

Sequential Intercept Model Mapping Report for Dane County, WI

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Final Report
January 16-17, 2018
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Policy Research, Inc.



ACKNOWLEDGEMENTS

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DISCLAIMER

The following report and map represent the voices and perspectives of the participants and facilitators in the room during the January 16-17, 2018 workshop. There are additional organizations and voices that are not reflected in this report and Dane County stakeholders look forward to incorporating further collaboration.

RECOMMENDED CITATION

Policy Research. (2018). *Sequential intercept model mapping report for Dane County*. Delmar, NY: Policy Research, Inc.

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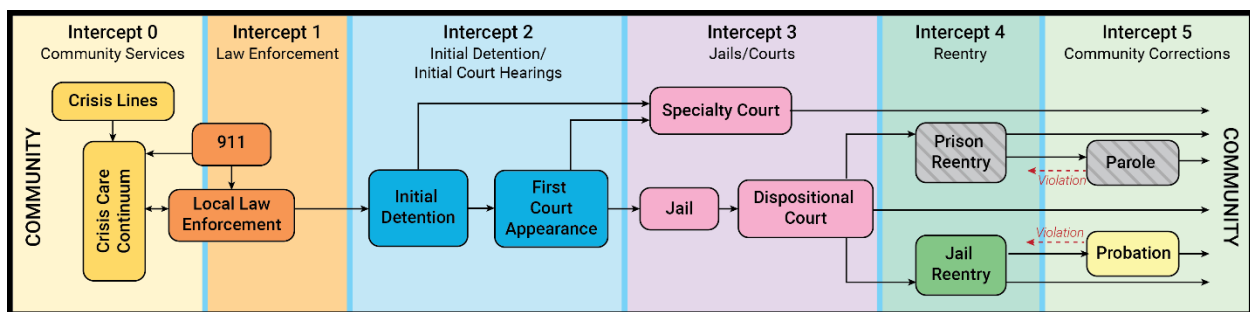
BACKGROUND

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



Sequential Intercept Mapping

AGENDA

Dane County, WI

January 16, 2018

8:15 **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

4:30 **Adjourn**

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

There will be break for lunch at approximately noon.

