Sequential Intercept Model Mapping Report for Palm Beach County, FL

Prepared by: Policy Research, Inc.

Travis Parker, Program Area Director

Ashley Krider, Senior Project Associate

Lisa Maye, Project Associate

July 16-17, 2019

Delmar, NY

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Final Report

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Travis Parker, Program Area Director

Ashley Krider, Senior Project Associate

Lisa Maye, Project Associate

Policy Research, Inc.

ACKNOWLEDGEMENTS

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CONTENTS

Background

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

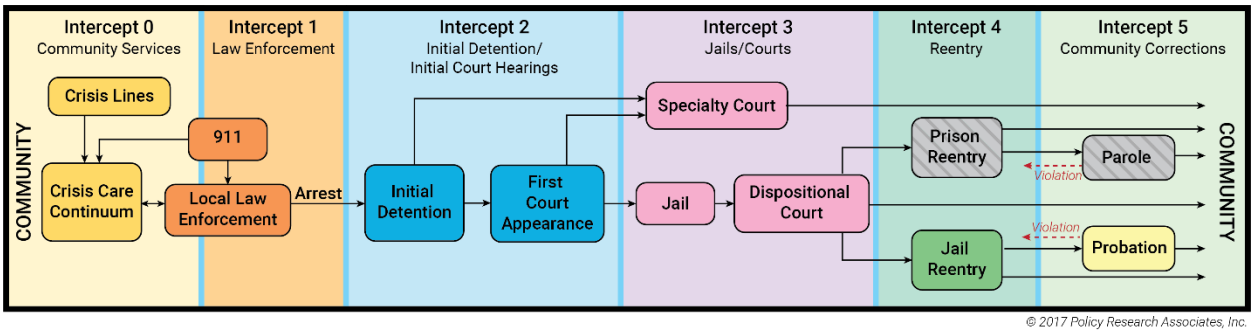
A Sequential Intercept Model mapping is a workshop to develop a map that illustrates how people with behavioral health needs come in contact with and flow through the criminal justice system. Through the workshop, facilitators and participants identify opportunities for linkage to services and for prevention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

The Sequential Intercept Mapping workshop has three primary objectives:

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

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

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



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

Palm Beach County previously took part in a one-day Sequential Intercept Mapping (SIM) workshop, provided by SAMHSA's GAINS Center for Behavioral Health and Justice Transformation, operated by Policy Research Associates, Inc. (PRA). Through the August 2014 SIM workshop, stakeholders identified top priorities for change, which included the following:

- Housing (23 votes)*
- Information/resource sharing (14 votes)*
- Family involvement/education (10 votes)
- Explore funding sources (9 votes)*
- Improve and/or expand continuum of crisis care (7 votes)*

Additional priorities included expanding social supports for homeless individuals, providing individualized care, increasing public awareness, expanding mental health diversion for higher charges, and expanding Crisis Intervention Team (CIT) training, including for dispatch officers.

*These items were also identified as top priorities in the most recent SIM workshop.

AGENDA

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SAFETY+JUSTICE CHALLENGE
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Sequential Intercept Mapping

AGENDA

Palm Beach County, FL

July 16, 2019

8:30 **Registration**

8:45 **Opening**
- Welcome and Introductions
- Overview of the Workshop
- Workshop Focus, Goals, and Tasks
- Collaboration: What's Happening Locally

What Works!
- Keys to Success

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

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

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

Wrap Up
- Review

4:30 **Adjourn**

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

There will be break for lunch at approximately noon.

POLICY RESEARCH, INC.

