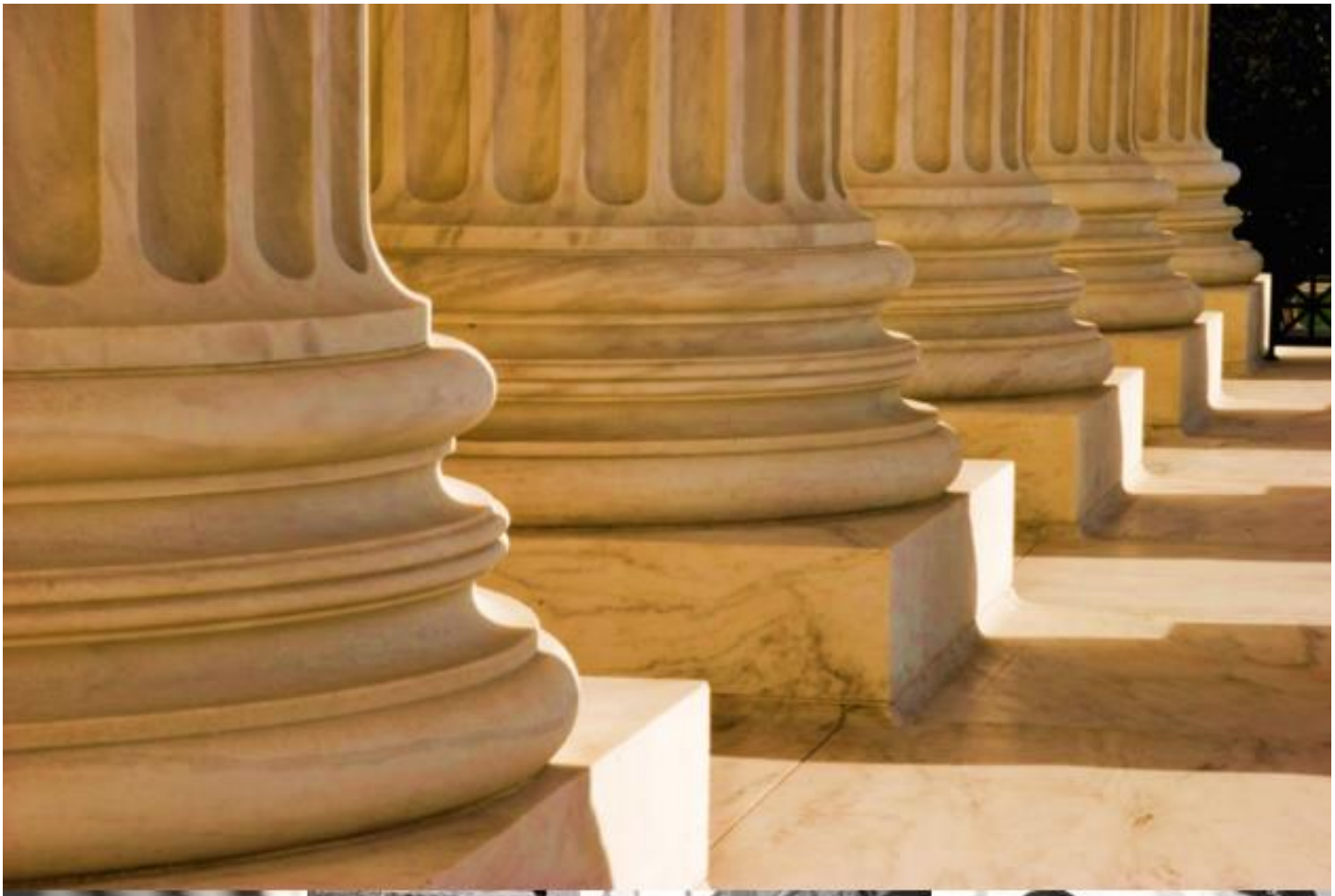

Sequential Intercept Model Mapping Report

Yuma County, AZ July 18-19, 2018

SAMHSA's GAINS Center Policy Research Associates, Inc.

SEQUENTIAL INTERCEPT MODEL MAPPING REPORT FOR YUMA COUNTY, AZ

July 18-19, 2018

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ACKNOWLEDGEMENTS

This report was prepared by Regina Huerter and Maureen McLeod of Policy Research Associates, Inc., for SAMHSA's GAINS Center for Behavioral Health and Justice Transformation. SAMHSA's GAINS Center wishes to thank the Arizona Complete Health Behavioral Health for supporting this event and to the Yuma Police Department for hosting this event.

We also want to thank the report review team: George Owens, Mike Byrd, Sandi Hoppough, John Abarca, Raul Fiveash, Mary Gonzales, Chris Humphrey, Joe Lackie, Johnnie Gasper, Olivia Wilson, Edgar Sandoval, Larissa Flores, Cesar Acosta, Amy Devins, Victoria Alarcon, Susan Pancrazi, Theresa Fox, Sylvia Flores. Special thanks to George Owens for his stewardship!

RECOMMENDED CITATION

SAMHSA's GAINS Center for Behavioral Health and Justice Transformation. (2018). *Sequential Intercept Model Mapping Report for Yuma County, AZ.* Delmar, NY: Policy Research Associates.

Contents

Introduction

Since 1995 SAMHSA's GAINS Center for Behavioral Health and Justice Transformation, operated by Policy Research Associates, has worked to expand community-based services and reduce justice involvement for adults with mental and substance use disorders in the criminal justice system. The GAINS Center is supported by the Substance Abuse and Mental Health Services Administration to focus on five areas:

- Criminal justice and behavioral health systems change
- Criminal justice and behavioral health services and supports
- Trauma-informed care
- Peer support and leadership development
- Courts and judicial leadership

On July 18-19, 2018, Regi Huerter and Maureen McLeod of SAMHSA's GAINS Center facilitated a Sequential Intercept Model Mapping Workshop in Yuma for the Yuma County Government. The workshop was hosted by the Yuma Police Department. Arizona Complete Health Behavioral Health supported the workshop. Approximately 60 representatives from Yuma County participated in the 1½-day event.

We extend a special thank you to Yuma County Adult Probation Deputy Chief Mike Byrd and to Arizona Complete Health Program Manager George Owens who opened the workshop on July 18, 2018, and to all of the Yuma County personnel who participated in the development and review of this document.

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.

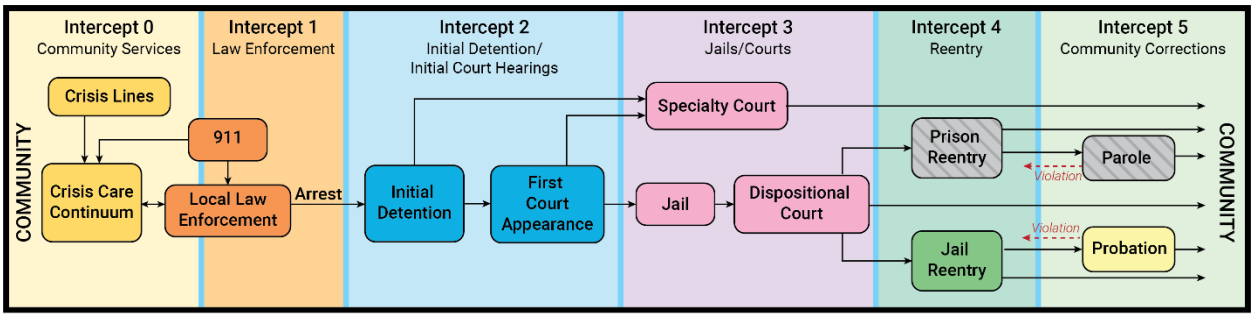
A Sequential Intercept Mapping is a workshop to develop a map that illustrates how people with behavioral health needs come in contact with and flow through the criminal justice system. Through the workshop, facilitators and participants identify opportunities for linkage to services and for prevention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

SAMHSA's GAINS CENTER

SAMHSA

Sequential Intercept Mapping Workshop

Yuma County, AZ

July 18, 2018

AGENDA

8:00 **Registration and Networking**

8:30 **Openings**
- 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
- Setting the Stage for Day 2

4:00 **Adjourn**

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

There will be break for lunch at approximately noon.

SAMHSA's GAINS CENTER

SAMHSA

Sequential Intercept Mapping Workshop

Yuma County, AZ

July 19, 2018

AGENDA

8:00 **Registration and Networking**

8:30 **Opening**
- Remarks
- Preview of the Day

Review
- Day 1 Accomplishments
- Local County Priorities
- Keys to Success in Community

Action Planning

Finalizing the Action Plan

Next Steps

Summary and Closing

12:00 **Adjourn**

There will be a 15 minute break mid-morning.

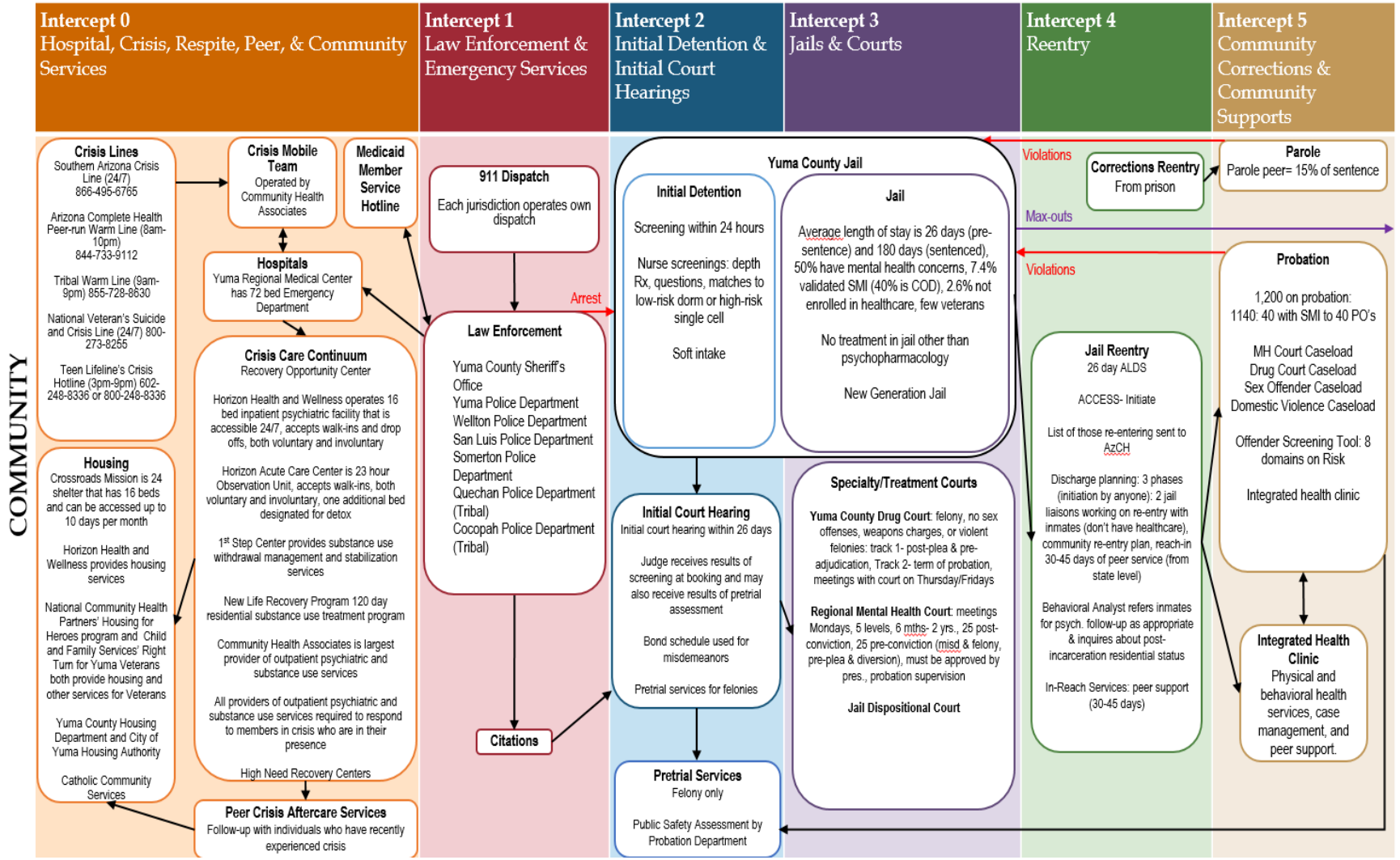
Sequential Intercept Model Map for Yuma County, AZ

Yuma County is comprised of five major population area -- Fortuna Foothills, San Luis, Somerton, Yuma and Wellton -- and borders with California and Mexico. The County has a military testing base, known as the Yuma Proving Grounds, and is home to the Yuma Marine Corps Air Station. Viewed as a tourist destination, the full-time resident population (estimated by the US Census Bureau in 2016 at 204,275) nearly doubles in the winter months. Government records indicate that the county has a high rate of unemployment, often upwards of 20%. Nearly one in five (19.4%) of county residents is without health insurance and 21.1% of the population lives in poverty. The community is largely Hispanic or Latino (62%) and includes nearly 15,000 veterans. More than a quarter of the population (26.3%) is foreign born. (https://www.census.gov/quickfacts/table/PST045215/04027 and information from the Yuma County SIM application)

Since the SIM workshop in July 2018, significant changes in the coordination and integration of healthcare services in Yuma County have resulted from mergers, realignments, and procedural modifications involving crisis management responders, medical and behavioral healthcare providers, and criminal justice personnel. While the nature of the services provided has often remained unchanged, the names of several of the participating agencies /providers have changed.

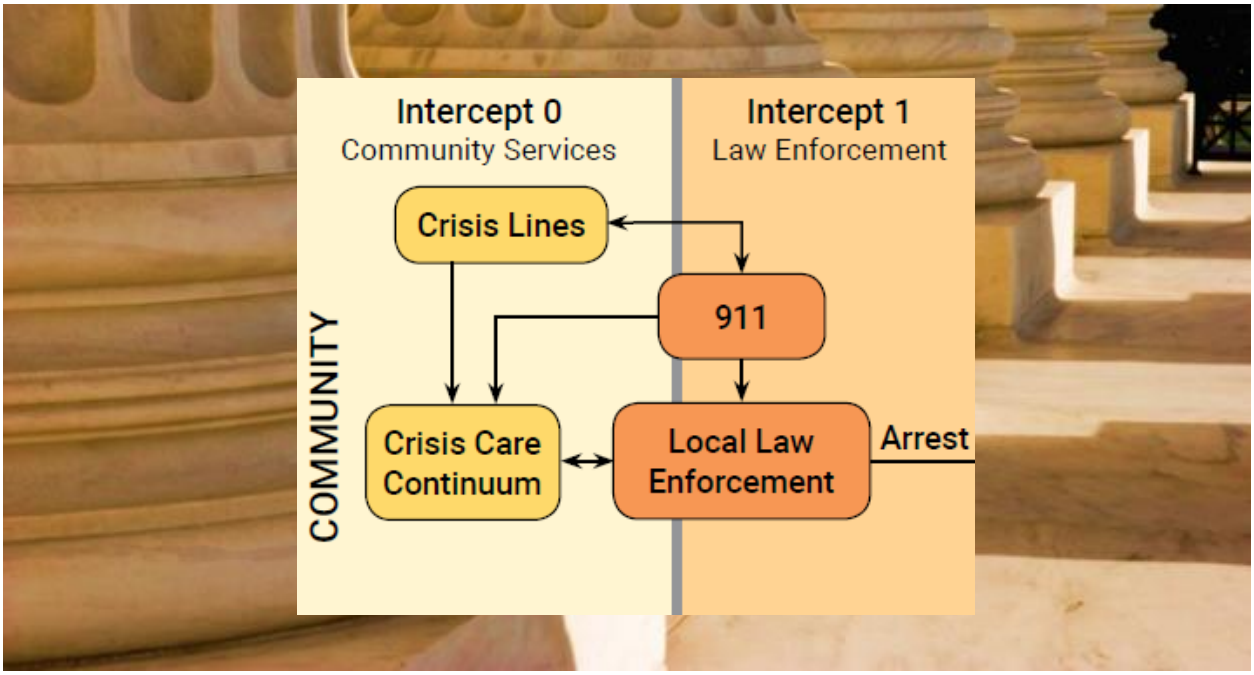
Beginning October 1, 2018, general mental health, CMS and AHCCCS funding steams were merged into an integrated model that provide complete care for behavioral and medical health issues. Two Managed Care groups emerged, Banner Health and Arizona Complete Health (AzCH). AzCH (formerly known as Cenpatico) has retained a primary focus on the SMI population and foster children. At AzCH, the case manager to patient staffing ratios reflect an understanding of the complexity of needs for justice-involved populations. For the general population, the case manager/Pt ratio has been set at 1:100; for justice-involved persons, this ratio has been set at 1:50. Banner Health is a second option for healthcare services, with a primary emphasis on medical health concerns. Nursewise, a provider of crisis management services, has been rebranded as the Southern Arizona Crisis Line, more familiarly referred to as The Crisis Line.