Sequential Intercept Mapping

AGENDA

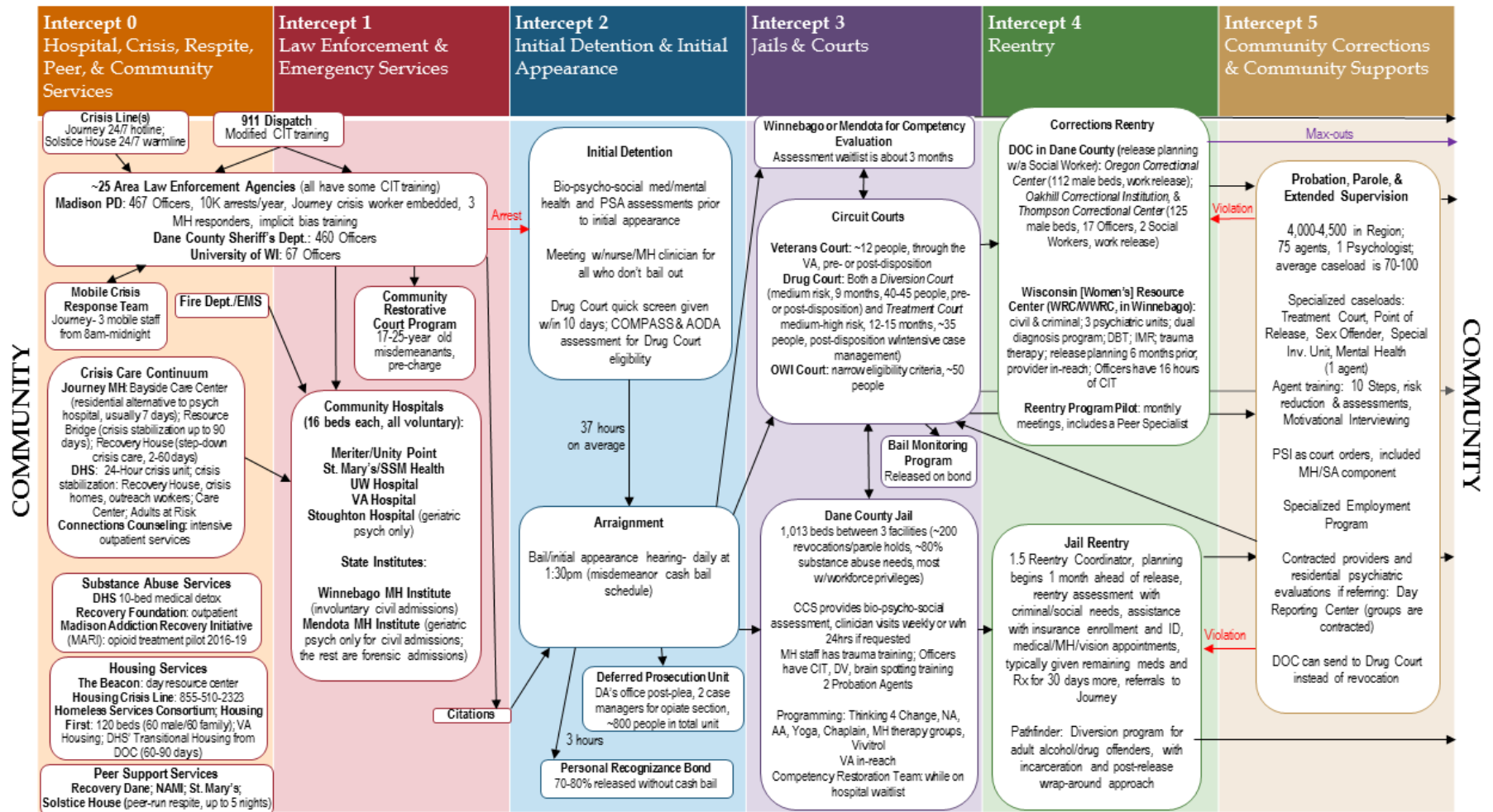
Dane County, WI

January 17, 2018

- 8:15** **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 DANE COUNTY, WI

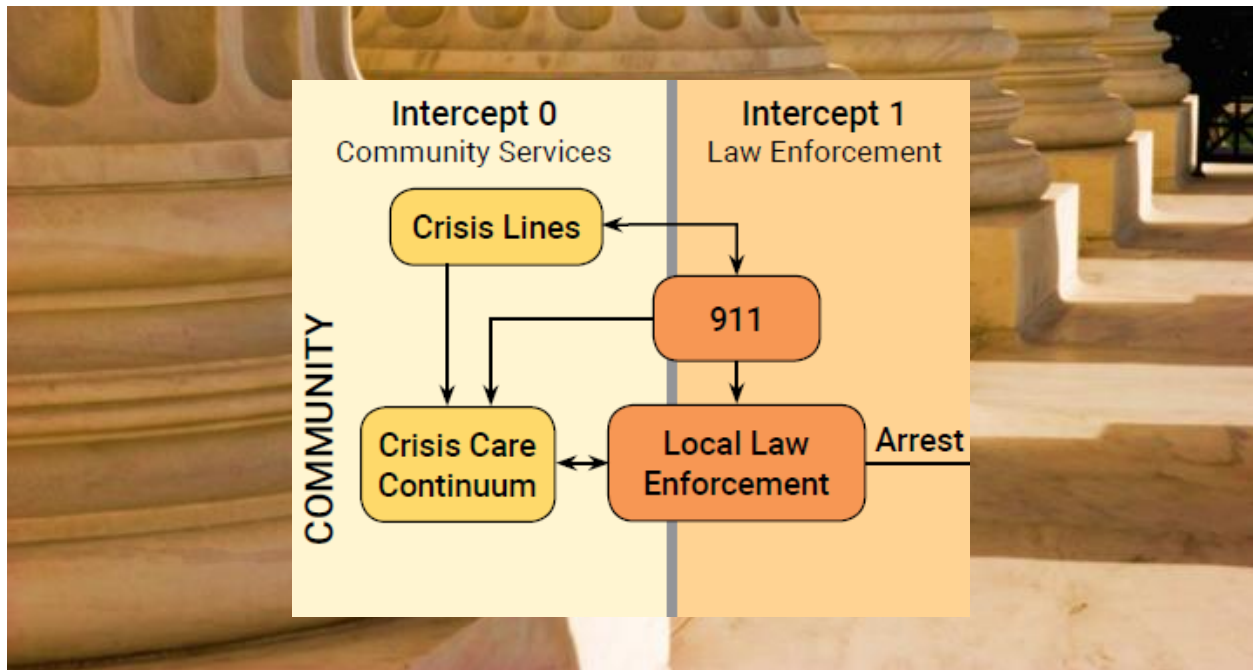




RESOURCES AND GAPS AT EACH INTERCEPT

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.

Note: comments reflect the audience in attendance during the SIM.



INTERCEPT 0 AND INTERCEPT 1

RESOURCES

- Focused Interruption Coalition (FIC) is a grassroots coalition with a plan to address racial disparities, violence, and recidivism within Madison.
- There is HSC representation at the monthly Recovery Dane meetings.
- There is broad agreement that Journey Mental Health Center is the “hub” to triage emergency mental health needs and provide information to law enforcement. Journey is but one of many community service providers, all of whom work closely with law enforcement.
- Journey operates a 24/7 mental health crisis line (608-280-2600), with three (two FTE) mobile staff available between 8am and midnight. There is on-call phone consultation available overnight.
- There is good collaboration between community service providers and law enforcement.
- Many community service providers employ Peer Support Specialists.
- Journey provides Mental Health First Aid (MHFA) training locally.
- Solstice House, a peer-run respite in Madison, operates a 24/7 warm-line (608-422-2383) with peers for non-crisis calls.
- 911 keeps high-quality records of calls.
- There was funding in the recent 2018 budget for Crisis Intervention Team (CIT) training for 911 staff, which NAMI oversees. The goal is to train all staff.
- The Fire Department is involved in mental health crisis prevention, as well as EMS more recently, and has two Community Paramedics for Madison mental health outreach.

