Sequential Intercept Model Mapping Report for Clark County, NV

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Delmar, NY

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Final Report
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ACKNOWLEDGEMENTS

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BACKGROUND

The Sequential Intercept Model, developed by Mark R. Munetz, M.D. and Patricia A. Griffin, Ph.D.,[1] has been used as a focal point for states and communities to assess available resources, determine gaps in services, and plan for community change. These activities are best accomplished by a team of stakeholders that cross over multiple systems, including mental health, substance abuse, law enforcement, pretrial services, courts, jails, community corrections, housing, health, social services, peers, family members, and many others.

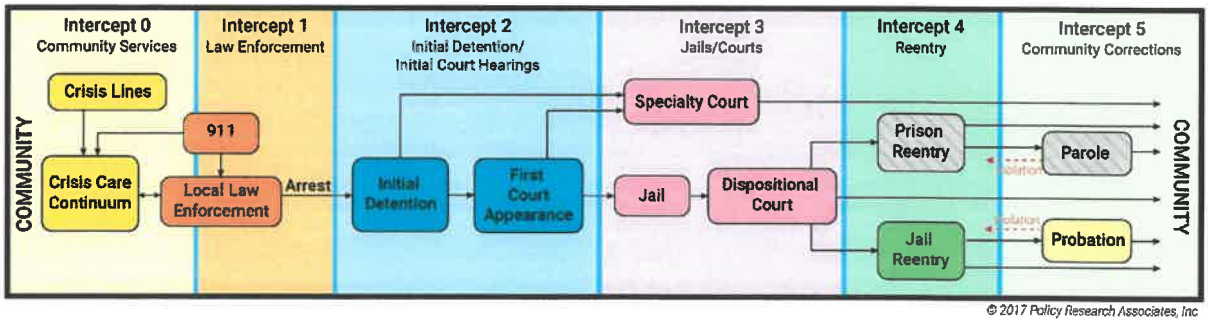
A Sequential Intercept Model mapping is a workshop to develop a map that illustrates how people with behavioral health needs come in contact with and flow through the criminal justice system. Through the workshop, facilitators and participants identify opportunities for linkage to services and for prevention of further penetration into the criminal justice system.

The Sequential Intercept Mapping workshop has three primary objectives:

1. Development of a comprehensive picture of how people with mental illness and co-occurring disorders flow through the criminal justice system along six distinct intercept points: (0) Mobile Crisis Outreach Teams/Co-Response, (1) Law Enforcement and Emergency Services, (2) Initial Detention and Initial Court Hearings, (3) Jails and Courts, (4) Reentry, and (5) Community Corrections/Community Support.

2. Identification of gaps, resources, and opportunities at each intercept for individuals in the target population.

3. Development of priorities for activities designed to improve system and service level responses for individuals in the target population



[1] Munetz, M., & Griffin, P. (2006). A systemic approach to the de-criminalization of people with serious mental illness: The Sequential Intercept Model. *Psychiatric Services*, *57*, 544-549.

AGENDA

PRI

SAFETY JUSTICE CHALLENGE

Sequential Intercept Mapping Workshop

AGENDA

Clark Co., NV

January 29, 2019

8:00 **Registration**

8:30 **Opening**
- Welcome and Introductions
- Overview of the Workshop
- Workshop Focus, Goals, and Tasks
- Collaboration: What's Happening Locally

What Works!
- Keys to Success

The Sequential Intercept Model
- The Basis of Cross-Systems Mapping
- Six Key Points for Interception

Cross-Systems Mapping
- Creating a Local Map
- Examining the Gaps and Opportunities

Establishing Priorities
- Identify Potential, Promising Areas for Modification Within the Existing System
- Top Five List
- Collaborating for Progress

Wrap Up
- Review

4:00 **Adjourn**

There will be a 15 minute break mid-morning and mid-afternoon.

There will be break for lunch at approximately noon.

PRI

SAFETY JUSTICE CHALLENGE

Sequential Intercept Mapping Workshop

AGENDA

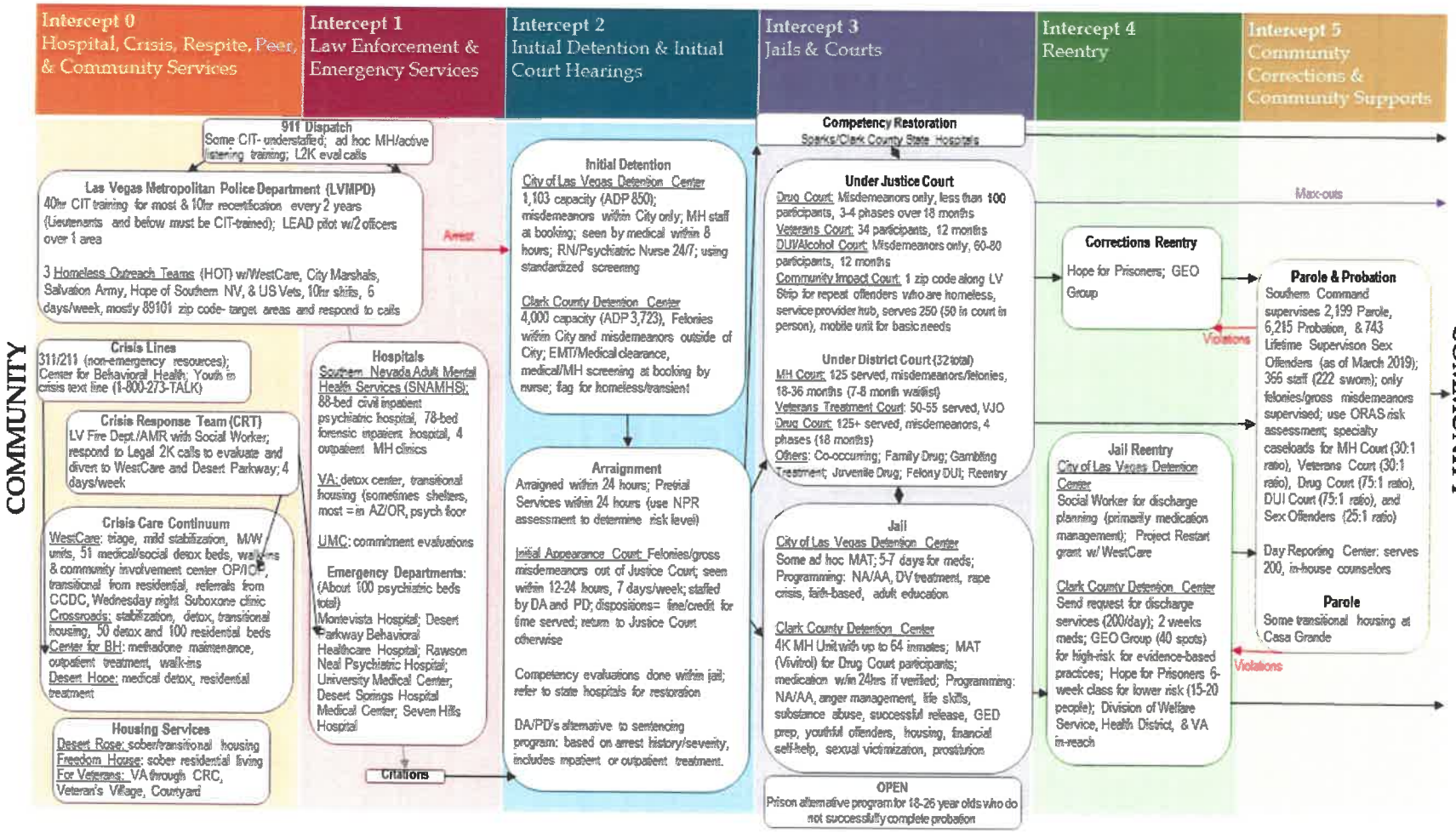
Clark Co., NV

January 30, 2019

8:00	**Registration and Networking**
8:30	**Opening** ▪ Remarks ▪ Preview of the Day
	Review ▪ Day 1 Accomplishments ▪ Local County Priorities ▪ Keys to Success in Community
	Action Planning
	Finalizing the Action Plan
	Next Steps
	Summary and Closing
12:00	**Adjourn**

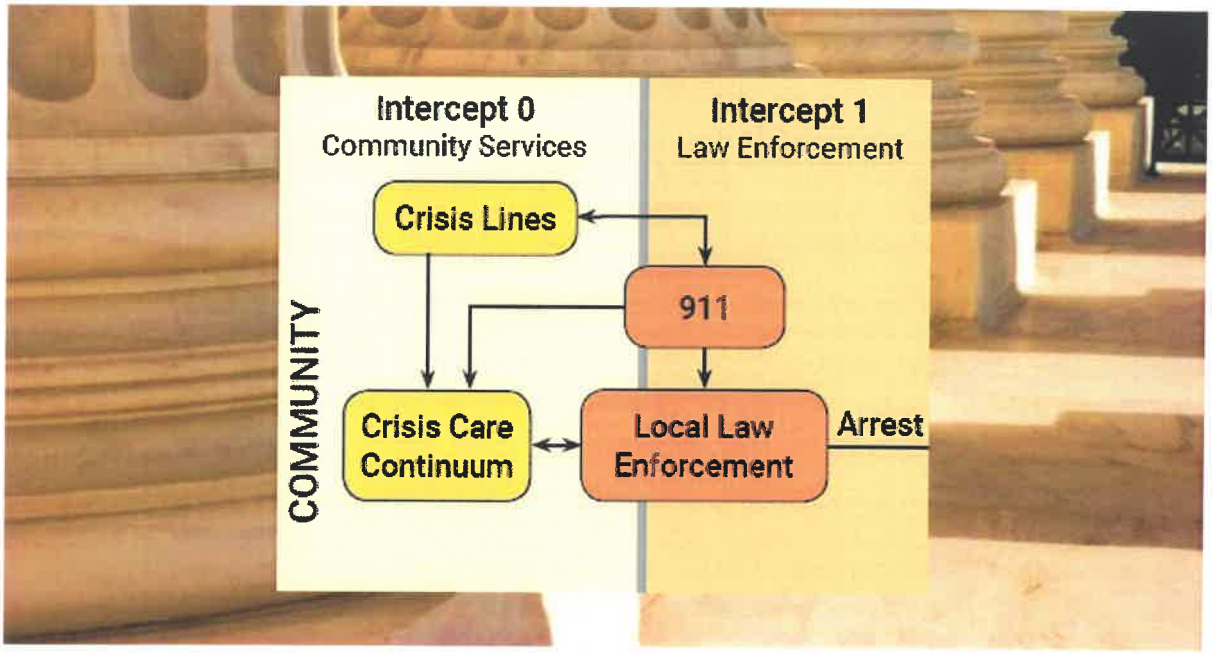
There will be a 15 minute break mid-morning.

SEQUENTIAL INTERCEPT MODEL MAP FOR CLARK COUNTY, NV



Resources and Gaps at Each Intercept

The centerpiece of the workshop is the development of a Sequential Intercept Model map. As part of the mapping activity, the facilitators work with the workshop participants to identify resources and gaps at each intercept. This process is important since the criminal justice system and behavioral health services are ever changing, and the resources and gaps provide contextual information for understanding the local map. Moreover, this catalog can be used by planners to establish greater opportunities for improving public safety and public health outcomes for people with mental and substance use disorders by addressing the gaps and building on existing resources.



INTERCEPT 0 AND INTERCEPT 1

RESOURCES

Crisis Lines

- The 3-1-1 line can be used as a non-emergency resource (similar to 211).
- The local 2-1-1 line can be used for information on Montevista Hospital and other resources that are available.
- There is a text service (1-800-273-TALK) for youth in crisis, which is a resource for the Clark County School District.

Healthcare

- Southern Nevada Adult Mental Health Services (SNAMHS) is a behavioral health system that consists of an 88-bed civil inpatient psychiatric hospital, a 78-bed forensic inpatient hospital, and four outpatient community mental health clinics. They accept walk-ins.
- Local hospitals include: Montevista Hospital; Spring Mountain Treatment Center (a juvenile facility); Desert Parkway Behavioral Healthcare Hospital; Rawson Neal Psychiatric Hospital; University Medical Center; Desert Springs Hospital Medical Center; Southern Nevada Adult Mental Health Services (SNAMHS); and Seven Hills Hospital.
- All hospitals listed have inpatient psychiatric beds (totaling at least 100 beds). Some of the general hospitals have smaller psychiatric units and all are able to triage individuals in psychiatric crisis through their Emergency Departments.

- WestCare provides "mild" crisis stabilization, detox, and outpatient or community involuntary (IOT) substance abuse services, available 24/7. Individuals must be cleared for dangerousness (L2K, see details below) before taken anywhere for stabilization services. The facility has 51 medical/social detox beds for men and women, as well as Suboxone. They also provide residential treatment with a housing component at the point of reentry. WestCare is also part of the Homeless Outreach Team (HOT, see below). The center was close to capacity at the time of the SIM.
- Crossroads Community Triage Center provides crisis stabilization, detox, and transitional housing, with the goal of providing similar services to WestCare, and a focus on the transition back to the community. This is a newer facility (December 2018 ribbon cutting) that is currently working to finalize their needed licensing. There will be 50 detox and 100 residential beds available when they open.
- The Center for Behavioral Health provides services for individuals in crisis, with four locations across Clark County. They accept walk-ins and provide methadone maintenance and outpatient treatment.
- Desert Hope Addiction Treatment Center provides residential treatment for co-occurring issues and medical detox.
- Desert Rose provides sober and transitional living, but no detox services.
- Freedom House offers residential sober living.
- Individuals can petition the court for a legal hold for psychiatric evaluation (L2K). This process often starts at the Family Law Self-Help Center of the Civil Self-Help Center.
- Through the Assisted Outpatient Treatment (AOT) program, individuals can request that law enforcement pick someone up and take them for medication and treatment.
- Law enforcement tends to spend less time waiting at private hospitals, after transporting individuals in crisis.

911 Dispatch

- 911 Dispatch can participate in Crisis Intervention Team (CIT) training. They also receive more brief trainings on Active Listening on occasion.

Law Enforcement and First Responders

- The Las Vegas Fire Department Crisis Response Team (CRT) responds to individuals in crisis using a Licensed Clinical Social Worker (LCSW) on one of the ambulances. The team is focused on expanding from two to eight officers. They respond to L2K calls to serve as a diversion option, and can transport to Desert Parkway and WestCare. The team also holds follow-up meetings to discuss individual outcomes.
    - CRT officers can conduct follow-up with persons who abuse the L2K system or who are at high risk. They will also coordinate with the Homeless Outreach Team (HOT) to identify up to 40 people who are high utilizers/familiar faces.

- The Las Vegas Metropolitan Police Department (LVMPD) provides the full 40-hour CIT training, as well as a 10-hour recertification training every two years. LVMPD is moving towards becoming an entirely mandated trained department in CIT. Officers who are the rank of Lieutenants and below must be CIT certified.
    - The LVMPD's Homeless Outreach Teams (HOT) utilize three groups of officers, City Marshals, and representatives from the Salvation Army, Hope of Southern Nevada, WestCare, and US Vets. The teams work 10-hour shifts, six days per week. The coverage area is currently within the city's zip code, but they are branching out into to two other zip codes, with the eventual goal to have six teams.
    - Officers are able to provide citations in lieu of arrest.
- The City of Henderson Police Department also participates in CIT Training.
- The City has a Law Enforcement Assisted Diversion (LEAD) pilot, with two LEAD officers in one area of command on day shifts only at this time. The University of Nevada, Las Vegas is collecting data on the LEAD program.
    - The LEAD team has served 300 individuals since it began in June 2018, with 10 active participants at the time of the SIM, who were either sober through Medication-Assisted Treatment (MAT) or counseling. There were 15 additional individual who were active and still using substances, utilizing harm reduction techniques. Arrest warrants had been served for 20 people due to non-compliance.
    - The Center for Behavioral Health and Bridge Counseling Associates are hubs for services, including MOUs with approximately 40 community-based providers.