SAFETY+JUSTICE CHALLENGE

Supported by the John D. and Catherine T. MacArthur Foundation

Sequential Intercept Mapping

AGENDA

Palm Beach County, FL

July 17, 2019

8:30 **Registration and Networking**

8:45 **Opening**
- Remarks
- Preview of the Day

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

Action Planning

Finalizing the Action Plan

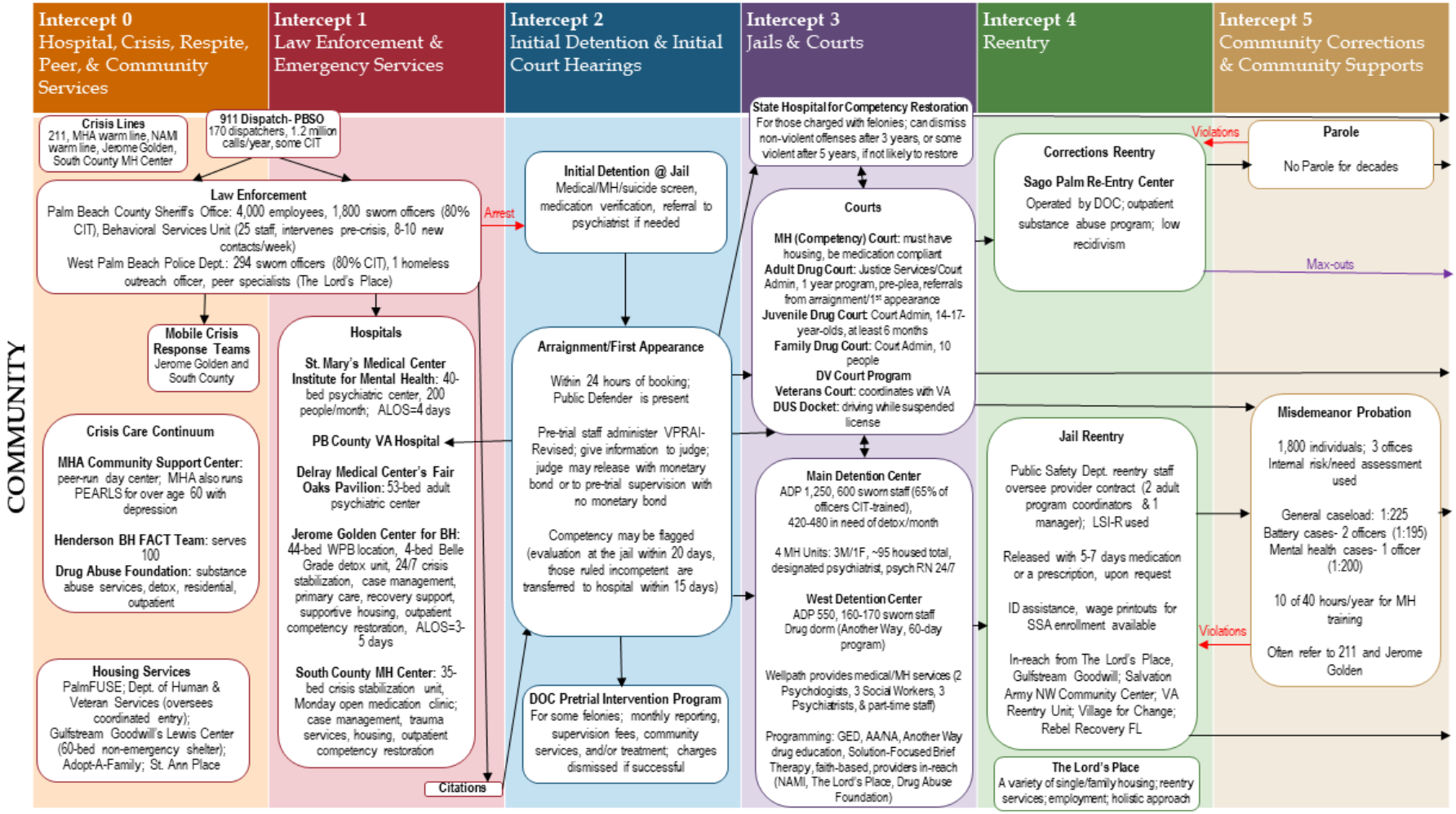
Next Steps

Summary and Closing

12:00 **Adjourn**

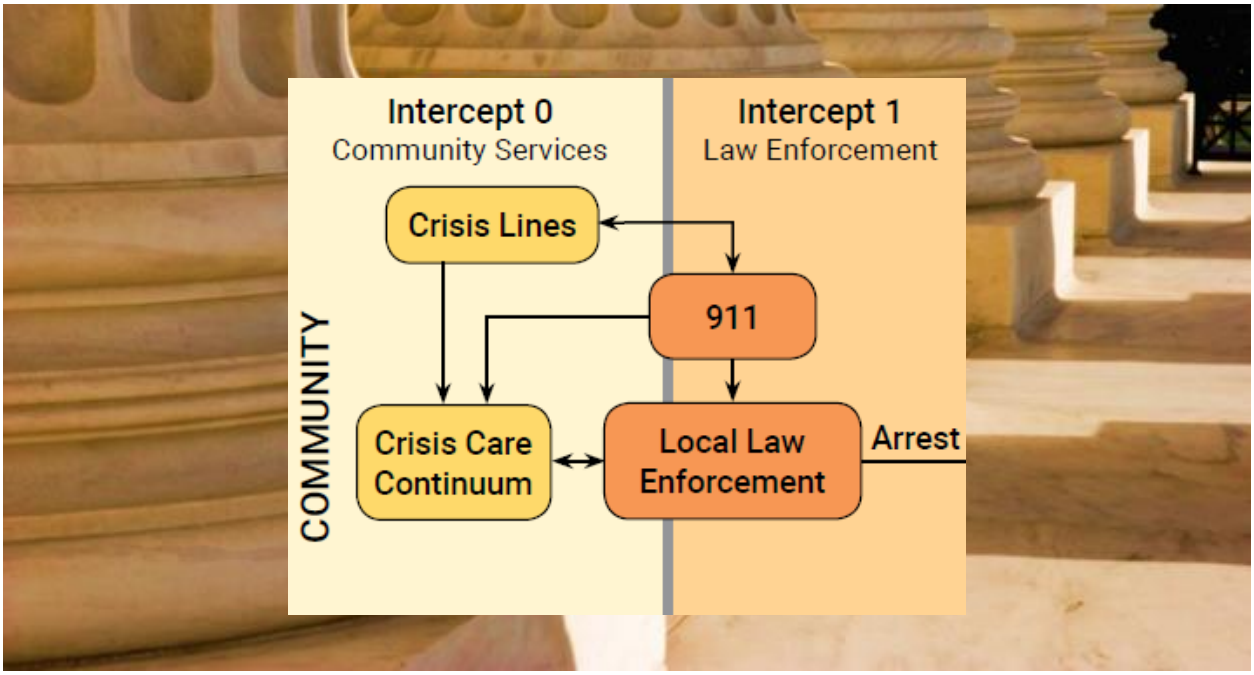
There will be a 15 minute break mid-morning.

Sequential Intercept Model Map for Palm Beach County, FL



RESOURCES AND GAPS AT EACH INTERCEPT

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



INTERCEPT 0 AND INTERCEPT 1

RESOURCES

Crisis Lines

- The 211 line is available 24/7 and receives about 300 calls per day, about 80 of which are from individuals in crisis situations. They perform a lot of triaging and referrals to Jerome Golden Mobile Crisis and South County Mental Health. They also answer the calls for the National Suicide Crisis and Rape Crisis Lines. Most call needs relate to housing and mental health. Crisis counselors have at least 100 hours of training prior to answering calls, including crisis de-escalation, Mental Health First Aid (MHFA), and ASIST suicide intervention. They also have an elder crisis outreach program with short-term case management, as well as the My Florida Vet program for veterans in crisis.
- The MHA warm line (previously called Mental Health GPS) receives crisis calls and has a Certified Recovery Peer Specialist on staff. Their main focus is service connection, and they often refer to Mobile Crisis and 211.
- NAMI also operates a warm line with a full-time Certified Family Support Specialist. The majority of calls are from family members of individuals in crisis.
- Both the South County Mental Health Center and Jerome Golden Mobile Crisis Teams have their own crisis lines.
- Additional case management services are available through Legacy, Boys Town (for youth), APD, and other agencies.

