“Nobody ever spoke to me like that before.”

Improving Interactions Within the Justice System

Recommended practices from national clinical experts convened by the NYC Mayor’s Office of Criminal Justice & Center for Justice Innovation

NYC Criminal Justice

Mayor’s Office of Criminal Justice

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The Mayor's Office of Criminal Justice is grateful for the individuals who took the time to share their insights at this roundtable. As New York City continues to hone its capacity to serve justice-involved people with elevated needs, the Mayor's Office of Criminal Justice will continue to gather various sources of expertise and work with providers on best practices to engage this high-needs population.

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Executive Summary

Most people who are arrested in New York City are not rearrested while they wait for a decision about the outcome of their case. However, a small group are rearrested at substantially elevated rates. And despite their clear need for supportive services, most of this group never receive intensive mental health, emotional health, or behavioral health interventions at any point during their time in the justice system.

Instead, most interactions people experience as they journey through the justice system are limited to a series of brief mandated encounters—check-ins, needs assessments, reminders, hearings. Despite their brevity, these encounters represent key intervention points[1] with the potential to change individuals' future well-being and behavior, either negatively or positively, through inevitable influences on their emotional and psychological well-being.

As New York City grapples with how to adequately serve people at highest need and highest risk of justice involvement, the New York City Mayor's Office of Criminal Justice and the Center for Justice Innovation convened a national roundtable of clinical experts in Manhattan on October 12, 2023. Participants were asked to distill their expertise and apply it to the range of processes that practitioners most frequently navigate within the criminal court system context. The goal was to identify key opportunities for making these processes as therapeutic and impactful as possible under the constraints of system-based practice—in New York City and across the country. This roundtable focused on the interactions most system-involved people actually have on a daily basis.

Specifically, intake screenings, routine monitoring appointments, and other brief mandated interventions are critical opportunities for providing trauma-informed care, which recognizes and responds to the high rates of trauma that people involved in the justice system experience.[2] Often, this trauma is experienced both prior to[3] and as a result of their involvement in the system.[4] Making use of these opportunities could go a long way toward increasing court appearances, reducing rearrests, and increasing engagement in longer-term supportive and therapeutic services. As the city continues to wrestle with the twin challenges of reducing crime and incarceration and improving behavioral health care in the city, this roundtable could not come at a more critical moment.

The roundtable sought to connect overall principles to concrete practices. While practitioners often refer to principles such as being trauma-informed, meeting people where they're at, strengths based, and non-judgmental, what does that actually look like in practice? And how can staff reconcile these most effectively with accountability? What specific words or actions generate increased engagement and connection with people who do not trust systems of any kind, much less the justice system?

This brief provides a list of concrete recommendations for providers, distilled from the roundtable discussion. It should be noted that none of these recommendations should be taken as conclusive or unequivocally endorsed by the Mayor's Office of Criminal Justice. Instead, MOCJ is providing a summary of the recommendations provided by experts based on their experiences in the field.

Some key themes of recommendations were:

1. **Introductions are essential:** While providers often blow past introductions and jump into content, issues such as how staff explain who they are and what they are doing can impact whether people are able to connect and participate fully.
2. **How practitioners engage with people impacts whether people engage:** Focusing on the actual experience people are having in the moment can help people see the value to themselves of engaging, and reduce the human threat responses that cause people to avoid engaging.
3. **Assess people's needs in a client-centered way:** How assessment information is gathered from the person—and assessment outcomes communicated back to the person—can make the difference between a barrier to engagement or an opportunity for connection and new self insight. Ensure clients are structurally supported.
4. **Ensure people are materially supported:** The physical experience people have when attending an appointment can impact their willingness to engage. Administrators and decisionmakers can support clients too.
5. **Create discharge and referral plans that are realistic and supportive:** Painting a clear picture in people's heads of the next steps can help make those steps easier to take.
6. **Administrators and decisionmakers can support clients too.**

These apply across several key stages of the provider-client relationship, which include establishing initial contact with the person, assessment and screenings, conducting sessions, discharge and referral plans. The final section on organizational factors may be especially relevant to administrators, containing recommended practices on staff training and supervision models and organizing provider services so interactions are more engaging, effective, and helpful.

Introductions are essential

The first moments of interaction with a new client are critical to the success of the relationship. Providers should be authentic and seek to foster connection and engagement. One roundtable participant noted, "The human check-in is an important relational part of every case manager intervention." The following items specify how practitioners can begin to establish engagement with clients:

1. **Start by giving your name.** Providers can begin the process of successfully engaging clients by providing their names. As one practitioner noted,

    - *"There is actually a lot of research that speaks to what makes people come back and what is really engagement. And when we train people, we don't rarely train on those aspects [like] orientation… this is my name. They have sat across from people many, many times and I can't tell you the number of times where someone goes into their routine, because this is same day every day for them."*

2. **Explain your role and responsibilities.** As with giving their names, providers can further humanize the interaction and prompt engagement by giving a brief explanation of their role and responsibilities, which may also be new and necessary information for the client:

    - *"The client doesn't maybe even remember which appointment this is or what your job is."*

3. **Provide physical/nonverbal cues of safety.** Providers' body language can set the tone for the interaction. Roundtable participants noted that non-verbal cues such as smiles and eye contact could establish a friendly, relaxed, and respectful atmosphere for the interaction:

    - "*The first moment that you're in the same space with the person is critical. And things like smiling and eye contact, that's not staring, but that's not... Like where your arms are, how you introduce yourself, if you reach out your hand or not. All of these things I think are actually in my experience, more important than the words that are coming out of somebody's mouth..."*

    Another provider noted:

    - *"I think the nonverbal ingredient here is just as important as the verbal. And I mean what people have been talking about is actually treating the person with respect and people can pick that up and they can also pick it up when they're not being respected, when they're being talked down to when they're being basically bossed around… that's why so much work has to go into training the people who are doing the intervention. Because if they are feeling both frightened of their clients and contemptuous of them, the client's going to pick it up right away."*

    Another practitioner noted that non-verbal cues extended to how providers presented themselves or how they organized their offices, arguing that these were key to creating a welcoming environment for clients:

    - *"Professionalism should not be this boxed in category of how we present, right? It should be the respect that we carry the field with, not necessarily the way we present or the way that we speak or the vernacular that we choose or our stature. And I think that sometimes we get so caught up in gatekeeping and the terminology and the professionalism of it all that we* *fall short… Spatial organization is big when it comes to trauma. If I've been sitting between somebody and they monitor my whole life, that's the last thing I want to do, right? Show me that you are a person. They could even go down to the way that the office is organized. Think about how differently individuals would act if our first encounter with them was in their element instead of ours."*

4. **Acknowledge the non-voluntary nature of the provider-client interaction.** Given that sessions are often legally mandated and that clients miss them at the risk of being jailed, practitioners advocated that providers acknowledge that the interaction as such:
    - *"Honesty is acknowledging the coercive nature of this interaction and labeling it for what it is…"*

How practitioners engage with people impacts whether people engage

Every interaction with a client is an opportunity for engagement. One of the roundtable participants noted: "The cases that do the best are the ones that are really connected to the case managers." While practitioners acknowledged that there were huge challenges to navigate when working with justice-involved clients – with both providers and clients being frequently subject to constraints they had little control over – they emphasized that there were specific techniques they used in sessions to make the time they spent with clients as therapeutic and impactful as possible, including the following items:

5. **Ask, "How can supervision be helpful to you?"** One roundtable participant suggested:
    - *"We have the person introduce themselves. 'Hi I'm so and so, thanks for coming in today. I'm [name], I'll be your probation officer. Part of my job is to uphold the conditions of the court. Part of my job is to help you look at your life and try to figure out the things that are kind of causing you problems and try to fix those. And we want you to lead a better life. We want you to be successful on probation." And then we end with this weird question, how can being on probation be helpful to you?"*

    The same participant acknowledged that the suggestion produced 'an awkward moment', noting:
    - *"The folks on probation sit there and [are] like, 'Oh, how could probation be helpful?' And you can hear them sort of thinking and they pause and then they say something and it is different depending on the person and the context of their lives but then we bounce off of that, I need help with my kids want to go back to school or I need to get clean. And all of a sudden there we go. And we kind of base it off the motivational interviewing model. The idea is that we want to elicit some level of change talk in that first 60 seconds of contact, but we end with this weird big question that puts their agenda front and center."*
6. **Ask how people are feeling in the here and now.** Roundtable participants emphasized the need to focus on the present, saying,
    - *"The main thing to do in that moment is to assess the here and now. I know it's really easy to refer back to an assessment, but usually the here and now is what gets people in trouble*

or disengaged. So let's just say if I have fifteen minutes, like a Medicaid unit. If I have fifteen minutes, the first thing I would probably do is assess their current mind state. How are you feeling in relation to the goals we set? Are they still the same? Do you see any barriers to those goals? Have any supports became apparent? Have any supports disappeared? So I think that's a really brief solution focused way to have a good clinical dialogue in a short period of time that could probably be had in passing."

7. **Focus on what clients are doing well.** Practitioners championed the power of positive reinforcement to create change, acknowledging that this often ran counter to the logic of the criminal legal system:

   - "*In that initial meeting we can ask how they were able to show up. What were all the things they were able to do to make that happen today? And how do we help support that moving forward?"*
   - *"[O]ur criminal justice system was set up on the basis of punishment as a behavior change model. But...if we think about reinforcement, positive reinforcement of behaviors and use those in our work, that will engender adherence because we know that that can be an effective modality of behavior change."*

8. **Make the most of the time you have.** As providers are not always be able to meet with the clients for the full amount of time, practitioners suggested using what time they have judiciously:

   - *"[Sometimes providers] wait 30 minutes and then the client shows up and is like, 'I got to go meet my homeboys in Harlem, but what's up?' And so [providers] know they have five minutes to make an impression, five minutes to meet the goal, to make me happy and five minutes to follow the adherence of the model. And what's relatively important is that they know that there's a goal for that specific session so if that goal is to assess a need for this client and connect them to a resource, they know that they're going to spend a certain amount of time just connecting, that's it."*

9. **Ask clients to identify a best life goal.** A common goal of sessions is to elicit 'change talk' from clients, i.e. having clients identify issues in their life that they would like to change. Practitioners suggested that it was more effective to have clients identify the goals that they personally found meaningful, rather than have providers impose their own goals on clients:

   - *"In the juveniles we have these reintegration mentors that show up at school, that show up, take kids out for lunch and have a discussion about struggles. But it all is tied towards the work that they've done before they left, which is to have an identifiable… best life goal. So it's not a little silly goal. I don't mean it's silly not to be rearrested. It's a big thing. But so what? You're not going to be arrested, what do you want your life to look like? And so the things that appear powerful to most of the folks we're working on are not dissimilar to our [own] goals… And so having people come and meet them where they are around those tasks with the treatment plan, if you will."*

10. **Structure interventions so that they are small and achievable.** Practitioners emphasized that small, targeted interventions were most likely to succeed:

    - *"If we… break down actual interventions that can be structured and worked through in small bites and case managers can make a specific productive, almost treatment-oriented opportunity."*

They encouraged providers to work with clients to identify goals that could be structured accordingly:

- *"I was going to say to your point, really being intentional about the time we spend on interventions and being intentional about how can we break them down and where... A good example of that would be SMART [specific, measurable, achievable, relevant, time-bound] goals. So if you ask an individual to identify a goal that's specific, measurable, attainable and all of those other factors, you can check in with them about that… and [it] gives you something that one, you can document to meet the requirements and, two, gives you a real baseline."*

11. **Formulate goals in positive, rather than negative, terms.** Another provider emphasized the importance of working with clients to formulate goals in positive rather than negative terms (or, as they expressed it, 'approach' vs. 'avoidance' goals), describing the process:

- *"We often provide [clients] with a short list of different types of values… tell us what [you] value. Then we move to, okay, you kind of value this. What's a goal you'd like to see happen in the next, depending on the timeframe you're seeing, three months, six months, you can change it up. And then when we move to something really specific, what can you do now? What's one step you could take in your valued life direction right now? And what we find is that... clients will verbalize things that offset criminogenic risk. I want to provide for my family is what I value. I'd like to get a full-time job in the next six months. I guess I could go to that employment group next week. And so we kind of funnel it down and then the next session is just a follow-up. Like, 'Okay, how did that go? And if it didn't go well, let's talk about why it didn't go well and then what could you keep doing to keep moving in that value direction or let's talk about a different value if you want.' And once it's on the table, values are something you can always keep pulling on. It's like a thread that's kind of always there. And so, it sort of moves these practitioners away from what I would describe as avoidance goals, like stop hanging out with your criminal friends, stop using drugs. And more of approach goals."*

12. **Remember and reference points discussed during the last session.** Practitioners suggested this was another opportunity to engage clients and build a sense of trust:

- *"This may sound like a simple thing, but I think starting off where you left off last time can be really meaningful. We've actually gotten that feedback from participants that somewhere in the opening of the short session, you sort of mentioned something that you talked about last time, it's a really concrete way to do a lot of things and to show that you care on just a human level, but also if you're doing an intervention, it's a nice way to sort of have that golden thread through all the meetings, but just in some kind of way picking up where you left off, but the onus on the provider to say, 'Last time we talked about this,' just actually clients are sometimes shocked that you would actually remember what they said to you last time."*

13. **Initiate between-session contacts e.g. texting.** A practitioner suggested that by contacting clients in between sessions, the effects of the sessions, which tended to be very short, could be amplified:

- *"We really, really emphasize the texting in between, how's it going, what's going on, reminders, that sort of normalizing, and then, also, reasons to contact. So, here's good reasons we orient to reasons to contact. So, one would be if you're having trouble and you need something, but another one would be if you've got some good news, you should text that, right? If you had an* *interview, please text me, let me know how the interview went. Those things really, really don't take a lot of clinician time, honestly."*

14. **Avoid assumptions.** Practitioners cautioned against making assumptions about any particular client's level of need, and suggested instead employing a universal precautions approach, i.e. treating clients as if they are at risk regardless of background or level of knowledge:
    - *"And with this population in particular, we just need to assume, take a universal precautions approach. We need to assume that we are working in that initial engagement to try to reduce the likelihood of lack of return, and that it's just as important on us to take a strategy to try to work against that."*

15. **Use narrative therapy.** A practitioner suggested that narrative therapy could successfully engage clients and have clients identify their goals on their own terms:
    - *"There is a therapeutic modality called narrative therapy. It is not a therapeutic modality that people use very often. I think it gets to all of these approaches...a model of narrative therapy where providers are trained to have people focus on their strengths and what is the story that people are, what is a story that you have told about yourself and how can we point out the strengths in your story and what makes your story more powerful?"*

