, and to impact them you have to treat the behavioral and social needs of young people.

What is the state of health care in most juvenile detention centers?

The standard of care in most juvenile detention centers leaves a lot to be desired. There are numerous problems with delivering this kind of care. Almost all juvenile care is delivered either by public sector staff or by private providers who are not the same providers who would see the children in the community. Restrictions on reimbursement and the lack of adolescent health expertise seriously constrain the scope and quality of services available to juveniles in detention.

How is the Juvenile Justice Center in Alameda County different from other detention centers?

First and foremost, we bought in a nationally recognized provider in adolescent health, which also happens to be Alameda's single largest community-based adolescent health care provider, into our juvenile detention facility. We ensured that our scope of practice was consistent with best practices in the pediatric and adolescent health community. We hired board-certified professionals in adolescent health who also have adolescent health as their specialty.

On the behavioral health side, we dramatically expanded the scope of our services. We doubled the size of our staff and services. In addition, we focused the staff on direct therapeutic services to juveniles and on ensuring continuity of care upon release or transfer to another facility. Historically, behavioral services for juveniles have been focused on court-ordered evaluations and crisis response. Our approach was to develop a therapeutic milieu on every living unit. Fulltime clinicians, at the masters or doctorate level, work on every living unit to provide direct services and to consult with probation, education, medical and community-based service providers.

We're getting results, too. In the first year of the JJC's operation, more than 600 juveniles released from the facility received care in the community. Within the JJC, the number of off-site transfers for health problems has fallen in half. Incidents of violence between youth, the use of pepper spray, and the need for seclusion and restraints have also declined significantly. These outcomes have been achieved in an environment where increasingly serious juvenile offenders are being placed at the county level.

"In the first year of the Juvenile Justice Center's operation, more than 600 juveniles released from the facility received care in the community. Within the JJC, the number of off-site transfers for health problems has fallen in half. Incidents of violence between youth, the use of pepper spray, and the need for seclusion and restraints have also declined significantly."

What is needed to replicate Alameda County's approach in other jurisdictions?

Critical to the challenge of replication is a real and authentic collaborative planning process where all stakeholders can review and reflect on current service delivery in the context of best practices for corrections, health care, and youth development. A second and equally important challenge is the political will and the resources available to implement the changes needed. Many – but not all – of the resources needed can be generated through aggressive pursuit of third-party reimbursement. Public officials and public systems in Alameda County made an investment in juvenile health and it is important to highlight this act of commitment. Resources can be leveraged,

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Bernalillo County Links Jail and Community to Treat Addicted Inmates

Bernalillo County, home to Albuquerque and the most populous county in New Mexico, holds a troubling distinction: Its jail has one of the highest rates of opiate addicts in the nation – 10 to 20 percent of those arrested have opiates, mainly heroin, in their system.

But the county also is gaining a national reputation for its response to the problem of drug addicts. For the last three years, it has run one of the country's handful of methadone maintenance programs in jails, and has opened detoxification programs and transition homes for people when they leave jail.

Now the county is starting a new initiative that will establish an even stronger treatment link for addiction between the jail and the community. County commissioners have earmarked $500,000 this year to treat 1,000 opiate addicts with a drug called suboxone, also known as buprenorphine. The drug has been shown in studies to prevent relapse, carries fewer health risks than methadone, and comes in the form of pills – eliminating the use of needles, which can spread infections such as HIV.

Just as important, though, is the fact that buprenorphine can be prescribed by doctors in the community and dispensed by a pharmacy – meaning that addicts can begin buprenorphine treatment while they're in jail and continue getting treatment in the community after leaving jail.

"I'm very excited about this new program," said John Dantis, deputy county manager for public safety. "With methadone treatment, you have to go to a clinic once a day and the person gets a high. With suboxone, it's like getting hypertension medication. A doctor gives you a 30-day supply, and you take the pill in your home."

The county enlisted several partners in the program, including the state Department of Health, Healthcare for the Homeless, The University of New Mexico, First Choice, the local FQHC network, and Community Oriented Correctional Health Services (COCHS). COCHS has provided technical assistance to the county in program design.

Linking Public Safety with Public Health

"I love the fact that Bernalillo County is using public safety dollars to treat a health problem," said Keith Barton, MD, medical director for COCHS. "It reflects recognition of the material relationship between public safety and community health. The county's decision to give [buprenorphine] to people leaving or still in jail has the potential to turn lives around."