Peer Support

- Many of the programs identified are using peer specialists as service providers and mentors.

Veterans

- There are many services available locally for veterans. The VA has provided some housing for veterans, including transitional housing via a shelter at first. The two local Veterans Justice Outreach (VJO) Coordinators are active in this area, and work directly with the psychiatric hospital in the county.
- Veteran's Village Las Vegas is a transitional and permanent housing residence for veterans with 24/7 crisis intervention services.

GAPS

Healthcare

- Most people needing detox services are taken to jail if they are not taken to the hospital. Clark County Detention Center (CCDC) is the primary detox provider in the area.
- WestCare has a small detox capacity only. WestCare and Clark County generally lack transitional services between detox/treatment and stabilization back into the community.
- There is a gap in medical detox services across the county.
- Southern Nevada Adult Mental Health Services (SNAMHS) will not accept individuals for detox services if they are in need of medical clearance.
- Some treatment facilities will not accept people who have prior violent offenses or without identification.
- There are no providers available for involuntary injections of medication for those who are issued Assisted Outpatient Treatment (AOT) holds. Hospitals will not administer forced medication in these cases.
- Many local behavioral health providers do not accept Medicare.
- Meth is a growing issues across the region.

911 Dispatch

- Dispatch is understaffed, which results in difficulty engaging in additional behavioral health training such as CIT.
- Dispatch collects relevant mental health information on an ad hoc basis, but not formally through a script.

Law Enforcement and First Responders

- The Fire Department carries Narcan, but law enforcement does not.
- If law enforcement transports an individual in crisis to UMC for medical clearance, the officer must remain with the person (often four to five hours) until he/she is cleared, and then transport to CCDC or SNAMHS.
- The City's Law Enforcement Assisted Diversion (LEAD) pilot is on a small-scale and is not currently funded.
- There is a gap in formal data collection and analysis of CIT calls/contacts.

Crisis Services

- The Las Vegas Fire Department Crisis Response Team (CRT) only serves one zip code currently, four days per week, although they hope to expand. It would be helpful to track follow-up service engagement to limit individuals "falling through the cracks."

Collection and Sharing of Data

- Data are not being collected nor tracked after a person is taken to an emergency department, for example with an L2K hold.
- There is some exploration of individuals who are high utilizers of services, but this is not guided by formal data, and there is no risk screening instrument currently used.

Housing

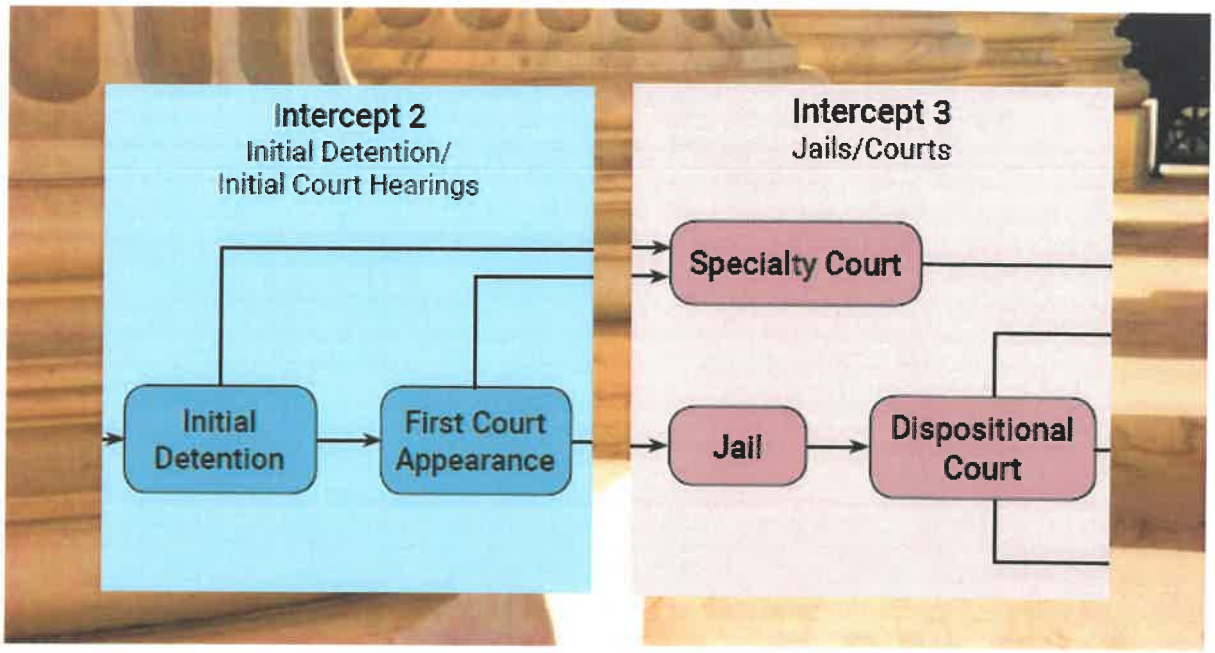
- There is a need for more housing generally across Intercepts 0/1, and transitional and residential housing in particular.

Peer Support

- Many peer specialist services are not reimbursable through Nevada Medicaid. Reimbursement is specific to the arrangement an organization has with Medicaid.

Veterans

- The VA contracts with a local residential facility, but they send people out of state (to Oregon and Arizona) primarily for services.



INTERCEPT 2 AND INTERCEPT 3

RESOURCES

Jail Structure and Personnel

- The City of Las Vegas Detention Center has a capacity of 1,103, with an average daily population of 850. The jail only houses individuals charged with misdemeanors. The average length of stay is 14 days.
    - Officers received Mental Health First Aid (MHFA) training three years ago.
- The Clark County Detention Center (CCDC) has a capacity of 4,000, with an average daily population of 3,723 at the time of the SIM.

Jail Services

- At the City of Las Vegas Detention Center, mental health staff are available at booking. Individuals are able to see the jail medical team within eight hours, and a RN and Psychiatric Nurse are available 24/7. They use an internal standardized screening and can pull and analyze the data.
    - Programming in the jail includes NA/AA, court-ordered domestic violence treatment, rape crisis services for men and women, faith-based services, and adult education.
    - MAT is available in the jail, but was reported as "whatever psych provides," and not including Vivitrol.
- Clark County Detention Center

- There is medical and mental health screening given at booking by a medical nurse. The mental health screen includes questions around suicide assessment and substance abuse, and there is an algorithm to determine if someone will see a mental health nurse or social worker for a more extensive mental health assessment.
    - *Post-note: After the SIM, NaphCare lost the CCDC medical contract to Wellpath. Wellpath will be taking over on June 1, 2019. This may be a good thing as City Detention and CCDC will now have the same medical and mental health provider.*
- Medications are available within 24 hours if verified by the pharmacy.
- There is a flag at booking for individuals who are homeless or transient. The jail will soon hold a homeless services "fair" within the facility.
- Programming in the jail includes anger management, life skills, substance abuse services, successful release, Celebrate Recovery, AA/NA, GED preparation, services for youthful offenders, housing and financial self-help, sexual victimization and female prostitution/trafficking services for women (with housing assistance following), Hope for Prisoners, and other faith-based services.
- There is a Mental Health Unit (4K) in the South Tower with a maximum capacity of 64 inmates. Group therapy consists of 10-15 inmates per session. There is also a unit for juvenile offenders and the jail is exploring creating a veterans unit.
- The jail is providing MAT using Vivitrol to individuals from Drug Court, including follow up through the Justice Courts based on a physician's consultation and judge's determination.

Pretrial Services

- Individuals at the City of Las Vegas Detention Center are seen by pretrial services (represented at booking) within 24 hours. They are using the validated Nevada Pretrial Risk Assessment (NPR), which issues a point system to determine risk of ROR.
- There is a misdemeanor diversion program that often receives individuals charged with misdemeanors who may be incompetent. In 2018, the program served 93 people.
- There may be discussion of individuals' competency to stand trial at this point. Competency evaluation requires evaluation by two doctors and is done within the jail. Individuals in need of restoration are sent to one of two state hospitals. This process has gotten faster since the opening of the local state hospital.

Problem-Solving Courts

- Individuals charged with felonies or gross misdemeanors may be diverted through the Initial Appearance Court. Potential participants are seen within 12-24 hours of booking, seven days per week including holidays, with two court sessions per day. At the time of the SIM, there were 35 individuals on the docket.

    - The District Attorney and Public Defenders are present at each court hearing and may provide physical or mental health information relevant to diversion efforts.
    - The judge considers the results from the NPR assessment given to all at booking.
    - Involvement in the court either leads to ROR, low bail with electric monitoring, or electric monitoring at other levels (low, medium, or high).
- There is a separate traffic docket for misdemeanor charges.
- The Justice Court operates the Drug Court, DUI/Alcohol Court, Veterans Courts and the Community Impact Court (CIC).
    - There are less than 100 individuals within the Drug Court, which has weekly staffing meetings. The Court is three to four phases over 18 months, and is for misdemeanors only.
    - The DUI/Alcohol Court meets once per week and has 60-80 participants. The program is 12 months long, and is for misdemeanors only.
    - The Veterans Court has 34 participants, which is low, and takes place over 12 months.
    - The Community Impact Court operates within one zip code along the Las Vegas strip and focuses on repeated offenders who are homeless. The Court serves as a center for services with about 350 community providers and operates five days per week. The Court serves 250 on an ongoing basis (with about 50 coming to court in person) and also offers showers and clothing through a mobile unit.
- The District Court operates several problem-solving courts (details below).
    - The Mental Health Court operates with 125 people currently. The program is 18-36 months for individuals charged with misdemeanors, and staff use the validated Ohio Risk Assessment System (ORAS). Housing and residential treatment is a condition of probation for all.
    - The Veterans Treatment Court meets biweekly with 50-55 people. The Veterans Justice Outreach (VJO) Coordinator is involved.
    - There is a Gambling Treatment Court with only two people at the time of the SIM.
    - Other problem-solving courts include the Reentry Drug Court (provides some MAT), Family Drug Court, Juvenile Drug Court, Felony DUI Court, and the OPEN prison alternative program for 18-26 year-olds who do not successfully complete probation. There is also a Co-occurring Court that has funding for residential treatment beds.

Data Collection and Sharing

- Data are collected regarding individuals released on their own recognizance from the City of Las Vegas Detention Center who fail to appear (FTA) in court.

GAPS

Jail Services

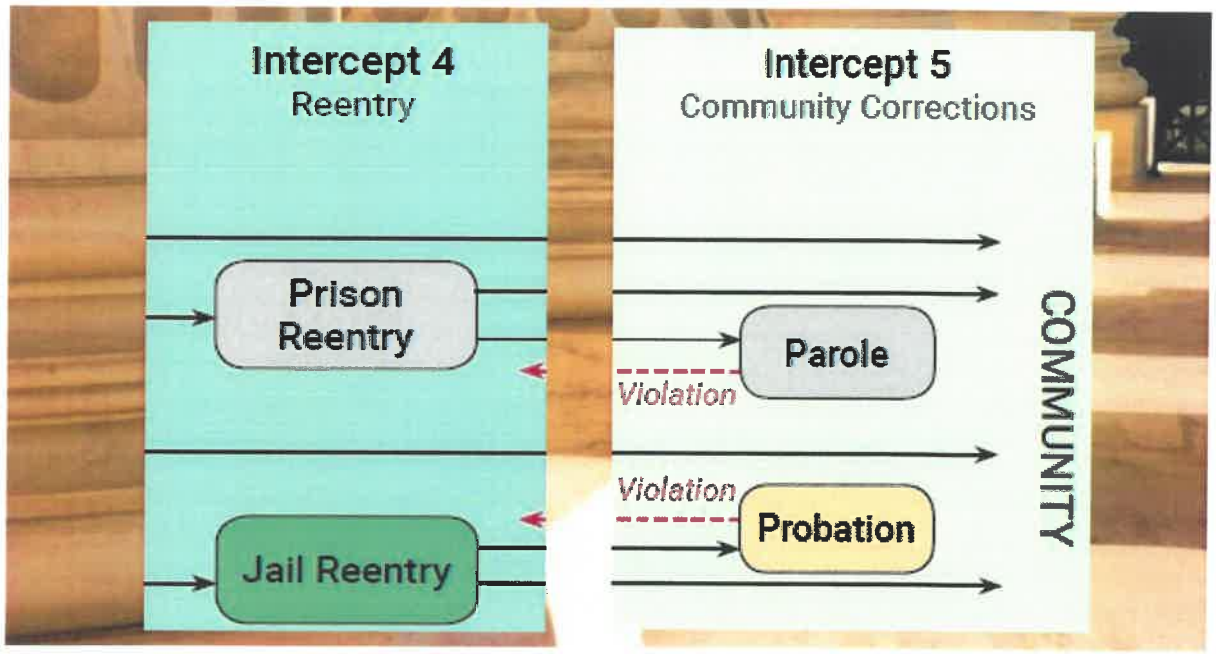
- City of Las Vegas Detention Center
    - There is a limited medication formulary at the Detention Center and it can take five to seven days to issue psychotropic medication(s). Approximately 20% of individuals are released before this point.
    - It may take 12-36 hours for people to be released on their own recognizance (ROR).
    - The upper level of the jail was converted for individuals with serious mental illness (SMI) who are not necessarily provided psychotropic medication, which can create problems.
    - Most detention officers are not CIT-trained.
    - Data are not utilized currently to understand service needs within the jail.
- Clark County Detention Center
    - Approximately 30% of detainees are released from CCDC on administrative orders before they can be seen by a nurse, and thus are not connected to potential behavioral health services.
    - Jail medical conducts a mental health assessment at booking, but this information is not used available, or used uniformly by others to help coordinate care within and as part of release planning.
    - There is no formal use of peer specialists within CCDC programming.
    - There is no MAT provided at CCDC unless individuals participate in Drug Court.

Pretrial Services

- There is no judicial involvement in the decision to release individuals on pretrial.
- The primary function of pretrial services is conducting risk assessments and in-person check-ins. The only mechanism for supervising individuals on pretrial release is electronic monitoring.
- There can be delays in competency evaluation and restoration.
- The DA's Office and PD's Office have an alternative to sentencing program that is based on arrest history, arrest severity, etc. It can include inpatient or outpatient treatment.

Problem-Solving Courts

- Judges do not routinely receive screening or assessment data regarding individuals' behavioral health information.
- There is a seven- to eight-month waiting list for the Mental Health Court, and the court has no current funding.
- The Mental Health Court provides supportive housing for individuals while in the program, but some are homeless following graduation.
- There is a need for additional MAT in the District Court's Drug Court.



INTERCEPT 4 AND INTERCEPT 5

RESOURCES

Jail Services

- A Social Worker provides some discharge planning services at the City of Las Vegas Detention Center.
- Anyone in CCDC has access to reentry services, and can send a request to receive them. About 200 requests per day are received. A Community Resource Guide is distributed to all inmates.
    - Two weeks of medication is provided at jail discharge by NaphCare.
    - There is a Division of Welfare Service in-house to set up services prior to reentry. There is also in-house medication and STI testing from the Health District.
        - There is an assessment and interview process based off of release dates.
    - The VA provides in-reach to refer veterans to service.
    - The GEO Group provides targeted outreach to inmates over 90-120 days and has 40 spots for men and women at higher-risk. The group provides evidence-based practices including Moral Reconation Therapy (MRT), substance abuse services, life skills, victim impact services, parenting classes, employment services, criminal thinking behavioral change, and a trauma curriculum for women. They also utilize the Level of Service Inventory-Revised (LSI-R) risk/need assessment tool and offer a transitional planning component to create a warm handoff to community providers, with 30-, 60-, and 90-day follow-ups.