16. **When meeting clients with substance use disorders, be open about realities.** Practitioners argued for a straightforward and realistic harm reduction approach for clients with substance use disorders, saying:
    - *"I think we just need to be ready for really embracing harm reduction and assuming there will be relapse and overdose… And so we can be very narrow in what information we want to get and separate out from that engagement piece. So not try to find their entire medical history, which probably actually exists already in records. Not trying to get deep down into the reasons why they're here, big picture. But really just being specific and triaging."*

17. **Design and implement modalities that take into account a client's identity and experiences.** Practitioners argued that certain modalities were not designed to account for race, ethnicity and culture, and that these should be implemented in ways that accounted for clients' experiences, particularly within the context of system involvement:
    - *"I've really been intentional about taking this very vanilla evidence-based model… talking about behavior patterns, we're talking about how families interact, but the model is not saying, 'There's colorism in this family and it impacts how you look at yourself.' And so if we're talking about these more, these constructs that impact how a person perceives themselves… if we're able to change the meaning around that, we can help them treat those people and themselves differently. And so we do see how it is impacting the way they engage in violence in the community and go to jail."*

18. **Where possible, give clients agency through choice.** While practitioners stated that individual providers could give clients agency through allowing them as many choices as possible, they emphasized that at an organizational level, administrators could also ensure that clients were empowered to choose providers and make decisions about other aspects of their treatment:

- *"The choice is crucial… where possible, [let clients have their] choice of providers, because I've seen this a lot in the clinical world that when something doesn't work out with the provider, they tend to blame the client: 'They're not doing right. They should just go back and work it out with the person and this is part of the work, this is their job to make it work the client.' But often it's just a mismatch. To the extent that you can also give agency to clients to choose treatments and treatments and providers...the PO, their choice of PO, if we could that would be great too."*

Explaining why providing clients with choice was so important, another practitioner stated:

- *"The one choice you don't have is not being in the court system right now. But without taking that one off the table… [I like to ask] what would work for you within a court treatment? What kind of [treatment] would you like given some choice that encourages adherence?"*

Assess people's needs in a client-centered way

The need to consistently engage clients extends to conducting screening assessments, which are important to determine clients' needs but can be stressful to both client and provider. The information-gathering exercises can feel both intrusive and repetitive, as if the provider is only going through the motions. Practitioners at the roundtable had a wealth of suggestions for making the process of conducting assessments as client-centered as possible.

19. **Ensure that there is a purpose to assessments.** Multiple practitioners stated that it was important to be intentional the purpose for which specific assessments were conducted. One practitioner said:

- *"Our first internal question should be how does this benefit the participant in the long run? And if we cannot draw that connection is probably not shaped in a way that's helpful to them. So literally drawing a direct connection saying like, okay, well this is going to, and even if you stand in conversation like, hey, this question may seem like it's unrelated, but if you express to me that you need [a given service type], this can contribute to the funding that goes towards [that service type] for the population we serve. So basically tying that external requirement to the internal outcomes."*

Another practitioner identified administrators as uniquely responsible for determining what screenings should be done and why:

- *"I think we have to push leaders in organizations to try to develop a full logic model around why we are even doing this. If leaders can't communicate how a screening is contributing to an immediate decision that helps the case move forward, the screening should not be done. It would be like taking a psychologist and saying, 'We are going to train you on assessing depression, but you don't know anything about depression or its manifestations and how it affects people's lives. But let's train you on giving the tool and scoring.'"*

20. **Where possible, conduct non-urgent assessments once client-provider relationship has been established.** Multiple practitioners argued that doing assessment upfront could detract from efforts to engage the client:

- *"I don't know why we think that we have to do all of this assessment upfront. We should separate out the task of engagement from assessment. Make engagement the first priority—with the exception of acute risks that you need to get on the table or some contact information. Assessment is really an ongoing endeavor. There are pressures to gather information as quickly as possible from the client, which might run counter to a softer opportunity for engagement."*
- *"I think that we have this ridiculous idea that we're going to meet the person and we're going to do this in-depth assessment and it has the unfortunate impact of, 'Welcome to my conveyor belts. I have to ask you all these questions,' and it becomes a box checking exercise for the practitioner. They grow numb, the clients have been through it before, it disempowers them. It makes them feel like they're not cared for. Also, I don't think we get the most honest information from people right up front when we don't know them. You're going to get better, more accurate information as you sort of form a relationship with somebody."*

Another practitioner agreed that assessments were more likely to yield honest information when conducted later in the relationship, saying,

- *"We get better information with better engagement."*

However, practitioners also made it clear that assessment for imminent risks should be carried out as soon as possible. Immediate risks include overdosing, suicidality, and homicide:

- *"There is also a very real issue of risk in some of the places we are talking about. Part of the assessment is the decision about whether somebody needs a secure setting or not, either to keep them alive in the case of a hospital, an emergency room, or to keep them from killing someone else imminently."*
- *"One of the [immediate] risks is, is someone going to go out and overdose and kill themselves the minute they get out because they haven't used in a while. So I'm very concerned about that. And I'm very concerned about suicide risk."*
- *"I think that the screeners should be focused on the first 48 hours of when the person is released. That is usually when they run back into their old crowd or they fall back into old habits. So I think screeners should [ask], 'Who is your support system when you get out of here? How do you cope? Who is the first person you're going to call when you leave? Who is the first person you're going to go to? Can I reach them if I can't reach you?'"*

21. **Balance information-gathering for program requirements and clients' own goals.** Given that the amount of time providers had with clients can be quite limited, practitioners suggested that providers remained mindful of why they were conducting screenings and how best to meet clients' needs within that context:

- *"Am I gathering this information for a Medicaid requirement or am I gathering this information to push the personal goal of the participant forward? And if I'm doing both, how can I strike a positive balance? Usually what that looks like is tying in your outcome with theirs. So, if you have a requirement of making sure this person is going to work part-time, say 20 hours a week or something, and that's just their regular overarching requirement… and then they tell you, 'Well, my personal goal is to stop being so angry.' So, what you may want to do is create time for both."*

22. **Prepare clients for the process of assessment.** Practitioners also suggested that preparing clients for the assessment process could 'inoculate [clients] by acknowledging that the process itself is traumatic because it represents all the times they've been through all the systems'. In practice, practitioners suggested:

   - "Being honest about the process, saying things like, 'I know I'm about to ask you a hundred questions that a hundred people have asked you before.'"
   - "The first thing in conversation I would ask to get the elephant out of the room, 'How many times have you been in a seat like this? What questions were you asked and what weren't you asked that you should have been asked?'"

23. **Use the assessment process to help clients understand themselves and their behaviors better.** Although the key purpose of assessments was to determine what risks clients pose to themselves and others, practitioners suggested that the assessment process could also be repurposed to help clients understand themselves and their behaviors better:

   - *"Therapeutic assessment involves using the process of psychological assessment to help people learn important and potentially life-changing things about themselves. It starts with the client's questions about their struggles in life. The goal is to work collaboratively and therapeutically to get to the root of the person's problems and then to use that understanding to answer the questions and help the client experience the answers. If people understand themselves better and get answers to their burning questions about themselves, how could that not be therapeutic? It is an evidence-based short-term intervention that facilitates growth and promises enduring change."*

24. **Start the assessment process by focusing on clients' questions about themselves.** Practitioners suggested that the assessment process could be conducted in a way that was client-centered and ultimately benefited the client:

   - *"Starting with their questions turns the table. It changes the atmosphere of the work. We can respond to their questions and collaborate to try and get good answers for them. This is a totally different approach than thinking that we know what we need to find out and what to do to help this person."*

25. **Connect the rest of the assessment to their initial questions about themselves.** Having started the assessment process in a client-centered way, practitioners suggested that the rest of the assessment could be conducted similarly:

   - *"One of the real advantages of therapeutic assessment is… when you ask [clients] what are their questions, they get engaged. And we collaborated with them to the search for little answers."*

26. **Where possible, ask assessment questions in a conversational manner.** Practitioners emphasized that providers could ask the questions listed on screening questionnaires in ways that felt less intrusive and more friendly, saying:

   - *"It is on… the therapist to be able to get all of the information I need you to [get] in a way that makes that person feel human and seen and like you're not a robot. The expectation is that you bring me this information and you better not do it in a way that makes this person feel like* *you're checking off a list to get information from them, being able to do an efficient job and get information that we need without us trying to structure what that looks like."*

Practitioners also gave examples of what this would look like in practice:

- *"Do you need to know how much food they have available? [Have] a conversation about what did you guys cook last night? Oh, my mother used to make the most amazing cornbread. Let me share the recipe with you. And what else did you guys eat? So what you making tonight? Do you have leftovers?..."*
- *"A lot of times if you listen to someone and you shake the questions in a way that can get the responses you want, it kind of goes back to training… I was working with… trauma assessments and how to get information from their population. I'm sure everybody here is familiar with the ACEs. So instead of going down each question you may ask them like, hey, have you ever been harmed as a child? What did they look like? And if you have a keen ear, you could check those boxes, right? Oh, I was yelled at, I was cursed at, okay, that's verbal abuse. I was physically beat. That's physical abuse."*

27. **However, the most sensitive questions should be asked in a less conversational manner.** Practitioners suggested that asking clients about traumatic experiences they had had in the past should be done impersonally:

- *"You tend to get better trauma reporting if you don't do it interpersonally. If it's done as sort of pencil paper, in other words, a checklist as opposed to, 'Were you raped, were you molested,' to look someone in the eye and have to say, yes, I was, whatever [it] is a) can be extremely triggering, b) it can be… sort of embarrassing, humiliating, shame-inducing… And in general if the goal is assessment as opposed to intervention, keep those very distinct and especially around trauma."*
- *"You tend to get better trauma reporting by not asking vague open-ended questions like have you experienced abuse. If it is done via structured, behaviorally anchored questions through either interview or self-report, clients often are willing to report on their experiences. To look someone in the eye and ask questions about past traumas can be triggering and can feel embarrassing. This work has to be done with transparency and sensitivity, clearly communicating to clients how and why the information will help inform their service planning."*