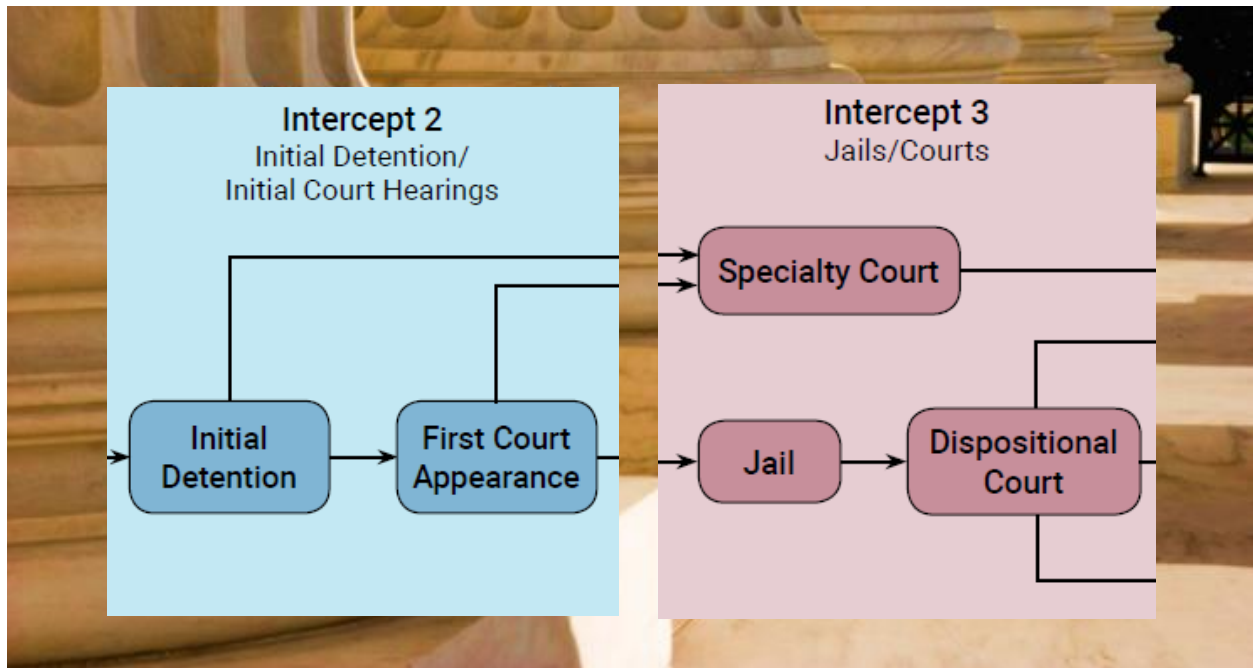
- Resource Bridge provides recovery-focused support and stabilization services to consumers transitioning from inpatient settings, jail and Emergency Services case management, in order to bridge the gap until longer term services can be established, thereby eliminating the need to place the individual on a waitlist.
- Many service providers provide mobile case management and support as well as program specific prescriber services.
- There is a centralized County intake for CCS, which is Medicaid-specific.
- Each of the four local hospitals can perform mental health holds, and accommodate about 16 patients each.
 - Peers are embedded within the St. Mary's emergency room to provide opioid overdose recovery follow-up.
- There is a 10-bed medical detox through DCHS that is typically full; trying to move to longer-term treatment within facility but currently provides a lot of withdrawal management.
- Strategic Behavioral Health plans to open a new local 72-bed hospital facility, with both secure and non-secure wings, with a projected opening in 2019.
- NAMI has a local [resource guide](#) available.
- [United Way 2-1-1](#) provides local information and referral services.
- Link Dane provides a [community resource guide](#) online.
- [The Beacon](#) is a comprehensive day resource center for people who are experiencing homelessness in Dane County.
- The Fire Department is looking at a diversion model in Manchester, New Hampshire.
- All area law enforcement departments have some CIT training (at least two officers per department) and there is now equivalent training in the Madison Police Academy.
- There is County-wide implicit bias training for law enforcement, which is being integrated into CIT.
- Madison law enforcement uses discretion and gives citations.
- Journey has had a crisis worker embedded in law enforcement for the past two years. Madison Police Department has five mental health officers and about 30 mental health liaisons, resulting in a more proactive, coordinated response, as well as receipt of better information from line officers.
- There is a strong willingness on behalf of the Dane County Sheriff's Office to address individuals' mental health and substance abuse crises first, and follow-up to criminal justice issues later. The Sheriff contracts with Correct Care Solutions to provide medical services to those in jail, which includes mental health and substance abuse services.
- MARI (Madison Area Recovery Initiative) pilot diverts individuals with opioid addiction for up to six months through a contract with the Madison Police Department and DHS.
 - Two additional case managers have been added to provide services.
- The Madison Police Department has a mental health standard operating procedure to follow.
- Journey provides quarterly eight-hour continuing education trainings around mental health to law enforcement.
- The Dane County CIT Collaborative Group is hosted by NAMI and meets twice per year.

- The hospitals hold cross-system meetings either quarterly or monthly, which has been very beneficial.
- There is a pre-charge Community Restorative Court program for 17-25 year-olds.

GAPS

- In 2017, there were 497 adult involuntary admissions in Dane County. Additional information about this group has not been explored.
- The crisis service system is unclear to family members in need, and even for those within the system.
- There is a lack of publicity regarding Recovery Dane (a resource center for people with mental health needs and their family) and supportive services overall.
- There are many calls to EMS with mental health needs (over 25,000 total calls).
- There is a scarcity of psychiatric providers.
- There are no Certified Peer Specialists with prior justice involvement working in the system locally, although there are about 40 peers who may become certified in the near future.
- Local hospitals partner with Journey Emergency Services Unit to prevent hospitalizations and instead divert people. However, hospitals are often on “divert” status. Reportedly, some hospitals are turning away “difficult clients” with mental health and substance abuse needs, although this was debated within the group present at the workshop.
- There are “fractures” between Madison and the surrounding areas, for example nine 911 call centers in the metro area have no way to transfer to each other.
- There is no 24/7 crisis respite currently available for law enforcement drop-offs, although Strategic Behavioral Health may fill this gap with a new facility planned for late 2019.
- Service provider waitlists can be up to six months long, and are influenced by the payer source. Clients are not prioritized for services.
- Fire/EMS is only able to transport to the hospital emergency rooms.
- There is a scarcity of diversion resources at night in particular, and a need for treatment on demand that is not reliant on payer source.
- There are over 30 contracted service providers, however, it is not clear what services are actually needed to meet the needs of persons in the county.
 - There is a general lack of services for substance abuse needs.
 - Payment source drives access to many services.
 - Lack of criteria for use of detox beds and type of withdrawal needed.
- Law enforcement spend excessive travel time (two and a half hours or more) transporting to state institutes (Winnebago or Mendota).
- There is a need for law enforcement diversion options for those who do not rise to the level of emergency detention.

- Emergency detention can take eight hours or more, crossing law enforcement shift, and averaging 17 total officer hours per detention.



INTERCEPT 2 AND INTERCEPT 3

RESOURCES

- Journey monitors civil commitments and service providers keep Journey informed of any non-compliance with the commitment.
- Commitment orders now include language regarding prior commitments, and formal, release of information language. Wisconsin legislation (108) allows information-sharing.
- Dane County Rule 206 calls for initial appearance within 48 hours of detention, which eliminates the potential to sit in jail for long amounts of time without a judicial decision of status.
- It takes an average of 37 hours from booking to bail hearing or initial appearance, which was accelerated from last year. The goal is 48 hours or less.
- Most (70-80%) of individuals are released on their own signature without cash bail. It takes about three hours to be released from jail. Release is possible without a court appearance. Municipal offenders are not jailed.
 - A state statute sets a bail cash schedule for misdemeanors.
 - MOSES (Madison Organizing in Strength, Equality, and Solidarity) has a bail fund but has not been able to identify those who would qualify.
 - The Bail Monitoring Program is for low-risk individuals released on bond and provides support from social workers, but is not specific to mental health.