- Hope for Prisoners has a six-week class for individuals who are lower risk and began a women's in-house class in the week following the SIM. It is at capacity with 15-20 participants. It is primarily a soft-skills program, focusing on substance abuse, parenting classes, emotional health, leadership, communication, anger management, vocational training, and financial literacy. Individuals are also referred to the County's GED course. Hope for Prisoners provides connection to transportation at release to continue services.

Prison Reentry

- Hope for Prisoners is in one women's and one men's DOC facility, as well as Casa Grande (transitional housing). Other programming includes skills development for individuals who are college-bound, followed by either a communications course for college credit or vocational training.
- The GEO Group is active in the prison also.

Community Reentry

- The Nevada DMV provides Clarity, an ID for individuals who are homeless, but it is not accepted by all relevant services. Hope for Prisoners pays for identification for some. Some services will accept a jail or prison ID, but others will not.

Parole and Probation

- There are 366 total Parole and Probation staff, with 222 sworn and 144 civilian.
- There is reportedly good communication and collaboration between the District Attorney's Office, the Public Defender's Office, CCDC, Parole and Probation, and reentry programs.
- Within Clark County, there are about 8,000 people on Probation and about 4,000 on Parole. They supervise only individuals convicted of felonies or gross misdemeanors, and use the ORAS statewide. There is open communication between the civilian/pretrial level and the sentenced supervision level, including transfer of assessment data.
- There are specialty Parole and Probation programs for individuals coming from Mental Health Court (30:1 ratio), Veterans Court (30:1 ratio), Drug Court (75:1 ratio), and DUI Court (75:1 ratio). There is also a specialty caseload for individuals who committed sex offenses, with a 25:1 ratio.
- The Day Reporting Center program is a joint effort between the Parole and Probation and Sentinel. It serves about 200 individuals and tracks outcome data. They provide in-house counselors for better engagement, which works well.
- There are now free assessments at Parole and Probation from providers doing in-reach. Most providers offer sliding scales for follow-up classes.
- Parole has some funding for housing.

GAPS

Jail Services

- There is not space at the City of Las Vegas Detention Center to provide needed reentry services. Given the shorter length of stay, it is difficult to sustain programming.
- There is no standardized reentry checklist or assessment used within the jail.
- There is no mechanism for CCDC population sorting for reentry services or a formal referral process (outside of individuals sending a request) due to lack of staffing at programs and reentry.
- Many NaphCare Social Worker discharge planners are simply setting up medication at release, versus more comprehensive discharge services.
- Both The GEO Group (40 slots) and Hope for Prisoners (15-20 slots) are currently at capacity, and are closed groups, although there is exploration to change this.

Community Reentry

- Transitional, long-term and reentry housing is a large gap. A lot of housing is not available to those with felonies, nor to sex offenders. Much of it is provided through corporations, which have many tenant restrictions.
- There is a lack of funding and beds for residential treatment.
- The Clarity or jail identifications do not work for all needed services.
- Transportation is a gap across the community.

Parole and Probation

- Parole and Probation may not be aware of mental health issues. Some Parole and Probation Officers elect to receive specialized mental health or substance abuse training, but nothing is mandated. There is no formalized screening or assessment process to identify client behavioral health needs.
- Peers are not involved in providing in-house services at Parole and Probation.
- Parole and Probation do not carry Narcan, and it is not given at reentry from locked facilities.

PRIORITIES FOR CHANGE

The priorities for change are determined through a voting process. Workshop participants are asked to identify a set of priorities followed by a vote where each participant has three votes. The voting took place on January 29, 2019. The top three priorities are highlighted in italicized text.

1. *Increase access to stabilization services, including housing and transportation (14 votes)*
2. *Address culture and increase buy in of agency administration and staff (12 votes)*
3. *Increase substance abuse, detox, and crisis stabilization drop-off diversion options for law enforcement (9 votes)*
4. Address and improve supervision of the (roughly 30% of booked) population released without any assessment or services, before the Initial Appearance Court; address failures to appear and administrative releases (6 votes)
5. Improve judicial-level case processing inefficiencies that impact jail population levels (6 votes)
6. Increase data sorting of populations and match to services; track and communicate data and analyze outcomes (6 votes)
7. Create infrastructure and demonstrate commitment to jail staff that reentry and alternatives to jail are priorities for the county, including reentry as part of the academy (5 votes)
8. Place DSS, reentry programs, jail services, and discharge planners in the same office area to end silos at CCDC and avoid duplication of efforts (4 votes)
9. Coordinate resources and information for specific high-needs clients (CIT, after actions, services) (2 votes)

10. Increase targeted services and "mandatory" involvement in services; increase engagement (1 vote)
11. Capture costs of current processes and educate county government entities concerning the systemic access, utilization, gaps, and needs of this population (0 vote)
12. Clarify HIPAA/CFR 42.2 restrictions and allowances in order to reduce duplication of information collection and data sharing (0 vote)

RECOMMENDATIONS

Clark County has a number of exemplary programs that address criminal justice/behavioral health collaboration. Still, the mapping exercise identified areas where programs may need expansion or where new resources and programming must be developed.

1. **Improve health care outcomes and reduce recidivism for people with mental and substance use disorders through increased jail services and a jail reentry program.**

   Improve public safety and public health outcomes by providing transition planning services to inmates with mental and substance use disorders. At a minimum, transition planning services should be offered to the sentenced population prior to release from the jail. Transition planning services can be provided by dedicated jail staff or by community-based providers who reach into the jail. The Transition from Jail to Community (TJC) Initiative, developed by the Urban Institute and National Institute of Corrections provides a clear structure for transition planning as well as an online learning toolkit. Also refer to the Guidelines for the Successful Transition of People with Behavioral Health Disorders from Jail and Prison (Blandford and Osher, 2013) and the Implementation Guide (SAMHSA, 2017).

   Improve access to Medicaid and Social Security benefits for persons released from jail and prison. Medicaid suspension or cancellation while incarcerated is a barrier to recovery. The Affordable Care Act has expanded access to Medicaid, yet communities across the country have lagged in enrolling justice involved individuals in Medicaid. A more aggressive and coordinated approach is needed to insure Medicaid benefits essential to continuing prescribed medication and accessing critical behavioral health services.

   Strategies include providing jail-based or diversion health personnel with access to the local Medicaid database to promptly identify enrollees and insure continuation of coverage. Social Security Disability (SSD) and Social Security Supplemental Income (SSI) provide medical benefits and income which can improve access to housing and other services. Social Security Outreach Access

and Recovery training (SOAR) can improve successful enrollments and reduce approval times from months to as soon as 60 days.

Inmates with mental health disorders should ideally be released with four weeks of medications, a prescription for psychotropic medications, and an appointment with a prescriber. Reentry from jail is an opportune time to connect people with mental disorders to community-based services.

Expand, coordinate, and connect reentry services to community supervision. Explore developing a Reentry Council or integrate current efforts into the work of existing workgroups/task forces. Issues to address include fair housing, "ban the box," and educating employers.

Communities may explore national models of faith-based involvement and the use of formerly incarcerated persons as mentors in reentry services. Two programs recommended for further exploration are Mission Behind Bars and Beyond and the Offender Alumni Association of Birmingham, Alabama.

See also *Reentry* in the Resources section later in this report.

2. **At all stages of the Sequential Intercept Model, gather data to document the processing of people with mental health and substance use disorders through the criminal justice system locally.**

Improving cross-system data collection and integration is key to identifying high-user populations, justifying expansion of programs, and measuring program outcomes and success. Creating a data match with information from local/state resources from time of arrest to pre-trial can enhance diversion opportunities before and during the arraignment process.

It is important for each organization to define terms initially, so there is a common definition developed of what populations/issues communities/organizations are trying to understand. Learn from each system how that data point is collected, coded and stored. Seek common identifiers to match populations.

Data collection does not have to be overly complicated. For example, some 911 dispatchers spend an inordinate amount of time on comfort and support calls. Collecting information on the number of calls, identifying the callers and working to link the callers to services has been a successful strategy in other communities to reduce repeated calls. In addition, establishing protocols to develop a "warm handoff" or direct transfers to crisis lines can also result in directing calls to the most appropriate agency and result in improved service engagement.

Dashboard indicators can be developed on the prevalence, demographics, and case characteristics of adults with mental and substance use disorders who are being arrested, passing through the courts, booked into the jail, sentenced to prison, placed on probation, etc.

A mental health dashboard can also be developed to monitor wait times in hospitals for people in mental health crises and transfer times from the emergency department to inpatient units or other services to determine whether procedures can be implemented to improve such responses. These dashboard indicators can be employed by a county planning and monitoring council to better identify opportunities for programming and to determine where existing initiatives require adjustments.

Consider joining the Arnold Foundation and National Association of Counties (NACo) Data-Driven Justice Initiative (DDJ). The publication "Data-Driven Justice Playbook: How to Develop a System of Diversion" provides guidance on development of data driven strategies and use of data to develop programs and improve outcomes.

See also the *Data Analysis and Matching* publications in the Resources section.

3. **Expand substance use disorder (SUD) identification and treatment options and integrate strategies with current initiatives.**

Participants identified SUD treatment capacity and access as a significant gap. The facilitators note the following SUD initiatives and encourage stakeholders to expand and integrate SUD initiatives with other initiatives described in this report.

- The 2016 SAMHSA publication, Screening and Assessment of Co-occurring Disorders in the Justice System developed by Roger Peters and the SAMHSA GAINS Center (see *Screening and Assessment* section of the Resources), provides an overview of screening and assessment and treatment of individuals with co-occurring disorders in the criminal justice system. In addition, Screening and Assessment instruments for mental illness, substance use, co-occurring disorders, treatment motivation and trauma/PTSD.

- The SAMHSA publication, Detoxification and Substance Abuse Treatment. Treatment Improvement Protocol (TIP) Series, No. 4 SAMHSA Tip 45, provides communities with guidance on a continuum of inpatient and outpatient care for detoxification services and identifies best practices.

- The San Diego Serial Inebriate Program is a nationally recognized program to offer services to a chronic inebriate population.

- The 2016 21st Century Cures Act offers significant funding opportunities to address the Opioid Crisis. When the SIM is applied to the Cures Act, communities can more easily examine the funding and programmatic opportunities offered by both HHS and DOJ funding streams. PRA developed a matrix to depict the funding source and program initiatives as they fall across the six Intercepts. It also indicates which Intercept a particular initiative falls into and whether an initiative spans multiple Intercepts.

Jails and prisons are increasingly utilizing Medication Assisted Treatment (MAT) at the point of reentry. See the *Medication Assisted Treatment* section of the Resources. Review current Medication Assisted Treatment (MAT) processes in the community and jail. Many jails are only giving Vivitrol or Suboxone to women who are pregnant. Ensure support, especially peer support, to help persons maintain MAT and their recovery. Consider a collective impact process to bring together harm reduction, prevention, treatment and enforcement strategies.

- Strategies may include treatment on demand, police follow-up and referral to services, a resource center, harm reduction/syringe exchange, and/or first responders trained in and carrying Naloxone.

- In the jail, this may include screening for use and withdrawal, withdrawal management on Buprenorphine, maintenance dosing and induction on Methadone and Buprenorphine paired with appropriate psychoeducational classes, peer support in the facility and upon release, and inmates leaving with Naloxone.

Also consider police diversion-to treatment strategies such as Law Enforcement Assisted Diversion (LEAD).

4. **Target strategies/interventions to address the arrest, incarceration, and re-arrest cycles of homeless individuals and other individuals that return to the healthcare and/or criminal justice system repeatedly.**

Communities across the country have developed strategies to concentrate resources on "familiar faces" or high utilizers of services. Strategies involve a developing a coordinating committee composed of mid- level managers of provider agencies, direct service individuals and criminal justice personnel who are able to mobilize resources to engage individuals in a timely way and at periods of high need, e.g., ER visit, police contact or arrest. Often the individuals identified as high users have priority for intensive services including ACT, case management and housing. These initiatives commonly report reductions in ER use, inpatient stays, police contacts and homelessness.

The Center for Supportive Housing FUSE Resource Center describes supportive housing initiatives for super utilizers (frequent users) of jails, hospitals, healthcare, emergency shelters and other public systems.

Camden New Jersey has developed a promising collaboration of healthcare, social service, and law enforcement services to address their "complex care" populations that have frequent contact with their hospitals and sometimes police. They have been showing success in reducing repeated contact and improving health.

See also the *Crisis Care, Crisis Response, and Law Enforcement* publications in the Resources below.

5. **Increase and improve housing options.**

Communities around the country have begun to develop more formal approaches to housing development, including use of the Housing First model. The 100,000 Home Initiative identifies key steps for communities to take to expand housing options for persons with mental illness.

A strong housing continuum includes emergency shelters, landlord support and intervention, rapid rehousing, Permanent Supportive Housing (with or without Housing First but including supportive services such as case management, treatment, employment, etc.), Supported Housing (partial rent subsidies), transitional housing, affordable rental housing, and home ownership. In addition,

consider how dependent care, institutional care, home-based services such as FACT, FUSE and ACT, halfway houses, and respite care can support specific populations needs.

The following resources are suggested to guide strategy development. See also *Housing* under Resources below.

- GAINS Center. Moving Toward Evidence-based Housing Program for Person with Mental Illness in Contact with the Justice System

- Stefancic, A., Hul, L., Gillespie, C., Jost, J., Tsemberis, S., and Jones, H. (2012). Reconciling Alternative to Incarceration and Treatment Mandates with a Consumer Choice Housing First model: A Qualitative study of Individuals with Psychiatric Disabilities. Journal of Forensic Psychology Practice, 12, 382–408.

- Tsemberis, S. (2010). Housing First: The Pathways Model to End Homelessness for People with Mental Illness and Addiction. Center City, MN: Hazelden Press.

- Stefancic, A., Henwood, B. F., Melton, H., Shin, S. M., Lawrence-Gomez, R., and Tsemberis, S. (2013). Implementing Housing First in Rural Areas: Pathways Vermont, *American Journal of Public Health*, *103*, 206–209.

- Shifting the Focus from Criminalization to Housing

- Lehman, M.H., Brown, C.A., Frost, L.E., Hickey, J.S., and Buck, D.S. (2012). Integrated Primary and Behavioral Health Care in Patient-Centered Medical Homes for Jail Releases with Mental Illness. *Criminal Justice and Behavior*, published online.

- Built for Zero (formerly Zero: 2016) is a rigorous national change effort working to help a core group of committed communities end veteran and chronic homelessness. Coordinated by Community Solutions, the national effort supports participants in developing real time data on homelessness, optimizing local housing resources, tracking progress against monthly goals, and accelerating the spread of proven strategies.

6. **Increase and improve transportation options.**

Transportation is frequently identified as a priority by communities across the country. Yet, nationally, few program models or planning strategies have been identified to address this critical component of service access.

The Ohio Association of County Behavioral Health Authorities published "White Paper: Criminal Justice and Behavioral Health Care, Housing, Employment, Transportation and Treatment" (January 2015). The White Paper describes three transportation initiatives:

- The NET – Plus initiative in Wood County, Ohio. NET Plus program coordinates transportation resources for Medicaid eligible populations and funds transportation for non-Medicaid eligible populations.

- The Hardin County Volunteers in Police Service (VIPS) initiative operated by the Sheriff's Department provides volunteer transportation to essential services for drug court clients.
- The Franklin County Turn it Around Transportation & Re-development Services provides transportation for workers to various employers. The program is funded by self-contribution, payroll deduction and/or employers.