Bruce Trigg, MD, medical director of the Public Health Program at the Metropolitan Detention Center in Albuquerque, has high hopes for the program.

"If you are a heroin addict, you're looking for a fix three or four times a day," he said. "But suboxone is good for 24 hours. So instead of spending your whole life seeking drugs, you have 24 hours a day to do everything else. It becomes like a diabetic dependent on insulin. Just like you need insulin if you're a diabetic, you'll need suboxone if you're an opiate addict."

He said the county money "means we are going to finally realize our dream to put a large number of people on treatment and link it to the jail."

The medication works by binding to receptors in the brain and nervous system, which helps prevent withdrawal symptoms in a person who has stopped taking narcotics such as heroin, morphine, or codeine. Suboxone produces less euphoric effects than heroin, for instance, making it eventually easier to stop taking.

Dantis, the deputy county manager for public safety, said that while the medication is essential to building a successful program, other services, such as halfway houses and job training, are equally as essential. He also sees the new suboxone program as an economic benefit to the county.

"It's our own little way of helping with economic development and reducing the numbers of people from continuing in these revolving doors, from the prison to the community and back to prison," he said. "It costs $67 a day to keep someone in jail – that's $2,000 a month to house them. If they are working, they pay $300 to $400 a month in taxes. That's a big turnaround when you break their addiction."

Indianapolis Focuses on Screening for Arrestees

The city of Indianapolis has a 24-7 central arrestee processing center (APC) where all arrestees are taken and arraigned. COCHS is working in a unique collaboration that includes safety net providers; the offices of the mayor, sheriff, public defender, public prosecutor, and public defender; the judge, commissioners, magistrates, and staff at the APC: and others.

The goal is to expand health and mental health screening into the APC using safety net providers. Under this plan, judges will incorporate the recommendations of the treatment team as a condition of release when offenders are released on their own recognizance.

"The partnership in Indianapolis represents an extraordinary breakthrough in advancing the connectivity approach," said COCHS Chief Operating Officer Paul Sheehan. "We look forward to working with all the partners to help implement this plan."

New COCHS MAPTool Supports Re-entry Planning

With support from the Robert Wood Johnson Foundation and the Jacob and Valeria Langeloth Foundation, COCHS has developed a web-based electronic mapping program to support offender re-entry planning. The COCHS Mapping Arrestee Population Tool (COCHS MAPTool) allows local correctional officials to identify where their detainee populations come from in reference to location of services that detainee are likely to need upon release.

When census data for ZIP codes are entered into MAPTool, it assigns a color gradient to each ZIP code area. The darker the color of the ZIP code area, the greater the percentage of detainees from that ZIP code. In identifying these population concentrations, users can then locate re-entry resources such as treatment centers for health, substance abuse, and mental health. They can also determine the relationship of those resources to the ZIP codes that have the highest percentage of detainees.

COCHS MAPTool is available for free at www.cochsmaptool.org.

The Case for Community-Based Treatment of Addicted Offenders

By David Rosenbloom, PhD, Director, Join Together

There are three related truths about a majority of inmates in America's jails: They are going home soon; they have serious substance use problems, and they are likely to return to jail. A significant percentage of people released from jail relapse and reoffend within days, as soon as they encounter their triggers for drug or alcohol use. Everyone involved in this cycle – from offenders to judges to cops on the street – knows the pattern all too well. Almost all agree that key to ending this life-destroying cycle is getting and keeping offenders off alcohol and drugs.

We can do that for many offenders. But we need to take a different approach to treating addiction. While they're in jail, inmates with diagnosed addiction problems should get treatment for those problems. A few do. But once released, there's no guarantee that former offenders continue addiction treatment. In fact, odds are pretty good that they're not connected to community-based care.

So it's no surprise that they fall into their old habits.

What we need to do is create connections for inmates while they're incarcerated, so that they can continue treatment started in jail after they are released into the community.

There are effective medications for treating opiate and alcohol addictions, usually in combination with counseling. But we have to use these effective medications in order to break the addiction cycle. We must establish links between jails and community substance abuse treatment providers, so that offenders have somewhere to go for treatment after incarceration.