Sequential Intercept Model Map for Yuma County, AZ



Resources and Gaps at Each Intercept

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



INTERCEPT 0 AND INTERCEPT 1

RESOURCES

At Intercepts 0 and 1, local and county behavioral health, medical and criminal justice system personnel, were able to identify significant resources in the following areas: Crisis Management Coordination, Emergency Preparedness, Crisis Lines and Crisis Mobile Team Services, Crisis Transportation, Emergency Medical and Psychiatric Services, Non-Emergency Services, Homeless Shelters and Housing Programs, Law Enforcement, Training, and Sliding Fee Providers. These resources are discussed in further detail below.

Crisis Management Coordination

Collaborative Crisis System meetings are held quarterly by AzCH First Responder Services staff. At these meetings, all key system partners (crisis providers, ED, first responder agencies and criminal justice system personnel) identify barriers and strengths in the crisis system and discuss systemic changes and issues. To assist with crisis situations in real time, AzCH has assigned a First Responder Liaison to Yuma County as the primary point of contact for all crisis system issues involving First Responder agencies. The complete Yuma Crisis System Protocol is updated annually by the AzCH First Responder Services team. The 2019 Crisis System Protocol is attached to this report.

Emergency Preparedness

Per the Crisis System Protocol, AzCH has adopted an inter-agency emergency preparedness plan to ensure continuity of operations and services in the event of a disaster or community crisis. In the development of this plan, AzCH has worked with local emergency and disaster preparedness entities to ensure AzCH is included in the county's response plans. Separate protocols and agreements have been developed outside of the crisis system protocols.

Crisis Lines and Crisis Mobile Team (CMT) Services

- **Crisis Lines -** The Yuma County region is served by several crisis lines.
    - The AZ Crisis Line (1-866-495-6735), formerly NurseWise, is a service provided through the Regional Behavioral Health Authority (RBHA), AzCH. The Crisis Line is available 24/7. Requests for services (from individuals or first responders) will triaged by licensed and non-licensed mental health professionals.
    - Arizona Complete Health also has a peer-run warm line, staffed by trained peers, that services Yuma and Tucson (1-844-733-9912). The hours of operation are 8:00am – 10:00pm daily.
    - The Native Youth Crisis line through YANAN (1-877-209-1266) is peer staffed and provides crisis services to Native-American youth. YANAN partners with The Crisis Line and CMT.
    - The Tribal Warm Line (TWL) is an AzCH peer support service, run by the Crisis Line. The TWL provides no cost over-the-phone support to American Indian community members and is staffed by Tribal Support Partners (TSPs) who are tribal members living in their own communities. The number is 855-728-8630. 9am-9pm 7 days a week, rolls to Crisis Line after hours
    - The National Veteran's Suicide and Crisis Line (1-800-273-8255 and press 1) provides mental health services to veterans and their families.
    - Teen Lifeline's crisis hotline is available at 602-248-8336 (call or text) or 800-248-8336 (call only). The hotline is staffed by a Master's level clinician 24/7. Peer counseling and the text messaging service is available daily 3:00 pm - 9:00 pm with after-hours support through the Crisis Response Network.

- **Crisis Mobile Team (CMT) Services -** In Yuma County, the CMT provider is Community Health Associates (CHA). CMT assessment and intervention services in the community are available to any person in the county regardless of insurance or enrollment status. CMT response time expectations are outlined in the attached

Crisis Protocol. First Responder calls to the Crisis Line are prioritized. In addition to phone based crisis stabilization, the AZ Crisis Line can also dispatch Crisis Mobile Teams (CMTs) to respond to the identified location for in-person crisis assessment and crisis stabilization.

Crisis Transportation

In situations involving medical or behavioral health crises, medical health needs are always prioritized. There are jurisdictional differences in law enforcement practice when a Title 36 patient pick-up is required under court order. In Yuma, law enforcement transports Title 36 patients to HHW (or other location specified in the court order) for drop off. If the individual is determined to be in need of emergency medical care, personnel at the drop off site call an ambulance to transport the patient to the ED at YRMC. In other jurisdictions, when there is medical necessity, law enforcement generally directly arrange for an ambulance to transport the Title 36 patient to the ED.

Per the Crisis Protocol (see https://www.azcompletehealth.com/ for updates), AHCCCS contractual requirements require CMTs to always strive to place a person in the least restrictive environment. For a person in crisis, this may mean a referral to a facility-based crisis service. Facility-based crisis services include Brief Intervention Programs (BIP), Social Detox, and Community Observation Centers. If there are no other safe alternatives, placement in a psychiatric facility may be needed on an emergency basis.

Due to shifts in funding streams, as of October 1, 2018, the process for assessing the medical and behavioral health needs of a patient who is independently transported to the ED (i.e., a CMT has not yet been engaged) has changed. If. Upon arrival at the hospital, a patient who is a member and assigned to Banner Health, United or AzCH is assessed by the Hospital Assessment Team (HAT) to determine the patient's Title 19 status. If the client is non-Title 19 and non-SMI or privately insured, CMTs may be called and may transport client to the ED.

Emergency Medical and Psychiatric Services

- **In-patient**
    - Yuma Regional Medical Center (YRMC) houses a 72-bed emergency department for patients with a demonstrated medical need. If there is not a demonstrated medical need, the hospital has no dedicated mental health psychiatric beds, nor the ability to hold individuals experiencing a mental health crisis.

- Horizon Health and Wellness (HHW) operates a free standing, behavioral health walk-in/drop off facility that provides services for people who are in need of immediate psychiatric intervention. HHW can provide services for adults only. Services may be accessed 24/7 via referral or walk-in basis. Referrals are accepted from, but not limited to, CMTs, EDs, law enforcement and other system partners. HHW provides in-patient services for both voluntary and involuntary clients. HHW's 16-bed psychiatric in-patient facility is a short-term stabilization unit for voluntary/involuntary members. This facility, the only such facility in Yuma, is attached to the observation unit and serves an average of 50 members per month with an average length of stay of 5 days. It is generally at 50% capacity. If a crisis bed is unavailable, a client may be referred to services in surrounding counties. In-patient beds outside of Yuma are often used to meet the need for longer stays and stabilization. Because of this arrangement, HHW is able to increase throughput and ensure all members have access to care while limiting hospital hold times. These data are reviewed monthly to ensure beds are available for community referrals from law enforcement and CMTs.

- **Out-patient**
  - Horizon Acute Care Center (HACC), operates a 23 hours walk-in-friendly Observation Unit. Law Enforcement can transport to Observation Unit at Horizon or to the ED at Yuma Regional Medical Center. In addition, there is 1 bed for voluntary detox stabilization in the Observation Unit.
  - Community Health Associates provides outpatient psychiatric and substance use services.
  - During regular business hours, per the Crisis Protocol: outpatient service providers will provide crisis intervention to their members who are in a crisis and in their presence. Contractual agreements between AzCH and provider agencies require that agencies will schedule urgent and emergency appointments, as necessary, to ensure that enrolled members can be seen at the agency when an emergency arises. CMTs are required to notify Health Homes of a crisis with an assigned member in real time. The Crisis Line and CMTs must coordinate with Health Homes in the development of an appropriate treatment plan

Non-Emergency Services

- In Yuma County, persons who have recently experienced a crisis are eligible for Second Responder services for 2 weeks – 45 days. These services are provided by

Peer Crisis Aftercare Services. Referrals for these services can be made by CMTs, Crisis Line, COC

Homeless Shelters and Housing Programs

- *Crossroads Mission* offers both a 24 hour, faith-based shelter and a Stabilization Center. The homeless shelter provides services to men, women, and children. In order to stay more than one night at the *Crossroads Mission* shelter, a person must present a valid ID (Jail ID and ACCHSS ID are satisfactory). Guests are allowed to stay at this facility for up to 10 consecutive days each month. Persons who are intoxicated are not admitted. A breathalyzer is given at check-in. The 16-bed (11 male, 5 female) stabilization center*, 1st Step Center* provides withdrawal management services and stabilization services.
- Persons can transition to the *New Life Recovery Program*, a 120-day residential program. Peer support, 12-Step, and other substance use disorder treatment services are available by licensed staff.
- Horizon Health and Wellness (HHW) provides various housing options including independent, transitional, HUD and supported housing, and supported employment services.
- *Right Turn for Yuma Veterans*, operated by Child and Family Service, Inc., provides transitional housing (room and board), navigation of financial support and services, medical benefits and re-engagement with community and family.
- National Community Health Partners runs "*Housing for Heroes*" veteran housing, employment and benefit support and homeless outreach services.
- Housing counseling and family-housing are available through both the Yuma County Housing Department, which oversees public housing and housing choice vouchers, and the City of Yuma Housing Authority. The Western Arizona Council of Governments operates "*A Hand Up Housing Counseling*".
- Catholic Community Services provides housing counseling and limited transitional housing for families and some senior housing options.

Law Enforcement

Yuma County is served by 5 law enforcement agencies plus tribal law enforcement.

- Yuma PD
- Yuma County Sheriff's Office
- Wellton PD
- San Luis PD
- Somerton PD
- Quechan PD (Tribal)

- Cocopah PD (Tribal)

Each jurisdiction has its own dispatchers. There are efforts to train 911 dispatchers in City of Yuma in CIT. Few dispatchers in other 911 centers have this training.

- 911 will dispatch the Crisis Mobile Team (CMT), Community Health Associates, or Border Health to the scene when an individual is in crisis.
- When encountering a person on the street, it is not uncommon for law enforcement agencies to contact the Medicaid member service hotline to ascertain the person's treatment agency to try to get someone to the person who knows them. Law Enforcement also regularly utilizes the Crisis Mobile Teams who will be dispatched to the scene within 30 minutes of activation to attempt community stabilization.

There are two law enforcement drop off sites for persons in crisis. These include:

- The Recovery Opportunity Center (AKA the ROC). This site does not accept minors or involuntary patients.
- Horizon Health and Wellness's 23-hour observation unit. This unit is a locked facility that opened in 2015. It accepts both voluntary and involuntary admissions. The goal of this 23-hour unit is to provide short term psychiatric evaluation and treatment to resolve the immediate crisis (discharge to the community with supports) or transfer to a higher level of care.

Training

AzCH provides a variety of training to behavioral health providers, criminal justice system personnel and First Responders throughout the county.

- Training on Adverse Childhood Experiences (ACEs) and Traumatic Brain Injury (TBI) are available. Monthly Mental Health First Aid training is provided for Public Safety and Fire/EMS.
- The nature and extent of training available to law enforcement officers varies by jurisdiction. In general, law enforcement personnel receive Mental Health First Aid and Traumatic Brain Injury (TBI) training. All Yuma PD officers (177 FT sworn officers) are trained in Mental Health First Aid. "Some" officers in San Luis PD, Somerton PD and Quechan PD are trained in Mental Health First Aid. "Most" officers in Cocopah PD (tribal) are trained in Mental Health First Aid.
- Across the various PDs, relatively few officers are CIT trained. While the Yuma PD has applied for a CIT training grant as part of the "One Mind" campaign, some members of the site team expressed a preference for Mental Health First Aid training. AzCH has offered to cover the costs related to this training for any first responders or other groups/persons working with individuals in crisis.

Arizona Sliding Fee Scale Providers

The website of the Arizona Department of Health Services, Bureau of Health Systems Development lists providers who offer behavioral health services on a sliding scale. The updated list of providers can be found at: https://www.azdhs.gov/documents/prevention/health-systems-development/sliding-fee-schedule/sliding-fee-behavioral-health-providers.pdf

GAPS

General Crisis Services

- There is a need for more community awareness of how to access various crisis services.
- In rural communities there may be lengthy wait times for crisis services. Heavy reliance on law enforcement for transportation to services.
- There is a lack of formal, integrated peer support services in Intercepts 0 and 1.

Psychiatric Emergency

YRMC is not licensed for psychiatric, in-patient services.

- About half of acute care patients presenting at the YRMC ED are sent to Horizon Health; these beds are at capacity approximately 50% of the time. In the second half of calendar year 2018, the HHW 23-hr observation unit averaged under 14 total hours on capacity (aka hospital hold) where they were unable to receive additional referrals (1.9% of the time.)
- As noted earlier in this report, the HHW 16-bed stabilization facility operates as a short -term inpatient unit to ensure capacity to house involuntary members coming from the community. To ensure that referrals are made appropriately to the correct facility, evaluations occur in the hospital prior to referral.
  - Medicaid bed capacity is currently tracked and providers report quite a bit of availability in southern Arizona at both IMD and Non-IMD facilities. This availability is distributed weekly to Hospital Assessment Teams, CMTs and 23-hr observation units to promote timely referrals and placement.
  - The number of Medicare beds are restricted in Yuma County, but an override is offered to HHW members during crisis for placement in the HHW stabilization unit if availability in southern Arizona is limited.
  - Hospitals reportedly do not have enough staff to provide service information to individuals who receive in-home healthcare services.
  - There are no psychiatric emergency teams, or dedicated access to mental health crisis services within EMS.

- Although not necessarily a gap in resources, it is notable that there is sometimes a mismatch between client need and the level of services to which a client is referred. Hospital assessment teams evaluate and can assist with community discharge via coordination with outpatient providers and resource assistance. If a member requires a higher level of care (e.g., in-patient), hospitals are asked not to directly refer to 23-hr observation (out-patient care) for crisis stabilization. Rather, if members meet criteria for a higher level of care, they should be directly referred up to inpatient care.

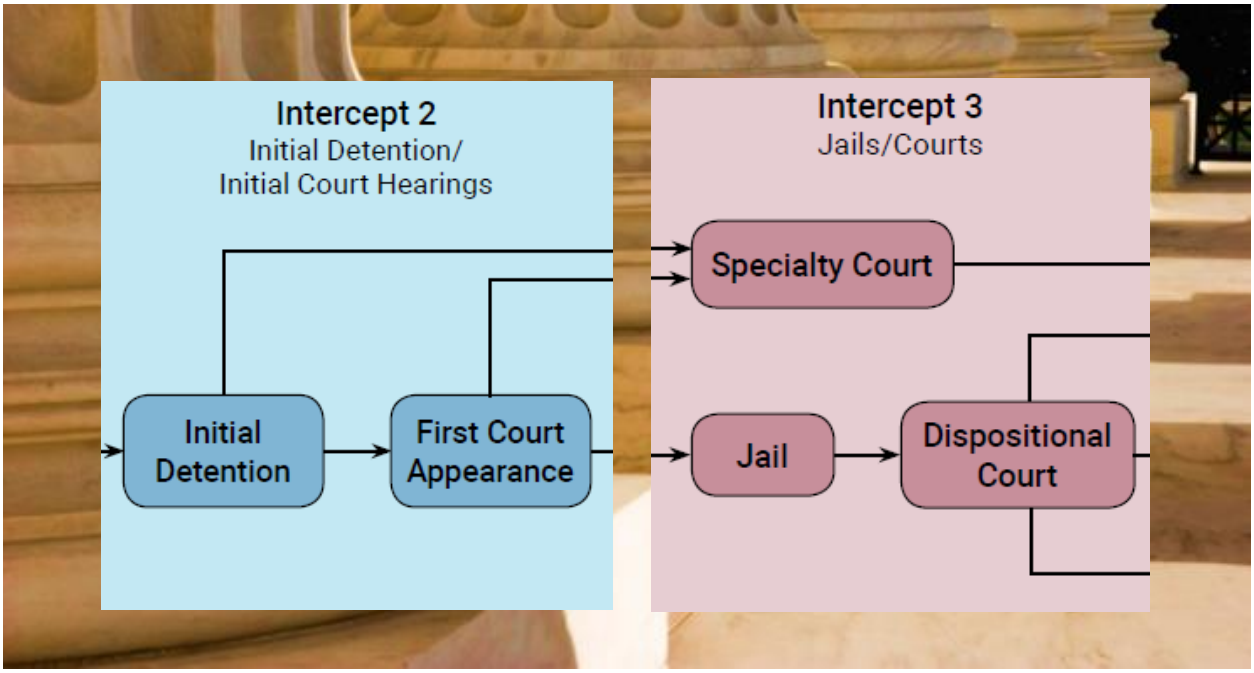
Information Sharing and Coordination

In an effort to improve crisis outcomes and care coordination, the Emergency Department would like to share information on behavioral health patients in the emergency department but may not have information on the patient's primary care physician.

- EDs are seeing an increase in the number of opioid users in Pain Management Clinics. There is no way at this time for Behavioral Health Treatment providers to know which patients have sought treatment in the ED.

Homeless Shelter Services

If *Crossroads Mission* does not have beds available in the detox center, individuals may be referred to services 3 hours away in Tucson, AZ. Other "detox" programs are available in Yuma County, but require insurance, non-Medicaid, or financial ability to pay.