For a copy of the White Paper or for further information, contact:
Ohio Association of County Behavioral Health Authorities
Attn: Cheri L. Walter, CEO
33 North High Street, Suite 500
Columbus, Ohio 43215
614-224-1111
www.oacbha.org

Explore the non-medical transportation services provided by counties and states, including the Wisconsin Department of Health Services BadgerCare+ program. Also review the SAMHSA resource *Getting There: Helping People with Mental Illnesses Access Transportation* (2004).

RESOURCES

Competency Evaluation and Restoration

- SAMHSA's GAINS Center. *Quick Fixes for Effectively Dealing with Persons Found Incompetent to Stand Trial.*
- Finkle, M., Kurth, R., Cadle, C., and Mullan, J. (2009) Competency Courts: A Creative Solution for Restoring Competency to the Competency Process. *Behavioral Science and the Law, 27,* 767-786.

Crisis Care, Crisis Response, and Law Enforcement

- Substance Abuse and Mental Health Services Administration. *Crisis Services: Effectiveness, Cost-Effectiveness, and Funding Strategies.*
- International Association of Chiefs of Police. *Building Safer Communities: Improving Police Responses to Persons with Mental Illness.*
- Suicide Prevention Resource Center. *The Role of Law Enforcement Officers in Preventing Suicide.*
- Saskatchewan Building Partnerships to Reduce Crime. *The Hub and COR Model.*
- Bureau of Justice Assistance. *Engaging Law Enforcement in Opioid Overdose Response: Frequently Asked Questions.*
- International Association of Chiefs of Police. Improving Police Response to Persons Affected by Mental Illness: Report from March 2016 IACP Symposium.
- International Association of Chiefs of Police. One Mind Campaign.

- Optum. In Salt Lake County, Optum Enhances Jail Diversion Initiatives with Effective Crisis Programs.
- The Case Assessment Management Program is a joint effort of the Los Angeles Department of Mental Health and the Los Angeles Police Department to provide effective follow-up and management of selected referrals involving high users of emergency services, abusers of the 911 system, and individuals at high risk of death or injury to themselves.
- National Association of Counties. Crisis Care Services for Counties: Preventing Individuals with Mental Illnesses from Entering Local Corrections Systems.
- CIT International.
- National Action Alliance for Suicide Prevention: Crisis Services Task Force. Crisis now: Transforming services is within our reach. Washington, DC: Education Development Center, Inc.

Data Analysis and Matching

- Data-Driven Justice Initiative. Data-Driven Justice Playbook: How to Develop a System of Diversion.
- Urban Institute. *Justice Reinvestment at the Local Level Planning and Implementation Guide.*
- The Council of State Governments Justice Center. *Ten-Step Guide to Transforming Probation Departments to Reduce Recidivism.*
- New Orleans Health Department. *New Orleans Mental Health Dashboard.*
- Pennsylvania Commission on Crime and Delinquency. *Criminal Justice Advisory Board Data Dashboards.*
- Corporation for Supportive Housing. *Jail Data Link Frequent Users: A Data Matching Initiative in Illinois* (See Appendix 3)
- Vera Institute of Justice. *Closing the Gap: Using Criminal Justice and Public Health Data to Improve Identification of Mental Illness.*

Housing

- Alliance for Health Reform. *The Connection Between Health and Housing: The Evidence and Policy Landscape.*
- Economic Roundtable. *Getting Home: Outcomes from Housing High Cost Homeless Hospital Patients.*
- 100,000 Homes. *Housing First Self-Assessment.*
- Urban Institute. *Supportive Housing for Returning Prisoners: Outcomes and Impacts of the Returning Home-Ohio Pilot Project.*
- Corporation for Supportive Housing. *NYC FUSE – Evaluation Findings.*
- Corporation for Supportive Housing. Housing is the Best Medicine: Supportive Housing and the Social Determinants of Health.
- Corporation for Supportive Housing. Guide to the FUSE Model.

Information Sharing

- American Probation and Parole Association. *Corrections and Reentry: Protected Health Information Privacy Framework for Information Sharing.*
- Legal Action Center. *Sample Consent Forms for Release of Substance Use Disorder Patient Records.*
- Council of State Governments Justice Center. Information Sharing in Criminal Justice-Mental Health Collaborations: Working with HIPAA and Other Privacy Laws.

Jail Inmate Information

- NAMI California. *Arrested Guides and Inmate Medication Forms.*

Medication Assisted Treatment (MAT)

- American Society of Addiction Medicine. *The National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use.*
- American Society of Addiction Medicine. *Advancing Access to Addiction Medications.*
- National Commission on Correctional Health Care and the National Sheriffs' Association. Jail-Based Medication-Assisted Treatment: Promising Practices, Guidelines, and Resources for the Field.

- Substance Abuse and Mental Health Services Administration. *Federal Guidelines for Opioid Treatment Programs*.
- Substance Abuse and Mental Health Services Administration. *Medication for the Treatment of Alcohol Use Disorder: A Brief Guide*.
- Substance Abuse and Mental Health Services Administration. *Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction (Treatment Improvement Protocol 40)*.
- Substance Abuse and Mental Health Services Administration. *Clinical Use of Extended Release Injectable Naltrexone in the Treatment of Opioid Use Disorder: A Brief Guide*.

Mental Health First Aid

- Mental Health First Aid.
- Illinois General Assembly. *Public Act 098-0195: Illinois Mental Health First Aid Training Act*.
- Pennsylvania Mental Health and Justice Center of Excellence. *City of Philadelphia Mental Health First Aid Initiative*.

Peers

- SAMHSA's GAINS Center. *Involving Peers in Criminal Justice and Problem-Solving Collaboratives*.
- SAMHSA's GAINS Center. *Overcoming Legal Impediments to Hiring Forensic Peer Specialists*.
- NAMI California. *Inmate Medication Information Forms*
- Keya House.
- Lincoln Police Department Referral Program.

Pretrial Diversion

- CSG Justice Center. Improving Responses to People with Mental Illness at the Pretrial State: Essential Elements.
- National Resource Center on Justice Involved Women. Building Gender Informed Practices at the Pretrial Stage.

- Laura and John Arnold Foundation. The Hidden Costs of Pretrial Diversion.

Procedural Justice

- Legal Aid Society. *Manhattan Arraignment Diversion Program.*
- Center for Alternative Sentencing and Employment Services. *Transitional Case Management for Reducing Recidivism of Individuals with Mental Disorders and Multiple Misdemeanors.*
- Hawaii Opportunity Probation with Enforcement (HOPE). *Overview.*
- American Bar Association. Criminal Justice Standards on Mental Health.

Reentry

- SAMHSA's GAINS Center. *Guidelines for the Successful Transition of People with Behavioral Health Disorders from Jail and Prison.*
- Community Oriented Correctional Health Services. *Technology and Continuity of Care: Connecting Justice and Health: Nine Case Studies.*
- The Council of State Governments. National Reentry Resource Center.
- Bureau of Justice Assistance. Center for Program Evaluation and Performance Management.
- Washington State Institute of Public Policy. *What Works and What Does Not?*
- Washington State Institute of Public Policy. *Predicting Criminal Recidivism: A Systematic Review of Offender Risk Assessments in Washington State.*

Screening and Assessment

- Center for Court Innovation. Digest of Evidence-Based Assessment Tools.
- SAMHSA's GAINS Center. Screening and Assessment of Co-occurring Disorders in the Justice System.
- STEADMAN, H.J., SCOTT, J.E., OSHER, F., AGNESE, T.K., AND ROBBINS, P.C. (2005). Validation of the Brief Jail Mental Health Screen. PSYCHIATRIC SERVICES, 56, 816-822.
- The Stepping Up Initiative. (2017). Reducing the Number of People with Mental Illnesses in Jail: Six Questions County Leaders Need to Ask.

Sequential Intercept Model

- Munetz, M.R., and Griffin, P.A. (2006). Use of the Sequential Intercept Model as an Approach to Decriminalization of People with Serious Mental Illness. *Psychiatric Services, 57*, 544-549.
- Griffin, P.A., Heilbrun, K., Mulvey, E.P., DeMatteo, D., and Schubert, C.A. (2015). *The Sequential Intercept Model and Criminal Justice*. New York: Oxford University Press.
- SAMHSA's GAINS Center. *Developing a Comprehensive Plan for Behavioral Health and Criminal Justice Collaboration: The Sequential Intercept Model*.

SSI/SSDI Outreach, Access, and Recovery (SOAR)

Increasing efforts to enroll justice-involved persons with behavioral disorders in the Supplement Security Income and the Social Security Disability Insurance programs can be accomplished through utilization of SSI/SSDI Outreach, Access, and Recovery (SOAR) trained staff. Enrollment in SSI/SSDI not only provides automatic Medicaid or Medicare in many states, but also provides monthly income sufficient to access housing programs.

- Information regarding SOAR for justice-involved persons.
- The online SOAR training portal.

Transition-Aged Youth

- National Institute of Justice. Environmental Scan of Developmentally Appropriate Criminal Justice Responses to Justice-Involved Young Adults.
- Harvard Kennedy School Malcolm Weiner Center for Social Policy. Public Safety and Emerging Adults in Connecticut: Providing Effective and Developmentally Appropriate Responses for Youth Under Age 21 Executive Summary and Recommendations.
- Roca, Inc. Intervention Program for Young Adults.
- University of Massachusetts Medical School. Transitions RTC for Youth and Young Adults.

Trauma-Informed Care

- SAMHSA, SAMHSA's National Center on Trauma-Informed Care, and SAMHSA's GAINS Center. *Essential Components of Trauma Informed Judicial Practice*.
- SAMHSA's GAINS Center. *Trauma Specific Interventions for Justice-Involved Individuals*.

- SAMHSA. *SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach*.
- National Resource Center on Justice-Involved Women. *Jail Tip Sheets on Justice-Involved Women*.

Veterans

- SAMHSA's GAINS Center. *Responding to the Needs of Justice-Involved Combat Veterans with Service-Related Trauma and Mental Health Conditions*.
- Justice for Vets. *Ten Key Components of Veterans Treatment Courts*.

APPENDICES

Appendix 1	Sequential Intercept Mapping Workshop Participant List
Appendix 2	Texas Department of State Health Services. *Mental Health Substance Abuse Crisis Services Redesign Brief.*
Appendix 3	Corporation for Supportive Housing. *Jail Data Link Frequent Users: A Data Matching Initiative in Illinois.*
Appendix 4	Dennis, D., Ware, D., and Steadman, H.J. (2014). Best Practices for Increasing Access to SSI and SSDI on Exit from Criminal Justice Settings. *Psychiatric Services, 65,* 1081-1083.
Appendix 5	100,000 Homes/Center for Urban Community Services. *Housing First Self-Assessment: Assess and Align Your Program and Community with a Housing First Approach.*
Appendix 6	Remington, A.A. (2016). *Skyping During a Crisis? Telehealth is a 24/7 Crisis Connection.*
Appendix 7	SAMHSA. *Reentry Resources for Individuals, Providers, Communities, and States.*

Appendix 1

Sequential Intercept Mapping Workshop Participant List

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Sequential Intercept Mapping Workshop Participant List

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Appendix 2

TEXAS
Department of State Health Services

Crisis Services

The Department of State Health Services (DSHS) funds 37 LMHAs and NorthSTAR to provide an array of ongoing and crisis services to individuals with mental illness. Laws and rules governing DSHS and the delivery of mental health services require LMHAs and NorthSTAR to provide crisis screening and assessment. Newly appropriated funds enhanced the response to individuals in crisis.

The 80th Legislature

$82 million was appropriated for the FY 08-09 biennium for improving the response to mental health and substance abuse crises. A majority of the funds were divided among the state's Local Mental Health Authorities (LMHAs) and added to existing contracts. The first priority for this portion of the funds was to support a rapid community response to offset utilization of emergency rooms or more restrictive settings.

Crisis Funds

- **Crisis Hotline Services**
  - Continuously available 24 hours per day, seven days per week
  - All 37 LMHAs and NorthSTAR have or contract with crisis hotlines that are accredited by the American Association of Suicidology (AAS)
- **Mobile Crisis Outreach Teams (MCOT)**
  - Operate in conjunction with crisis hotlines
  - Respond at the crisis site or a safe location in the community
  - All 37 LMHAs and NorthSTAR have MCOT teams
  - More limited coverage in some rural communities

$17.6 million dollars of the initial appropriation was designated as community investment funds. The funds allowed communities to develop or expand local alternatives to incarceration or State hospitalization. Funds were awarded on a competitive basis to communities able to contribute at least 25% in matching resources. Sufficient funds were not available to provide expansion in all communities served by the LMHAs and NorthSTAR.

Competitive Funds Projects

- **Crisis Stabilization Units (CSU)**
  - Provide immediate access to emergency psychiatric care and short-term residential treatment for acute symptoms
  - Two CSUs were funded
- **Extended Observation Units**
  - Provide 23-48 hours of observation and treatment for psychiatric stabilization
  - Three extended observation units were funded
- **Crisis Residential Services**
  - Provide from 1-14 days crisis services in a clinically staffed, safe residential setting for individuals with some risk of harm to self or others
  - Four crisis residential units were funded
- **Crisis Respite Services**

- Provide from 8 hours up to 30 days of short-term, crisis care for individuals with low risk of harm to self or others
- Seven crisis respite units were funded

- **Crisis Step-Down Stabilization in Hospital Setting**
  - Provides from 3-10 days of psychiatric stabilization in a psychiatrically staffed local hospital setting
  - Six local step-down stabilization beds were funded
- **Outpatient Competency Restoration Services**
  - Provide community treatment to individuals with mental illness involved in the legal system
  - Reduces unnecessary burdens on jails and state psychiatric hospitals
  - Provides psychiatric stabilization and participant training in courtroom skills and behavior
  - Four Outpatient Competency Restoration projects were funded

The 81st Legislature

$53 million was appropriated for the FY 2010-2011 biennium for transitional and intensive ongoing services.

- **Transitional Services**
  - Provides linkage between existing services and individuals with serious mental illness not linked with ongoing care
  - Provides temporary assistance and stability for up to 90 days
  - Adults may be homeless, in need of substance abuse treatment and primary health care, involved in the criminal justice system, or experiencing multiple psychiatric hospitalizations
- **Intensive Ongoing Services for Children and Adults**
  - Provides team-based Psychosocial Rehabilitation services and Assertive Community Treatment (ACT) services (Service Package 3 and Service Package 4) to engage high need adults in recovery-oriented services
  - Provides intensive, wraparound services that are recovery-oriented to address the child's mental health needs
  - Expands availability of ongoing services for persons entering mental health services as a result of a crisis encounter, hospitalization, or incarceration

Appendix 3

Jail Data Link Frequent Users
A Data Matching Initiative in Illinois

Overview of the Initiative

The Corporation for Supportive Housing (CSH) has funded the expansion of a data matching initiative at Cook County Jail designed to identify users of both Cook County Jail and the State of Illinois Division of Mental Health (DMH).

This is a secure internet based database that assists communities in identifying frequent users of multiple systems to assist them in coordinating and leveraging scarce resources more effectively. Jail Data Link helps staff at a county jail to identify jail detainees who have had past contact with the state mental health system for purposes of discharge planning. This system allows both the jail staff and partnering case managers at community agencies to know when their current clients are in the jail. Jail Data Link, which began in Cook County in 1999, has expanded to four other counties as a result of funding provided by the Illinois Criminal Justice Information Authority and will expand to three additional counties in 2009. In 2008 the Proviso Mental Health Commission funded a dedicated case manager to work exclusively with the project and serve the residents of Proviso Township.

Target Population for Data Link Initiatives

This project targets people currently in a county jail who have had contact with the Illinois Division of Mental Heath.