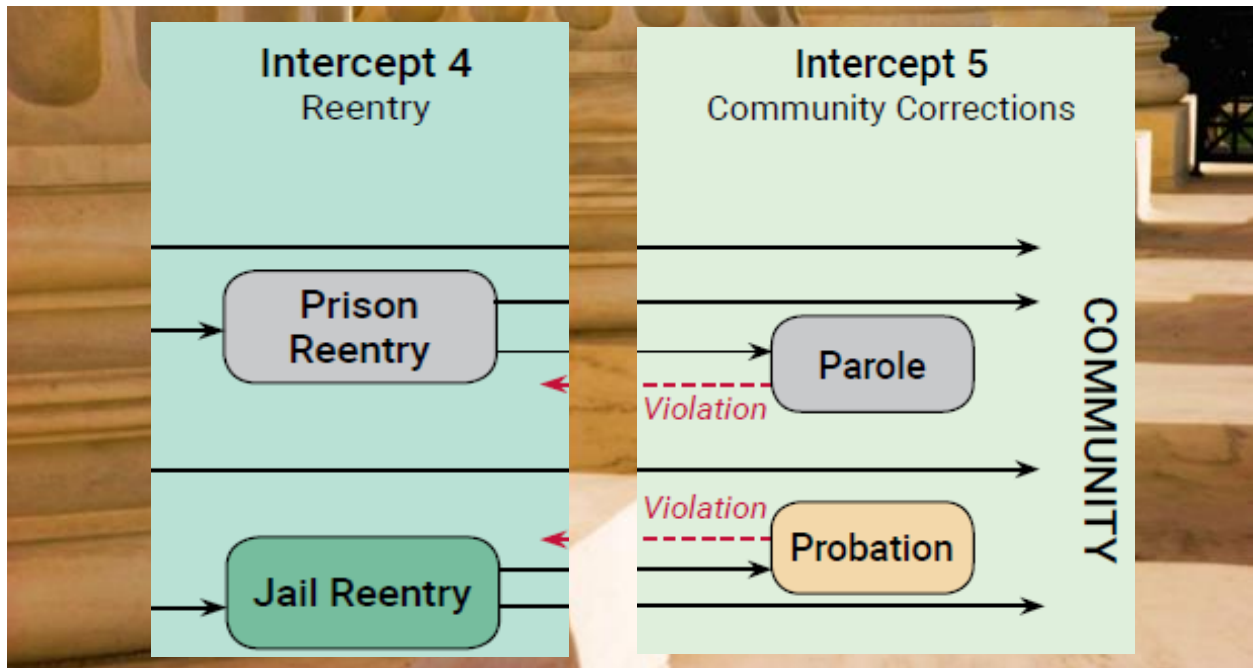
- The PSA given at booking is the subject of a two-year Harvard study. The study was underway for eight months at the time of the workshop and involved a control group of individuals whose PSA scores were not given to the Commissioner.
- A Drug Court quick screen is given within 10 days of arraignment. The AODA assessment is administered by Journey Mental Health, the contracted Drug Court coordinator.
- Jail programming includes Thinking for a Change (T4C), Narcotics Anonymous, Alcoholics Anonymous, Yoga, access to a Chaplain, and mental health group therapy.
- Some data is available from the jail, but is based on self-report:
 - Rated capacity: 1013
 - From November 2016 to August 2017, 8,747 intake assessments were completed.
 - 33% of these individuals were on mental health medication in the past.
 - 25% were on mental health medication currently.
 - 37% had received previous mental health treatment.
 - 46% were given a mental health diagnosis in the past.
 - 21% reported self-harm in their past.
- Approximately 48% of the jail population are on psychotropic medication.
 - Vivitrol can be made available within the jail for opioid addiction treatment.
 - The formulary is broad; efforts are made to continue medications for persons in jail.
 - Some medications can be brought to the jail to ensure continuity.
- A new jail was approved in the 2018 budget, which will consolidate the three existing facilities. It will be equipped for separate mental health housing, additional programming, direct supervision, and an area for 17-year-olds. Current bed count of 1013 will be reduced by 91 beds.
- Both the Drug Court's Diversion Court (for individuals at medium risk) and Treatment Court (for individuals at medium to high risk) have a 34% re-arrest rate for those who completed the program.
 - A veterans docket may be offered (12 persons are currently involved).
- The DA has a dedicated unit that can offer deferred prosecution for opioid offenses. Deferral is open for 2 yrs.
- The DA has a special mental health prosecutor.
- Resource Bridge and the jail have improved coordination of services. Currently, there are seven referrals.
- Work release is statutory. EHM is used to monitor. Approximately 230 individuals are eligible to work, volunteer or be on jail diversion
- All individuals meet with a nurse at booking for a general medical screen; CCS staff (two) conduct a narrated bio-psycho-social medical assessment with all individuals who will be detained, if their bail is not ready for their release at this time.
 - At booking, persons are being asked about veteran status; flyers about veteran resources are available and visible in the jail.

- Multi-level codes are used to categorize level of mental health acuity.
 - Incarcerated persons can request services and are seen within 24 hours.
- A dedicated analyst has been hired to look across the criminal justice system and analyzing available data. Dashboards, trends, etc. have not yet been determined.
- Persons in segregation receive automated checks.
- Two probation officers work out of the jail to assist fellow agents in interviewing inmates to speed up the process and alleviate overcrowding. It is a combined effort and all work collaboratively. They have access to all areas of the jail.
- A competency restoration process, including access to medications, can begin while individuals are in jail.
- A data sharing MOU is in process, including establishing a common identifier.
- At Oakhill Correctional Institution, treatment is available for incarcerated veterans.