INTERCEPT 2 AND INTERCEPT 3

RESOURCES

Integrated Health Clinic

An integrated health clinic within probation, specifically targeted to address the needs of members being released from jails and prisons, opened in June 2018. The clinic includes physical health and psychiatric services, justice-trained care managers, forensic peer support, probation and parole. The clinic is a result of a series of coordinated events between the Yuma County Board of Supervisors, Yuma County Administrator, Arizona Complete Health Integrated Health (formerly Cenpatico Integrated Care), Yuma County Detention Center, Arizona Department of Corrections, local law enforcement, probation, parole, peer run organizations, Health Homes (now incorporated into the open fee for service model) and specialty providers to include housing, employment and other supportive agencies within the community. The committee used the *"Guidelines for Successful Transition of People with Mental or Substance Abuse Disorders for Jail and Prison: Implementation Guide"*; monthly leadership meetings have been held for the past two years and there are regularly over 30 people in attendance. The leadership committee has:

- Created a provider resource guide and professional directory.

- Held professional forums and cross-discipline training to introduce evidence-based practices with a focus on Risk, Needs and Responsivity. Future training will include actuarial risk used by probation and parole.
- Provided jail liaisons who are co-located within the jail to work with attorneys, judges, probation and parole on release planning for people that are detained. Detained individuals are placed in one of three programs to help meet their needs for release.
- Achieved data integration through a series of administrative orders and MOU's. Self-generated reports utilize jail, prison, probation and treatment data to merge specific fields to ascertain elements essential to care and coordination (e.g., Does the person have Medicaid or some type of insurance? Do they have a history with a provider? Are they in an open episode of care? When are they scheduled for release? etc.)
    - Developed a health information exchange between the jail/prison and the clinic, so that records are readily available to ensure timely up-to-date information.
    - Used the data to notify the individual's Health Home that the member has been detained, and to begin release planning. Data are also used to ensure connection to Medicaid or some other benefit resource, e.g., Veterans Administration. Work is currently taking place to automate and expedite Medicaid (re)activation upon release and to assist with medication and placement.
    - Measured outcomes such as recidivism and average length of stay. Initial results show a 4% reduction in recidivism this year from last as indicated by the integrated data collected from the jail on open members.

Pretrial Services

Pre-trial services are available to felony defendants only. A bond schedule is used for persons detained on misdemeanor charges. Probation completes the Public Safety Assessment (PSA), developed by the Laura and John Arnold Foundation, and gives a recommendation to the judge: bail, release on own recognizance (ROR), remand, or pre-trial supervision. A combination of phone in and face-to-face supervision is utilized in pre-trial.

- Very few defendants are remanded to jail for inability to post bail. The average length of stay in the jail is 26 days for pre-sentence inmates.
- There are contracts with tribal courts, but not with Immigration and Customs Enforcement (ICE)

Courts, Prosecutors Office and Treatment Courts

- Yuma County Attorney's office has 4 civil attorneys and 22 criminal prosecutors.
  - Law enforcement gives arrest information directly to the judge prior to prosecutor involvement
  - There are 4 municipal courts that handle misdemeanors and initial appearances. The Justice Center has 6 Superior Court Judges, 3 of whom handle criminal or felony cases and 3 pro tem/commissioners. There are 4 Justices of the Peace in Yuma County (2 in JP1; and 1 each in JP2 and JP3) who handle initial appearances and misdemeanors in the JP courts.
  - HOPE, Inc. has a new jail liaison staff funded by AzCH. The program goal is to assist members and potential members released from Yuma County Detention to enroll into services. The jail liaison will engage with individuals to provide peer support and provide warm handoff into the community pre or post initial court appearances.

- **Regional Mental Health Court:** Started in 2013, there are currently slots for 60 participants, divided between post-conviction participants and deferred felony/misdemeanor participants who are not on probation and will have their charges dismissed upon successful completion. These latter participants do not have any direct supervision.
- Participation in post-conviction felony Mental Health Court is voluntary as a condition of probation, following screening and acceptance. In order to be deemed eligible for participation, the person must have been determined to be SMI or must have a pending determination, AXIS 1 primary diagnosis, or co-occurring MH/SA disorder, or as deemed appropriate by the Court.
  - The Probation department provides supervision. Through the process, an undesignated felony can become a misdemeanor
  - Counseling and other services are facilitated by a number of community resource agencies and cover mental health treatment, substance abuse treatment, medical health, trauma, housing, employment and other services. The court is facilitated by a pro-tem Judge, a court coordinator, various treatment staff, prosecuting and defense attorneys and probation officers.
  - Participation in pre-conviction Mental Health Court is voluntary. Participants can have any level of offense but must have a diagnosis for a serious mental illness (SMI). Upon successful completion, the case is dismissed in jurisdictional court. There is no direct supervision.

- **Drug Court**: Drug Court is 20 years old. Drug Court capacity is 150 cases (post-plea/pre-adjudication cases and post-conviction cases). The program is a minimum 18 months in length, with a minimum of 212 hours of direct programming utilizing the Matrix Model or Living in Balance Model from Hazelden. All participants receive substance abuse counseling ranging from in-patient residential services through intensive outpatient, standard outpatient, relapse and prevention. As other needs are identified, additional services may be sought (i.e., medicated assisted treatment, trauma services, cognitive behavioral therapy – MRT, housing, employment, etc.) Cases involving sex offenses, violence or injury using a weapon are excluded. There are 2 felony drug court teams, each with an assigned judge, internal and external staff, 2 probation officers, 2 county attorneys and 1 public defender. The teams share a surveillance officer who conducts field investigations. Probation officers carry caseloads of approximately 50 clients and use trauma informed care as a basis for interaction. Generally, the time under supervision is 18- 24 months. There is a sincere effort to celebrate participants' small and large successes. Nearly 3/5 (58%) of the defendants do not reoffend post-conviction.
    - In-House Staff – Substance Abuse Counselors hired by Yuma County Adult Probation who work directly for the probation department and not an outside agency.
    - External Agency Staff – Currently, there are 3 substance abuse counselors who are employed by outside counseling agencies, but are specifically assigned to the Drug Court Program. Although these counselors work for local community agencies, because of their specific assignment to Drug Court, they are provided work space in the probation department and conduct all their business at adult probation

Yuma County Jail and Medical Services

- The jail capacity is 756. The average length of stay in jail is 26 days pre-sentence and 180 days once sentenced. Housing ranges from dormitory settings to individual cells. Average number of arrests per person is less than 2.
- The Yuma County Sheriff's Office has three main divisions: Administration, Detention, and Patrol.
- AzCH reported that, based on data collected between Oct 2017 and May 2018, greater than 50% of the detained/incarcerated population have a mental health concern and over 433 persons were released with an appointment at a mental health or other treatment service. Reports show 40% of incarcerated persons left the jail with benefits or entitlements in place.
- Behavioral health information is gathered in several places, by several people:

- WellPath Care (formerly Correct Care Solutions) for medical services since 2007
- Arresting law enforcement officers complete a questionnaire noting specific behaviors/needs/observations of the arrestee.
- At booking, a jail Detention Officer completes the Brief Medical Assessment, a screen which includes medical information, mental health history, and potential suicidal ideation
- If there are signs of medical issues, the Nurse completes a medical screening which was developed from National Commission on Correctional Health care Standards for Jails. Then, if it is determined that the inmate is medically compromised, the jail sends inmate by ambulance to hospital.
- An Administrative Order (RHBA, MCOs), specific to the court system, is in place to share basic information with the courts in an effort to best coordinate care services.

- Jail liaisons from AzCH initiate the Medicaid enrollment process prior to release with activation 24-48 hours post-release.
- Banner Health is currently using case managers for prerelease planning for its members. The addition of Banner Health jail liaisons is being discussed.
- All jail releasees receive information and a referral to the integrated medical clinic.
- Pharmacy services are contracted out.

Treatment and Other Supports

Crossroads has been providing services for 20 years including a hybrid of community-based Intensive Outpatient (IOP) care and in-patient residential treatment program. The program uses the ASI-R to assess clients.

GAPS

Maximizing Resources

Explore how to maximize resources between County Mental Health (CMH) and local Federal Qualified Health Center (FQHC) to reduce cost of drugs, treatment providers. Sunset Clinic is the only FQHC in Yuma County and has a mobile van.

- There is a lack of clarity about when a person needs to be in the emergency department or jail based on medical clearance. Probation, law enforcement. YRMC and HHW should engage in discussion about thresholds for “Medical assessment and Medically Cleared”.

Jail Services

- Full data profile is needed for jail population: warrants, failure to post bail, or failure to appear (FTA).
- Residence status at entry or upon release not formally asked or tracked
- Screening for intellectual developmental disabilities (IDD) is not conducted
- Currently, persons do not receive jail based Medication Assisted Treatment (MAT) due to funding. The Sheriff department is willing to have MAT protocols.
- Frequently, persons leaving the jail do not have identification. ID's are difficult to obtain prior to release. Jail ID's do not work at the Department of Motor Vehicles (DMV), however, Jail ID's could be used to temporally help access some services.

Treatment Courts

- The Mental Health Treatment Court (MHTC) would benefit from a proactive, consistent approach. Currently, the court occurrence is infrequent, and provider case managers change often, resulting in inconsistent support and service delivery.
- The coordination and warm-hand off between Mental Health Treatment Court and mental health services could improve.
- Post- court transition would improve client stability; a jail program module that includes transition and stabilization would improve overall client outcomes.
- Drug Court isn't utilizing peer supports. The incorporation of peer supports could reduce the challenges of connecting to family and transition to the community.
  - Continuity in Drug Court is with Banner Managed Care Organization (MCO), which is a contractual system with partners.
- **Veteran's Problem Solving Court -** There are discussions underway to establish a Veteran's Court that would work with persons charged at a municipal/misdemeanor level. At the time of the SIM, 120 inmates were veterans. There may be more who did not disclose their status.

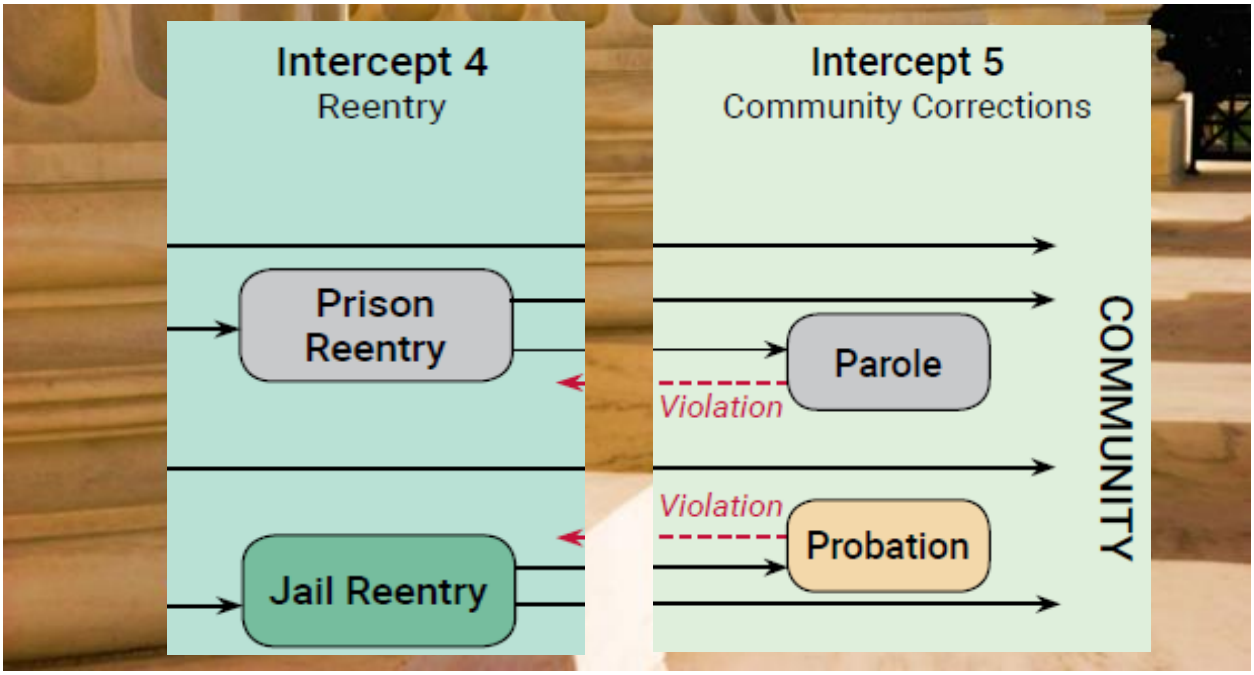
Treatment Options

- Residential or in-patient substance use disorder treatment options are limited. Residential treatment capacity is an issue often running 98% full. The lack of treatment slots may result in persons being in the jail.

- Horizon Health and Wellness does not offer in-patient substance use disorder treatment. Out-patient treatment is a hybrid of 2 in-house and 2 out-sourced staff.

Community Bridges maintains a 24-bed co-educational facility in Yuma for acute care and provides treatment for SUD on an out-patient basis.

- *Crossroads Mission* maintains a 60-bed SUD facility for patients in 120-day in-patient treatment.



INTERCEPT 4 AND INTERCEPT 5

RESOURCES

Local leadership has established meetings with probation/parole and treatment to strengthen relationships and develop a better understanding of each other's work. Leadership reports that the data share between probation, jail and Medicaid has allowed the group to identify gaps in coverage. One example that was cited was that, at the beginning of 2018, there were approximately 340 people on probation who are Medicaid eligible and not in an open episode of care. Data were utilized in the planning of the integrated clinic. During probation intakes, clients are informed about the integrated clinic and appointments are scheduled. The intake appointment attendance rate increased from 50% to 90%. Working as an integrated team will assist people and the timeliness of service delivery.

Jail Capacity and Behavioral Health Services

- Yuma County Jail is a "new generation" facility with a focus on treatment and medication management. The facility has a rated capacity of 756. Mental Health treatment is provided by the contracted medical provider in a clinic setting. There is no group mental health programming.

- Corrections officers complete a 40-hour course at the Academy on general MH issues.

Daily, AzCH receives a list from the jail of who is in custody. About 20% of the inmates are screened by the Behavior Analyst Mental Health Screening and Appraisal / Suicide Risk Assessment; roughly 18% of those screened are determined to have a serious mental illness (SMI). Upon determination, the individual's name is run through the AzCH data system to see if they are a client. AzCH Membership Data is matched with Yuma County Adult Detention Center Bookings data and results in the Yuma County Detention Center Statistics report. The report for the 8-month period between 10/1/17 – 5/31/18 shows:

- There were 4,060 bookings at the jail. Slightly more than half (50.1%) were AzCH members. Per the Cenpatico Membership /Jail Data Merged Report (Oct. 1, 2107 - May 31, 2018), almost a third (30.6%) of AzCH members were in an open episode or under care at the time of booking. Of the AzCH members not in an open episode at the time of booking, 2.6 % were designated with SMI, 53.9% were designated as having General MH issue, and 35.2% were booked with SUD.
- The data also show that 68% of the detained population were booked only one time during the reporting period; nearly a quarter (22%) were booked twice, and 10% were booked 3-5 times.
- Questions about the types and amounts of prescribed medications are asked by jail-based nurses and psychiatrist during the psychiatric review; an ROI is in place to share information ("pass-down" via the same form used by AzCH) with staff at the integrated health care clinic. Efforts are underway to rely on electronic records but, at this time, there is insufficient information being uploaded. At intake, if the individual does not have a Health Home, they are referred to the center for services.
- AzCH provides care coordination and medication management. The medication formulary is robust; approximately $100,000 is spent annually on psychotropic medication.

Release Planning and Reentry

When an Arizona Complete Health member is 30-45 days from release, electronic data sharing is activated. A re-entry release plan is supported by 2 jail liaisons, and includes treatment orders that can go to the individual's doctor. The treatment timeline begins in jail with an AzCH staff member, followed by information to the community care provider/doctor. Forensic Peer Supports assist members from either jail or prison to the integrated clinic; peer support can continue throughout process to support the member. Several resources and support systems are activated to address a variety of needs through the release plan. These can include medical health, behavioral health, housing, and transportation services.

- Jail Liaisons work with people in both jails and prisons to assist in release planning in three primary ways:
    1. **Care Coordination:** If person is connected with a Health Home, the jail liaison will email the case manager and advise them of custody status and request a release plan.
    2. **Community Re-entry:** Person may need a Medicaid application and will need to be connected to a Health Home. Jail Liaison meets with the individual allowing them to guide provider choice. Through an automated system, the Health Home is advised to coordinate care with that member prior to release. Jail Liaison will complete the Medicaid application, if needed.
    3. **Reach-In Initiative:** Where the release date is known, 30-45 days pre-release, jail liaison will initiate planning electronically as part of data sharing. Liaison will complete a Medicaid application, utilizing electronic appointment scheduling.
- In general, the Health Home is notified of the release date and appointments are electronically scheduled for the Health Clinic. Within 10 days of release, all willing members meet with an Adult Recovery Team (comprised of attorneys, providers and judicial personnel) to coordinate care and ensure that a care manager has been assigned.