- **Jail Data Link – Cook County:** Identifies on a daily basis detainees who have had documented inpatient/outpatient services with the Illinois Division of Mental Health. Participating agencies sign a data sharing agreement for this project.
- **Jail Data Link – Cook County Frequent Users:** Identifies those current detainees from the Cook County Jail census who have at least two previous State of Illinois psychiatric inpatient hospitalizations and at least two jail stays. This will assist the jail staff in targeting new housing resources as a part of a federally funded research project beginning in 2008.
- **Jail Data Link – Expansion:** The Illinois Criminal Justice Information Authority provided funding to expand the project to Will, Peoria, Jefferson and Marion Counties, and the Proviso Mental Health Commission for Proviso Township residents.

Legal Basis for the Data Matching Initiative

Effective January 1, 2000, the Illinois General Assembly adopted **Public Act 91-0536** which modified the Mental Health and Developmental Disabilities Administrative Act. This act allows the Division of Mental Health, community agencies funded by DMH, and any Illinois county jail to disclose a recipient's record or communications, without consent, to each other, for the purpose of admission, treatment, planning, or discharge. No records may be disclosed to a county jail unless the Department has entered into a written agreement with the specific county jail. Effective July 12, 2005, the Illinois General Assembly also adopted **Public Act 094-0182,** which further modifies the Mental Health and Developmental Disabilities Administrative Act to allow sharing between the Illinois Department of Corrections and DMH.

Using this exception, individual prisons or jails are able to send their entire roster electronically to DMH. Prison and jail information is publically available. DMH matches this information against their own roster and notifies the Department of Corrections Discharge Planning Unit of matches between the two systems along with information about past history and/or involvement with community agencies for purposes of locating appropriate aftercare services.

Sample Data at a Demo Web Site

DMH has designed a password protected web site to post the results of the match and make those results accessible to the Illinois Department of Corrections facility. Community agencies are also able to view the names of their own clients if they have entered into a departmental agreement to use the site.

In addition, DMH set up a demo web site using encrypted data to show how the data match web site works. Use the web site link below and enter the User ID, Password, and PIN number to see sample data for the Returning Home Initiative.

- https://sisonline.dhs.state.il.us/JailLink/demo.html
  - UserID: cshdemo
  - Password: cshdemo
  - PIN: 1234

Program Partners and Funding Sources

- **CSH's Returning Home Initiative:** Utilizing funding from the Robert Wood Johnson Foundation, provided $25,000 towards programming and support for the creation of the Jail Data Link Frequent Users application.
- **Illinois Department of Mental Health:** Administering and financing on-going mental health services and providing secure internet database resource and maintenance.
- **Cermak Health Services:** Providing mental health services and supervision inside the jail facility.
- **Cook County Sheriff's Office:** Assisting with data integration and coordination.
- **Community Mental Health Agencies:** Fourteen (14) agencies statewide are entering and receiving data.
- **Illinois Criminal Justice Authority:** Provided funding for the Jail Data Link Expansion of data technology to three additional counties, as well as initial funding for three additional case managers and the project's evaluation and research through the University of Illinois.
- **Proviso Township Mental Health Commission (708 Board):** Supported Cook County Jail Data Link Expansion into Proviso Township by funding a full-time case manager.
- **University of Illinois:** Performing ongoing evaluation and research

Partnership Between Criminal Justice and Other Public Systems

Cook County Jail and Cermak Health Service have a long history of partnerships with the Illinois Department of Mental Health Services. Pilot projects, including the Thresholds Justice Project and the Felony Mental Health Court of Cook County, have received recognition for developing alternatives to the criminal justice system. Examining the systematic and targeted use of housing as an intervention is a logical extension of this previous work.

Managing the Partnership

CSH is the primary coordinator of a large federal research project studying the effects of permanent supportive housing on reducing recidivism and emergency costs of frequent users of Cook County Jail and the Illinois Department of Mental Health System. In order to facilitate this project, CSH funded the development of a new version of Jail Data Link to find the most frequent users of the jail and mental health inpatient system to augment an earlier version of Data Link in targeting subsidized housing and supportive mental health services.

About CSH and the Returning Home Initiative

The Corporation for Supportive Housing (CSH) is a national non-profit organization and Community Development Financial Institution that helps communities create permanent housing with services to prevent and end homelessness. Founded in 1991, CSH advances its mission by providing advocacy, expertise, leadership, and financial resources to make it easier to create and operate supportive housing. CSH seeks to help create an expanded supply of supportive housing for people, including single adults, families with children, and young adults, who have extremely low-incomes, who have disabling conditions, and/or face other significant challenges that place them at on-going risk of homelessness. For information regarding CSH's current office locations, please see www.csh.org/contactus.

CSH's national *Returning Home Initiative* aims to end the cycle of incarceration and homelessness that thousands of people face by engaging the criminal justice systems and integrating the efforts of housing, human service, corrections, and other agencies. *Returning Home* focuses on better serving people with histories of homelessness and incarceration by placing them to supportive housing.

Corporation for Supportive Housing
Illinois Program
205 W. Randolph, 23rd Fl
Chicago, IL 60606
T: 312.332.6690
F: 312.332.7040
E: il@csh.org
www.csh.org

Appendix 4

Substance Abuse and Mental Health Services Administration
SAMHSA
www.samhsa.gov • 1-877-SAMHSA-7 (1-877-726-4727)

SOAR

SSI/SSDI Outreach, Access and Recovery
for people who are homeless

January 2013

Best Practices for Increasing Access to SSI/SSDI upon Exiting Criminal Justice Settings

Dazara Ware, M.P.C. and Deborah Dennis, M.A.

Introduction

Seventeen percent of people currently incarcerated in local jails and in state and federal prisons are estimated to have a serious mental illness.[1] The twin stigmas of justice involvement and mental illness present significant challenges for social service staff charged with helping people who are incarcerated plan for reentry to community life. Upon release, the lack of treatment and resources, inability to work, and few options for housing mean that many quickly become homeless and recidivism is likely.

The Social Security Administration (SSA), through its Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) programs, can provide income and other benefits to persons with mental illness who are reentering the community from jails and prisons. The SSI/SSDI Outreach, Access and Recovery program (SOAR), a project funded by the Substance Abuse and Mental Health Services Administration, is a national technical assistance program that helps people who are homeless or at risk for homelessness to access SSA disability benefits.[2]

SOAR training can help local corrections and community transition staff negotiate and integrate benefit options with community reentry strategies for people with mental illness and co-occurring disorders to assure successful outcomes. This best practices summary describes:

- The connections between mental illness, homelessness, and incarceration;
- The ramifications of incarceration on receipt of SSI and SSDI benefits
- The role of SOAR in transition planning
- Examples of jail or prison SOAR initiatives to increase access to SSI/SSDI
- Best practices for increasing access to SSI/SSDI benefits for people with mental illness who are reentering the community from jails and prisons.

Mental Illness, Homelessness, and Incarceration

In 2010, there were more than 7 million persons under correctional supervision in the United States at any given time.[3] Each year an estimated 725,000 persons are released from federal and state prisons, 125,000 with serious mental illness.[4] More than 20 percent of people with mental illness were homeless in the months before their incarceration compared

[1] Bureau of Justice Statistics. (2006). *Mental health problems of prison and jail inmates.* Washington, DC: U.S. Department of Justice, Office of Justice Programs

[2] Dennis, D., Lassiter, M., Connelly, W., & Lupfer, K. (2011) Helping adults who are homeless gain disability benefits: The SSI/SSDI Outreach, Access and Recovery (SOAR) program. *Psychiatric Services,* 62(11)1373-1376

[3] Guerino, P.M. Harrison & W. Sabel. *Prisoners in 2010.* NCJ 236096. Washington DC: U.S. Department of Justice, Bureau of Justice Statistics, 2011.

[4] Glaze, L. *Correctional populations in the U.S. 2010,* NCJ 236319. Washington D.C.: U.S. Department of Justice, Bureau of Justice Statistics 2011

with 10 percent of the general prison population.[5] For those exiting the criminal justice system, homelessness may be even more prevalent. A California study, for example, found that 30 to 50 percent of people on parole in San Francisco and Los Angeles were homeless.[6]

Mental Health America reports that half of people with mental illness are incarcerated for committing nonviolent crimes, such as trespassing, disorderly conduct, and other minor offences resulting from symptoms of untreated mental illness. In general, people with mental illnesses remain in jail eight times longer than other offenders at a cost that is seven times higher.[7] At least three-quarters of incarcerated individuals with mental illness have a co-occurring substance use disorder.[8]

Homelessness, mental illness, and criminal justice involvement create a perfect storm, requiring concerted effort across multiple systems to prevent people with mental illness from cycling between homelessness and incarceration by providing them the opportunity to reintegrate successfully into their communities and pursue recovery.

To understand the interplay among mental illness, homelessness, and incarceration, consider these examples:

- In 2011 Sandra received SSI based on her mental illness. She was on probation, with three years remaining, when she violated the terms of probation by failing to report to her probation officer. As a result, Sandra was incarcerated in a state prison. Because she was incarcerated for more than 12 months, her benefits were terminated. Sandra received a tentative parole month of September 2012 contingent on her ability to establish a verifiable residential address. The parole board did not approve the family address she submitted because the location is considered a high crime area. Unfortunately, Sandra was unable to establish residency on her own as she had no income. Thus, she missed her opportunity for parole and must complete her maximum sentence. Sandra is scheduled for release in 2013.
- Sam was released from prison after serving four years. While incarcerated, he was diagnosed with a traumatic brain injury and depression. Sam had served his full sentence and was not required to report to probation or parole upon release. He was released with $25 and the phone number for a community mental health provider. Sam is 27 years old with a ninth grade education and no prior work history. He has no family support. Within two weeks of release, Sam was arrested for sleeping in an abandoned building. He was intoxicated and told the arresting officer that drinking helped the headaches he has suffered from since he was 14 years old. Sam was sent to jail.
- Manuel was arrested for stealing from a local grocery store. He was homeless at the time of arrest and had a diagnosis of schizophrenia. He was not receiving any community mental health services at the time. Manuel has no family. He was sent to a large county jail where he spent two years before being arraigned before a judge. His periodic acute symptoms resulted in his being taken to the state hospital until he was deemed stable enough to stand trial. However, the medications that helped Manuel's symptoms in the hospital weren't approved for use in the jail, and more acute episodes followed. Manuel cycled between the county jail and the state hospital four times over a two-year period before being able to stand before a judge.

Based on real life situations, these examples illustrate the complex needs of people with serious mental illnesses who become involved with the justice system. In Sandra's and Sam's cases, the opportunity to apply for SSI/SSDI benefits on a pre-release basis would have substantially reduced the period of incarceration, and in Manuel's case, access to SSI immediately upon release would have decreased the likelihood he would return to jail. But how do we ensure that this happens?

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[5] *Reentry Facts.* The National Reentry Resource Center. Council of State Governments Justice Center. Retrieved December 6, 2012, from http://www.nationalreentryresourcecenter.org/facts

[6] California Department of Corrections. (1997). *Preventing Parolee Failure Program: An evaluation.* Sacramento: Author.

[7] Mental Health America. (2008). *Position Statement 52: In support of maximum diversion of persons with serious mental illness from the criminal justice system.* Retrieved from http://www.mentalhealthamerica.net.

[8] Council of State Governments. (2002). *Criminal Justice/Mental Health Consensus Project.* Lexington, Kentucky: author.

Incarceration and SSA Disability Benefits

Correctional facilities, whether jails or prisons, are required to report to SSA newly incarcerated people who prior to incarceration received benefits. For each person reported, SSA sends a letter to the facility verifying the person's benefits have been suspended and specifying the payment to which the facility is entitled for providing this information. SSA pays $400 for each person reported by the correctional facility within 60 days. If a report is made between 60 and 90 days of incarceration, SSA pays $200. After 90 days, no payment is made.

The rules for SSI and SSDI beneficiaries who are incarcerated differ. Benefits for SSI recipients incarcerated for a full calendar month are suspended, but if the person is released within 12 months, SSI is reinstated upon release if proof of incarceration and a release are submitted to the local SSA office. SSA reviews the individual's new living arrangements, and if deemed appropriate, SSI is reinstated. However, if an SSI recipient is incarcerated for 12 or more months, SSI benefits are terminated and the individual must reapply. Reapplication can be made 30 days prior to the expected release date, but benefits cannot begin until release.

Unfortunately, people who are newly released often wait months before their benefits are reinstituted or initiated. Few states or communities have developed legislation or policy to insure prompt availability of benefits upon release. Consequently, the approximately 125,000 people with mental illness who are released each year are at increased risk for experiencing symptoms of mental illness, substance abuse, homelessness, and recidivism.

SSDI recipients are eligible to continue receiving benefits until convicted of a criminal offense and confined to a penal institution for more than 30 continuous days. At that time, SSDI benefits are suspended but will be reinstated the month following release.

Role of Transition Services in Reentry for People with Mental Illness

Since the 1990s, the courts have increasingly acknowledged that helping people improve their mental health and their ability to demonstrate safe and orderly behaviors while they are incarcerated enhances their reintegration and the well-being of the communities that receive them. Courts specializing in the needs of people with mental illness and or substance use disorders, people experiencing homelessness, and veterans are designed to target the most appropriate procedures and service referrals to these individuals, who may belong to more than one subgroup. The specialized courts and other jail diversion programs prompt staff of various systems to consider reintegration strategies for people with mental illness from the outset of their criminal justice system involvement. Transition and reintegration services for people with mental illness reflect the shared responsibilities of multiple systems to insure continuity of care.

Providing transition services to people with mental illness within a jail or prison setting is difficult for several reasons: the quick population turnover in jails, the distance between facilities and home communities for people in prisons, the comprehensive array of services needed to address multiple needs, and the perception that people with mental illness are not responsive to services. Nevertheless, without seriously addressing transition and reintegration issues while offenders remain incarcerated, positive outcomes are far less likely upon release and recidivism is more likely.

Access to Benefits as an Essential Strategy for Reentry

The criminal justice and behavioral health communities consistently identify lack of timely access to income and other benefits, including health insurance, as among the most significant and persistent barriers to successful community reintegration and recovery for people with serious mental illnesses and co-occurring substance use disorders.

Many states and communities that have worked to ensure immediate access to benefits upon release have focused almost exclusively on Medicaid. Although access to Medicaid is critically important, focusing on this alone often means that needs for basic sustenance and housing are ignored. Only a few states (Oregon, Illinois, New York, Florida) provide for Medicaid to be suspended upon incarceration rather than terminated, and few states or communities have developed procedures to process new Medicaid applications prior to release.

The SOAR approach to improving access to SSI/SSDI. The SSI/SSDI application process is complicated and difficult to navigate, sometimes even for professional social service staff. The SOAR approach in correctional settings is a collaborative effort by corrections, behavioral health, and SSA to address the need for assistance to apply for these benefits. On average, providers who receive SOAR training achieve a first-time approval rate of 71 percent, while providers who are not SOAR trained or individuals who apply unassisted achieve a rate of 10 to 15 percent.[9] SOAR-trained staff learn how to prepare comprehensive, accurate SSI/SSDI applications that are more likely to be approved, and approved quickly.

SOAR training is available in every state. The SOAR Technical Assistance Center, funded by SAMHSA, facilitates partnerships with community service providers to share information, acquire pre-incarceration medical records, and translate prison functioning into post-release work potential. With SOAR training, social service staff learn new observation techniques to uncover information critical to developing appropriate reentry strategies. The more accurate the assessment of factors indicating an individual's ability to function upon release, the easier it is to help that person transition successfully from incarceration to community living.