Behavioral Health Funding

- The Southeast Florida Behavioral Health Network (SEFBHN) is the managing entity for behavioral health funding for a five-county region, including Palm Beach.
- The Drug Abuse Foundation of West Palm Beach provides substance abuse prevention education, crisis services, detox, residential services, and outpatient treatment. They serve about 5,000 individuals per year.
- The Palm Healthcare Foundation and the Quantum Foundation are also funders of local behavioral health services.
- PBC Community Services was created to operationalize the 2017 Palm Beach County's Approach to the Opioid Crisis report and create a more recovery-centric system.

Healthcare

- The Jerome Golden Center for Behavioral Health is a community mental health center, and has two co-ed psychiatric units with 44 beds at their West Palm Beach facility, as well as a smaller unit in Belle Glade that has four beds for detox. The length of stay is between three to five days at Jerome Golden. Services include access a psychiatric medication clinic upon discharge, medication-assisted treatment (MAT), a partial hospitalization program through Medicare, some housing services, a co-occurring residential program that accepts many individuals from jail, and peer support specialists.
- The South County Mental Health Center provides case management, crisis intervention, and residential services, including a 35-bed crisis stabilization unit.
- There are seven Baker Act receiving facilities in the County, including St. Mary's Medical Center's Institute for Mental Health, a 40-bed psychiatric center, serving about 200 individuals per month. All admissions go through the emergency department transfer center, where nursing staff can evaluate and refer to the Institute for Mental Health. Individuals meet with psychiatric staff within 24 hours to triage and prepare for discharge. The average length of stay at St. Mary's is just over four days.
- The Delray Medical Center's Fair Oaks Pavilion is a 53-bed adult psychiatric center in Delray Beach with inpatient programs for those with addictions, acute or chronic psychiatric disorders, and other conditions. They also offer an inpatient geriatric program.

Law Enforcement and First Responders

- There are about 4,000 Palm Beach County Sheriff's Office (PBSO) employees (1,800 sworn), including 800 corrections deputies. Most officers have received Crisis Intervention Team (CIT) training or Mental Health First Aid (MHFA), and the CIT training is being integrated into the training academy. About 80% of sworn officers are CIT trained, and some deputies have MSW degrees as well.
    - There are about 25 staff in the Sheriff Office's Behavioral Services Unit, including eight therapists. The unit's goal is to respond and locate alternatives to

incarceration and intervene pre-crisis. The unit may respond through dispatch or patrol requests. They average between eight and ten new contacts per week. Individuals are monitored to some extent for a year, especially if they aren't engaged in other services.

- The West Palm Beach Police Department (WPD) has 294 sworn officers, as well as 110 civilian staff. About 80% of sworn officers are trained in CIT. They also have one homeless outreach officer, along with peer specialists from The Lord's Place who are able to interact with the public. There is reportedly good information sharing and collaboration between WPD and the PBSO.
    - The FBI's Behavioral Analysis Unit will provide upcoming training to the WPD. They're also pursuing risk assessment training from the Secret Service.
- Law enforcement officers are able to quickly return to service following transporting someone to a hospital or Baker Act receiving facility. The wait time is estimated at five to ten minutes.

911 Dispatch

- PBSO Dispatch receives about 1.2 million calls for service each year, with about 170 911 dispatchers. About 20 to 25 dispatch officers complete the yearly 40-hour CIT training, as well as additional suicide and "mini CIT" training. There are about 800-900 total hours of training required for dispatch officers before they are released to answer calls independently. It is mandatory that any call answered with a crisis possibility has a CIT-trained law enforcement officer response.

MAT

- The Fire Department carries Narcan for opioid overdose reversal.