Cases usually identified by probation 2-5 weeks before release. Probation initiates the release plan process using a newly developed release plan form. Banner/AzCH identifies who the client belongs to and coordinates assignment of the release plan to a community agency for completion. Plan is completed by community agency with probationer input and forwarded to probation for plan approval. Probation reviews and approves plan and notifies plan creator and jail to initiate release on agreed upon date and time.

For cases already on probation and open with a local provider who find themselves in custody for a period of 30 days or longer, the assigned PO sends the release plan request directly to the assigned case manager at the local agency. Development of the plan takes place and is sent back to the PO for review and approval. Probation reviews and approves plan and notifies plan creator and jail to initiate release on agreed upon date and time.

Community Supervision - Probation and Parole

Probation, in partnership with Arizona Complete Health has created an integrated approach to client health with a care center in the probation office building. The center includes basic primary medical care, behavioral health screening, assessment and care, traumatic brain injury (TBI) screening and support, trauma assessment, treatment needs, and peer support.

Probation has 40 probation officers to serve approximately 1200 probationers. Probation officers are trained in Motivational Interviewing (MI), and the probation department uses the Offender Screening Tool (OST) and Field Reassessment Offender Screening Tool (FROST) to determine Risk/Needs, and the Wide Range Achievement Test (WRAT) to determine pre-post high school reading levels.

- Standard probationer to PO ratio is 65:1; 50:1 for Drug Court. Currently, probation is supervising 40 individuals living with an SMI diagnosis.
- Probation was part of bi-weekly *"Release Team Meeting"* meetings aimed to help with transitional services. These meetings have been discontinued following the development of a Jail Release Plan that has been distributed to all of the partnering agencies. Justice-trained case managers are assigned to work with probation officers.
- As a condition of probation, probationers must sign a Release of Information (ROI) form with all providers prior to the receipt of services. Probation helps probationers set up appointments with service providers.
- Probation supervises probationers experiencing homelessness, and employs the VI-SPDAT to coordinate access to housing.
- Probation works closely with *Crossroads Mission*, TLCR, and other agencies to provide rapid rehousing to those accepting shelter options.
- The sex offender population is the population experiencing the highest level of homelessness. They are not accepted at transitional housing or other facilities.
- Probation is engaged in cross-system trainings with treatment providers. They hope to broaden the audience to include other supportive systems such as housing, medical, peer, employment and other support services. The annual justice treatment forum is another place of cross- system training. Many of the treatment and recovery providers brought brochures/pamphlets to the SIM to help promote information about their services.

Information Sharing to Improve Coordination

An administrative order is in place to share information with specific to court personnel, for the purposes of client care coordination. A release of information is still required for more detailed information. In addition, there are MOU's between probation and treatment agencies.

GAPS

Jail-Based Behavioral Health Support

- The rate of co-occurring SMI/Substance Use Disorder is estimated at over 40% with limited to no access to essential Opioid Use Disorder Medication Assisted Treatment

(MAT) drugs, Methadone and Buprenorphine. In addition, broader scope, if an individual has medications that can be verified, generally, the sheriff's department will allow those drugs to be brought to the facility to be administered, otherwise people are left to wait for their medication until they are released.
    - There is a lack of psychiatric time allotted to meet the needs of the inmates.
    - No medications are given upon release for jail.
- As of October 1, 2018, AzCH-funded jail liaisons only facilitate assistance with release plans for AzCH members. There is currently no mechanism for clients open with Banner Health to see an outside treatment provider while in jail other than Community Health Associates. To address this, Banner Health is using case managers at this time to coordinate release planning but is examining the addition of their own jail liaison(s). Banner has their own Justice-trained person, who coordinates with the Health Homes.
- Review current inmate screening process to ensure universal screening. It is unclear who is not screened and what the criteria is for screening.

Jail Data

- Data for release planning is tracked; the number of persons who opt-out of services should be tracked; strategies to increase involvement in health care have not been created.
- Information about inmate needs is not collected for non-AzCH members.
- There is need to continue to work on data/information sharing with AzCH upon release from jail
- Currently, the number of people with a substance use disorder is not tracked.
- The length of stay for those living with mental health disorders is not tracked

Jail, Post-release and Community Support

- There is no treatment or programming in the jail.
- Individuals are released without medication; most services do not continue post-release
- Jail-based mental health staff is limited, impacting continuity of care.

Community Support

- Housing is difficult to find for previously incarcerated individuals and, more specifically, for sex offenders.
- Individuals in need of services often cannot pay for them once in the community.
- There is a high level of municipal offenders in jail

- Coordination and communication should be at the forefront. Probation is connected to the health center, but collaboration with jail staff and parole could improve; communication and collaboration between service providers and probation could also be strengthened. The Department of Development Services (DDS) is working on updated statistics for tracking homelessness and any connections to treatment.
- A focus needs to be on jail diversion.
- The Regional Mental Health Court and 2 Superior Court Divisions could be augmented with a Drug court or track.
- There are questions about Developmental Disability eligibility requirements

Incompetent to Stand Trial (IST)

- There is a long wait for a bed at the state hospital resulting in individuals remaining in jail, often longer than they would have if sentenced to jail for the same offense.

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 July 18, 2018. The top three priorities are highlighted in italicized text.

1. ***Perform a data collections analysis using standardized language (23 votes)***
2. ***Improve communications between providers (20 votes)***
3. ***Reduce caseloads for case managers (15 votes)***
4. ***Enhance continuity of care in and out of the jail setting (12 votes)***
5. Increase expectations of agencies to understand the scope and practice of criminal justice and behavioral health partners (8 votes)
6. Create a substance use drop-off site (8 votes)
7. Improve the quality and utilization of treatment beds (6 votes)
8. Coordinate cross training of staff (4 votes)
9. Create, update, and disseminate resource guides (4 votes)
10. Celebrate and coordinate recovery (3 votes)
11. Dedicate staff to justice involved populations (3 votes)
12. Undertake efforts to increase court appearance rates (0 votes)

Strategic Action Plans

PRIORITY AREA 1

PERFORM A DATA COLLECTION ANALYSIS USING STANDARDIZED LANGUAGE

Objectives	Action Step	Who	When
Create a centralized data sharing repository for use by all stakeholders in the mental health process.	1. Conduct stakeholder meeting/workshop 2. Develop database sharing agreements 3. Obtain resources from GAINS Center/ORA 4. Disseminate dictionary to all stakeholders 5. Provide training to all database users	PM: Shannon G. Champions: George Mike Jill Amy	
Produce a dictionary for data base upon centralized database data fields	1. Conduct stakeholder meeting/workshop 2. Develop database sharing agreements 3. Obtain resources from GAINS Center/ORA 4. Disseminate dictionary to all stakeholders 5. Provide training to all database users	PM: Shannon G. Champions: George Mike Jill Amy	

PRIORITY AREA 2

IMPROVE COMMUNICATIONS BETWEEN PROVIDERS

Objectives	Action Step	Who	When
Identify providers of mental health services	Develop a communications workgroup	Law enforcement/County Agencies, Health Homes, Probation/State, Specialty Advocacy Providers, Hospital, Fire Department and EMS	Crisis meeting is held quarterly: next meeting is September 18th (may need to change day to reduce scheduling conflicts)
Expand Crisis System Team meetings	Develop agenda items prior to the next meeting, expand the participant list, and discuss each representative's role in the meeting	George, Wes, and Maria	Month prior to meeting
Update and maintain points of contact	Create a committee	George, Wes, and Maris	Month prior to meeting
Create and update community resource guide	Add agency/organizations' names, contact information, and brief description of services to crisis system meeting agenda - Staffing/distribution - Meeting sub-committee group	All	SAA
Improve and maintain participation in Crisis System meetings - Vary meeting locations for convenience and see others' locations	Get the word out/advertise - Attend & participate - Add event/training announcements in Crisis System meeting agenda	All	SAA

PRIORITY AREA 3

REDUCE CASELOADS FOR CASE MANAGERS

Objectives	Action Step	Who	When
To create a manageable caseload that can provide quality not quantity services in order to produce better outcomes	Reduce paperwork requirements, implement mandatory standardized ratio for ICCA: - General Mental Health: 1:75 - High Needs: 1:25 - Medical Needs: 1:25 Train staff on how to manage caseloads Three man team method: clinician, case manager, and peer specialist Have the CEO shadow a case manager for a week, "go to ICCA and run the caseload for data proof positive of caseloads"	Arizona Complete Health Integrated Health Care Banner Health ICCA CEO	

PRIORITY AREA 4

ENHANCE CONTINUITY OF CARE IN AND OUT OF THE JAIL SETTING

Objectives	Action Step	Who	When
Diversion of police contact keeping people out of jail	Flyers for all departments including law enforcement, probation, jail, and community Place for clients to go instead of jail, possibly run by volunteers	Hollie Mellor, Sandi Hoppough, Joe Lackie Raul Fiveash, Sandi Hoppough, Shannon Braman, Lynn McGee, Mike Kettunen	
Address barriers to programming	Define and share security clearance What type of programs can be available in jail? Initiated in the jail setting. What are the requirements to implement programs by targeted population	Joe Lackie, Wendy Lugo Sandi Hoppough, Lyn McGee, Mike Kettunen, Joe Lackie, Wendy Lugo	
How do we communicate resources to justice involved individuals	Closed circuit TV for information	Sandi Hoppough, Lynn McGee, George Owens, Wendy Lugo	
Medications and general information sharing for the jail	Quicker turnaround time for records/ pharmacy standardized ROI	Joe Lackie, Wendy Lugo, George Owens, Hollie Mellor, Sandi Hoppough	
Understand jail population at any given time			
Determine the process for transitioning from jail to community	Prisoner Review/ Reentry Team (PRT) Coordinate Transition Plans with Probation North End Community Connection hand off		

Quick Fixes

While most priorities identified during a Sequential Intercept Model mapping workshop require significant planning and resources to implement, quick fixes are priorities that can be implemented with only minimal investment of time and little, if any, financial investment. Yet quick fixes can have a significant impact on the trajectories of people with mental and substance disorders in the justice system.

- Improve first responder knowledge of and usage of crisis system services available to them. First Responder Liaison Wes Lore will be outreaching all first responder agencies within Yuma County and offering to provide crisis education tailored to first responder needs.
- Improve drop- off process- Susan and Larissa to discuss

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.

- Fire/EMS Policy to take individuals to the hospital rather than the current alternatives.
- Additional resources needed to increase staffing.
- Law enforcement out of Yuma have limited staff and resources.

Recommendations

The following recommendations have been developed in response to the SIM discussion and groups identified priorities and action plans. Action plans as developed at the SIM are included in the Action Plan section and should be considered as a recommendation to continue to move forward regardless if they are included in the recommendations below. We encourage stakeholders to review and prioritize recommendations and SIM Action Plans according to aligned interests and current county priorities. Some of the following recommendations are more general than others; none are intended to be prescriptive but, rather, suggestions of how to approach identified issues. Most recommendations include references to websites, articles and documents, or examples of work being done across the country. Inclusion of such websites, articles, documents and work taking place across the country are only examples and not intended to be exhaustive. In addition, inclusion in this report is not endorsement from PRA or PRI, but is intended to help point those reading this document in a direction to self-explore and determine actions regarding gaps in their system.

RECOMMENDATION 1

ESTABLISH STANDARDIZED METRICS AND DATA-SHARING ACROSS COUNTY AGENCIES TO IMPROVE DATA-INFORMED DECISION-MAKING.

The basis of this strategy came from the priority areas and Action Plan #1. Cross-system data can help us improve overall system outcomes at the micro and macro level. It is essential to identify system gaps and resource utilization. It can help us understand returns on our investments and improve outcomes. Individualized data is necessary to identify and stratify potential populations for alternative processing and inform strategies to build a more responsive system. It allows you to tell your story of your success. Unfortunately, all too often criminal justice data systems are transactional or operational in nature,

making them “data rich but analysis poor” with reporting functions limited to boilerplate reports. Generally, disciplinary stakeholders have their own data systems, each with unique individual identifiers making data matching very limited. Many do not capture trends, let alone allow for data integration or interface with other systems within the justice or behavioral health systems.

The SIM Action Plan group identified the following two objectives: 1) Standardize language and create a centralized data sharing repository, 2) Produce a dictionary for data, based upon centralized database for data fields. Following are some areas of work to consider and resources.

Phase I

Convene a cross-system/discipline technology (IT) and user working group, including those who enter data, to walk through their data systems:

- Take a current or recent data set and “walk” through the data for a small group of individuals to explore what is, and isn’t collected. Identify what data is entered, and when, what is fixed vs free form, who is it shared with, how is it shared, who has access, how is access provided and by whom, what is the original source of data, how is it verified; how is data pulled and pushed; what is part of a boilerplate report, etc.
- Review any data sharing memorandums of agreement. Create memorandums as appropriate.
- Define terms and definitions of each data point. Review current and adjust codebooks as needed.
- Determine who already has access to enter, read, or change each data point.
- Determine if a data point is private information or public.
- Look at both charge-based and individual-based data.
- Determine costs for each step in the process.
- Create a data dictionary that includes *shared definitions* and *defined terms* to ensure there is a common definition of what populations/issues you are trying to understand; learn from each system how that data point is collected, coded, and stored. Determine common identifiers to match populations. Sometimes, the best you will have is “name and date of birth”. Some key terms to define are: serious mental illness, substance use disorder, incompetent to stand trial, pre-trial eligibility, homeless and housing status. Terms that surround tracking race and ethnicity also need to be defined.
- Add an “opt out” clause to release of information about information collection for data sharing (as appropriate) and analysis purposes.

Rather than tackle the entire system, start with integrating two or three parts of one system – such as pre-trial and detention/jail data; or emergency department, mobile crisis and triage center. After some success, look to add cross-discipline information such as jail-based mental health and substance use information and pre-trial screening and outcomes.

Phase II

- Develop a case-process flow analysis and data including race/ethnicity, gender, age, time to process each step, level of offense and risk, bond eligibility and status, average length of stay for the general population and for someone with a mental illness or a substance use disorder.
- Use data to understand trends. To the degree possible, use both charge-based and individual-based data and look historically at issues such as repeat offenders, common offense locations, system processing and access to services. Historical data can reflect trends and target or illuminate issues.
- If possible overlay access and utilization of mental health and substance use treatment and medication. Include failure to appear and lengths of stay in jail.
- Track data for racial and ethnic disparity across all programs. Examine criteria, acceptance, successful completion rates and technical violations.
- Track technical violation data to understand the impact on the jail and improve use of sanctions and incentives.
- Create cost measures that can be added to the analysis.
- Include race, ethnicity, age, and gender in data analysis.

Increase common understanding about information sharing:

- Increase cross-system understanding of HIPAA, 42 CFR Part 2, and HMIS for mental health, substance use, and homelessness information sharing. Educate stakeholders on information and data sharing between protected entities, between protected and non-protected entities, and between non-protected entities.

Current State Laws Regarding Information Sharing	
Health Information and the Law: Arizona	http://www.healthinfolaw.org/state-topics/3,63/f_states

Guidance on Applicable Federal Law	
HIPAA.com	Website
Health Information Privacy Portal Source: US Department of Health and Human Services	Website
Frequently Asked Questions: Applying the Substance Abuse Confidentiality Regulations to Health Information Exchange Source: Substance Abuse and Mental Health Services Administration	PDF
Disclosure of Substance Use Patient Records: How Do I Exchange Part 2 Data? Source: Office of the National Coordinator for Health Information Technology	PDF
Homeless Management Information System	
HUD Exchange Homeless Management Information System Guide and Tools	Website
McKinney-Vento Homeless Assistance Act Source: HUD Exchange	PDF
Information-Sharing Guidance	
Opportunities for Information Sharing to Enhance Public Safety Outcomes Source: IJIS Institute, Urban Institute	PDF
Prioritizing Justice-to-Health Exchanges Task Team Final Report Source: Bureau of Justice Assistance	Website

Corrections and Reentry: Protected Health Information Privacy Framework for Information Sharing Source: American Probation and Parole Association	PDF
A Comparative Analysis of HL7 and NIEM: Enabling Justice-Health Data Exchange Source: National Consortium for Justice Information and Statistics	PDF
Information Sharing in Criminal Justice-Mental Health Collaborations: Working with HIPAA and Other Privacy Laws	PDF
Mental Health Information Systems Source: World Health Organizations	Website

Tracking population-specific data:

- Track *population specific* data (see also *Familiar Face* Recommendation) across a sample of cases to create a case flow process by race/ethnicity, gender and age, identify areas of redundancy such as screening and assessments, unnecessary wait times, disparity and access to services. Types of data points may include average time stamps between processes by type and level of offense, pre-trial and bond eligibility including holds (parole, other jurisdictions, and federal), time from eligibility to time of release, release volume by time of day and day of the week; sentencing outcomes, revocations by reason and outcomes, diversion utilization and outcomes, and program and jail program access, capacity and utilization.
- Identify a "familiar face" population through analysis of court data by individual first, and then by charges and address, accounting for housing instability and experiences of homelessness. From there, look at pre-trial and bond eligibility as well as jail stays. If available, look at detention/jail program service use (including medical and behavioral health) and jail stays associated with court sanctions or technical violations. This should result in the identification of low-level offenders with high-needs.