GAPS

- There are large racial and ethnic disparities around cash bail and hold times. Individuals in jail are disproportionately male and black.
- There is a lack of data around the numbers of individuals awaiting bail and the bail amounts.
- The jail is unable to extract data from the collected bio-psycho-social screenings as the questions are open-ended.
 - Screening tools are not used to sort populations.
 - Treatment/services and jail based support and reentry can be disjointed if persons are not considered a CCS client.
- The Drug Court's Diversion Court has a slightly higher (4%) re-arrest rate for individuals who did *not* complete the program, than for those who did, based on data from 2014-16.
 - Criteria may limit access to treatment courts.
 - There are no youth problem solving courts.
- Information is not shared between jail and probation, parole.
 - PSI are done when ordered.
- Medication may be stopped if person's prescription for medication is not current. Release with medications is based on type of medication. A three-day bridge of medication is typical, but a 30-day prescription is available.
- If questions of competency are raised, persons are detained at the state institutes (Winnebago or Mendota) longer than normal due to a waitlist of up to three months.
 - There is a shortage of forensic beds to meet the need, and it is a three-hour drive to Winnebago.
 - Persons who violate rules during the wait time, such as assault, may receive new charges.

- Revocations to jail may be the only way for some persons to receive some services.
 - The jail does have dedicated treatment units.
- Oakhill Correctional Institution’s wait list may be as long as four to six months, and there is not a criteria-based priority list to receive services.
- An unknown release date impacts ability for continued services.



INTERCEPT 4 AND INTERCEPT 5

RESOURCES

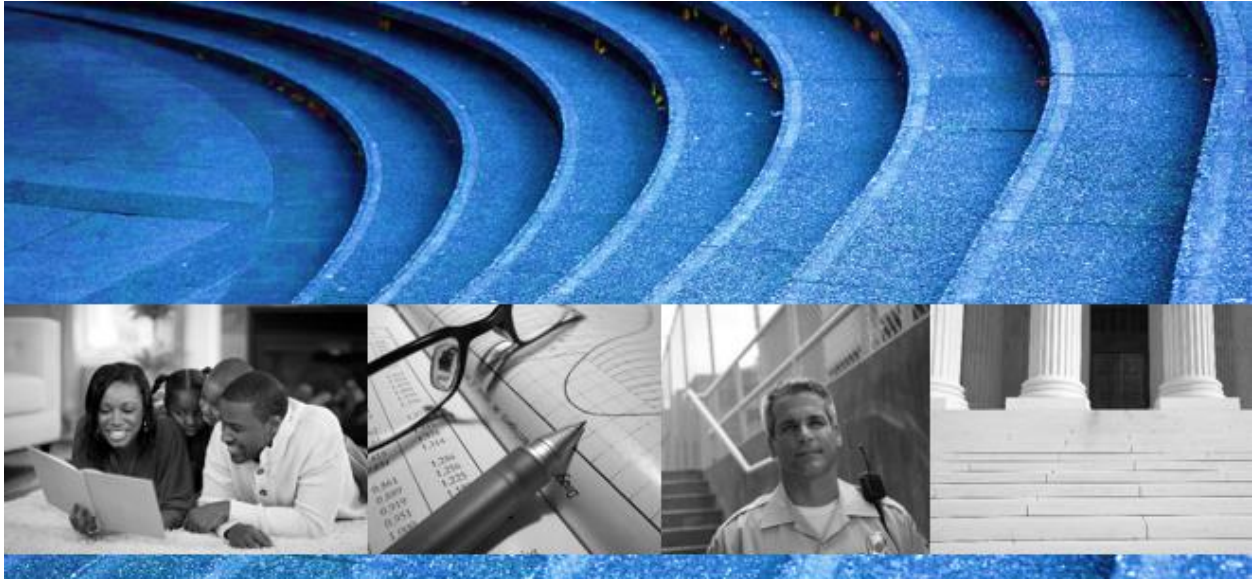
- Madison Area Urban Ministry's (MUM's) Journey Home program works to reduce recidivism by providing housing, employment, support and treatment, transportation, case management, and education services for individuals newly released from prison.
- Madison Organizing in Strength, Equality, and Solidarity (MOSES) provides additional post-release support, as well as policy advocacy.
- There are one and a half reentry staff in the jail, covering both behavioral health and general reentry. A reentry assessment is conducted one month prior to release, when the date is known.
 - Reentry staff assist with enrollment in Medicaid and setting up community provider appointments.
 - They can also assist with identification, if needed.
- Individuals are released with between three and 30 days of medication, depending on which it is.
- There is a Reentry Coordination Meeting that occurs.
- The Pathfinder program utilizes electric home monitoring for individuals with substance abuse issues.
- The DOC begins release planning six months prior to prison release date and provides dual diagnosis services and referral to community providers.
- Some Corrections Officers have training in mental health.

- Probation has a reentry crisis pilot that utilizes forensic peers
- Probation's Welcome Home program provides transition planning and assistance gaining benefits.
- There is a day reporting program for Probation.
- MAT (Medication Assisted Treatment) is available in Dane County, and there is a new methadone clinic locally.
- The Urban League, PRI, Porchlight, the Department of Vocational Rehabilitation, the Department of Workforce Development, and the Jobs Center all provide employment services.
- St. Vincent, Community Action, Trinity Pharmacy, Nehemiah, Lazarus, and JFF all provide additional community services locally.
- The COMPAS risk and need assessment tool is given by DOC and used by probation.

GAPS

- There are a lot of gaps around housing and homelessness in Dane County.
 - The housing vacancy rate is low, making access challenging, and there is a lack of diverse housing options.
 - Some treatment modalities are not available to clients due to housing stability (at Solstice House, for example).
 - The HUD definition of homelessness may limit access. Many persons are deemed ineligible for HUD Housing resources.
 - The criminal justice-involved population is not a high priority for housing providers.
 - Coordination with housing providers is inconsistent and uncoordinated.
 - Lack of available data surrounding homelessness in Dane County. Eligibility for homeless resources is not known across all systems and providers. Definitions are also not known (e.g., couch surfing).
 - Housing providers use the VI-SPDAT to triage needs, but not all clients qualify. Other system stakeholders do not have access to the VI-SPDAT.
- Unknown release dates makes planning for release and access to services challenging. Individuals may not be added to provider waitlists, and/or may be ineligible for services due to changing release dates.
- The availability of reentry resources is not the same for sentenced and un-sentenced persons.
- There are inconsistent services and access in jail and within reentry, particularly concerning substance abuse treatment.
- There is a gap around access to treatment. Providers often have long waitlists and there is no treatment on demand. Treatment is also often dependent on insurance providers.
- There is a gap around transportation. Treatment services and scheduling is not coordinated and not centralized, making access and compliance difficult.