Continuing Treatment for Opiate Addicts

We're starting to see this happen with opiate addiction, although the majority of jails remain hostile to medication-assisted treatment. The Food and Drug Administration (FDA) has approved two medications for treating opiate addiction: methadone and buprenorphine.

Methadone has been around for decades. When used properly and at the right dose, methadone has helped thousands of addicts get and stay sober. Some jails have programs that start opiate addicts on treatment and continue treatment in the community. However, the vast majority of opiate addicts released from jail on methadone are required to go to a methadone clinic – usually very far from where they live – every day to get the medicine, often preventing them from finding and keeping a job.

Other jails provide methadone to prisoners who were on it prior to arrest. However, vast swaths of the criminal justice system refuse to use methadone at all. It is still common for jails to forcibly wean prisoners from the medication. Ridiculous regulations and official prejudice about methadone treatment are driven by fear of its potential for misuse rather than by the hope it provides for people who use.

Buprenorphine Offers Advantages for Treating Opiate Addiction

Buprenorphine—also known as suboxone—is a newer oral medication that has a significant advantage: It can be prescribed by physicians in the community and dispensed for a week or month at a time from the corner pharmacy. Buprenorphine has been shown to be very effective and safe, especially when combined with medical management or counseling.

A jail-based clinic with trained personnel is a highly appropriate place to initiate this treatment and make a solid plan for connecting the offender to a community-based physician or clinic before release. A person leaving jail on buprenorphine can have the stability to get through the initial stress triggers. And, if the person does use, the medication will prevent a satisfying high that can lead to immediate long-term relapse.

Treating Alcoholism

A similar approach could be used to treat alcohol addiction. The FDA has approved three medications shown to be effective in treating alcoholics: Antabuse, Campral, and naltrexone. None of these has great success records because patients, especially those with disordered lives, often stop taking the medicine.

However, naltrexone can now be dispensed in a once-a-month injection (Vivitrol™). This formulation offers a real opportunity to break the cycle of alcoholism – but only if corrections and community providers collaborate. Diagnosis and treatment would begin while an offender is in jail and would include a plan for partnering with a community-based provider who comes into the jail to meet the offender and get consent to treatment and other essential services. The offender would start the medication while still in jail. He would be released while the medication is still active and continue getting injections from a community-based provider.

"Relapse is a call for more treatment, not punishment. A person in jail can't get a job or support his family. A person in the community on treatment has a chance to do both and end the cycle of dependency."

The beauty of this long-lasting medication is that the decision to start treatment can be separated by weeks from the stressful events around release that so often trigger relapse. The medication would provide many alcoholic offenders with the stability they need to transition from jail to continued treatment and other services.

There's a strong financial case for long-term medication-supported drug and alcohol treatment. A year of injectible naltrexone and counseling costs about $11,700; methadone treatment and counseling averages about $3,800 for a year; and a year of buprenophine treatment may cost up to $6,200. On the other hand, a year in jail costs between $20,000 and $40,000.

Addiction is a chronic relapsing condition. For many addicts, treatment should be ongoing, just as it is for chronic diseases like diabetes and hypertension. Relapse is a call for more treatment, not punishment. A person in jail can't get a job or support his family. A person in the community on treatment has a chance to do both and end the cycle of dependency.

COCHS and Project ECHO Team up to Enhance Care for Opiate Addiction for Jail Inmates

Community Oriented Correctional Health Services (COCHS) and Project Extension for Community Care Outcomes (known as Project ECHO), both grantees of the Robert Wood Johnson Foundation, are working together to expand access to treatment of opiate addiction with buprenorphine while strengthening connectivity between jails and their communities.

Project ECHO began in 2003 by using web-based telemedicine training and consults to help rural doctors and nurses in New Mexico attack widespread hepatitis C. In 2006, ECHO launched programs in mental health disorders, substance abuse, gestational diabetes and rheumatologic diseases.

More recently, ECHO has trained a cadre of physicians to prescribe and monitor the use of buprenorphine, a new and promising medication for treating opiate addiction. Unlike methadone, which generally requires treatment in an inpatient center, buprenorphine can be prescribed by doctors in the community.

Keith Barton, MD, medical director of COCHS, noted that use of buprenorphine allows health care providers to treat opiate addiction much as they would a chronic disease, like diabetes. "People with diabetes use medication to maintain their health so that they can work and function in society," Barton said. "People leaving jail with an addiction problem need to be able to carry on their lives while they're on treatment. They need to be able to work and support their families, both to stay out of jail and stay healthy. Proper use of buprenorphine can help them do that."