Data-sharing technology

- Terms such as interface, integrated, and interoperability are used interchangeably, however they may have different meanings. Refer to this quick guide on the differentiation between the terms. In many cases, levels of data integration can be achieved but the ability to interface systems is a tremendous leap forward. Interoperability, especially across disciplines, is often challenging and not necessary to improve system coordination and outcomes. A moto to keep in mind is "don't let great get in the way of good."

Some counties, such as Johnson County (KS), have created their own county-wide data hub. In Johnson County, the data hub is built on a system called My Resource Connection My Resource Connection (MyRC). Other counties are benefiting from the cumulative benefits of open source technology which can reduce system reliance on closed, proprietary systems. Open source consortiums like the Open Justice Broker's Consortium (OJBC) (PDF and Website) specialize in cross-system data. OJBC began their work in Hawaii to connect human service and criminal justice data systems. They now have members in Pima County (AZ) and Adams County (CO) as well as the states of Michigan, Massachusetts, Maine, and Vermont. In each case, the new county or state is able to benefit from the other systems' work, resulting in expediting the process and reducing costs.

Adams County (CO) offers the following lessons learned:

1. Start with survey to develop and document a unified vision, mission, and goals.
2. Establish a governance structure to set policy and technical priorities, from what kind of data makes sense to share to who will have access and where it will reside
3. Set up the necessary protections, from data sharing and management control agreements to intergovernmental agreements and rules of access.
4. Use project charters to align stakeholders, researchers, and technologists behind a unified set of goals and expectations for projects in development
5. Use justice information sharing standards when possible as laid out by the National Information Exchange Model (NIEM) and Global Reference Architecture (GRA)
6. Map data, build database, and develop research, sharing, and analytics tools

- Check with local universities to see if they can help map your data tracking and information system. Some universities have specific departments that partner with Counties and States. The Harvard School of Law, Government Performance Lab and Code for America can be helpful partners in developing strategies and connection to others who are doing similar work.

Dashboards

- 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. Tools like Microsoft PowerBI are free and fairly easy to use.
- 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. Louisville (KY) and Denver (CO) are among the jurisdictions with strong jail mental health dashboards.
- 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.

RECOMMENDATION 2

IMPROVE COMMUNICATIONS BETWEEN PROVIDERS

Improving communication between providers was identified as priority area #2. In addition to the objectives and action items developed by the SIM Action Planning Work Group (see Action Planning Section in this document), consider having communications (public information officers), new letter publication staff, etc. attend some of the existing meetings. Have them identify a way to help communicate the work taking place within and across the stakeholders. Include them as part of the communications workgroup if it is established.

Note that this group's objectives incorporated several of the identified priority areas that were not selected as an Action Planning group: Inventory, update and create a community resource guide (covers priority area # 9); Convene and rotate location of cross-system and discipline meetings (covers priority area # 8); Increase expectations of agencies to understand the scope and practice of criminal justice and behavioral health partners (covers priority area #5).

RECOMMENDATION 3

ENHANCE CONTINUITY OF CARE IN AND OUT OF THE JAIL SETTING: INCREASE COUNTY-WIDE DEFLECTION AND DIVERSION STRATEGIES.

The basis of this recommendation # 3 and recommendation #4 came from the SIM priority areas and Action Plan #4. This recommendation should be dovetailed with *Identify "familiar face" high-utilizer populations to help manage costs, reduce unnecessary utilization of services while increasing individual stabilization. Develop "high utilizer" strategies*.

It is recommended that the county builds on its existing crisis resources, and takes a comprehensive look, perhaps even a "mini-SIM" focusing on Intercept 0 and Intercept 1 from a consumer and system view.

1. Increase Deflection and Diversion Strategies

The ability to increase client stabilization through community and alternative processes is at the heart of criminal justice deflection and diversion strategies. Law enforcement based deflection requires immediate access to services, without barriers. System and public support for law enforcement discretion is critical to supporting deflection strategies. In general, "deflection" is pre-arrest or citation and refers to law enforcement utilizing non-criminal justice supports without any official criminal justice action, while "diversion" may be pre or post-arrest or pre-or post-booking. Diversion often refers to the use of an alternative criminal justice course of action. For example: police deescalating an individual, using clinical co-responders, taking an individual to a triage center, sobering center, or emergency department is seen as deflection; the addition of a citation, or other criminal justice stakeholders involvement and offering an alternative to traditional case processing such as treatment court, deferred prosecution or judgement, or Law Enforcement Assisted Diversion (LEAD) are diversion strategies.

Document Actions to Understand Trends, Costs and Populations

The importance of documentation of "deflection" and "diversion" actions taken by law enforcement cannot be overstated. At the very least, documentation should note if the action taken was: de-escalation, hospitalization, transportation and referral to services, citation, arrest and detained, etc.

- Determine how to identify or flag repeat/frequent individuals for law enforcement so they can initiate the deflection or diversion process. See the Familiar Face recommendation for more information.
- Create a baseline and track by deflection and diversion strategy.
- A simple "check-box" used by law enforcement, as within Fairfax County (VA) and Dade County (FL) can document actions taken.
    - Track the total number of dispatch calls to persons with behavioral health issues and sort by actions – de-escalation, cite, arrest/detained, deflect/divert, and "No Probable Arrest," "Probable Misdemeanor Arrest," or "Probable Felony Arrest."
    - Track the percentage and type of calls specialized police units/officers are responding to and prioritize calls if necessary.
    - Establish costs of various actions to determine return on deploying various strategies.

Deflection

The following strategies can improve immediate support for an individual and improve access to services, and appropriate service match.

1. Increase **coordination and access** to crisis services, especially psychiatric beds**.**
    - Address issues of emergency departments being on "divert" status. Explore and address why hospitals are on "divert" status.
        - Strategies should be developed to streamline access to beds and increase capacity of hospital resources. Explore the development of, and use of a bed registry across the crisis triage and the hospital network. Such a registry could be helpful in tracking availability when services are needed.
        - Consider how to improve "release-to-supports" to improve stabilization and continuity of care including medication, housing, and emotional supports.
    - Coordinate with county and state crisis call centers and lines. Physically call crisis call lines and review websites, billboards, public information about crisis services. Ensure information is up-to date and access and messages are clear. Talk with

Colorado Crisis Services about they developed their robust, statewide referral database.

- Review current recipients of deflection and diversion strategies. Compile data to understand recipient needs and evaluate the match to meet the recipient needs.
- Address the "churn" effect of persons repeatedly coming through the process without different results, and remove "constriction" issues where the system becomes clogged due to limitations in moving persons to the next step.
- Examine the process to access services and criteria to access services; match risk and need to services; formalize referral processes; and increase knowledge of what services do and don't offer.
    - Use data and other methods to learn about current processes, and who is receiving services including their risk and needs level. Review any existing contracts or agreements to understand current expectations.
    - Develop agreements that include service match to risk and need levels. Develop outcome metrics and clarify expectations. Create strategies to streamline referral processes. Commit to have dedicated services and "slots" for justice-involved persons with medium to high risk and needs. Address concerns of service providers in taking higher risk offenders. Routinely address issues and make adjustments.

2. Utilize co-response clinical strategies

A joint, clinical mental health and law enforcement/first responder response is known as "co-responders or clinical co-response." Generally, once law enforcement has secured the scene and determined they do not have to make an arrest, clinicians work directly with law enforcement to help determine the best clinical response for the individual. Although co-response strategies vary from community to community, the general framework entails a licensed clinician who rides along with law enforcement or can be requested to the scene of a mental health crisis. The crux of a co-response strategy is that the licensed clinician can assist law enforcement in de-escalating the crisis, establish a warm hand-off to services, and provide proactive follow-up to improve the likelihood of long-term services engagement. Some law enforcement departments have specific teams that routinely work together, others have a more general response. In some cases, regular patrol requests a co-responder while other departments have officers and co-responders working specific areas known for "high-needs" calls. Regardless of the model, to be effective, "community-based crisis response" must be adequately staffed to respond promptly to crisis calls. More communities are coordinating mobile crisis/co-response 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. The Crisis Now report provides a comprehensive overview of crisis services and a crisis framework. Some states with advanced crisis frameworks include Colorado, Texas, New York, Virginia and California. In addition, consider the viewpoints and experiences of individuals with lived experience and family members when designing deflection and diversion programs.

- Explore the use of virtual crisis response strategies such as video conferencing and telehealth to support law enforcement officers and other first responders responding to crisis situations. Use of videoconferencing to expand access to the mental health consultation is increasingly being used to connect law enforcement with mental health professionals. Counties with varying populations, from large counties (e.g., Harris County, TX), medium counties (Lancaster County, NE), and small counties (Yuma County, AZ), have employed this technology to improve response times of mental health co-responders. For reference, see the overview of virtual crisis response from Springfield (MO) provider Behavioral Health Response.
- Additional crisis response strategies for consideration:
    - Expand CIT training and coordinate across each of the law enforcement entities and 9-1-1 call takers in the surrounding municipalities.
    - Continue to offer Mental Health First Aid training to first responders including EMS/Fire and other justice system stakeholders.
    - Increase coordination with Probate Court regarding guardianship and outpatient commitment.
    - Explore using a Social Impact Bond. Reference the Urban Institute report on Denver's experience.
    - Explore a county or state tax to ensure funding and increase availability of services. Some of the counties with a tax include Bernalillo County (NM) and Denver (CO).

3. Sub-acute Triage and Stabilization Services

Sub-acute triage and stabilization models vary across the United States.

- Review current program data to create an understanding of who is, and who isn't accessing these services, what services are offered and gaps in need and care. Examine treatment match to client need and gaps in level of care based on population needs. Based on service needs, examine the necessity of adding new crisis service models which can allay the need for the

psychiatric emergency service admissions. Before implementing a new service, explore how the service will work with existing mental health, law enforcement, and EMS/Fire responses.

- Mental health crisis services triage and stabilization units can be a tremendous asset in a community; however, any brick-and-mortar setting will be underused and without the desired outcomes unless the following conditions are met:
  - Stakeholders obtain a clear understanding of the need for a facility;
  - Stakeholders establish a formal commitment to utilize the facility;
  - Stakeholders focus efforts on integrating the existing crisis response process; and,
  - Stakeholders understand that, without pro-active follow-up, post-crisis services, and engagement strategies, the use of crisis services by an individual will continue into the future.

4. Homeless Intervention Strategies

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

A strong housing continuum includes emergency shelters, landlord support and intervention, rapid rehousing, Permanent Supportive Housing (with or without Housing First but including supportive services such as case management, treatment, employment, etc.), Supported Housing (partial rent subsidies), transitional housing, affordable rental housing, and home ownership. In addition, consider how dependent care, institutional care, home-based services such as FACT, FUSE and ACT, halfway houses, and respite care can support specific populations needs.

- The Corporation 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.
    - Work with homeless service providers and triage systems to improve coordination and access to shelter and housing providers.

- Understand and, where possible, address provider criteria that limits access of criminal justice, or persons living with mental health or substance use issues. Whenever possible, work collaboratively to improve access to housing, the environment of shelters and housing to promote safety and stabilization.
- Prioritize and coordinate access to housing, especially housing first and permanent supportive housing models. Access to coordinated housing is usually based on scores such as the Vulnerability Index and Service Prioritization Decision Assistance Tool (VI-SPDAT).
- Diversify housing options such as transitional, supportive and supported housing. In addition, a comment was made that "many shelters only provide that function but do not connect persons with longer term housing services". Discussions with shelter providers and persons who have experienced homelessness could result in expanded thinking and repurposing of some of the shelter beds.
- Housing persons charged with a sex offense is challenging across the country. Review current housing codes, zoning, etc. to see what rules, statutes actually preclude sex offenders from living in the area. Address these issues as needed. See if Shared Living Arrangements (SLA) are allowed under existing codes, if so, SLA models have been shown to increase accountability for sex offenders and recidivism among sex offenders.
- Similar to permanent supportive housing, consider combining affordable housing with access to supportive services to increase housing stability.
- The Doe Fund, Ready to Work models create alternatives to jail or release from jail that include housing, employment, and life skills training
- Landlord Liaison projects increase the likelihood that landlords will accept individuals with justice system involvement and higher needs.
- Coordinated entry helps communities prioritize housing resources
- Funding that supports move in costs, deposits, damage repair, etc.
- Right Home, Right Time, Right Support:
    - Learn the various housing funding streams at the municipal, county, state, federal and private levels
        - State and Federal housing vouchers and public housing options, Veterans Affairs Supportive Housing (VASH), Family Unification Program (FUP), Emergency Solutions Grants (ESG), Home Purchase Assistance Program (HPAP), Tenant-based Rental

Assistance (TBRA), Permanent Supportive Housing (PSH) and PHS Bonus, PSH Shelter Plus Care (PSH(S+C))

  - Inventory who is currently in supported housing to ensure match with level of need.

- Coordinate with your local HUD CoC - Continuum of Care
  - Understand U.S. Department of Housing and Urban Development (HUD) definitions to access various housing options.
  - Understand HUD rules and compare to local housing authority rules
  - Work to prioritize criminal justice housing under you CoC and housing authority.
- The following resources may help inform 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.

5. Review and improve client community stabilization.

Community-based supports such as Assisted Outpatient Treatment (AOT), Assertive Community Treatment (ACT) and Forensic- ACT processes and Frequent Users Service Enhancement (FUSE) are some of the core programs that can help stabilize high-needs clients in the community. It is likely that those served by these programs are all eligible for Supplemental Security Income (SSI), or Social Security Disability Income (SSDI). All of the models are staff intensive and require comprehensive support including housing, medications, case management, access to primary, mental health and substance use disorder interventions.

- Review current contracts, eligibility, number served, services, and outcomes for these services.
- Review and improve how these programs interface with Probate Court practices.
- Consider bridging ACT services with incompetent to stand trial populations and community restoration models.
- Review and create outcome-based agreements to support the implementation of AOT, ACT/FACT and FUSE with fidelity.
    - Work the state/regional SSI/SSDI Outreach, Access and Recovery (SOAR) providers to apply for SSI/SSDI entitlements. If not already enrolled, the SOAR process can be initiated for those under AOT, in the state hospital, in psych-units in community hospitals or under mental health alerts in jails and prisons. Cross system coordination will be critical to not duplicate efforts and complete the applications.

6. Create Shared Values

Deflection and diversion in the criminal justice system requires shared values and response to individuals with high needs. Routinely discuss the challenges and various points of view held by various justice stakeholders.

- Provide a way to "listen to understand" (rather than to "respond") to each other and explore concepts such as accountability, public safety, "victim" and tolerance level for various diversion options. Invite community members, providers and persons with lived experience to be part of the discussions. Use the LEAN concept of "customers" to identify impacted sectors (e.g., business, family, victims).
- Develop a process to respond to concerns about deflection/diversion. Develop a collaborative message that communicates that deflection and diversion are appropriate strategies to use in case a negative event occurs.
- Develop a cost model of the traditional system and deflection/diversion strategies.

- Consider developing a restorative justice based response to low level offenses such as shoplifting, loitering and quality of life offenses. Perhaps develop a sheriff-run work crew to support clean-up, graffiti removal, care of flower beds and gardens to offset municipal costs and provide an alternative to jail for unpaid fines and fees.

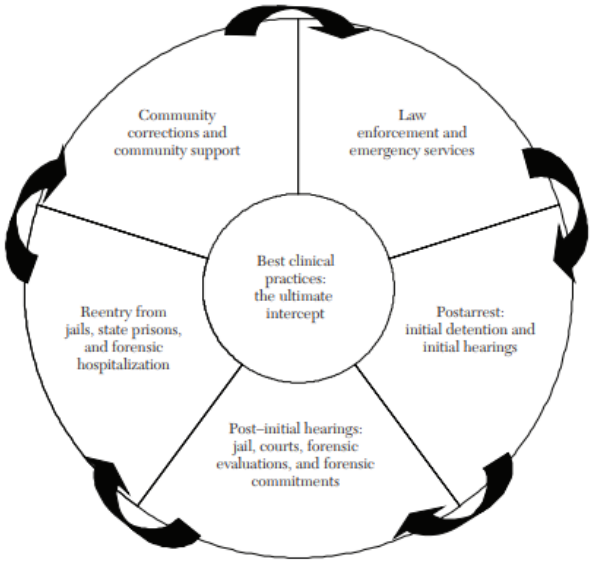
7. Post-booking stabilization

Post-booking stabilization process (not program) provides opportunities at multiple points to screen and address behavioral health, including who receives information about post booking options, who can be diverted out and to what, what is needed to stabilize individuals in jail, and what services are persons needed to be released to in the community. Essential elements 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.