- There is a gap around the role of family/advocacy within the treatment system.
- Although the COMPASS is given by DOC, risk scores are not used to sort the inmate population for risk and need for services. High-risk persons are not prioritized or targeted for services.



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 16, 2017. The top three priorities are highlighted in italicized text.

1. *Create a secure psychiatric center that is medically based (19 votes)*
 - a. *Incorporated in Action Planning group #1*
2. *Increase access to affordable housing for justice-involved population (14 votes)*
 - a. *The focus of Action Planning group #4*
3. *Create a voluntary crisis drop-off center and appropriate treatment services (13 votes)*
 - a. *Incorporated in Action Planning group #1*
4. Use data to identify specific populations (high cost/high utilizers) and create appropriate treatment services (9 votes)
 - a. Included in Action Planning group #2
5. Create cross-Intercept treatment/resource data models/data points by race/ethnicity-program evaluation definitions/data dashboard, including payer sources (9 votes)
 - a. Included in Action Planning group #2
6. Increase utilization of forensic peers across Intercepts (3 votes)
 - a. Included in Action Planning group #3
7. Enhance communication and coordination of care plans (3 votes)
 - a. Included in Action Planning group #3
8. Create community-based teams at Intercept 2 (2 votes)
 - a. Included in Action Planning group #3
9. Expand case management across Intercepts (2 votes)

- a. Included in Action Planning group #3
- 10. Develop transportation resource coordination (1 vote)
- 11. Create rapid response at Intercepts 1 and 2 (0 votes)

ACTION PLANS

Priority Area #1: List the information/questions needed to inform the upcoming mental health study RFP (pre-work to address Priorities 1 and 3)

Note: During Day 2 of the SIM workshop, Lindsay Wallace of NAMI reported that a new 72-bed drop-off center from Strategic Behavioral Health would be built in Dane County, beginning in late fall 2018, with capacity for both a secure and non-secure wing. SBH will solicit community involvement and feedback in accordance with the upcoming mental health study.

| Objective | Action Step | Who | When |
|---|---|--|--|
| <p>Describe current situation: mental health system crisis stabilization center in Dane County</p> <p>How many are in the private system?</p> <p>How many use County system because of inability to access the private system?</p> <p>-Identify gaps</p> <p>-Make recommendations</p> | <p>Interviews</p> <p>Focus groups</p> <p>Review of studies (Race to Equity, workgroups, SIM report, Mead & Hunt report)</p> | <p>DHS</p> <p>Hire consultant with experience with cultural competencies</p> | <p>RFP by 2/2018</p> <p>Proposals by 3/2018</p> <p>Contract by 4/2018</p> <p>Results by 9/2018</p> |
| <p>Public costs to criminal justice interaction:</p> <p>How many service hours by Fire/EMS/PD/courts/homeless shelters?</p> | <p>Data aspect</p> | | |

| | | | |
|---|--|--|--|
| <p>Definitions/data:</p> <p>Common definitions/data collection around individuals in jail with mental health needs- focus on serious mental illness (what percentage?)</p> <p>Did interaction manifest from mental illness? How to define mental illness?</p> | <p>Require a review/consideration of past work</p> <p>Data review</p> <p>File review of sample- too subjective?</p> | | |
| <p>Process</p> | <p>Address substance abuse as treatable mental illness- how to define mental illness?</p> <p>How best to change problematic behavior? Treatment/punishment?</p> <p>How can the entire system be more integrated?</p> | | |
| <p>Statutory/legislative review</p> | <p>How do WI statutes impact possibly solutions?</p> | | |
| <p>Data integration</p> | <p>Better data mining to lessen law enforcement hours at hospitals?</p> <p>Triage center?</p> <p>How much money for police to transport? Office hours?</p> | | |

| | | | |
|--|---|---|--|
| <p>Best practices in similar communities</p> | <p>Best practices in: data and care management</p> <p>How can hospitals participate in the system?</p> <p>Impact of CIT training?</p> <p>Inventory of current innovative pilots like EMS?</p> <p>Are health services effective?</p> <p>What is the nature of the coverage?</p> <p>What are the benefits of improvement (human, cost, time)?</p> <p>What are the barriers to seeing private providers?</p> <p>Peer support as a bridge to professional help?</p> <p>Stop gap approaches</p> <p>What bridges the gap for private pay?</p> | <p>Effective collaborations between public/private?</p> | |
| <p>Cost</p> | <p>How much does treatment cost vs. jail?</p> | | |

| | | | |
|-----------|---|-----------------------------------|--|
| Attitudes | <p>Assess level of access to psychiatry</p> <p>What is the average wait time to get to providers across insurance?</p> <p>Why the federal government does not designate Dane County as a shortage area</p> <p>What is continuity of care from arrest to reentry?</p> <p>Trends by population over time (students, etc.)</p> | | |
| Process | Efficiencies in processes? | | |
| Risk | How to identify/perceive those at risk? Attitudes? | How to measure? Using what tools? | |