The positive outcomes produced by SOAR pilot projects within jail and prison settings around the country that link people with mental illness to benefits upon their release should provide impetus for more correctional facilities to consider using this approach as a foundation for building successful transition or reentry programs.[10] Below are examples of SOAR collaborations in jails (Florida, Georgia, and New Jersey) and prison systems (New York, Oklahoma, and Michigan). In addition to those described below, new SOAR initiatives are underway in the jail system of Reno, Nevada and in the prison systems of Tennessee, Colorado, Connecticut, and the Federal Bureau of Prisons.

SOAR Collaborations with Jails

Eleventh Judicial Circuit Criminal Mental Health Project (CMHP). Miami-Dade County, Florida, is home to the highest percentage of people with serious mental illnesses of any urban area in the United States – approximately nine percent of the population, or 210,000 people. CMHP was established in 2000 to divert individuals with serious mental illnesses or co-occurring substance use disorders from the criminal justice system into comprehensive community-based treatment and support services. CMHP staff, trained in the SOAR approach to assist with SSI/SSDI applications, developed a strong collaborative relationship with SSA to expedite and ensure approvals for entitlement benefits in the shortest time possible. All CMHP participants are screened for eligibility for SSI/SSDI.

From July 2008 through November 2012, 91 percent of 181 individuals were approved for SSI/SSDI benefits on initial application in an average of 45 days. All participants of CMHP are linked to psychiatric treatment and medication with community providers upon release from jail. Community providers are made aware that participants who are approved for SSI benefits will have access to Medicaid and retroactive reimbursement for expenses incurred for up to 90 days prior to approval. This serves to reduce the stigma of mental illness and involvement with the criminal justice system, making participants more attractive "paying customers."

In addition, based on an agreement established between Miami-Dade County and SSA, interim housing assistance is provided for individuals applying for SSI/SSDI during the period between application and

[9] Dennis et al., (2011). *op cit.*

[10] Dennis, D. & Abreu, D. (2010) SOAR: Access to benefits enables successful reentry, *Corrections Today, 72*(2), 82–85.

approval. This assistance is reimbursed to the County once participants are approved for Social Security benefits and receive retroactive payment. The number of arrests two years after receipt of benefits and housing compared to two years earlier was reduced by 70 percent (57 versus 17 arrests).

Mercer and Bergen County Correctional Centers, New Jersey. In 2011, with SOAR training and technical assistance funded by The Nicholson Foundation, two counties in New Jersey piloted the use of SOAR to increase access to SSI/SSDI for persons with disabilities soon to be released from jail. In each county, a collaborative working group comprising representatives from the correctional center, community behavioral health, SSA, the state Disability Determination Service (DDS), and (in Mercer County only) the United Way met monthly to develop, implement, and monitor a process for screening individuals in jail or recently released and assisting those found potentially eligible in applying for SSI/SSDI. The community behavioral health agency staff, who were provided access to inmates while incarcerated and to jail medical records, assisted with applications.

During the one year evaluation period for Mercer County, 89 individuals from Mercer County Correction Center were screened and 35 (39 percent) of these were deemed potentially eligible for SSI/SSDI. For Bergen County, 69 individuals were screened, and 39 (57 percent) were deemed potentially eligible. The reasons given for not helping some potentially eligible individuals file applications included not enough staff available to assist with application, potential applicant discharged from jail and disappeared/couldn't locate, potential applicant returned to prison/jail, and potential applicant moved out of the county or state. In Mercer County, 12 out of 16 (75 percent) SSI/SSDI applications were approved on initial application; two of those initially denied were reversed at the reconsideration level without appeal before a judge. In Bergen County which had a late start, two out of three former inmates assisted were approved for SSI/SSDI.

Prior to this pilot project, neither behavioral health care provider involved had assisted with SSI/SSDI applications for persons re-entering the community from the county jail. After participating in the pilot project, both agencies remain committed to continuing such assistance despite the difficulty of budgeting staff time for these activities.

Fulton County Jail, Georgia. In June 2009, the Georgia Department of Behavioral Health and Developmental Disabilities initiated a SOAR pilot project at the Fulton County Jail. With the support of the facility's chief jailer, SOAR staff were issued official jail identification cards that allowed full and unaccompanied access to potential applicants. SOAR staff worked with the Office of the Public Defender and received referrals from social workers in this office. They interviewed eligible applicants at the jail, completed SSI/SSDI applications, and hand-delivered them to the local SSA field office. Of 23 applications submitted, 16 (70 percent) were approved within an average of 114 days.

SOAR benefits specialists approached the Georgia Department of Corrections with outcome data produced in the Fulton County Jail pilot project to encourage them to use SOAR in the state prison system for persons with mental illness who were coming up for release. Thirty-three correctional officers around the state received SOAR training and were subsequently assigned by the Department to work on SSI/SSDI applications.

SOAR Collaborations with State and Federal Prisons

New York's Sing Sing Correctional Facility. The Center for Urban and Community Services was funded by the New York State Office of Mental Health, using a Projects for Assistance in Transition from Homelessness (PATH) grant, to assist with applications for SSI/SSDI and other benefits for participants in a 90-day reentry program for persons with mental illness released from New York State prisons. After receiving SOAR training and within five years of operation, the Center's Community Orientation and Reentry Program at the state's Sing Sing Correctional Facility achieved an approval rate of 87 percent on 183 initial applications, two thirds of which were approved prior to or within one month of release.

Oklahoma Department of Corrections. The Oklahoma Department of Corrections and the Oklahoma Department of Mental Health collaborated

to initiate submission of SSI/SSDI applications using SOAR-trained staff. Approval rates for initial submission applications are about 90 percent. The Oklahoma SOAR program also uses peer specialists to assist with SSI/SSDI applications for persons exiting the prison system. Returns to prison within 3 years were 41 percent lower for those approved for SSI/SSDI than a comparison group.

Michigan Department of Corrections. In 2007 the Michigan Department of Corrections (DOC) began to discuss implementing SOAR as a pilot in a region where the majority of prisoners with mental illnesses are housed. A subcommittee of the SOAR State Planning Group was formed and continues to meet monthly to address challenges specific to this population. In January 2009, 25 DOC staff from eight facilities, facility administration, and prisoner reentry staff attended a two-day SOAR training. The subcommittee has worked diligently to develop a process to address issues such as release into the community before a decision is made by SSA, the optimal time to initiate the application process, and collaboration with local SSA and DDS offices.

Since 2007, DOC has received 72 decisions on SSI/SSDI applications with a 60 percent approval rate in an average of 105 days. Thirty-nine percent of applications were submitted after the prisoner was released, and 76 percent of the decisions were received after the applicant's release. Seventeen percent of those who were denied were re-incarcerated within the year following release while only two percent of those who were approved were re-incarcerated.

Park Center's Facility In-Reach Program. Park Center is a community mental health center in Nashville, Tennessee. In July 2010, staff began assisting with SSI/SSDI applications for people with mental illness in the Jefferson County Jail and several facilities administered by the Tennessee Department of Corrections, including the Lois M. DeBerry Special Needs Prison and the Tennessee Prison for Woman. From July 2010 through November 2012, 100 percent of 44 applications have been were approved in a average of 41 days. In most cases, Park Center's staff assisted with SSI/SSDI applications on location in these facilities prior to release. Upon release, the individual is accompanied by Park Center staff to the local SSA office where their release status is verified and their SSI/SSDI benefits are initiated.

Best Practices for Accessing SSI/SSDI as an Essential Reentry Strategy

The terms jail and prison are sometimes used interchangeably, but it is important to understand the distinctions between the two. Generally, a jail is a local facility in a county or city that confines adults for a year or less. Prisons are administered by the state or federal government and house persons convicted and sentenced to serve time for a year or longer.

Discharge from both jails and prisons can be unpredictable, depending on a myriad of factors that may be difficult to know in advance. Working with jails is further complicated by that fact that they generally house four populations: (1) people on a 24-48 hour hold, (2) those awaiting trial, (3) those sentenced and serving time in jail, and (4) those sentenced and awaiting transfer to another facility, such as a state prison.

Over the past several years, the following best practices have emerged with respect to implementing SOAR in correctional settings. These best practices are in addition to the critical components required by the SOAR model for assisting with SSI/SSDI applications.[11] These best practices fall under five general themes:

- Collaboration
- Leadership
- Resources
- Commitment
- Training

Collaboration. The SOAR approach emphasizes collaborative efforts to help staff and their clients navigate SSA and other supports available to people with mental illness upon their release. Multiple collaborations are necessary to make the SSI/SSDI application process work. Fortunately, these are the same collaborations necessary to make the overall transition work. Thus, access to SSI/SSDI can become

[11] See http://www.prainc.com/soar/criticalcomponents.

a concrete foundation upon which to build the facility's overall discharge planning or reentry process.

- **Identify stakeholders.** Potential stakeholders associated with jail/prisons include
  - ✓ Judges assigned to specialized courts and diversion programs
  - ✓ Social workers assigned to the public defenders' office
  - ✓ Chief jailers or chiefs of security
  - ✓ Jail mental health officer, psychologist, or psychiatrist
  - ✓ County or city commissioners
  - ✓ Local reentry advocacy project leaders
  - ✓ Commissioner of state department of corrections
  - ✓ State director of reintegration/reentry services
  - ✓ Director of medical or mental health services for state department of corrections
  - ✓ State mental health agency administrator
  - ✓ Community reentry project directors
  - ✓ Parole/probation managers

- **Collaborate with SSA to establish prerelease agreements.** SSA can establish prerelease agreements with correctional facilities to permit special procedures when people apply for benefits prior to their release and will often assign a contact person. For example, prerelease agreements can be negotiated to allow for applications to be submitted from 60 to 120 days before the applicant's expected release date. In addition, SSA can make arrangements to accept paper applications and schedule phone interviews when necessary.

- **Collaborate with local SOAR providers to establish continuity of care.** Given the unpredictability of release dates from jails and prisons, it is important to engage a community-based behavioral health provider to either begin the SSI/SSDI application process while the person is incarcerated or to assist with the individual's reentry and assume responsibility for completing his or her SSI/SSDI application following release. SOAR training can help local corrections and community transition staff assure continuity of care by determining and coordinating benefit options and reintegration strategies for people with mental illness. Collaboration among service providers, including supported housing programs that offer a variety of services, is key to assuring both continuity of care and best overall outcomes post-release.

- **Collaborate with jail or prison system for referrals, access to inmates, and medical records.** Referrals for a jail or prison SOAR project can issue from many sources – intake staff, discharge planners, medical or psychiatric unit staff, judges, public defenders, parole or probation, and community providers. Identifying persons within the jail or prison who may be eligible for SSI/SSDI requires time, effort, and collaboration on the part of the jail or prison corrections and medical staff.

Once individuals are identified as needing assistance with an SSI/SSDI application, they can be assisted by staff in the jail or prison, with a handoff occurring upon release, or they can be assisted by community providers who come into the facility for this purpose. Often, correctional staff, medical or psychiatric staff, and medical records are administered separately and collaborations must be established within the facility as well as with systems outside it.

Leadership. Starting an SSI/SSDI initiative as part of transition planning requires leadership in the form of a steering committee, with a strong and effective coordinator, that meets regularly. The Mercer County, New Jersey SOAR Coordinator, for example, resolves issues around SSI/SSDI applications that are brought up at case manager meetings, oversees the quality of applications submitted, organizes trainings, and responds to concerns raised by SSA and DDS.

The case manager meetings are attended by the steering committee coordinator who serves as a liaison between the case managers and steering committee. Issues identified by case managers typically require additional collaborations that must be approved at the steering committee level. Leadership involves frequent, regular, and ad hoc communication among all parties to identify and resolve challenges that arise.

It is essential that the steering committee include someone who has authority within the jail or prison system as well as someone with a clinical background who can assure that the clinical aspects of implementation are accomplished (e.g., mental status

exams with 90 days of application, access to records, physician or psychologist sign off on medical summary reports).

Resources. Successful initiatives have committed resources for staffing at two levels. First, staff time is needed to coordinate the overall effort. In the Mercer County example above, the steering committee coordinator is a paid, part-time position. If there is someone charged with overall transition planning for the facility, the activities associated with implementing assistance with SSI/SSDI may be assumed by this individual.

Second, the staff who are assisting with SSI/SSDI applications need to be trained (typically 1-2 days) and have time to interview and assess the applicant, gather and organize the applicant's medical records, complete the SSA forms, and write a supporting letter that documents how the individual's disability or disabilities affect his or her ability to work. Full-time staff working only on SSI/SSDI applications can be expected to complete about 50-60 applications per year using the SOAR approach. Assisting with SSI/SSDI applications cannot be done efficiently without dedicated staffing.

Finally, our experience has shown that it is difficult for jail staff to assist with applications in the jail due to competing demands, staffing levels, skill levels of the staff involved, and staff turnover. Without community providers, there would be few or no applications completed for persons coming out of jails in the programs with which we have worked. Jail staff time may be best reserved for: (1) identifying and referring individuals who may need assistance to community providers; (2) facilitating community provider access to inmates prior to release from jail; and (3) assistance with access to jail medical records.

Commitment. Developing and implementing an initiative to access SSI/SSDI as part of transition planning requires a commitment by the jail or prison's administration for a period of at least a year to see results and at least two years to see a fully functioning program. During the start up and early implementation period, competing priorities can often derail the best intentions. We have seen commitment wane as new administrations took office and the department of corrections commissioner changed. We have seen staff struggle without success to find time to assist with applications as part of the job they are already doing. We have seen many facilities, particularly state departments of corrections, willing to conduct training for staff, but unwilling or unable to follow through on the rest of what it takes to assist with SSI/SSDI applications.

Training. Training for staff in jails and prisons should include staff who identify and refer people for assistance with SSI/SSDI applications, staff who assist with completing the applications, medical records staff, and physicians/psychologists. The depth and length of training for each of these groups will vary. However, without the other elements discussed above in place, training is of very limited value.

Training in the SOAR approach for jail and prison staff has been modified to address the assessment and documentation of functioning in correctional settings. Training must cover the specific referral and application submission process established by the steering group in collaboration with SSA and DDS to ensure that applications submitted are consistent with expectations, procedures are subject to quality review, and outcomes of applications are tracked and reported. It is important that training take place after plans to incorporate each of these elements have been determined by the steering committee.

Conclusion

People with mental illness face extraordinary barriers to successful reentry. Without access to benefits, they lack the funds to pay for essential mental health and related services as well as housing. The SOAR approach has been implemented in 50 states, and programmatic evidence demonstrates the approach is transferable to correctional settings. Acquiring SSA disability benefits and the accompanying Medicaid/Medicare benefit provides the foundation for reentry plans to succeed.

For More Information

To find out more about SOAR in your state or to start SOAR in your community, contact the national SOAR technical assistance team at soar@prainc.com or check out the SOAR website at http://www.prainc.com/soar.

Appendix 5

Housing First Self-Assessment

Assess and Align Your Program and Community with a Housing First Approach

100,000 HOMES

CUCS center for urban community services

HIGH PERFORMANCE SERIES

The 100,000 Homes Campaign team identified a cohort of factors that are correlated with higher housing placement rates across campaign communities. The purpose of this High Performance Series of tools is to spotlight best practices and expand the movement's peer support network by sharing this knowledge with every community.

This tool addresses Factor #4: *Evidence that the community has embraced a Housing First/Rapid Rehousing approach system-wide.*

The full series is available at: http://100khomes.org/resources/high-performance-series

Housing First Self-Assessment

Assess and Align Your Program with a Housing First Approach

A community can only end homelessness by housing every person who is homeless, including those with substance use and mental health issues. Housing First is a proven approach for housing chronic and vulnerable homeless people. Is your program a Housing First program? Does your community embrace a Housing First model system-wide? To find out, use the Housing First self-assessments in this tool. We've included separate assessments for:

- Outreach programs
- Emergency shelter programs
- Permanent housing programs
- System and community level stakeholder groups

What is Housing First?