RECOMMENDATION 4

IMPROVE JAIL-BASED SERVICES AND TRANSITION PLANNING TO REDUCE RECIDIVISM AND IMPROVE HEALTH AND OTHER OUTCOMES For DETAINED OR JAILED INDIVIDUALS.

Public safety and public health outcomes can be improved by providing in-jail services, transition planning and coordinated continuity of care of inmates with mental and substance use disorders. The terms "transition" and "reentry" are used interchangeably in this recommendation. It may be helpful to think of jail services and reentry in terms of a "hub-and spoke" model where the jail is the *hub* and responsible for specific actions such as identification of needs, care that increases stabilization, and coordination with *spokes* or strategies for continuation of care and access to services in the community. In addition, it is helpful to think about the intercepts as a circle rather than a linear model with resources in Intercepts 0 and 1, and 4 and 5 being interchangeable and interdependent.



Sequential Intercept Model as a Revolving Door
(Munetz & Griffin, 2006)

Therefore, this recommendation is intertwined with several other recommendations.

Specific Reentry and Transition Planning Items

- Medications at Release: a) provide inmates with at least a weeks' worth of psychotropic medication (some may not be appropriate) or a paid prescription and location where it can be filled; b) Educate on how to administer and provide Narcan (Naloxone) at release for opioid dependent individuals; c) Have posters, pamphlets and videos in the jail visitation and booking on how to administer Narcan.
- Use a standardized reentry need assessment tool (GAINS Reentry Checklist).
- Develop a multi-party, cross discipline release of information with opt-out rather than opt-in language.
- Increase probation response to mental health needs. Colorado Probation uses a brief mental health screen.
- Sort the jail population by risk to reoffend and increase jail-based programming for medium-high and high-risk individuals.
- Improve transportation, coordination, and access to services.
    - Use of Uber Health may be one possible solution.

    - Map current provider resources, hours of operation, criteria to participate, costs, number of persons served, etc.

- Maximize co-location/one-stop services and centralizing resources across the county. Use existing resources such as a triage center or the integrated care clinic.
- Inventory housing and build a housing continuum.
- Survey or hold focus groups with probationers, family members and providers to understand issues and how to improve coordinated release from jail.
- Map out the current communication (staff roles, documents, consent to release information forms, process, hours of operation, etc.) between the jail, probation, parole and community providers. Review and adjust release times to improve the likelihood that services will be open at the time of release. Make adjustments. Use "opt-out" rather than "opt-in" language on the client release of information.
- Improve universal screening of mental health, substance use disorders, cognitive impairment including traumatic brain injury and Intellectual Developmental Disabilities.
- Develop a video of programs and services that runs in the jail booking, library, dorms, etc.
- Develop a standard volunteer/provider training to provide services in the jail and letter of application to enter the jail. Create a standardized approval and review process. Convene jail-community provider meetings to discuss challenges and improve coordination.
- Track data of those who return to jail with reoccurring primary and behavioral health issues. Track data regardless if they are a current Banner or Az Complete Care member. Provide reentry, health and non-health services to inmates regardless if they are a health care member. Create specific education and intervention strategies to address re-occurring population needs.
- Review the Washington State "Pathways HUB" model in addition to the current reentry health strategies.

Some of the most challenging aspects of implementing "jail-to-community transition" is programming space, safety and contraband, access to populations, movement within the facility and availability of time/slots to deliver services. Often, secure facilities use inmate resources to operate the facility which limits "programming time". In addition, inmates in facility housing pods, units or modules are often mixed or based on classification systems that don't mirror programming needs; moving inmates requires staff and can compromise safety in the facility.

Various models are used to deliver jail transition services. Some facilities have dedicated jail staff, others use community-based providers who reach into the jail. Some facilities allow only a very limited number of non-sheriff department staff into the facility. Ideally, to build continuity of services, the same providers who provide services in jail, continue services into the community. At the very least, there should be a coordinated and streamlined process. Appropriately, most jails use volunteers to deliver some services, however, it can result in inconsistent delivery and availability of services. Generally, evidence-based programs require trained and dedicated staff to increase program fidelity.

Ideally, planning for reentry should begin as soon as the individual is incarcerated and should include risk and need assessments, targeted services in the jail, and reentry planning to meet core needs during the first day, week, month, and up to 6-9 months. The following two documents provide comprehensive information about jail to community transition:

- Guidelines for Successful Transition of People with Mental or Substance Use Disorders from Jail and Prison: Implementation Guide publication provides information reentry for 'high needs" populations. It includes the APIC guidelines of "Assess-Plan-Identify-Coordinate". The guidelines include: Conduct Universal Screening, Follow up positive screens with comprehensive assessments, Design individual treatment plans, Develop collaborative responses that match need and risk, Identify interventions in transition planning practices, Establish policies to facilitate continuity of care, Coordinate justice system and community services, Share information to advance cross-system goals and Encourage cross training.
- The Urban Institute and National Institute of Corrections has developed the Transition from Jail to Community (TJC) Initiative and online learning toolkit. Both of these documents include an excellent framework for developing comprehensive reentry policies and practices.

Improve Access to Medicaid and Social Security Benefits

The jail health provider has been very proactive about ensuring access to health benefits. The following information is included as an outline of this issue and to identify some additional areas of work.

Medicaid suspension or cancellation while incarcerated is a barrier to recovery and stabilization. The Affordable Care Act has expanded access to Medicaid, yet communities across the country have lagged in enrolling justice involved individuals in Medicaid. A more aggressive and coordinated approach is needed to insure Medicaid benefits essential to continuing prescribed medication and accessing critical behavioral health services. Don't assume that populations are being identified - often individuals in the justice system who present with high levels of substance use disorder have co-occurring mental health or cognitive impairment.

Consider the following:

- Provide jail-based or diversion health personnel with access to the local Medicaid database to promptly identify enrollees and insure continuation of coverage.
- Social Security Outreach Access and Recovery training (SOAR) can improve successful enrollments and reduce approval times from months to as soon as 60 days. Work with your existing SOAR team and SSI/SSDI to ensure applications are completed for persons who are likely eligible and would benefit from SSI/SSDI.
- Provide a cross-discipline training on SSI/SSDI, including documentation needed for a SSI/SSDI application.
- Make sure individuals are asked what insurance they have: Medicaid, SSI/ SSDI, private, none. Review intake forms to see if that information is already collected during jail booking/medical screening and hospitals, BHD, and during CART and Mobile Crisis contacts.
- Enroll individuals who do not have insurance in Medicaid, as eligible. Everyone who has been identified as a high utilizer should be considered for SSI/SSDI application.
- Continue to address health needs of clients post release including "health home" models. Review current partnerships and make sure the jail, health care provider, and health center partnerships are maximizing what a Health Center (under Section 330, a.k.a. Federally Qualified Health Centers or FQHC) can offer.

Improve Inmate/Patient Stabilization through Medication Consistency

- Review the jail, local health center (FQHCs), community mental health, state corrections, and state hospital medication formularies to promote and coordinate medication consistency, and release with medications and an appointment to a mental health care provider.
- Ideally, inmates/patients are released with up to four weeks of medication based on ability of a new, community-based appointment date. Reentry from jail is an opportune time to create continuity of care and connect people with community-based services. A warm-hand off to the next appointment can be supported by utilizing peer support.
- Colorado has developed a state-wide criminal justice formulary across jails, community mental health, state hospital, Department of Corrections, and state Medicaid. They are willing to share the formulary and process. In addition, work with existing resources to reduce costs of purchasing medication and improve long-term health outcomes.
    - Confirm that the county, including the jail medical provider is a member of the Group Purchasing Organization, Minnesota Multistate Contracting Alliance for Pharmacy (MMCAP) to reduce the cost of medications.

- Work with local hospitals and Federally Qualified Health Care (FQHC) centers to create primary, mental health and substance use care continuity.

Broader Reentry and Transition Planning Committee

Diverse stakeholders including jail administrators, volunteers, and providers representing employment, housing, education, veteran services, courts, prosecutors, public defenders, pre-trial services, human services, substance use, mental and primary health – including local representatives from a local Federally Qualified Healthcare Center (FQHC) are all important in designing and delivering reentry services. County or state *Social Security Outreach Access and Recovery (SOAR)* providers, managers of Assisted Outpatient Treatment and Wellness Recovery Action Plans (WRAP) facilitators can all be very helpful with overall coordination of mental health services. In addition, it is imperatives to include previously incarcerated individuals and recovery peers, and/or representatives from an inmate council, and inmate family members as members of the group.

Some of the core areas of reentry programming include, but are not limited to:

- Design and improve coordination and access to comprehensive and coordinated jail-to community reentry services.
    - Inventory current policies and practices. Literally walk through the process from booking to release to identify resources and gaps.
    - Review the APIC and TJC documents identified above.
    - Inventory and strategically address the unintended or "collateral consequences" of jail and prison.
    - Review current programming staffing levels, community provider services and transition of care from one facility to another and from facilities to the community.
- Work on broad, community based issues:
    - Access to fair housing and employment through "ban the box" efforts
    - Release with identification and referrals to specific services
    - Educating employers on how to read and understand criminal histories.
    - According to state law, ensure voting rights for incarcerated persons.
    - Release times and transportation are often issues that need to be addressed.
- Increase continuity of health care:

- Whenever possible reduce length of stay for persons SSI/SSDI to under 30 days so they do not lose this benefit.
- Assist in the process of applying for Federal entitlements such as SSI/SSDI. SOAR providers should be used to assist with this process.
- Ensure identification and access to veteran services. Most jails have an assigned Veteran Justice Outreach (VJO) person.
- Ensure identification and initial enrollment of persons eligible for Medicaid.
- Increase access to Wellness Recovery Action Plan (WRAP) plan facilitation.
- Create a way to notify community based providers of who is in jail. Many jails simply send a daily spreadsheet to providers.

Larger issues to address by specific stakeholder groups, not necessarily the broader reentry committee identified above.

- Review current health care provider contracts. Review the medication formulary, access and availability of services and ensure universal screening.
- Review the use of and availability of programming space within the jail and explore developing specific behavioral health units for mental health and substance use and program staffing as part of the plan. Some of the county jails with dedicated mental health, substance use disorder or reentry programming include jails in Denver, CO; Allegheny County, PA; Henrico County, VA; and San Diego County, CA. Talk with Denver County Jail for ideas on operating dedicated mental health, and substance use treatment units as well as mental health discharge planning and navigation from jail to community. Shane.Grannum@denvergov.org; Rhuerter@prainc.com.
- Build on current Yuma County integrated care model intended to integrate reentry programing with primary medical, behavioral health, employment, and justice system support. Programs such as the Transitions Clinic can help provide an integrated, whole health approach. Bexar County Bexar County (TX), and Bernalillo County (NM) have creative approaches to integrated justice and health care.
- Work in partnership with the municipal detention/holding facilities, county jail, and department of corrections to create a mental health unit that can serve serious offenders with serious mental illnesses.

Screening

"Universal screening" is key to sorting populations by risk and needs. Generally, detention and jail facilities have a medical/health provider that conducts basic health and some mental health screens.

- For the greater, general population, transition planning services should be offered to the medium-high risk sentenced population prior to release from the jail. Consider the using risk/need assessment tools adopted by the county to identify and sort the population. Some of the common tools used include the: Level of Service Inventory- SV (LSI, there are several versions, SV stands for short version), Compas, Ohio Risk Assessment System (ORAS), Women's Risk Need Assessment (WRNA), Service Planning Instrument for Women (SPIN-W), etc. Or a simple "risk-based" tool such as the Proxy screening tool to sort jail populations by risk level and prioritize for jail reentry services. Women's Assessment Tools: Women's Risk Need Assessment or the Service Planning Instrument for Women.

Most jails report having over 25% of their population living with mental illness and over 60% with co-occurring mental health and substance use disorders. Recognizing the challenges of the jail booking process, short screening tools are critical to quickly identify needs. Many screening tools such as the Brief Jail Mental Health Screen, are in the public domain. Additional brief mental health screens include the: Correctional Mental Health Screen and Mental Health Screening Form III.

All too often, screening for substance use disorders and cognitive impairment is overlooked resulting in persons with these high needs left without services that can begin to address their needs. Refer to the comprehensive review of screening and assessment instruments for justice-involved individuals published by SAMHSA in 2016.

RECOMMENDATION 5

IDENTIFY "FAMILIAR FACE" HIGH UTILIZER POPULATIONS TO HELP MANAGE COSTS, REDUCE UNNECESSARY UTILIZATION OF SERVICES WHILE INCREASING INDIVIDUAL STABILIZATION. DEVELOP "HIGH UTILIZER" STRATEGIES.

It is important to differentiate between a) identifying a "familiar face" population (which, at some level, is static); b) understanding the reasons for frequent use of jail, behavioral health, and medical services; and c) using information to inform strategies from proactive identification of people at risk to be "familiar faces." Identify strategies to objectively flag, intervene and serve these familiar faces.

Use historical data from the court, jail, mobile crisis, etc., to start the identification process of high utilizers. Build on efforts such as mobile crisis and other deflection and diversion strategies to identify high utilizers or "familiar face" populations within and across various systems. Use the lessons learned to increase information sharing, service implementation, identify gaps and improve outcomes.

General High Utilizer Identification Process

Build relationships and establish a working group across justice and non-justice stakeholders; establish goals to improve outcomes for highly vulnerable populations. Build on existing resources such as a Continuum of Care, homeless providers, and law enforcement Crisis Intervention Team programs.

- Convene the county mental health provider, county hospital, police, fire, EMS, 9-1-1, courts, prosecutors, public defenders, sheriff, homeless providers, withdrawal management services, etc. to understand various high utilizer populations from their perspective.

- Determine data points and seek agreements to analyze and share data at the aggregate and individual level.
- Map current system flow, frequency, costs for various populations.
  - Define, identify, stratify and create strategies to meet the needs of various high utilizing populations. Some populations to consider:
    - Emergency services such as fire, EMS and emergency rooms for non-emergency issues
    - Calls for police services where calls are based on mental health or intellectual disability
    - Incompetent to stand trial repeat individuals with low level, non-violent offenses
    - Repeated use of withdrawal management and police contact
    - Repeated overdose of substance use disorders resulting in emergency care and use of naloxone.
    - Repeated technical violators of probation services
    - Failure to appear and high court utilization for low level offenses
    - Parents where child abuse/neglect has been substantiated and frequent arrest or citation for substance use or levels of mental health disorders.
  - Track outcomes of police contact. The importance of documenting pre-booking actions including citation, arrest, hospitalization, de-escalation, and referral, cannot be overstated.
    - Determine how to flag individuals for police so they can initiate the deflection or diversion process.

        - Create a baseline and track by deflection and diversion strategy.
        - A simple “check-box” used by law enforcement, as within Fairfax, VA and Dade County, FL, can document actions taken.
            - Track the total number of dispatch calls to persons with behavioral health issues and sort by actions – arrest, deflect/divert, or “No Probable Arrest,” “Probable Misdemeanor Arrest,” and “Probable Felony Arrest.”
            - Track the percentage and type of calls specialized police units/officers are responding to and prioritize calls, if necessary.
    - Develop dashboard to track 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. Systems such as Microsoft Power BI allow flexibility in presenting information.
        - 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.
- Identify top system utilizers through analysis of court data (tickets, municipal and misdemeanor) by individual first, and then by offense, address of offense, etc. Share the list with justice system stakeholders: police, 9-1-1, pre-trial/bond eligibility and LOS before release, failure to appear (FTA), warrants, risk and need scores, detention frequency and LOS, engagement in detention/jail program services (including medical and behavioral health), probation and parole, and Department of Corrections, including technical violations and outcomes, etc. Stratify the list in ascending order of arrests or jail days; create a reasonable cut off point. Copy the list and add codes for identified behavioral health issues to a separate, protected list. This should result in understanding a lower level offender with high needs.
    - Map offense locations to understand density of offenses by offense type and develop strategies to improve outcomes.
- Share the list, with full name, known alias, and date of birth (not including protected health information) with additional non-justice stakeholders: homeless systems (HMIS), hospitals, detox

facilities, Human Services, Fire/EMS, community mental health, treatment providers, and other relevant community providers to understand the utilization, needs and gaps in resources.

- Providers may not be able to provide individual information, but they can provide information by cohort regarding levels of utilization of their systems.
- Request costs of services when possible.
- Develop MOUs with appropriate stakeholders to obtain more comprehensive data.
- Work with state systems such as Medicaid and behavioral health payers to provide utilization costs.
- Develop strategies to address specific population needs.

RECOMMENDATION 6

CREATE A COMPREHENSIVE SUBSTANCE USE DISORDER STRATEGY: POPULATION IDENTIFICATION and TREATMENT RESOURCES IN THE JAIL AND COMMUNITY.

SIM Workshop participants identified substance use disorder treatment capacity and access as a significant gap. The facilitators note the following substance use disorder initiatives and encourage stakeholders to expand and integrate substance use disorder treatment initiatives with other initiatives described in this report.