28. **Include adult scales for trauma in assessments.** Practitioners noted a common gap in many assessment strategies, which was that trauma assessment tended to focus on adverse child experiences (ACE). They emphasized that traumatic experiences could occur during adulthood and that it was important to screen for those too:

- *"A lot of programs take the ACEs scale and use that as their trauma system. And they're very problematic because it's not assessed for adult traumas for some of the most common traumas that tend not to be personal. So [the] most common trauma in the US population is car accidents. Well, it doesn't assess for that at all."*

29. ***Reuse prior assessments where possible.*** In order to avoid repeating screening questions, practitioners suggested that providers refer to prior assessments conducted for that client, if the information could be made available:

- *"To work in the system we already have, what I would do is hire a lab, get a release, go out, have that person go collect data or the assessment that the individual has already taken if and when possible."*

30. **Where applicable, ask clients to complete self-reports ahead of time.** This tends to save time and allows providers to ask follow-up questions:

    - *"Clients can do the self-reports ahead of time and the clinician can read it before the session so that you don't ask the same questions again but only ask clarifying questions. That's respectful."*

31. **Allow participants to expand on their responses.** One practitioner suggested that allowing clients to expand on the responses they gave during assessments could be empowering or helpful for clients:

    - *"After we give [assessments], we do an extended inquiry, which is to talk with the person about unusual responses or reactions … you answered this question this way, can you tell me more about that? And try to gather idiographic information… and I think clients often really appreciate that being able to expand what they have said."*

32. **Share assessment results with participants.** Another way that the often burdensome process of client assessment could be transformed into a helpful or positive experience was to share assessment results with clients:

    - *"I think another way to keep engagement is to share the results with it if that's possible in certain settings, it is really helpful for people to know and it engages them in future testing to know that, hey, there are answers about myself that I'm going to know from this assessment."*

33. **Assess clients' trauma on multiple levels, including the sociological.** Practitioners acknowledged that while they had little control over larger structural factors that determined clients' system involvement, they nevertheless emphasized the need to discuss and assess such factors:

    - *"As it relates to trauma informed approach, I look at that as assessing harm on all levels. So micro, macro, like a sociological approach to trauma. So what that may look like, is has this person experienced systemic trauma? Has this person experienced institutionalized marginalization? Has this person experienced trauma within the home?... So I may ask, 'Hey, miracle question, right? Tomorrow you are the perfect version of you. What does that look like? What happened to remove you away from that person? What are some barriers to self-actualization at the systemic, institutional and individual level?'*

    Another practitioner added:

    - *"So we are in a system that is traumatizing people, and then we're saying, 'How do we break the cycle of trauma that we are putting on these people?' So I think that it's important to stop and think about how we are creating… a hierarchy in which people come into this setting knowing we've created a system where they know that they have to engage with us in order to move through an involuntary process."*

Ensure people are materially supported

34. **Provide clients with food and drink.** Oftentimes, practitioners found that offering clients snacks and coffee re-energized clients and incentivized attendance:

    - *"We had a coffee machine and snacks, we found [this] made a huge difference… and having coffee and snacks greatly increased attendance and people just, they were coming from work, they were tired and it just made people feel like they were home."*

35. **Use environmental cues to show clients they are valued.** Practitioners reported that inexpensive initiatives such as using high-quality printed materials also helped increase compliance:

    - *"The quality of our printed materials, like when we use color as opposed to black and white, actually increased compliance filling out stuff."*

36. **Address clients' basic needs.** Practitioners recommended that providers pay attention to and, where possible, try to meet clients' basic needs, arguing this not only materially assisted clients during vulnerable transition points, but also helped engage clients by letting them know they were cared for by providers:

    - *"Meeting people where they're at and addressing basic needs, especially at vulnerable transition times and really letting people know that you care about them. And I'm thinking about a program we have where people are coming from state prison back to the community and we do a call with them beforehand and we ask them things like, 'What's your shoe size? What size coat would you buy if you went to a store?' And so when they come out and we have boots for them in the winter and a coat and it's actually their size, it's like those little moments that let people know that we truly care about taking care of them during transitions."*

37. **Use incentives.** Other practitioners spoke to the power of incentives, saying:

    - *"I think that incentivizing all kinds of engagements with the program works well and we usually do it with money. People just need money. It's never enough. It's not going to sustain their life. But it works to incentivize, I think keep people engaged and it helps keep them involuntarily afterwards. Also, because I think if your whole experience with the program is a threat of punishment, it's like your relationship with the program, why would you stay there? That doesn't even feel good. But if what you've experienced along the way is, 'The program's making me feel good about my successes? Maybe I'll stick around.'"*