In a related project, COCHS is also working with the New Mexico Department of Health, which began offering buprenorphine to inmates in the Doña Ana County Detention Center in January. The Las Cruces Public Health Office has been using buprenorphine since July 2007 to help residents of Doña Ana County.

"The expansion to the detention center will give us opportunity to help people before they are released," Ray Stewart, director of public health services for the Department of Health in southwestern New Mexico, told the *Sun-News*. "This can have a positive impact on their lives by giving them a head start on the road to recovery and reduce the incidences of repeat offenses."

In combination with aggressive pre-release discharge planning and follow-up in the community, multidisciplinary professionals will work as resources for opiate addicts to maintain themselves on buprenorphine after release into the community.

For more information about Project ECHO, go to: http://echo.unm.edu/. For more information about the Doña Ana County initiative, visit the Public Health Division Region 5 website at www.healthynm.org.

Information Technology Opportunites Part of Stimulus Package

Included in President Barack Obama's economic stimulus package is the Health Information Technology and Economic and Clinical Health (HITECH) Act, which appropriates $19.2 billion to encourage the adoption of electronic health records (EHRs). HITECH also calls for the creation of "regional health information technology extension centers," local support organizations to help health providers install and use EHRs. The Primary Care Information Project (PCIP) in New York City is doing this already. Working with a vendor, the PCIP has implemented an EHR system in two outpatient clinics, 10 community health centers, 150 small group physician practices and even the women's jail. Mayor Michael Bloomberg proposes to expand the use of this EHR system throughout the city's correctional facilities.

Thus the stimulus project may present an opportunity to local correctional officials interesting in implementing the COCHS approach to connectivity with their communities. For more information on the HITECH Act, go to www.thomas.gov. For more information on PCIP, go to www.nyc.gov/html /doh/html/pcip/pcip.shtml.

DC Meeting Focus on Lessons and Opportunities from COCHS Approach

The third annual COCHS stakeholder meeting, held March 10-11 in Washington, DC, brought together leaders from government, corrections, community health, and philanthropy to discuss lessons learned from the dissemination and implementation of community-based health care in local jails. The meeting was supported by the Robert Wood Johnson Foundation (RWJF), the Jacob and Valeria Langeloth Foundation, and the California Endowment.

The first day focused on the experiences of three cities – Boston, Indianapolis, and the District of Columbia – with establishing a program incorporating the COCHS concept of community/correctional connectivity.

Presenters also provided details on COCHS MAPTool, a web-based electronic mapping program developed by COCHS to support offender re-entry planning, and a manual produced for COCHS that describes the legal relationships possible between health care centers and local correctional facilities.

In addition, meeting participants heard how stakeholders in the community and in correctional health can create interconnectivity around addiction treatment for offenders, both in jail and in the community.

On the second day of the meeting, participants took an in-depth look at the challenges of providing community-based health care to juvenile offenders, drawing in particular on the experiences of an innovative program at the Juvenile Justice Center in Alameda County, CA, the prototype for Juvenile Offenders Community Health Services (JOCHS), COCHS new partner program.

Nancy Barrand, program officer for RWJF, termed the meeting a success. "The conference validated RWJF's goals to establish COCHS as a way to show communities how they can connect their resources to improve the quality of health care provided to some of their most vulnerable populations," she said. "We look forward to seeing what happens next."

Juvenile Offending and Detention

- Law enforcement agencies made 2.2 million arrests of persons under age 18 in 2003. The most serious charge in almost half of all juvenile arrests was larceny-theft, simple assault, a drug abuse violation, disorderly conduct, or a liquor law violation. Only 4 percent were for violent crimes such as murder, rape, robbery, and aggravated assault.
- Juvenile courts handled 1.6 million delinquency cases in 2002 – up from 1.1 million in 1985. However, the volume of delinquency cases has declined since 1997 for most offense categories (11 percent overall).
- Many youth in the juvenile justice system have been in custody before - some several times. In 2003, 62 percent of youth released from custody had at least prior commitment. Of those in custody before, 43 percent of girls and 39 percent of boys said they had been held five or more times. Only 19 percent were living with two parents, and 26 percent were not living with any parent when they entered custody.
- In 2002, blacks were 16 percent of the juvenile population but 29 percent of the delinquency caseload.
- White youth accounted for the largest number of delinquency cases involving detention, although they were the less likely to be detained.
- In 1 in 5 delinquency cases in 2002, the youth was detained between referral to court and case disposition.
- Median time in juvenile detention placement is 15 days.