Priority Area #2: Data (encompassing Priorities 4 and 5)

| Objective | Action Step | Who | When |
|---|---|--|--------------------------|
| <p>“Connect” criminal justice system data with behavioral health system data to identify high utilizers</p> | <p>Debrief CJC and request a motion to move forward with investigating high utilizers of Medicare within the County</p> <p>Smaller study prior to MOU- research study for high utilizers (costs across systems and frequency)</p> | <p>Clark/Reyes</p> <p>Campbell</p> <p>Enger</p> | <p>1/25/18 (12:15pm)</p> |
| <p>Jail data concerning serious mental illness</p> | <p>Establish definitions of: serious mental illness and co-occurring disorders</p> <p>Read screening and assessment report by Roger Peters (background re: data and definitions)</p> <p>Data technical assistance- screening tool at jail</p> <p>How many people score on current screen- serious mental illness?</p> | <p>County; Policy Research Inc.</p> <p>Policy Research to include in SIM report</p> <p>CCS, DCSO</p> | <p>January 2018</p> |

Priority Area #3: Improve system navigation through case management, care plans, and peer integration (encompassing Priorities 6-9)

Target population: people seeking help from police/fire/paramedics, people who did not commit a crime/cannot be ED'ed, and people with needs that are reentering the community

| Objective | Action Step | Who | When |
|--|--|--|--------------------------|
| Designate a point-of-contact who helps people through the system | County to issue an RFP to hire a Peer Specialist Team (including a supervisor) to provide Peer Specialists in various areas of the system | Todd C, Lynn Green, Mary Grabot, Galen Streebe, Sharon Corrigan, Dane County Reentry, Peer Specialists/Mentors, Troy Enger, Dave Mahoney, Scott (Madison Fire), Koval, CCS Mental Health, Hannah Flannigan, JMHC | Include in 2019 budget |
| Point-of-contact peer follows a person through the entire justice system (or to avoid charges), from initial police contact through release from jail and possible probation | Utilize peers who have a working knowledge of the justice system | | Process would be ongoing |
| Point-of-contact person is a peer with lived experience (Certified Specialist or Peer Mentor) | Peer Specialists create working relationships with police, fire, mental health ambulance, jail mental health, jail reentry, and probation/parole | | Process would be ongoing |

Priority Area #4: Housing

| Objective | Action Step | Who | When |
|---|--|--|--|
| Increase communication between agencies that work with individuals who are homeless and housing providers (both referrals and ongoing communications) | Identify who is not at the table currently (ex: regional corrections, jail, mental health providers) Release of information on VI-SPDAT- expand to cover the jail and other parts of the system | Homeless Services Consortium (HSC) Core Committee | Next HSC meeting Next meeting (1/18/18) |



PARKING LOT

Some gaps identified during the Sequential Intercept Mapping are too large or in-depth to address during the workshop. These issues are listed below.

- There is lack of clarity around area hospitals and relationships to law enforcement transport. Much of this is driven by the insurance payer source.
- The HUD definition of homelessness is narrow.
- There was no HMO representation at the SIM workshop, although they are a large player locally.



RECOMMENDATIONS

1. Develop a Crisis Continuum of Care that is integrated with the City/County Police Crisis Intervention Team (CIT) initiative across Madison and other law enforcement departments.

- Expand CIT Training and coordinate across each of the police entities in the surrounding municipalities
- Provide Mental Health First Aid training to all uniformed officers
- Expand crisis care treatment interventions

To be effective, mobile crisis or co-responders must be adequately staffed to respond promptly to crisis calls. More communities are coordinating mobile crisis team responses with law enforcement especially during peak call hours and co-locating services or embedding clinicians in police district headquarters. Often these services are augmented by providing telephone or videoconference consultation to law enforcement. Over the past few years, the Substance Abuse and Mental Health Services Administration (SAMHSA) and many states have begun to identify a “[Continuum of Care for Crisis Services](#).” In addition, states including Texas, New York, Virginia, and California have state-funded initiatives to enhance crisis services in communities.

2. Examine the feasibility and need for alternatives to detention and pre-adjudication diversion options for people with mental health disorders at Intercept 2.

Defendants with mental health disorders who are remanded to pretrial detention often have worse public safety outcomes than defendants who are released to the community pending disposition of their criminal cases. Consider proportional responses based on the severity of a defendant’s criminal risk and behavioral health treatment needs.

- Defendants with pending cases who are released to pre-trial services as an alternative to detention. These may be cases with moderate criminal risk, but where the individuals would benefit from community-based services that are not available while in pretrial detention and pretrial failure can be avoided.
- A deferred prosecution approach where a low-risk defendant is directed to participate in a short-term community-based treatment program. Successful completion of the program results in

dismissal of the charges while failure results in remand to custody and continuation of the criminal case.

- Explore a competency court docket, such as was established by the Seattle Municipal Court, to reduce time spent in jail during the competency process. Refer to the [journal article](#) by Finkle and colleagues (2009) and the [2013 report](#) on the Seattle Municipal Court Mental Health Court, which houses the competency court docket.

3. Develop more formal and coordinated screening and diversion strategies for arraignment diversion (Intercept 2) and pre-plea diversion (Intercept 3).

Formalizing screening protocols at arraignment and at the jail is the first step in expanding and implementing diversion strategies. Many screens, such as the [Brief Jail Mental Health Screen](#), are in the public domain.

Additional brief mental health screens include the:

- [Correctional Mental Health Screen](#)
- [Mental Health Screening Form III](#)

Brief alcohol and drug screens include the:

- [Texas Christian University Drug Screen V](#)
- [Simple Screening Instrument for Substance Abuse](#)
- [Alcohol, Smoking and Substance Involvement Screening Test](#)

Essential elements of Intercept 2 diversion can be found in the SAMHSA Monograph, "[Municipal Courts: An Effective Tool for Diverting People with Mental and Substance Use Disorders in the Criminal Justice System](#)." The monograph identifies four essential elements of arraignment diversion programs. Improving screening, clinical assessment, and behavioral health disorders who are released without referral or follow-up. The [CASES Transitional Case Management](#) and the [Manhattan Arraignment Diversion Program](#) are two examples.