- *Substance use disorder treatment levels:* The American Society of Addiction Medicine's ASAM criteria is the result of a collaboration that began in the 1980s to define one national set of criteria for providing outcome-oriented and results-based care in the treatment of addiction. Today the criteria have become the most widely used and comprehensive set of guidelines for placement, continued stay and transfer/discharge of patients with addiction and co-occurring conditions.
  - ASAM Criteria- Determining Severity Ratings
  - Understanding and Utilizing the ASAM Placement Criteria
- The 2016 SAMHSA publication *Screening and Assessment of Co-occurring Disorders in the Justice System* developed by Roger Peters and the SAMHSA GAINS Center (see *Screening and Assessment* section of the Resources), provides an overview of screening and assessment and treatment of individuals with co-occurring disorders in the criminal justice system. In addition, Screening and

Assessment instruments for mental illness, substance use, co-occurring disorders, treatment motivation and trauma/PTSD. Recommended screening tools include:

  - Texas Christian University Drug Screen V
  - Simple Screening Instrument for Substance Abuse
  - Alcohol, Smoking and Substance Involvement Screening Test

- The SAMHSA publication, Detoxification and Substance Abuse Treatment. Treatment Improvement Protocol (TIP) Series, No. 4 SAMHSA Tip 45, provides communities with guidance on a continuum of inpatient and outpatient care for detoxification services and identifies best practices.
- Jails and prisons are increasingly utilizing Medication Assisted Treatment (MAT) at the point of reentry. The American Society of Addiction Medicine has established a National Practice Guideline to provide information on evidence-based treatment for opioid use disorder.
- The American Academy of Addiction Psychiatrists has established a clinical support system for providers, including prescribers working with justice-involved individuals. Education and training are available through the following web portal.
- The National Sheriffs' Association and the National Commission on Correctional Health Care have established promising practices and guidelines for jail-based Medication Assisted Treatment.
- The San Diego Serial Inebriate Program is a nationally recognized program to offer services to a chronic inebriate population.
- There are several curricula that can be helpful to use within the facility. See Jail Based Substance Abuse Treatment Literature Review for details.
  - General cognitive curricula such as: Thinking for a Change (TFC) and Moral Reconation Therapy (MRT) are effective, but can be lengthy to administer.
  - The SMART Recovery curriculum is shorter in length to administer.
    - InsideOut is a SMART Recovery program for substance abuse treatment in correctional settings.
  - The Matrix Model is a curriculum for persons suffering from methamphetamine use disorder.

Medication Assisted Treatment (MAT) protocols in the jail and community:

- Review current Medication Assisted Treatment (MAT) processes in the community and jail. Many jails are only giving Vivitrol, or Suboxone to women who are pregnant.
- Ensure support, especially peer support, to help persons maintain MAT and their recovery. See the *Medication Assisted Treatment* section of the Resources portion of this report.
- Strategies may include treatment on demand, police follow-up and referral to services, a resource center, harm reduction/syringe exchange, and/or first responders trained in and carrying Naloxone.
- Consider a collective impact process to bring together harm reduction, prevention, treatment and enforcement strategies. Think of both process, and individual-, policy-, and place-based strategies.
- Full jail/criminal justice facility MAT for opioid use disorder includes:
    - Screening for use and withdrawal
    - Withdrawal management on Buprenorphine
    - Maintenance dosing and induction on Methadone and Buprenorphine paired with appropriate psychoeducational classes, and
    - Peer support in the facility and upon release
    - Inmates leaving with Naloxone (Narcan)
    - Approximately 1% of the over 3000 county jails is offering a full spectrum of MAT protocols. Dr. Rai at Denver County Jail is open to discussing their model that provides all levels of MAT: maintenance, induction, withdrawal management, psych/social education and Narcan at release.

See *Jail-Based Medication-Assisted Treatment: Promising Practices, Guidelines, and Resources for the Field*, October 2018, https://www.ncchc.org/jail-based-mat., National Sheriffs' Association, National Commission on Correctional Health Care.

Trauma-informed curricula such as Seeking Safety, TREM, and M-TREM are important to offer as trauma is often underpinning substance use disorders.

- Seeking Safety is a non-clinical curriculum.
- Basic post-traumatic stress disorder assessment may be helpful to use. The Abbreviated PCL-C is a shortened version of the PTSD Checklist – Civilian version.

Clients with cognitive impairment often go undetected but may fail to comply with justice demands and fail to comprehend forms of treatment due to their impairments. Screening for cognitive impairment is important.

- Traumatic Brain Injury
  - The Ohio State University (OSU) Traumatic Brain Injury (TBI) Identification Method (OSU TBI-ID) is a standardized procedure for eliciting a person's lifetime history of TBI via a 3-5 minute structured interview.
  - SAMHSA's TIP 57: Trauma-Informed Care in Behavioral Health Services helps professionals understand the impact of trauma.
- Cognitive Impairment:
  - The Cognitive Failures Questionnaire (CFQ) was developed to assess the frequency with which people experienced cognitive failures, such as absent-mindedness, in everyday life.
  - Mini-Mental State Examination (MMSE)
  - The Saint Louis University Mental Status Examination (SLUMS) is a brief oral/written exam given to people that are suspected to have dementia or Alzheimer's disease. Instructions are found here.

RECOMMENDATION 7

EXAMINE THE NEED FOR PRETRIAL INTERVENTIONS TO REDUCE FAILURE TO APPEAR OF INDIVIDUALS WHO ARE BOOKED AND RELEASED.

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

Proportional Responses

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. The Milwaukee County Pre-trial Diversion program offers diversion opportunities using restorative justice and other accountability models Milwaukee County Pre-trial Diversion
- Consider 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.
- Explore implementing a detention Population Review Team (PRT) process similar to the one in Lucas County, Ohio Lucas County, Ohio. Weekly meetings are held with the prosecutor, public defender, jail representatives, mental health professionals, and others when appropriate. The team reviews a list of individuals in pre-trial custody to determine why a person is being detained and if he or she can be safely released before trial or have his/her case resolved quickly. For example, some individuals are released to mental health services as part of pre-trial conditions. In other cases, if the case during the normal course of action would result in a plea, the plea offer expedited rather than waiting to set a trial date.

- Consider including peers from Hope Inc., or another peer program, at initial court appearances. They can encourage treatment engagement, adherence to pre-trial terms and conditions and assist with Medicaid applications and general outreach and navigation.

RECOMMENDATION 8

IMPROVE PRE- AND POST-ARREST DIVERSION OPPORTUNITIES FOR INCOMPETENT TO STAND TRIAL POPULATIONS.

Participants discussed the Incompetent to Stand Trial (IST) population who are detained 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, deflection of repeat individuals and improved coordination with Probate Court can reduce unnecessary revolving patterns of persons where

competency has historically been an issue. See the American Bar Association legal standards (2016) for diversion strategies for the individuals charged with misdemeanors who are deemed incompetent to stand trial (Criminal Justice Standard on Mental Health 7.4- 8(e)).

Competency: Deflect or Divert Repeat Offenders

We encourage the justice community to think proactively about how to use deflection strategies to reduce the number of individuals involved in the justice system where there are potential concerns around competency.

- Consider using a "familiar face" triage process to deflect low-level offenders to services including a triage center, housing first and supportive housing resources and ACT; work collaboratively with Probate Court, guardianship and AOT services to improve long-term community based support.
- Stable housing is critical to individuals with high needs being successful in the community. SIM participants recognize the need to build a housing strategy.
- Consider convening a working group to review the current state of competency and competency restoration, including frequency of raised competency over the past several years, type of charges, evaluation/restoration outcomes, and individual information including mental health and substance use history/treatment, housing status, insurance status, and natural supports, if known.

In addition to the threshold of danger to self or others, some state laws support placing an individual on a mental health hold when gravely disabled. Contra Costa NAMI has created a *Survival Guide* and form that family and providers can use to document an individual's behaviors and be used to build the case for grave disability. Improve coordination among stakeholders to increase efficacy of the *Survival Guide.*

- *Survival Guide: A Practical Plan for Supporting a Loved One with a Mental Illness* (PDF)
- *Cover Letter for Family Information Forms (AB 1424) and Authorization for Verbal Release of Information Form* (PDF)

The American Academy of Psychiatry and Law has created guidelines for competency evaluation. 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.

Competency Restoration: Nationally, (Zapf and Roesch, 2011) research shows 75-90% of incompetent but restorable defendants are restored, generally, within 6 months of restoration efforts. 13-01-1901 Zapf Standard Protocols for Tx to Restore Competency.pdf Zapf, P. (2013). *Standardizing Protocols for Treatment to Restore Competency to Stand Trial: Interventions and Clinically Appropriate Time Periods* (Document No. 13-01-1901). Olympia: Washington State Institute for Public Policy.

GAINS Center (2007) Restoration Stage considerations, authored by Dr. Debra Pinals:

- Utilization Management of restoration beds – suitability for community or jail-based restoration, prompt return to court upon restoration, capacity to transfer between levels of care as needed during restoration
- Standardization across settings, reasonable statutory timeframes for restoration, jail and community-based restoration
    - Group learning Format (Noffsinger, 2001; Mossman et al., 2007)
    - Education, anxiety reduction, guest lectures, mock trials, video modules, post-restoration module, current legal events.
    - Potential new methodologies: Cognitive Remediation Strategies – Attention, memory, reasoning and executive functioning (Schwalbe, E., and Medalia. A. 2007)
        - The Slater Method (Wall et al., 2003), Restoration for defendants with intellectual disability. Inpatient and outpatient versions utilizing phases that build on knowledge, understanding and repetition

Restoration practices and settings vary from most restrictive inpatient, usually at a state mental health hospital or jail-based, to community-based outpatient. According to the National Judicial College, the following practices are suggested:

- Psychotropic Medication: *Sell v. United States*, 539 U.S.166 (2003) identifies conditions under which antipsychotic drugs can be administered against a defendant's wishes for the purpose of restoring competency but only in rare, limited circumstances. *Washington v. Harper,* 494 U.S

210 (1990) authorizes the involuntary medication of inmates who are dangerous to themselves or others and cannot give informed consent by use of an internal administrative process. Additional, inter-institutional medication challenges include sharing formulary information, access to and maintenance on medications once stabilized; restoration education to prescribers and medication consistency in the community.

- Frequent Status Updates to the Court, and/or Assigned Case Managers: Forensically trained case managers who access services, track progress and update court.
    - Establish protocols that preset or advance the return court date within 24 hours on a misdemeanor and 10 days for a felony.
- Forensic Telehealth –Secure video conferencing during restoration (e.g. Wisconsin); Videoconferencing for "Sell" hearings (e.g. Texas and Nevada).
- Restoration settings from most restrictive to least include: Inpatient usually at a State Mental Health Hospital, Jail Based, and Community-based Outpatient. Considerations, at the very least should include the level, type/nature of the offense (e.g., violent felony vs quality of life), patient/defendant safety related concerns for self and others, staffing and expertise of evaluators and restoration services; access to appropriate medications and is the setting conducive to restoration?
    - Outpatient Community Restoration (OPCR): WJP-5-228 Outpatient Comp Restoration.pdf; *Lookin' for beds in all the wrong places: Outpatient competency restoration as a promising approach to modern challenges;* Gowensmith, W. Neil, Frost, Lynda E., Speelman, Danielle W.,Therson, Danielle E. Psychology, Public Policy, and Law, Vol 22(3), Aug 2016, 293-305 APA PsycNET. Also see the *SAMHSA's GAINS Center's Quick Fixes for Effectively Dealing with Persons Found Incompetent to Stand Trial (2007).*
        - Often used for patients/defendants with lower level, non-violent cases
        - Housing stability and ability to pay is a consideration in some locations
        - Generally stable on medication or willing to accept medication
        - Mental Health Courts may have a "Competency Court" docket attached that is associated with OPCR
    - Jail-based Competency Restoration(JBCR): Jail based Comp Restor.pdf; RISE Jail based programs A-7-Restoring-Individuals-Safely-and-Effectively-(RISE).pdf; RISE program at Arapahoe County, CO Detention Center

- Dr. Reena Kapoor, MD, explores the question of impact of the setting on restoration in her Commentary: Jail-based competency restoration (2011). Some of the issues surrounding JBCR are: Will it increase the number of persons in jail? Is there a racial/ethnic or socio-economic issue? Does the setting impact competency restoration? Doe it let the state off the hook? Will it prevent us from taking a hard look at current practices that need to be addressed?

Additional competency resources and information:

- Florida has developed a Competency Restoration Kit: CompKit slidex.tips_florida-state-hospital-compkit.pdf.
- There a few articles on long-term restoration; attached is one from the Journal of the American Academy of Psychiatry and the Law (JAAPL) JAAPL Long Term Competence Restoration Rates.pdf
- Legacy of Jackson v. Indiana How Reasonable has Become Unreasonable.pdf
- Trueblood vs Washington State. Joint Approval for Settlement of Agreement; Case 2:14-cv-01178-MJP Document 584-1 Filed 08/16/18 Link: Trueblood settlement

RECOMMENDATION 9

INCORPORATE THE USE OF PEERS AND PEER SUPPORT AND RECOVERY ACROSS INTERCEPTS.

Peer specialists and peer support services can assist in helping inmates with mental illness/addiction to engage in treatment. They can be instrumental as part of a re-entry team to help an inmate connect with services upon release. 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. Peers can work one-on one or in a setting such as a "living room" model or as part of homeless, crisis evaluation centers, emergency departments, treatment courts, jail and reentry services, mental health and detox settings. Please review the resources below for information.

- *The 2014 SAMHSA publication* Toolkit for Evaluating Peer Respites *provides information on developing Peer Respite Centers.*
- Philadelphia's Department of Behavioral Health and Intellectual Disability Services has created a helpful Peer Support Toolkit.

- There are many other resources available such as Medicaid Coverage of Peer Support for People with Mental Illness.
- Wellness Recovery Action Plans (WRAP) are integral to individual recovery and can be integrated into probation or other case management plans.
- Living Room Living Room, Global Journal of Community Psychology Practice.pdf https://www.gjcpp.org/pdfs/2013-007-final-20130930.pdf
    - Best Practices for Effectively Integrating Peer Staff in the Workplace, New York State Office of Mental Health (2017)
    - Florida Peer Services Handbook, Florida Department of Children and Families, Office of Substance Abuse and Mental Health (2016)
    - Peer Services Toolkit: A Guide to Advancing and Implementing Peer-Run Behavioral Health Services, ACMHA: The College for Behavioral Health Leadership (Now called the College of Behavioral Health Leadership) and Optum (2015)
    - Enhancing the Peer Provider Workforce: Recruitment, Supervision, and Retention, National Association of State Mental Health Program Directors (2014)

RECOMMENDATION 10

INCREASE CONTINUITY OF HEALTH CARE BETWEEN THE ER AND JAIL.

Convene a working group made up of probation, law enforcement, YRMC, Horizon Health to discuss definitions, terms, conditions and thresholds for “Medical assessment and Medically Cleared”.

The process of medical clearance to be in jail is a common issue. The National Commission on Correctional Health Care (NCCHC) and the CHC Guidelines provide good information about standards of care. https://www.ncchc.org/filebin/Publications/CHC-Guidelines.pdf https://www.ncchc.org. According to the NCCHC’s *CorrectCare* Volume 21, Issue 3, Summer 2007, Question and Answer section, the following information should be considered.

- Review Correctional Care Standards: J-A-01 Access to Care and J-E-02 Receiving Screening and important standard J-D-05 Hospital and Specialty Care. Following is information gleaned from the NCCHC CorrectCare response:

- Is the level of care needed available in the jail facility? If the jail has an infirmary, what scope of care is available? Is there a sheltered housing area where the inmate can receive the necessary services? What is the jail medical, mental health staffing pattern?
- Does the ER physician know what level of care is available at the jail? A visit to the jail and an exchange of information about its health staffing and capabilities are essential to good planning between jail and ER health administrators and physicians.
- Is the ER physician thinking about return to jail as a return to home care? Would the hospital send the patient home? Does the inmate-patient simply need observation that could be done by minimally trained correctional officers, or does he or she need nursing care that is (or is not) available on-site?

In addition, consider blending resources and using the integrated health center for minor abrasions, stitching, etc. rather than more expensive levels of care prior to being detained. The Bexar County Sobering Center is a good model to follow.

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.*
- 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.
- Bureau of Justice Assistance. *Engaging Law Enforcement in Opioid Overdose Response: Frequently Asked Questions.*

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

DATA ANALYSIS AND MATCHING

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

HOUSING

- Alliance for Health Reform. *The Connection Between Health and Housing: The Evidence and Policy Landscape.*
- Economic Roundtable. *Getting Home: Outcomes from Housing High Cost Homeless Hospital Patients.*
- 100,000 Homes. *Housing First Self-Assessment.*

- Urban Institute. *Supportive Housing for Returning Prisoners: Outcomes and Impacts of the Returning Home-Ohio Pilot Project.*
- Corporation for Supportive Housing. *NYC FUSE – Evaluation Findings.*
- Corporation for Supportive Housing. Housing is the Best Medicine: Supportive Housing and the Social Determinants of Health.
- Corporation for Supportive Housing. Guide to the FUSE Model.