According to the National Alliance to End Homelessness, Housing First is an approach to ending homelessness that centers on providing homeless people with housing as quickly as possible – and then providing services as needed. Pioneered by **Pathways to Housing** (www.pathwaystohousing.org) and adopted by hundreds of programs throughout the U.S., Housing First practitioners have demonstrated that virtually all homeless people are "housing ready" and that they can be quickly moved into permanent housing before accessing other common services such as substance abuse and mental health counseling.

Why is this Toolkit Needed?

In spite of the fact that this approach is now almost universally touted as a solution to homelessness and Housing First programs exist in dozens of U.S. cities, few communities have adopted a Housing First approach on a systems-level. This toolkit serves as a starting point for communities who want to embrace a Housing First approach and allows individual programs and the community as a whole to identify where its practices are aligned with Housing First and what areas of its work to target for improvement to more fully embrace a Housing First approach. The toolkit consists of four self-assessments each of which can be completed in under 10 minutes:

- **Housing First in Outreach Programs Self-Assessment** (to be completed by outreach programs)
- **Housing First in Emergency Shelters Self-Assessment** (to be completed by emergency shelters)
- **Housing First in Permanent Supportive Housing Self-Assessment** (to be completed by supportive housing providers
- **Housing First System Self-Assessment** (to be completed by community-level stakeholders such as Continuums of Care and/or government agencies charged with ending homelessness)

How Should My Community Use This Tool?

- **Choose the appropriate Housing First assessment(s) –** Individual programs should choose the assessment that most closely matches their program type while community-level stakeholders should complete the systems assessment
- **Complete the assessment and score your results** – Each assessment includes a simple scoring guide that will tell you the extent to which your program or community is implementing Housing First
- **Share your results with others in your program or community** – To build the political will needed to embrace a Housing First approach, share with other stakeholders in your community
- **Build a workgroup charged with making your program or community more aligned with Housing First** - Put together a work plan with concrete tasks, person(s) responsible and due dates for the steps your program and/or community needs to take to align itself with Housing First and then get started!
- **Send your results and progress to the 100,000 Homes Campaign –** We'd love to hear how you score and the steps you are taking to adopt a Housing First approach!

Who Does This Well?

The following programs in 100,000 Campaign communities currently incorporate Housing First principles into their everyday work:

- **Pathways to Housing –** www.pathwaystohousing.org
- **DESC –** www.desc.org
- **Center for Urban Community Services –** www.cucs.org

Many other campaign communities have also begun to prioritize the transition to a Housing First philosophy system-wide. Campaign contact information for each community is available at http://100khomes.org/see-the-impact

Related Tools and Resources

This toolkit was inspired the work done by several colleagues, including the National Alliance to End Homelessness, Pathways to Housing and the Department of Veterans Affairs. For more information on the Housing First efforts of these groups, please visit the following websites:

- **National Alliance to End Homelessness –** www.endhomelessness.org/pages/housingfirst
- **Pathways to Housing –** www.pathwaystohousing.org
- **Veterans Affairs (HUD VASH and Housing First, pages 170-182)** - http://www.va.gov/HOMELESS/docs/Center/144_HUD-VASH_Book_WEB_High_Res_final.pdf

For more information and support, please contact Erin Healy, Improvement Advisor - 100,000 Homes Campaign, at ehealy@cmtysolutions.org

Housing First Self-Assessment for Outreach Programs

1. **Does your program receive real-time information about vacancies in Permanent Supportive Housing?**
   - **Yes** = 1 point
   - **No** = 0 points

Number of Points Scored:

2. **The entire process from street outreach (with an engaged client) to move-in to permanent housing typically takes:**
   - More than 180 days = 0 points
   - Between 91 and 179 days = 1 point
   - Between 61 and 90 days = 2 points
   - Between 31 and 60 days = 3 points
   - 30 days or less = 4 points
   - Unknown = 0 points

Number of Points Scored:

3. **Approximately what percentage of chronic and vulnerable homeless people served by your outreach program goes straight into permanent housing (without going through emergency shelter and transitional housing)?**
   - More than 75% = 5 points
   - Between 51% and 75% = 4 points
   - Between 26% and 50% = 3 points
   - Between 11% and 25% = 2 points
   - 10% or less = 1 point
   - Unknown = 0 points

Number of Points Scored:

4. **Indicate whether priority consideration for your program's services is given to potential program participants with following characteristics.** *Check all that apply*:

Participants who demonstrate a high level of housing instability/chronic homelessness

Participants who have criminal justice records, including currently on probation/parole/court mandate

Participants who are actively using substances, including alcohol and illicit drugs Participants who do not engage in any mental health or substance treatment services

Participants who demonstrate instability of mental health symptoms (NOT including those who present danger to self or others)

Checked Five = 5 points

Checked Four = 4 points

Checked Three = 3 points

Checked Two = 2 points

Checked One = 1 point

Checked Zero = 0 points

Total Points Scored:

To calculate your Housing First Score, add the total points scored for each question above, then refer to the key below:

Total Housing First Score:

If you scored: 13 points or more

- ✓ Housing First principles are likely being implemented ideally

If you scored between: 10 – 12 points

- ✓ Housing First principles are likely being well-implemented

If you scored between: 7 – 9 points

- ✓ Housing First principles are likely being fairly well-implemented

If you scored between: 4 - 6 points

- ✓ Housing First principles are likely being poorly implemented

If you scored between: 0 – 3 points

- ✓ Housing First principles are likely not being implemented

Housing First Self-Assessment
For Emergency Shelter Programs

1. **Does your program receive real-time information about vacancies in Permanent Supportive Housing?**
   - **Yes** = 1 point
   - **No** = 0 points

Number of Points Scored:

2. **Approximately what percentage of chronic and vulnerable homeless people staying in your emergency shelter go straight into permanent housing without first going through transitional housing?**
   - More than 75% = 5 points
   - Between 51% and 75% = 4 points
   - Between 26% and 50% = 3 points
   - Between 11% and 25% = 2 points
   - 10% or less = 1 point
   - Unknown = 0 points

Number of Points Scored:

3. **Indicate whether priority consideration for shelter at your program is given to potential program participants with following characteristics.** *Check all that apply*:

   Participants who demonstrate a high level of housing instability/chronic homelessness

   Participants who have criminal justice records, including currently on probation/parole/court mandate

   Participants who are actively using substances, including alcohol and illicit drugs Participants who do not engage in any mental health or substance treatment services

   Participants who demonstrate instability of mental health symptoms (NOT including those who present danger to self or others)

   Checked Five = 5 points

   Checked Four = 4 points

Checked Three = 3 points

Checked Two = 2 points

Checked One = 1 point

Checked Zero = 0 points

Total Points Scored:

To calculate your Housing First Score, add the total points scored for each question above, then refer to the key below:

Total Housing First Score:

If you scored: 10 points or more

- ✓ Housing First principles are likely being implemented ideally

If you scored between: 6 – 9 points

- ✓ Housing First principles are likely being fairly well-implemented

If you scored between: 3 - 5 points

- ✓ Housing First principles are likely being poorly implemented

If you scored between: 0 – 2 points

- ✓ Housing First principles are likely not being implemented

Housing First Self-Assessment for Permanent Housing Programs

1. **Does your program accept applicants with the following characteristics:**

a) Active Substance Use

- Yes = 1 point
- No = 0 points

b) Chronic Substance Use Issues

- Yes = 1 point
- No = 0 points

c) Untreated Mental Illness

- Yes = 1 point
- No = 0 points

d) Young Adults (18-24)

- Yes = 1 point
- No = 0 points

e) Criminal Background (any)

- Yes = 1 point
- No = 0 points

f) Felony Conviction

- Yes = 1 point
- No = 0 points

g) Sex Offender or Arson Conviction

- Yes = 1 point
- No = 0 points

h) Poor Credit

- Yes = 1 point
- No = 0 points

i) No Current Source of Income (pending SSI/DI)

- Yes = 1 point
- No = 0 points

Question Section	# Points Scored
Active Substance Use	
Chronic Substance Use Issues	
Untreated Mental Illness	
Young Adults (18-24)	
Criminal Background (any)	
Felony Conviction	
Sex Offender or Arson Conviction	
Poor Credit	
No Current Source of Income (pending SSI/DI)	
Total Points Scored in Question #1:	

2. **Program participants are required to demonstrate housing readiness to gain access to units?**
   - No – Program participants have access to housing with no requirements to demonstrate readiness (other than provisions in a standard lease) **= 3 points**
   - Minimal – Program participants have access to housing with minimal readiness requirements, such as engagement with case management **= 2 points**
   - Yes – Program participant access to housing is determined by successfully completing a period of time in a program (e.g. transitional housing) **= 1 point**
   - Yes – To qualify for housing, program participants must meet requirements such as sobriety, medication compliance, or willingness to comply with program rules **= 0 points**

Total Points Scored:

3. **Indicate whether priority consideration for housing access is given to potential program participants with following characteristics.** *Check all that apply*:

   Participants who demonstrate a high level of housing instability/chronic homelessness

   Participants who have criminal justice records, including currently on probation/parole/court mandate

   Participants who are actively using substances, including alcohol and illicit drugs (NOT including dependency or active addiction that compromises safety)

   Participants who do not engage in any mental health or substance treatment services

   Participants who demonstrate instability of mental health symptoms (NOT including those who present danger to self or others)

   Checked Five = 5 points

Checked Four = 4 points

Checked Three = 3 points

Checked Two = 2 points

Checked One = 1 point

Checked Zero = 0 points

Total Points Scored:

4. **Indicate whether program participants must meet the following requirements to ACCESS permanent housing.** *Check all that apply*:

Complete a period of time in transitional housing, outpatient, inpatient, or other institutional setting / treatment facility

Maintain sobriety or abstinence from alcohol and/or drugs

Comply with medication

Achieve psychiatric symptom stability

Show willingness to comply with a treatment plan that addresses sobriety, abstinence, and/or medication compliance

Agree to face-to-face visits with staff

Checked Six = 0 points

Checked Five = 1 points

Checked Four = 2 points

Checked Three = 3 points

Checked Two = 4 points

Checked One = 5 point

Checked Zero = 6 points

Total Points Scored:

To calculate your Housing First Score, add the total points scored for each question above, then refer to the key below:

Total Housing First Score:

If you scored: 21 points or more

- ✓ Housing First principles are likely being implemented ideally

If you scored between: 15-20 points

- ✓ Housing First principles are likely being well-implemented

If you scored between: 10 – 14 points

- ✓ Housing First principles are likely being fairly well-implemented

If you scored between: 5 - 9 points

- ✓ Housing First principles are likely being poorly implemented

If you scored between: 0 – 4 points

- ✓ Housing First principles are likely not being implemented

Housing First Self-Assessment
For Systems & Community-Level Stakeholders

1. **Does your community set outcome targets around permanent housing placement for your outreach programs?**
    - Yes = 1 point
    - No = 0 points

Number of Points Scored:

2. **For what percentage of your emergency shelters does your community set specific performance targets related to permanent housing placement?**
    - 90% or more = 4 points
    - Between 51% and 89% = 3 points
    - Between 26% and 50% = 2 points
    - 25% or less = 1 point
    - Unknown = 0 points

Number of Points Scored:

3. **Considering all of the funding sources for supportive housing, what percentage of your vacancies in existing permanent supportive housing units are dedicated for people who meet the definition of chronic and/or vulnerable homeless?**
    - 90% or more = 4 points
    - Between 51% and 89% = 3 points
    - Between 26% and 50% = 2 points
    - 25% or less = 1 point
    - Unknown = 0 points

Number of Points Scored:

4. **Considering all of the funding sources for supportive housing, what percentage of new supportive housing units are dedicated for people who meet the definition of chronic and/or vulnerable homeless?**

   - 90% or more = 4 points
   - Between 51% and 89% = 3 points
   - Between 26% and 50% = 2 points
   - Between 1% and 25% = 1 point
   - 0% (we do not dedicate any units to this population) = 0 points
   - Unknown = 0 points

Number of Points Scored:

5. **Does your community have a formal commitment from your local Public Housing Authority to provide a preference (total vouchers or turn-over vouchers) for homeless individuals and/or families?**

   - Yes, a preference equal to 25% or more of total or turn-over vouchers = 4 points
   - Yes, a preference equal to 10% - 24% or more of total or turn-over = 3 points
   - Yes, a preference equal to 5% - 9% or more of total or turn-over = 2 points
   - Yes, a preference equal to less than 5% or more of total or turn-over = 1 point
   - No, we do not have an annual set-aside = 0 points
   - Unknown = 0 points

Number of Points Scored:

6. **Has your community mapped out its housing placement process from outreach to move-in (e.g. each step in the process as well as the average time needed for each step has been determined)?**

   - Yes = 1 point
   - No = 0 points

Number of Points Scored:

7. **Does your community have a Coordinated Housing Placement System or Single Point of Access into permanent supportive housing?**
    - Yes = 1 point
    - Partial = ½ point
    - No = 0 points

Number of Points Scored:

8. **Does your community have a Coordinated Housing Placement System or Single Point of Access into permanent subsidized housing (e.g. Section 8 and other voucher programs)?**
    - Yes = 1 point
    - Partial = ½ point
    - No = 0 points

Number of Points Scored:

9. **Does your community have different application/housing placement processes for different populations and/or different funding sources? If so, how many separate processes does your community have?**
    - 5 or more processes = 0 points
    - 3-4 processes = 1 point
    - 2 processes = 2 points
    - 1 process for all populations = 3 points

Number of Points Scored:

10. **The entire process from street outreach (with an engaged client) to move-in to permanent housing typically takes:**
    - More than 180 days = 0 points
    - Between 91 and 179 days = 1 point
    - Between 61 and 90 days = 2 points
    - Between 31 and 60 days = 3 points
    - 30 days or less = 4 points
    - Unknown = 0 points

Number of Points Scored:

11. **Approximately what percentage of homeless people living on the streets go straight into permanent housing (without going through emergency shelter and transitional housing)?**
    - More than 75% = 5 points
    - Between 51% and 75% = 4 points
    - Between 26% and 50% = 3 points
    - Between 11% and 25% = 2 points
    - 10% or less = 1 point
    - Unknown = 0 points

    Number of Points Scored:

12. **Approximately what percentage of homeless people who stay in emergency shelters go straight into permanent housing without first going through transitional housing?**
    - More than 75% = 5 points
    - Between 51% and 75% = 4 points
    - Between 26% and 50% = 3 points
    - Between 11% and 25% = 2 points
    - 10% or less = 1 point
    - Unknown = 0 points

    Number of Points Scored:

13. **Within a given year, approximately what percentage of your community's chronic and/or vulnerable homeless population who exit homelessness, exits into permanent supportive housing?**
    - More than 85% = 5 points
    - Between 51% and 85% = 4 points
    - Between 26% and 50% = 3 points
    - Between 10% and 24% = 2 points
    - Less than 10% = 1 point
    - Unknown = 0 points

Number of Points Scored:

14. **In a given year, approximately what percentage of your community's chronic and/or vulnerable homeless population exiting homelessness, exits to Section 8 or other long-term subsidy (with limited or no follow-up services)?**

- More than 50% = 4 points
- Between 26% and 50% = 3 points
- Between 10% and 25% = 2 points
- Less than 10% = 1 point
- Unknown = 0 points

Number of Points Scored:

15. **Approximately what percentage of your permanent supportive housing providers will accept applicants with the following characteristics:**

a) Active Substance Use

- Over 75% = 5 points
- 75%-51% = 4 points
- 50%-26% = 3 points
- 25%-10% = 2 points
- Less than 10% = 1 points
- Unknown = 0 points

b) Chronic Substance Use Issues

- Over 75% = 5 points
- 75%-51% = 4 points
- 50%-26% = 3 points
- 25%-10% = 2 points
- Less than 10% = 1 points
- Unknown = 0 points

c) Untreated Mental Illness

- Over 75% = 5 points
- 75%-51% = 4 points
- 50%-26% = 3 points
- 25%-10% = 2 points
- Less than 10% = 1 points
- Unknown = 0 points

d) Young Adults (18-24)

- Over 75% = 5 points
- 75%-51% = 4 points
- 50%-26% = 3 points
- 25%-10% = 2 points
- Less than 10% = 1 points
- Unknown = 0 points

e) Criminal Background (any)

- Over 75% = 5 points
- 75%-51% = 4 points
- 50%-26% = 3 points
- 25%-10% = 2 points
- Less than 10% = 1 points
- Unknown = 0 points

f) Felony Conviction

- Over 75% = 5 points
- 75%-51% = 4 points
- 50%-26% = 3 points
- 25%-10% = 2 points
- Less than 10% = 1 points
- Unknown = 0 points

g) Sex Offender or Arson Conviction

- Over 75% = 5 points
- 75%-51% = 4 points
- 50%-26% = 3 points
- 25%-10% = 2 points
- Less than 10% = 1 points
- Unknown = 0 points

h) Poor Credit

- Over 75% = 5 points
- 75%-51% = 4 points
- 50%-26% = 3 points
- 25%-10% = 2 points
- Less than 10% = 1 points
- Unknown = 0 points

i) No Current Source of Income (pending SSI/DI)

- Over 75% = 5 points

- 75%-51% = 4 points
- 50%-26% = 3 points
- 25%-10% = 2 points
- Less than 10% = 1 points
- Unknown = 0 points

Question Section	# Points Scored
Active Substance Use	
Chronic Substance Use Issues	
Untreated Mental Illness	
Young Adults (18-24)	
Criminal Background (any)	
Felony Conviction	
Sex Offender or Arson Conviction	
Poor Credit	
No Current Source of Income (pending SSI/DI)	
Total Points Scored in Question #17:	

To calculate your Housing First Score, add the total points scored for each question above, then refer to the key below:

Total Housing First Score:

If you scored: 77 points or more

- ✓ Housing First principles are likely being implemented ideally

If you scored between: 57 – 76 points

- ✓ Housing First principles are likely being well-implemented

If you scored between: 37 – 56 points

- ✓ Housing First principles are likely being fairly well-implemented

If you scored between: 10 – 36 points

- ✓ Housing First principles are likely being poorly implemented

If you scored under 10 points

- ✓ Housing First principles are likely not being implemented

Appendix 6

SKYPING DURING A CRISIS?

Telehealth is a 24/7 Crisis Connection

Arnold A. Remington
Program Director, Targeted Adult Service Coordination Program

When Nebraska law enforcement officials encounter people exhibiting signs of mental illness, a state statue allows them to place individuals into emergency protective custody. While emergency protective custody may be necessary if the person appears to be dangerous to themselves or to others, involuntary custody is not always the best option if the crisis stems from something like a routine medication issue.

Officers may request that counselors evaluate at-risk individuals to help them determine the most appropriate course of action. While in-person evaluations are ideal when counselors are readily available, officers often face crises in the middle of the night and in remote areas where mental health professionals are not easily accessible.

The Targeted Adult Service Coordination program began in 2005 to provide crisis response assistance to law enforcement and local hospitals dealing with people struggling with behavioral health problems. The employees respond to law enforcement calls to provide consultation, assistance in recognizing a client's needs and help with identifying resources to meet those needs. The no-charge service program offers crisis services to 31 law enforcement agencies in 15 rural counties in the southeast section of the Cornhusker state.

Six months ago, the program offered select law enforcement officials a new crisis service tool: telehealth. The Skype-like technology makes counselors available 24/7, even in remote rural parts of the state. Officers can connect with on-call counselors for face-to-face consultations through secure telehealth via laptops, iPads or Toughbooks in their vehicles.

The technology, which is in use in select jails and police and sheriff departments, is proving to be a win-win for both law enforcement officers and clients. Officers no longer have to wait for counselors to arrive for consultations. In rural communities, it is too common for officers to wait for up to two hours for counselors traveling from long distances.

Telehealth also supports the Targeted Adult Service Coordination program's primary goal of preventing individuals from being placed under emergency protective custody. The program maintains an 82 percent success rate of keeping clients in a home environment with proper supports. The technology promotes faster response times that mean more expedient and more appropriate interventions for at-risk individuals, particularly those in rural counties.

So far, the biggest hurdle has been getting law enforcement officers to break out of their routines and adopt the technology. Some officers still want in-person consultations, a method that is preferable when counselors are available and nearby. But when reaching a counselor is not expedient and sometimes not even possible, telehealth can play an invaluable role.

Police officers' feedback on telehealth has been mainly positive. Officers often begin using the new tool after hearing about positive experiences from colleagues. As more officers learn that they can contact counselors with a few keystrokes from their cruisers, telehealth will continue to grow. The Targeted Adult Service Coordination program plans to expand the technology next year by making it available to additional police and sheriff departments.

Telehealth has furthered the Targeted Adult Service Coordination program's goal of diverting people from emergency protective custody and helping them become successful, contributing members of the community. This creative approach to crisis response provides clients with better care and supports reintegration and individual autonomy.

Appendix 7

KEY ISSUE: REENTRY

REENTRY RESOURCES FOR INDIVIDUALS, PROVIDERS, COMMUNITIES, AND STATES

LEARN ABOUT SAMHSA REENTRY RESOURCES FOR:

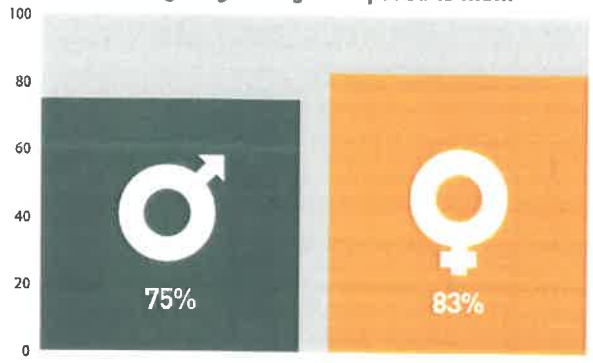
- Behavioral Health Providers & Criminal Justice Practitioners
- Individuals Returning From Jails & Prisons
- Communities & Local Jurisdictions
- State Policymakers

AT A GLANCE

Individuals with mental and substance use disorders involved with the criminal justice system can face many obstacles accessing quality behavioral health service. For individuals with behavioral health issues reentering the community after incarceration, those obstacles include a lack of health care, job skills, education, and stable housing, and poor connection with community behavioral health providers. This may jeopardize their recovery and increase their probability of relapse and/or re-arrest. Additionally, individuals leaving correctional facilities often have lengthy waiting periods before attaining benefits and receiving services in the community. Too often, many return to drug use, criminal behavior, or homelessness when these obstacles prevent access to needed services.
The Office of National Drug Control Policy reports:

- More than 40% of offenders return to state prison within 3 years of their release.
- 75% of men and 83% of women returning to state prison report using illegal drugs.

More women returning to state prison report using illegal drugs compared to men.



ISSUE DATE 4.1.16

Behavioral health is essential to health.
Prevention works.
Treatment is effective.
PEOPLE RECOVER.

Substance Abuse and Mental Health Services Administration
SAMHSA
www.samhsa.gov
DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

SAMHSA efforts to help meet the needs of individuals with mental and substance use disorders returning to the community, and the needs of the community include:

- Grant programs such as the Offender Reentry Program (ORP) that expand and enhance substance use treatment services for individuals reintegrating into communities after being released from correctional facilities.
- Actively partnering with other federal agencies to address the myriad of issues related to offender reentry through policy changes, recommendations to U.S. states and local governments, and elimination of myths surrounding offender reentry.
- Providing resources to individuals returning from jails and prisons, behavioral health providers and criminal justice practitioners, communities and local jurisdictions, and state policymakers.

At federal, state and local levels, criminal justice reforms are changing the landscape of criminal justice policies and practices. In 2015, federal efforts focused on reentry services and supports for justice-involved individuals with mental and substance use disorders have driven an expansion of programs and services.

Reentry is a key issue in SAMHSA's Trauma and Justice Strategic Initiative. This strategic initiative addresses the behavioral health needs of people involved in - or at risk of involvement in - the criminal and juvenile justice systems. Additionally, it provides a comprehensive public health approach to addressing trauma and establishing a trauma-informed approach in health, behavioral health, criminal justice, human services, and related systems.

SAMSHA RESOURCES

This key issue guide provides an inventory of SAMHSA resources for individuals returning from jails and prisons, behavioral health providers and criminal justice practitioners, communities and local jurisdictions, and states.

RESOURCES FOR BEHAVIORAL HEALTH PROVIDERS AND CRIMINAL JUSTICE PRACTITIONERS

GAINS Reentry Checklist for Inmates Identified with Mental Health Needs (2005)

This publication provides a checklist and template for identifying and implementing a successful reentry plan for individuals with mental and substance use disorders. http://www.neomed.edu/academics/criminal-justice-coordinating-center-of-excellence/pdfs/sequential-intercept-mapping/GAINSReentry_Checklist.pdf

Quick Guide for Clinicians: Continuity of Offender Treatment for Substance Use Disorder from Institution to Community

Helps substance abuse treatment clinicians and case workers to assist offenders in the transition from the criminal justice system to life after release. Discusses assessment, transition plans, important services, special populations, and confidentiality. http://store.samhsa.gov/product/Continuity-of-Offender-Treatment-for-Substance-Use-Disorder-from-Institution-to-Community/SMA15-3594

Trauma Informed Response Training

The GAINS Center has developed training for criminal justice professionals to raise awareness about trauma and its effects. "How Being Trauma-Informed Improves Criminal Justice System Responses" is a one-day training for criminal justice professionals to:

- Increase understanding and awareness of the impact of trauma
- Develop trauma-informed responses
- Provide strategies for developing and implementing trauma-informed policies

This highly interactive training is specifically tailored to community-based criminal justice professionals, including police officers, community corrections personnel, and court personnel. http://www.samhsa.gov/gains-center/criminal-justice-professionals-locator/trauma-trainers

SOAR TA Center

Provides technical assistance on SAMHSA's SSI/SSDI Outreach, Access and Recovery (SOAR), a national program designed to increase access to the disability income benefit programs administered by the Social Security Administration (SSA) for eligible adults who are experiencing or are at risk of homelessness and have a mental illness, medical impairment, and/or a co-occurring substance use disorder. http://soarworks.prainc.com/

RESOURCES FOR INDIVIDUALS RETURNING FROM JAILS AND PRISONS

SAMHSA's Behavioral Health Treatment Locator

Search online for treatment facilities in the United States or U.S. Territories for substance abuse/addiction and/or mental health problems. https://findtreatment.samhsa.gov/

Self-Advocacy and Empowerment Toolkit

Find resources and strategies for achieving personal recovery goals. http://www.consumerstar.org/resources/pdf/JusticeMaterialsComplete.pdf

Obodo

Find resources and information and make connections in your community. Users set up profiles, add photos, bookmark resources and interests, and can email other members. https://obodo.is/

SecondChanceResources Library

Find reentry resources and information. http://secondchanceresources.org/

Right Path

Resources and information for persons formerly incarcerated, and the people who help them (parole officers, community service staff, family and friends). http://rightpath.meteor.com/

RESOURCES FOR COMMUNITIES AND LOCAL JURISDICTIONS

Establishing and Maintaining Medicaid Eligibility upon Release from Public Institutions

This publication describes a model program in Oklahoma designed to ensure that eligible adults leaving correctional facilities and mental health institutions have Medicaid at discharge or soon thereafter. Discusses program findings, barriers, and lessons learned. http://store.samhsa.gov/product/Establishing-and-Maintaining-Medicaid-Eligibility-upon-Release-from-Public-Institutions/SMA10-4545

Providing a Continuum of Care and Improving Collaboration among Services

This publication examines how systems of care for alcohol and drug addiction can collaborate to provide a continuum of care and comprehensive substance abuse treatment services. Discusses service coordination, case management, and treatment for co-occurring disorders. http://store.samhsa.gov/product/Providing-a-Continuum-of-Care-Improving-Collaboration-Among-Services/SMA09-4388

***A Best Practice Approach to Community Reentry from Jails for Inmates with Co-occurring Disorders: The APIC Model* (2002)**

This publication provides an overview of the APIC Model, a set of critical elements that, if implemented, are likely to improve outcomes for persons with co-occurring disorders who are released from jail. http://homeless.samhsa.gov/resource/a-best-practice-approach-to-community-re-entry-from-jails-for-inmates-with-co-occurring-disorders-the-apic-model-24756.aspx

***Guidelines for the Successful Transition of People with Behavioral Health Disorders from Jail and Prison* (2013)**

This publication presents guidelines that are intended to promote the behavioral health and criminal justice partnerships necessary to successfully identify which people need services, what services they need, and how to match these needs upon transition to community-based treatment and supervision. https://csgjusticecenter.org/wp-content uploads/2013/12/Guidelines-for-Successful-Transition.pdf

SAMHSA's Offender Reentry Program

Using grant funding, the program encourages stakeholders to work together to give adult offenders with co-occurring substance use and mental health disorders the opportunity to improve their lives through recovery. http://www.samhsa.gov/grants/grant-announcements/ti-15-012

Bridging the Gap: Improving the Health of Justice-Involved People through Information Technology

This publication is a review of the proceedings from a two-day conference convened by SAMHSA in 2014. The meeting aimed to address the problems of disconnected justice and health systems and to develop solutions by describing barriers, benefits, and best practices for connecting community providers and correctional facilities using health information technology (HIT). http://www.vera.org/samhsa-justice-health-information-technology

RESOURCES FOR STATE POLICYMAKERS

Behavioral Health Treatment Needs Assessment for States Toolkit

Provide states and other payers with information on the prevalence and use of behavioral health services; step-by-step instructions to generate projections of utilization under insurance expansions; and factors to consider when deciding the appropriate mix of behavioral health benefits, services, and providers to meet the needs of newly eligible populations. http://store.samhsa.gov/shin/content//SMA13-4757/SMA13-4757.pdf

Medicaid Coverage and Financing of Medications to Treat Alcohol and Opioid Use Disorders

This publication presents information about Medicaid coverage of medication-assisted treatment for opioid and alcohol dependence. Covers treatment effectiveness and cost effectiveness as well as examples of innovative approaches in Vermont, Massachusetts, and Maryland. http://store.samhsa.gov/product/Medicaid-Coverage-and-Financing-of-Medications-to-Treat-Alcohol-and-Opioid-Use-Disorders/SMA14-4854

All publications are available free through SAMHSA's store

http://store.samhsa.gov/

POWERED BY TRAKQR

SAMHSA TOPICS

Alcohol, Tobacco, and Other Drugs ■ Behavioral Health Treatments and Services ■ Criminal and Juvenile Justice ■ Data, Outcomes, and Quality
Disaster Preparedness, Response, and Recovery ■ Health Care and Health Systems Integration ■ Health Disparities ■ Health Financing
Health Information Technology ■ HIV, AIDS, and Viral Hepatitis ■ Homelessness and Housing ■ Laws, Regulations, and Guidelines
Mental and Substance Use Disorders ■ Prescription Drug Misuse and Abuse ■ Prevention of Substance Abuse and Mental Illness
Recovery and Recovery Support ■ School and Campus Health ■ Specific Populations ■ State and Local Government Partnerships
Suicide Prevention ■ Trauma and Violence ■ Tribal Affairs ■ Underage Drinking ■ Veterans and Military Families ■ Wellness ■ Workforce