Source: Juvenile Offenders and Victims: 2006 National Report. *Washington, DC: US Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention. Available at www.ojjdp.ncjrs.gov/ojstatbb/nr2006/index.html.*

A new report from the Office of Juvenile Justice and Delinquency Prevention provides information on characteristics of facilities in which juveniles are held. Juvenile Residential Facility Census, 2004: Select Findings *is available at www.ncjrs.gov/pdffiles1/ojjdp/222721.pdf.*

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but they cannot be created out of thin air. Other jurisdictions that want to follow this example must understand that additional resources are necessary to bring this level of care to juveniles.

What is the payoff to society from investing in juvenile health?

We have built a separate system for juvenile offenders based on the simple premise that age affects culpability. Embedded in this system is a mandate for rehabilitation and, I would argue, youth development. Even the most simple population-based analysis of juveniles in detention will show disproportionate rates of trauma, abuse, and victimization. More than 90 percent of girls in detention in Alameda County are known to our child protection system. Victimization, poverty, mental health disorders, substance abuse, and unstable and sometimes chaotic family systems all contribute to a limited ability to avoid risky behavior and make healthy choices. These challenges, combined with the immediacy of adolescence, lead young people to have a limited view of the future and what's possible for them. It's really a question of hope – or, in other words, it's an investment in young people's adaptive and creative capacities.

JOCHS seeks to fulfill the mandate for rehabilitation through an integrated medical and behavioral health program. The payoff to society is healthy and productive citizens, a reduction in recidivism, and the fulfillment of a promise to our young people. We offer them an opportunity not just to survive but to thrive. JOCHS aims to help young people achieve a better future for themselves and for their families.

The Alameda County Story

The Juvenile Justice Center (JJC) in Alameda County, CA, is the first juvenile detention center to integrate public health with public safety, recognizing that youth trying to pick up their lives after leaving detention need stable connections with providers of health and other supportive services in the community.

Alameda established a unique collaborative among the agencies and supportive service providers that touch the lives of juveniles. After issuing a request for proposals, the county discovered a vibrant market for health care providers interested in serving incarcerated youth. Three federally qualified health centers and one proprietary provider submitted bids. Because of its experience providing pediatric care in the community, the county selected Children's Hospital & Research Center in Oakland to be the primary medical service provider at the JJC.

In April 2007, Alameda County opened a new, state-of-the-art facility that includes a 360-bed juvenile hall with an integrated court that houses five court rooms and offices for the district attorney, public defender, intake and assessment services, court clerk, sheriff, social services, mental health agency, county Office of Education, county library, and probation staff.

Children's Hospital operates a licensed adolescent treatment facility at the JJC under the supervision of the Alameda County Health Services Agency (ACHSA). A 3,400-square-foot primary and specialty care medical unit is the medical program's operational center. Each of the JJC's 12 living units has a "mini-medical" unit with an exam room and behavioral health office staffed by a full-time clinician.

To address high rates of mental illness and substance use, the JJC doubled its behavioral health services staffing, from 17 to 33 full-time equivalents. ACHSA led a collaborative planning process that designed unit-specific therapeutic interventions and services for youth.

The collaborative that oversees the JJC developed alternatives to incarceration, including home supervision, GPS monitoring, and a mental health court for juvenile offenders meant to divert seriously ill children from detention.

All children who enter the JJC receive a comprehensive medical and mental health assessment. Each child leaves with a medical history, any medications needed, and an appointment for follow-up care in the community. Children's Hospital operates health clinics next to Oakland's two largest high schools, which helps support continuity of care.

The JJC is more than a detention center; it is an integrated service hub designed to help juveniles break the cycle of arrest and incarceration and lead better, healthier lives.

In Brief

New Manual from COCHS Outlines Legal Partnerships between Jails and Health Centers

Just out: Affiliations between Health Centers and Local Correctional Facilities to Produce Continuity of Care for Offenders, a manual describing the legal relationships possible between health care centers and local correctional facilities. Feldesman Tucker Leifer Fidell LP, legal counsel for the National Association of Community Health Centers, produced this tool for COCHS to help foster new partnerships and support innovative approaches around the provision of community-based inmate care. COCHS is making this manual available for free download at www.cochs.org.