4. Address the Incompetent to Stand Trial (IST) population.

Participants discussed the IST population who are retained in jail while waiting transfer to a state forensic hospital. The IST issue is a challenge for states across the country, but strategies have emerged to reduce the number of individuals found IST, provide outpatient restoration alternatives and reduce IST inpatient length of stay. In addition, coordinating strategies within the state forensic leadership will be a critical pathway toward reducing this challenge. This may include coordinating across other activities as well, including thinking through how an IST patient may be eligible for AOT services, or able to be diverted through crisis services and then longer term supports. For cases in which charges are minor, legal standards, such as the American Bar Association standards from 2016, point to consideration of diversion strategies for the misdemeanor who is incompetent to stand trial (see [standard 7.4-8\(e\)](#)).

Stakeholder meetings from the local jurisdiction and the state to focus on this population can be helpful. [Outpatient competency-related programs](#) can also be considered. Also see the SAMHSA’s GAINS Center’s *Quick Fixes for Effectively Dealing with Persons Found Incompetent to Stand Trial* (2007).

5. 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.

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. Review jail dashboards using simple tools to extract and report the information in a routine manner. Some examples include: Denver, Colorado; Johnson County, Kansas; and Data Driven Justice platforms that have been developed across the country.

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.

Join 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.

6. Expand the utilization of peer support across Intercepts.

Increase the purpose and role of peer involvement and support in every priority and agenda item. Peer support has been found to be particularly helpful in easing the traumatization of the

corrections process and encouraging consumers to engage in treatment services. Settings that have successfully involved peers include crisis evaluation centers, emergency departments, jails, treatment courts, and reentry services. Please see the below resources on *Peers* for more information.

7. 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.

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.

8. 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. 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.

9. 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



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.](#)

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.](#)

Information Sharing

- American Probation and Parole Association. [Corrections and Reentry: Protected Health Information Privacy Framework for Information Sharing.](#)

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.](#)
- 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

- SAMHSA. [*Screening and Assessment of Co-Occurring Disorders in the Justice System.*](#)
- 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.*

LOCAL PROGRESS SINCE SIM WORKSHOP

Overview of SIM workshop video (four minutes): <https://youtu.be/DHoDjjJrc6E>

Goals of SIM workshop video (one minute):

<https://www.youtube.com/watch?v=yn9Ao2edpL8&feature=youtu.be>

SIM Map Draft (see page 4)

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

Jan 16-17, 2018

Sequential Intercept Model – Policy Research, Inc. with Dane County, WI

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Appendix 2

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

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 Health.

- **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.



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Appendix 4



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?

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 reinstated 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 approved in an 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**



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

| <u>Question Section</u> | <u># Points Scored</u> |
|--|------------------------|
| 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

| <u>Question Section</u> | <u># Points Scored</u> |
|--|------------------------|
| 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

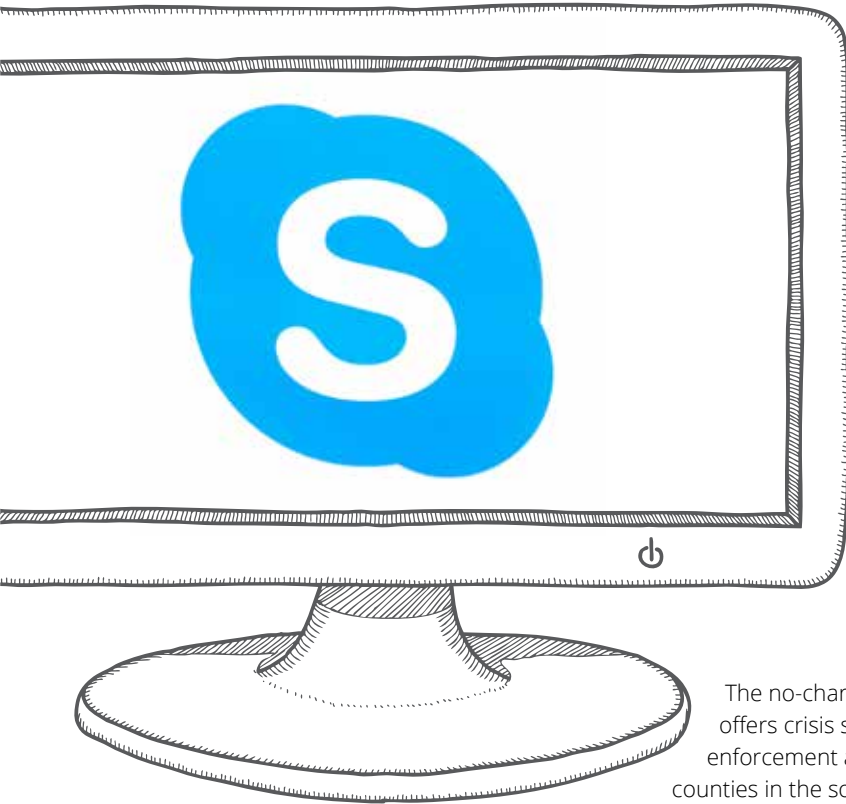
If you scored between: 10 – 36 points

- ✓ 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

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.

When Nebraska law enforcement officials encounter people exhibiting signs of mental illness, a state statute 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.

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:

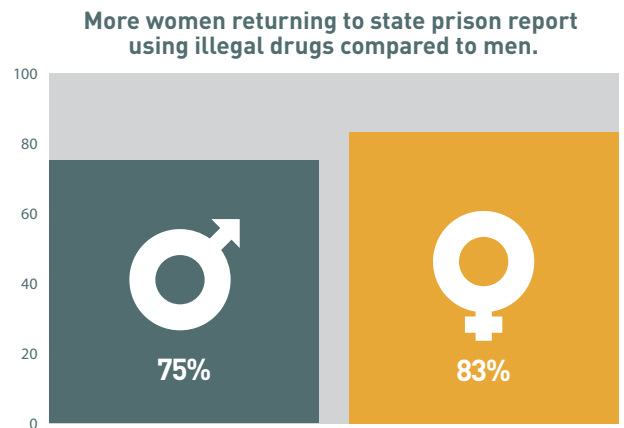
- Behavioral Health Providers & Criminal Justice Practitioners
- Individuals Returning From Jails & Prisons
- Communities & Local Jurisdictions
- State Policymakers

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.



ISSUE DATE 4.1.16

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



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/>



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