Create discharge and referral plans that are realistic and supportive

Roundtable participants identified discharges as key transition points for clients. Therefore, best practices for formulating and implementing discharge and referral plans were discussed:

38. **Formulate specific discharge plans.** Practitioners emphasized the importance of specificity in creating discharge plans, saying:

- *"I really pushed clinicians to be far more specific about discharge plans. No, it has to be like where are they going in their neighborhood? Where is it? They introduce them on a Zoom call to the people they're going to meet when they get there. That level of specificity I think then allows the person who receives them to have every little contact be like, we all know what we're working on, how's it going? What's getting in the way? Is it working?"*

39. **Coordinate with other services and providers to more accurately assess people's needs and connect them with the resources that they need.** Practitioners championed an approach known as integrated care, i.e. having a supportive team work together to help clients get what they need:

- *"… when they are in jail or prison, meeting a peer specialist is really helpful because they start to build the relationship. And when they come out we bridge them out, introduce them to the services in the community face-to-face, not just a phone call or a Zoom. And then start building on the whole social context of what they need, which then improves the clinical involvement because their quality of life is changing, shifting, and getting better and allowing them to be more self-determined, more hopeful and more empowered… And just holding other providers' feet to the fire is really important."*

Another practitioner cautioned against simply referring clients to different programs:

- *"Some may have this referral mindset, that my job is just to refer them to different programs. The question comes down to, well, what are you going to talk about? What are you going to do with this particular person? But we want our practitioners to have some targets and then it may not be clinical targets. Let's say it's criminal friends or companions. So we'll ask the person the question, how did criminal friends contribute to this person getting arrested the last time? And then we sometimes get this, I don't know. Okay, so then the person sort of checked the box somewhere, but can you explain the story and how does criminal friends put this person at risk for future rearrests? We want to kind of get into the fabric of people's lives… we'd like our practitioners to have a case plan based on the unique risk profile of the person."*

Ensure staff are adequately trained and supported

While many of the items discussed above can be implemented by individual providers, practitioners participating at the roundtable repeatedly emphasized that the challenges faced by providers working within the criminal court system at large were vast. Practitioners discussed the steps that administrators in provider organizations could take to ensure service quality, particularly with respect to staff training and supervision:

40. **Ensure that providers feel safe and not stressed.** Practitioners acknowledged that ensuring providers were comfortable was often easier said than done where organizations were understaffed and individual providers were often overwhelmed, but nevertheless emphasized that it was an important part of ensuring quality service provision:

- *"There are challenges, which I totally understand, but [it] also doesn't put the provider in a space where they feel comfortable and not stress themselves. They're not then going to bring that into the session with the person."*

41. **When training, give providers examples of good client interactions.** One roundtable participant gave an example of what their organization did when training providers, saying:

    - *"We started collecting recordings and we started kind of looking at things and giving feedback and started to get things that we liked… They have examples like, this is what we're shooting for. You play these for the practitioners and all of a sudden it's like the light bulbs go off. Oh, this is what I'm supposed to be doing. This is what this conversation is supposed to sound like…. [M]odels are incredibly valuable and they have to be aligned with the practices that the agency or program would like. But I find without [examples], it's hard to get real movement and it's hard to get convergence around whatever you define as your best practices."*
    - *"If we're thinking about then how do we bridge that gap that many clinicians have, I think then some clinicians, there needs to be time training clinicians in this space about how to move from just gathering the information to the art of having a conversation with people."*

42. **Train providers on engagement and the art of conversation.** A practitioner emphasized that there was a lack of provider training on client engagement:

    - *"There is actually a lot of research that speaks to what makes people come back and what is really engagement. And when we train people, we rarely train on those aspects. We train on procedural aspects, policy and procedure."*

43. **Ensure that practitioners who are engaging with clients' trauma are properly trained.** While the discussion emphasized the importance of providing trauma-informed care, one practitioner expressed caution, saying,

    - *"I used to do trauma work as a clinical psychologist. I think you need a lot of training, a lot of support to be the practitioner. And there's different types of trauma and we have experts that are more versed in trauma at this table than I am. But I would be reluctant for untrained unskilled practitioners to be zeroing in on explicitly trauma-based discussions in the engagement phase."*

44. **Provide providers with information relating to the criminal legal system and risk assessments.** Practitioners argued that providers should have basic knowledge about the criminal legal system and the ways it impacts system-involved people's lives, since this is necessary information:

    - *"Staff must also be trained in background context… we take our professionals and practitioners and we train them in the assessment, but we don't train them in the background... it's sort of like taking a psychologist and saying, we're going to train you on assessing depression, but you don't know anything about depression yet or the different manifestations of depression and what it looks like and how it affects people's lives. But let's train you on giving the tool and scoring it. I think we do this with risk assessment a lot, the criminogenic risk assessments that we teach people to do the assessments, but they have no background in how these areas play out in people's lives."*