INFORMATION SHARING

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

JAIL INMATE INFORMATION

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

MEDICATION ASSISTED TREATMENT (MAT)

- American Society of Addiction Medicine. *The National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use.*
- American Society of Addiction Medicine. *Advancing Access to Addiction Medications.*
- National Commission on Correctional Health Care and the National Sheriffs' Association. Jail-Based Medication-Assisted Treatment: Promising Practices, Guidelines, and Resources for the Field.
- Substance Abuse and Mental Health Services Administration. *Federal Guidelines for Opioid Treatment Programs.*
- Substance Abuse and Mental Health Services Administration. *Medication for the Treatment of Alcohol Use Disorder: A Brief Guide.*
- Substance Abuse and Mental Health Services Administration. *Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction (Treatment Improvement Protocol 40)*.

- Substance Abuse and Mental Health Services Administration. *Clinical Use of Extended Release Injectable Naltrexone in the Treatment of Opioid Use Disorder: A Brief Guide*.

MENTAL HEALTH FIRST AID

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

PEERS

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

PRETRIAL DIVERSION

- CSG Justice Center. Improving Responses to People with Mental Illness at the Pretrial State: Essential Elements.
- National Resource Center on Justice Involved Women. Building Gender Informed Practices at the Pretrial Stage.
- Laura and John Arnold Foundation. The Hidden Costs of Pretrial Diversion.

PROCEDURAL JUSTICE

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

REENTRY

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

SCREENING AND ASSESSMENT

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

SEQUENTIAL INTERCEPT MODEL

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

SSI/SSDI OUTREACH, ACCESS, AND RECOVERY (SOAR)

Increasing efforts to enroll justice-involved persons with behavioral disorders in the Supplement Security Income and the Social Security Disability Insurance programs can be accomplished through utilization of SSI/SSDI Outreach, Access, and Recovery (SOAR) trained staff. Enrollment in SSI/SSDI not

only provides automatic Medicaid or Medicare in many states, but also provides monthly income sufficient to access housing programs.

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

TRANSITION-AGED YOUTH

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

TRAUMA-INFORMED CARE

- SAMHSA, SAMHSA's National Center on Trauma-Informed Care, and SAMHSA's GAINS Center. *Essential Components of Trauma Informed Judicial Practice*.
- SAMHSA's GAINS Center. *Trauma Specific Interventions for Justice-Involved Individuals*.
- SAMHSA. *SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach*.
- National Resource Center on Justice-Involved Women. *Jail Tip Sheets on Justice-Involved Women*.

VETERANS

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

Appendices

INDEX

Appendix 1

Agency	Attendee
Achieves Human Services	Brenda Mcadams
Achieves Human Services	Shannon Braman
Adult Probation	Mike Byrd
Adult Probation	Sandi Hoppough
Arizona Children's	Rachel Franck
Assurance health and Wellness	Yesnia Torres
Assurance health and Wellness	Sonya Holyfield
Banner Health	Michael Gardner
CBI	John Abarca
CBI	
Cenpatico	George Owens
Cenpatico	Wesley Lore
Cenpatico	Nursewise
Cenpatico	Amy Devins
Cenpatico	Maria Stengal
Cenpatico	Jennifer Hawkins
City of Yuma	Gary Knight-Ask Mayor
Cocopah	Joe Jenkins
Community Health Associates	Kara Ahearn
Community Health Associates	Chris Humphries
Community Legal Services	James Marshall
Cross Roads Mission	Cesar Acosta
Cross Roads Mission	Rene Sonoqui
Division of Developmental Disabilities	Justin Harris
Division of Developmental Disabilities	Tyrone Peterson orLouis Ruiz
HACY	Adriana Medrano
Hope Inc.	Sylvia Flores
Hope Inc.	Larissa Flores
Horizon Health and Wellness	Alonda Brown
Horizon Health and Wellness	Cambi Cogburn
Members	Hope inc will provide
Members	Hope inc will provide
Members	TLCR will provide

Regional Border Health	Edgardo Figueroa
Regional Border Health	Ines Gonzalez
San Luis Police Department	Miquel Alvarez
Self Help-DBSA	Karen Billingsley
Social Security	Wilma Carrasquillo-Facio
TLCR	Hollie Mellor
TLCR	Dr. Alberta
TLCR	Victoria Alacron
Vertical Church	Mike Kettunen
Hope Center	Loretta Davis
Welton Police Department	Donald Jones
YPD	John Lekan
YPD	Clinton Norred
YPD	Sgt Raul Fiveash
YRMC	Susan Pancrazi
YRMC	Jill Nelson
YRMC	Sr. Bharat Magu
Yuma County Attorney	Jon Smith
Yuma County Detention Center/Yuma County Sheriff Department	Olivia Wilson
Yuma County Detention Center/Yuma County Sheriff Department	Captain Lackey
Yuma County Superior Court	Judge Haws
Yuma County Superior Court	Juge Walsma
Yuma County Health Department	Diana Gomez
Yuma County Health Department	Gloria Coronado
Yuma County Jail	Wendy Lugo
Deputy Yuma County Attorney	Theresa Fox
Yuma County Public Defender	Terri Capozzi

Appendix 2

TEXAS Department of State Health Services

Crisis Services

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

The 80th Legislature

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

Crisis Funds

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

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

Competitive Funds Projects

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

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

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

The 81st Legislature

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

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

Appendix 3

Jail Data Link Frequent Users
A Data Matching Initiative in Illinois

Overview of the Initiative

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

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

Target Population for Data Link Initiatives

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

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

Legal Basis for the Data Matching Initiative

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

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

Sample Data at a Demo Web Site

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

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

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

Program Partners and Funding Sources

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

Partnership Between Criminal Justice and Other Public Systems

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

Managing the Partnership

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

About CSH and the Returning Home Initiative

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

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

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Illinois Program
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Appendix 4

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

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

January 2013

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

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

Introduction

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

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

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

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

Mental Illness, Homelessness, and Incarceration

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Incarceration and SSA Disability Benefits

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

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

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

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

Role of Transition Services in Reentry for People with Mental Illness

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

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

Access to Benefits as an Essential Strategy for Reentry

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

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

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

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

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

SOAR Collaborations with Jails

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

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

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

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

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

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

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

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

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

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

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

SOAR Collaborations with State and Federal Prisons

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

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

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

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

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

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

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

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

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

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

- Collaboration
- Leadership
- Resources
- Commitment
- Training

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Conclusion

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

For More Information

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

Appendix 5

Housing First Self-Assessment

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

100,000 HOMES

CUCS center for urban community services

HIGH PERFORMANCE SERIES

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

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

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

Housing First Self-Assessment

Assess and Align Your Program with a Housing First Approach

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

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

What is Housing First?

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

Why is this Toolkit Needed?

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

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

How Should My Community Use This Tool?

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

Who Does This Well?

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

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

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

Related Tools and Resources

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

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

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

Housing First Self-Assessment for Outreach Programs

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

Number of Points Scored:

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

Number of Points Scored:

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

Number of Points Scored:

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

    - ☐ Participants who demonstrate a high level of housing instability/chronic homelessness
    - ☐ Participants who have criminal justice records, including currently on probation/parole/court mandate
    - ☐ Participants who are actively using substances, including alcohol and illicit drugs Participants who do not engage in any mental health or substance treatment services
    - ☐ Participants who demonstrate instability of mental health symptoms (NOT including those who present danger to self or others)

    Checked Five = 5 points

    Checked Four = 4 points

    Checked Three = 3 points

    Checked Two = 2 points

    Checked One = 1 point

    Checked Zero = 0 points

Total Points Scored:

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

Total Housing First Score:

If you scored: 13 points or more

- ✓ Housing First principles are likely being implemented ideally

If you scored between: 10 – 12 points

- ✓ Housing First principles are likely being well-implemented

If you scored between: 7 – 9 points

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

If you scored between: 4 - 6 points

- ✓ Housing First principles are likely being poorly implemented

If you scored between: 0 – 3 points

- ✓ Housing First principles are likely not being implemented

Housing First Self-Assessment
For Emergency Shelter Programs

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

Number of Points Scored:

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

Number of Points Scored:

3. **Indicate whether priority consideration for shelter at your program is given to potential program participants with following characteristics.** *Check all that apply*:
    - ☐ Participants who demonstrate a high level of housing instability/chronic homelessness
    - ☐ Participants who have criminal justice records, including currently on probation/parole/court mandate
    - ☐ Participants who are actively using substances, including alcohol and illicit drugs Participants who do not engage in any mental health or substance treatment services
    - ☐ Participants who demonstrate instability of mental health symptoms (NOT including those who present danger to self or others)

    Checked Five = 5 points

    Checked Four = 4 points

Checked Three = 3 points

Checked Two = 2 points

Checked One = 1 point

Checked Zero = 0 points

Total Points Scored:

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

Total Housing First Score:

If you scored: 10 points or more

- ✓ Housing First principles are likely being implemented ideally

If you scored between: 6 – 9 points

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

If you scored between: 3 - 5 points

- ✓ Housing First principles are likely being poorly implemented

If you scored between: 0 – 2 points

- ✓ Housing First principles are likely not being implemented

Housing First Self-Assessment for Permanent Housing Programs

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

a) Active Substance Use

- Yes = 1 point
- No = 0 points

b) Chronic Substance Use Issues

- Yes = 1 point
- No = 0 points

c) Untreated Mental Illness

- Yes = 1 point
- No = 0 points

d) Young Adults (18-24)

- Yes = 1 point
- No = 0 points

e) Criminal Background (any)

- Yes = 1 point
- No = 0 points

f) Felony Conviction

- Yes = 1 point
- No = 0 points

g) Sex Offender or Arson Conviction

- Yes = 1 point
- No = 0 points

h) Poor Credit

- Yes = 1 point
- No = 0 points

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

- Yes = 1 point
- No = 0 points

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

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

Total Points Scored:

3. **Indicate whether priority consideration for housing access is given to potential program participants with following characteristics.** *Check all that apply*:
    - ☐ Participants who demonstrate a high level of housing instability/chronic homelessness
    - ☐ Participants who have criminal justice records, including currently on probation/parole/court mandate
    - ☐ Participants who are actively using substances, including alcohol and illicit drugs (NOT including dependency or active addiction that compromises safety)
    - ☐ Participants who do not engage in any mental health or substance treatment services
    - ☐ Participants who demonstrate instability of mental health symptoms (NOT including those who present danger to self or others)

    Checked Five = 5 points

Checked Four = 4 points

Checked Three = 3 points

Checked Two = 2 points

Checked One = 1 point

Checked Zero = 0 points

Total Points Scored:

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

- ☐ Complete a period of time in transitional housing, outpatient, inpatient, or other institutional setting / treatment facility
- ☐ Maintain sobriety or abstinence from alcohol and/or drugs
- ☐ Comply with medication
- ☐ Achieve psychiatric symptom stability
- ☐ Show willingness to comply with a treatment plan that addresses sobriety, abstinence, and/or medication compliance
- ☐ Agree to face-to-face visits with staff

Checked Six = 0 points

Checked Five = 1 points

Checked Four = 2 points

Checked Three = 3 points

Checked Two = 4 points

Checked One = 5 point

Checked Zero = 6 points

Total Points Scored:

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

Total Housing First Score:

If you scored: 21 points or more

- ✓ Housing First principles are likely being implemented ideally

If you scored between: 15-20 points

- ✓ Housing First principles are likely being well-implemented

If you scored between: 10 – 14 points

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

If you scored between: 5 - 9 points

- ✓ Housing First principles are likely being poorly implemented

If you scored between: 0 – 4 points

- ✓ Housing First principles are likely not being implemented

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

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

Number of Points Scored:

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

Number of Points Scored:

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

Number of Points Scored:

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

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

Number of Points Scored:

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

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

Number of Points Scored:

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

   - Yes = 1 point
   - No = 0 points

Number of Points Scored:

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

Number of Points Scored:

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

Number of Points Scored:

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

Number of Points Scored:

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

Number of Points Scored:

11. Approximately what percentage of homeless people living on the streets go straight into permanent housing (without going through emergency shelter and transitional housing)?

- More than 75% = 5 points
- Between 51% and 75% = 4 points
- Between 26% and 50% = 3 points
- Between 11% and 25% = 2 points
- 10% or less = 1 point
- Unknown = 0 points

Number of Points Scored:

12. Approximately what percentage of homeless people who stay in emergency shelters go straight into permanent housing without first going through transitional housing?

- More than 75% = 5 points
- Between 51% and 75% = 4 points
- Between 26% and 50% = 3 points
- Between 11% and 25% = 2 points
- 10% or less = 1 point
- Unknown = 0 points

Number of Points Scored:

13. Within a given year, approximately what percentage of your community's chronic and/or vulnerable homeless population who exit homelessness, exits into permanent supportive housing?

- More than 85% = 5 points
- Between 51% and 85% = 4 points
- Between 26% and 50% = 3 points
- Between 10% and 24% = 2 points
- Less than 10% = 1 point
- Unknown = 0 points

Number of Points Scored:

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

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

Number of Points Scored:

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

a) Active Substance Use

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

b) Chronic Substance Use Issues

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

c) Untreated Mental Illness

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

d) Young Adults (18-24)

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

e) Criminal Background (any)

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

f) Felony Conviction

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

g) Sex Offender or Arson Conviction

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

h) Poor Credit

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

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

- Over 75% = 5 points

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

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

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

Total Housing First Score:

If you scored: 77 points or more

- ✓ Housing First principles are likely being implemented ideally

If you scored between: 57 – 76 points

- ✓ Housing First principles are likely being well-implemented

If you scored between: 37 – 56 points

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

If you scored between: 10 – 36 points

- ✓ Housing First principles are likely being poorly implemented

If you scored under 10 points

- ✓ Housing First principles are likely not being implemented

Appendix 6

SKYPING DURING A CRISIS?

Telehealth is a 24/7 Crisis Connection

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

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

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

The Targeted Adult Service Coordination program began in 2005 to provide crisis response assistance to law enforcement and local hospitals dealing with people struggling with behavioral health problems. The employees respond to law enforcement calls to provide consultation, assistance in recognizing a client's needs and help with identifying resources to meet those needs.

The no-charge service program offers crisis services to 31 law enforcement agencies in 15 rural counties in the southeast section of the Cornhusker state.

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

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

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

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

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

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

Appendix 7

KEY ISSUE: REENTRY

REENTRY RESOURCES FOR INDIVIDUALS, PROVIDERS, COMMUNITIES, AND STATES

LEARN ABOUT SAMHSA REENTRY RESOURCES FOR:

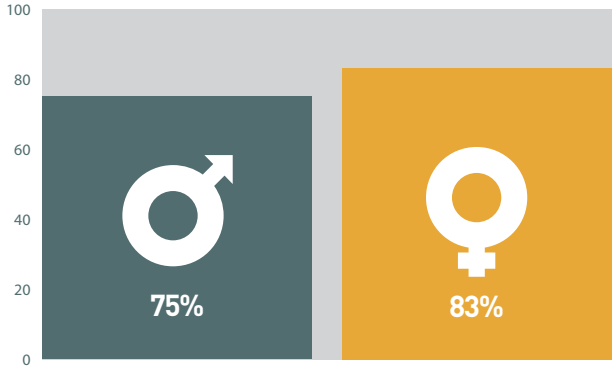
- Behavioral Health Providers & Criminal Justice Practitioners
- Individuals Returning From Jails & Prisons
- Communities & Local Jurisdictions
- State Policymakers

AT A GLANCE

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

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

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



ISSUE DATE 4.1.16

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

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

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

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

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

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

SAMSHA RESOURCES

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

RESOURCES FOR BEHAVIORAL HEALTH PROVIDERS AND CRIMINAL JUSTICE PRACTITIONERS

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

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

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

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

Trauma Informed Response Training

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

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

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

SOAR TA Center

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

RESOURCES FOR INDIVIDUALS RETURNING FROM JAILS AND PRISONS

SAMHSA's Behavioral Health Treatment Locator

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

Self-Advocacy and Empowerment Toolkit

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

Obodo

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

SecondChanceResources Library

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

Right Path

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

RESOURCES FOR COMMUNITIES AND LOCAL JURISDICTIONS

Establishing and Maintaining Medicaid Eligibility upon Release from Public Institutions

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

Providing a Continuum of Care and Improving Collaboration among Services

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

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

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

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

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

SAMHSA's Offender Reentry Program

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

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

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

RESOURCES FOR STATE POLICYMAKERS

Behavioral Health Treatment Needs Assessment for States Toolkit

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

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

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

All publications are available free through SAMHSA's store

http://store.samhsa.gov/

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