World Health Organization Health in Prisons Project Releases Toolkit for Policymakers

The World Health Organization (WHO) Health in Prisons Project (HIPP) recently released a toolkit for policymakers focused on HIV/AIDS in places of detention. The document underscores the link between prison health and public health and the imperative to promote health and address HIV in prisons to protect the health of the broader community. Recommendations are based on the requirements of international law and standards, scientific evidence, and best practice experience. Established in 1995, WHO-HIPP supports member states' efforts to improve public health by addressing health and health care in prisons, and helps to create the link between prison health and public health systems at the national and international levels. The project also released a fact sheet on prison health, which highlights the impact of inmates' health on their families and the communities they come from and return to after incarceration. Both documents are available on the HIPP website at: www.euro.who.int/prisons.

New Report Finds People in Custody Have High Rates of Untreated Chronic Disease

According to a study to be published in the April issue of the *American Journal of Public Health*, people in correctional facilities suffer a much higher rate of serious and chronic illness than the general public. The study looked at health care for inmates using the 2002 Survey of Inmates in Local Jails and the 2004 Survey of Inmates in State and Federal Correctional Facilities. In federal, state, and local jails, 38.5 percent of inmates, 42.8 percent of inmates, and 38.7 percent of inmates, respectively, had a chronic medical condition. The study concludes that many inmates with a serious chronic illness fail to receive care while incarcerated and that improvements are needed in correctional health care. An abstract of the study is available at the journal's website: www.ajph.org/cgi/content/abstract/AJPH.2008.144279v1.

National Association of Counties and Bureau of Justice Assistance Publish Transition Planning Guide

The National Association of Counties (NACO) and the Bureau of Justice Assistance (BJA) released a planning guide for county-level policymakers interested in re-entry options for offenders with mental health and substance abuse disorders. It identifies five characteristics of promising practices in local transition planning: (1) collaboration; (2) access to benefits; (3) sustainability; (4) cultural/gender components; and, (5) community linkages. Based on these essential elements, they developed descriptions of six locations with model programs to profile in more detail in the guide. The publication, titled, "Reentry for Safer Communities: Effective County Practices in Jail to Community Transition Planning for Offenders with Mental Health and Substance Abuse Disorders," is available at: www.ojp.usdoj.gov/BJA/pdf/Reentry_Safer_Comm pdf.

Second Chance Act Grant Information Soon Available

The Department of Justice (DOJ) will soon release the solicitation for the Second Chance Act demonstration grants to state and local governments. Applications are due by May 21. A similar solicitation for mentoring grants to nonprofit organizations is also expected. To help potential applicants navigate the process, the Justice Center of the Council of State Governments has created fact sheets on the state and local grant program and the nonprofit program. The Second Chance Act, which was signed into law in April 2008, authorizes a number of grants to governments and nonprofits to provide services to support offender re-entry and promote lower recidivism. The Justice Center fact sheets for state and local governments and nonprofits are available at: http://reentrypolicy.org/announcements/sca_grant_solicitation.

NASHP Paper Looks at Health Coverage for Transitional Youth

The National Academy for State Health Policy (NASHP) has published Improving Access to Health Coverage for Transitional Youth, which describes ways for states to expand Medicaid and State Children's Health Insurance Program (SCHIP) eligibility to youth in the juvenile justice and foster care systems. The paper looks at the specific challenges youth-serving agencies face as they try to assist clients looking to obtain and maintain health insurance. The NASHP paper focuses on three ways states can improve their ability to keep youth enrolled in Medicaid and SCHIP: (1) simplify enrollment; (2) enhance retention through transitions; and (3) better integrate and coordinate services with partners. The NASHP report received funding support from the Robert Wood Johnson Foundation and the John D. and Catherine T. MacArthur Foundation. NASHP is an independent academy of state health policymakers working to improve state health policy and practice. A copy of the paper is available at: www.nashp.org.

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Community Oriented Correctional Health Services (COCHS) is a non-profit organization established to help communities around the country connect the health care provided in local correctional centers with health care provided in the community. Ultimately, COCHS hopes to help local communities around the country reduce the incidence of chronic disease and the cost of of health care.

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