45. **Incorporate instruction on common experiences of systems that often vary by race and other important factors into training curriculums.** Practitioners proposed that clinicians have a thorough understanding of how different groups have experienced systems and system gaps that have let them down throughout their lives, as well as the impacts these have likely had on the clients they work with:

    - *"If [clinicians] lack a certain knowledge, it makes it very difficult for them… coming into spaces without that knowledge, their stories, their narratives about how this person got to this place and why they're here [will be] very different from a narrative of somebody who understands how this person has been harmed over and over and over again, and how they're presenting because of the harm that has been visited on them throughout their lifetime."*

46. **Identify individual providers who may be causing harm.** Many practitioners felt that an important aspect of ensuring provider quality was to identify individual providers who might be causing harm and to address these behaviors:

    - *"There is a small percentage [of practitioners] that consistently are rated poorly regardless of their training, their background, their degree, their license, their whatever. If you don't collect that data, you lose an opportunity… to weed out people who are causing harm."*

    Elaborating further on why it was important to address poorly-rated providers, another practitioner said:

    - *"It was the clinician's feelings about the clients that predicted dropout… And so one issue is the clinician competence, but the other is just, it was largely whether they felt like their clients weren't motivated. So if you feel like your clients aren't trying, you basically subtly treat them in a way that gets them to quit essentially is was what we think. And the interesting thing is that a lot of those assumptions I don't think are accurate."*

    In terms of operationalizing the approach, the first provider added:

    - *"We have to really think out exactly how that would happen, but in general it would be something along the lines of informing the clients that it's going to be aggregated data across many people that a single rating will not [cause someone to be fired], but that it will be assessed, it will be used. And then if someone consistently has poor ratings, it seems like that's time for a discussion with the employee: here are your ratings and what's going on and so on and so forth. And then eventually letting go of people who did not meet a certain basic standard. Because overall what you find with these ratings and generally satisfaction ratings, people tend to rate them extremely highly unless something is terribly wrong."*

Administrators and decisionmakers can support clients too

Given the challenges that individual providers faced when working with justice-involved clients, roundtable participants emphasized that administrators had the decision-making power to make choices that were supportive of clients.

47. **Build multiple connections between the program and clients.** Practitioners suggested that as far as possible, administrators design programs so that individuals were connected to it and the organization in as many ways as possible to ensure retention:

- *"So if one person leaves, the person is still connected to the program in a larger way. If their caseworker leaves, they don't just kind of drop out of programming, they know other people there. It can be done by offering group services. And so they're connected to the program in meaningful ways that go beyond… short check-ins with their case manager. There are multiple connections, meaningful connections to the program. It builds community amongst the staff in the program and then it builds a sense of community as well with the participants."*

48. **Funding levels and funding models determine ability to engage people.** Although the roundtable was focused on using clinical expertise to make contacts within the criminal legal system as therapeutic and impactful as possible, time and again practitioners returned to the importance of funding to the systems and organizations that providers worked within:

- *"I think [this] also relates to how these systems are developed, where they're overwhelmed, they're short-staffed, they have a lot of mandates… There are lots of burden and challenges, which I totally understand, but also doesn't put the provider in a space where they feel comfortable and not stressed themselves. They're then going to bring that into the session with the [client]. So I think there are ways to practice and train on that, but it also requires work and resources around that."*

A second practitioner was more blunt, saying:

- *"I'm going to pivot into my administrative role for a minute and say, I think we need more money. There needs to be a real influx of money in this space. We have to be able to spend the money to save the money in the long run. So we all come to this work, I hope, because we want to help people. But I think there is a real financial issue that we're running into"*

Another practitioner explained how the difference in funding models could translate to visible differences in outreach and impact:

- *"At [service provider] we have mobile behavioral health teams. Half of them are funded by Medicaid, and half of them are similar services but funded by the city. And so just that funding difference there makes for dramatically different service provision and ability to engage with people. If you get referred [under one of these models], we have two weeks to try and find you and we try regardless to find you and we get paid zero dollars for that and then we move on to the next person after two weeks because simply we need to keep the lights on… [But if you're assigned to [the city-funded] program, we are funded all around engagement. So you can spend a very long time outreaching someone, engaging them, having the door slammed on your face so you don't get that 15 minute billable act visit. And it really, the funding model determines this ability to really engage people and we can spend months doing that and then eventually the services might look very similar to what you get on the [Medicaid-funded service], but I think we either need to free some of these services for Medicaid funding or push to have payers recognize this outreach and engagement as an actual service. Not all services happen for at least 15 minutes face to face."*

Endnotes

[1] Munetz, M. R. & Griffin, P. A. (2006). Use of the Sequential Intercept Model as an Approach to Decriminalization of People with Serious Mental Illness. Psychiatric Services 57: 4: 447-592; Lee, R. & Callahan, L. (2022). Trauma-Informed Approaches Across the Sequential Intercept Model. Council of State Governments.

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[4] Hammer, S., Tsunekawa, J., McAuliffe, S., & Fishbane, A. (2023). Increasing Court Appearance: Winning Strategies from Around the Country. ideas42.