Crisis Services

- The Jerome Golden Center for Behavioral Health has a Mobile Crisis Response Team that receives many referrals from law enforcement.
- The South County Mental Health Center also has a Mobile Crisis Response Team and reports positive interactions with CIT-trained officers in particular.
- The Mental Health Association (MHA) of Palm Beach County operates the Community Support Center, a peer-run day center for adults with mental health or substance abuse needs. They also operate the Program to Encourage Active Rewarding Lives (PEARLS) community-based problem-solving treatment program for adults over the age of 60 who are experiencing mild to moderate depression.
- The 2017 Behavioral Health Needs Assessment led to the creation of Be Well PBC, an initiative focused on increasing and improving interagency coordination and alignment of behavioral health services and more widely engaging community members in innovative solutions.

- The Henderson Behavioral Health Forensic Assertive Community Treatment (FACT) team serves about 100 clients locally.

Shelters

- The Department of Human and Veterans Services oversees the coordinated entry process for housing in the County, with Homeless Outreach Teams and linkage to veterans' benefits. They serve roughly 1,000 households per year, and link to the VA if they engage a veteran who is homeless.
- Gulfstream Goodwill Industries operates the Senator Philip D. Lewis Center, a 60-bed non-emergency shelter (interim housing), and receives many individuals who did not follow through with treatment, as well as occasional law enforcement drop-offs. Twenty beds are earmarked for 18- to 20-year-olds. They are part of the PalmFUSE initiative and provide employment services, substance use and mental health treatment, and GED programs.
- Adopt-A-Family of the Palm Beaches, Inc. assists families with finding housing and services. They provide access to services for more than 2,000 families with children each year. They are the lead agency at the Lewis Center.
- St. Ann Place is a church outreach center for homeless men and women.

Peer Support

- In addition to operating their warmline, NAMI Peer Support Specialists respond to the community to build relationships and engage in services. They also offer youth and peer mentoring programs, as well as the Ending the Silence educational program for youth with mental health issues.
- MHA operates Peer Place, a peer support center for adults recovering from mental illness and addiction, with almost 100 monthly support groups.

Collection and Sharing of Data

- The Managing Entity has a tracking system for individuals who are high utilizers of services. With consent, the information can be released to cross-systems stakeholder for continuity of care and coordination.

GAPS

Crisis Line

- The 211 line is not able to share caller information with other relevant stakeholders.

Healthcare

- There is a communication gap between hospitals, in particular for those with no payer source.

- The South County Mental Health Center is often over bed capacity, and it is very difficult to gain provider appointments.
- There are many individuals with complex cross-systems needs that the Jerome Golden Center encounters and may not be fully able to serve. Average length of stay increases in some of these cases.
- Individuals are reportedly discharged from the hospital as stable after three to five days, but often decompensate in lieu of longer-term treatment.
- Many otherwise eligible clients lack Social Security benefits for years, and it is difficult to complete the application process to become approved. The SSI/SSDI Outreach, Access, and Recovery (SOAR) process exists locally, but individuals aren't always involved or aware for the resource. Clients in the state hospital are also discharged without benefits.

911 Dispatch

- It would be helpful for PBSO to receive more integrated information sharing around prior context of repeat callers, particularly around mental health crises.

MAT

- Access to Medication-Assisted Treatment (MAT) in the community is limited.
- Narcan is not always carried by law enforcement, or available inside the jails.

Crisis Services

- There is no substance abuse receiving facility available in the County, which is a significant gap.
- There is a need for a centralized crisis support one-stop drop-off for law enforcement that can triage to individualized services.
- There is a gap in immediate access to resources including medication and provider appointments for those who do not rise to the level of Baker Act consideration. Waitlists for psychiatrist and therapy appointments can be up to several months, due to funding and staffing shortages. This can lead to crisis escalation in some cases.
    - There are very few private psychiatrists who will accept Medicaid, and many psychiatrists associated with the hospitals are currently full.
- The institutional appearance and unsettled environment of some local service agencies is a reported barrier to client engagement. There is one first-episode psychosis program in the community, but the environment is also not ideal.

Shelters

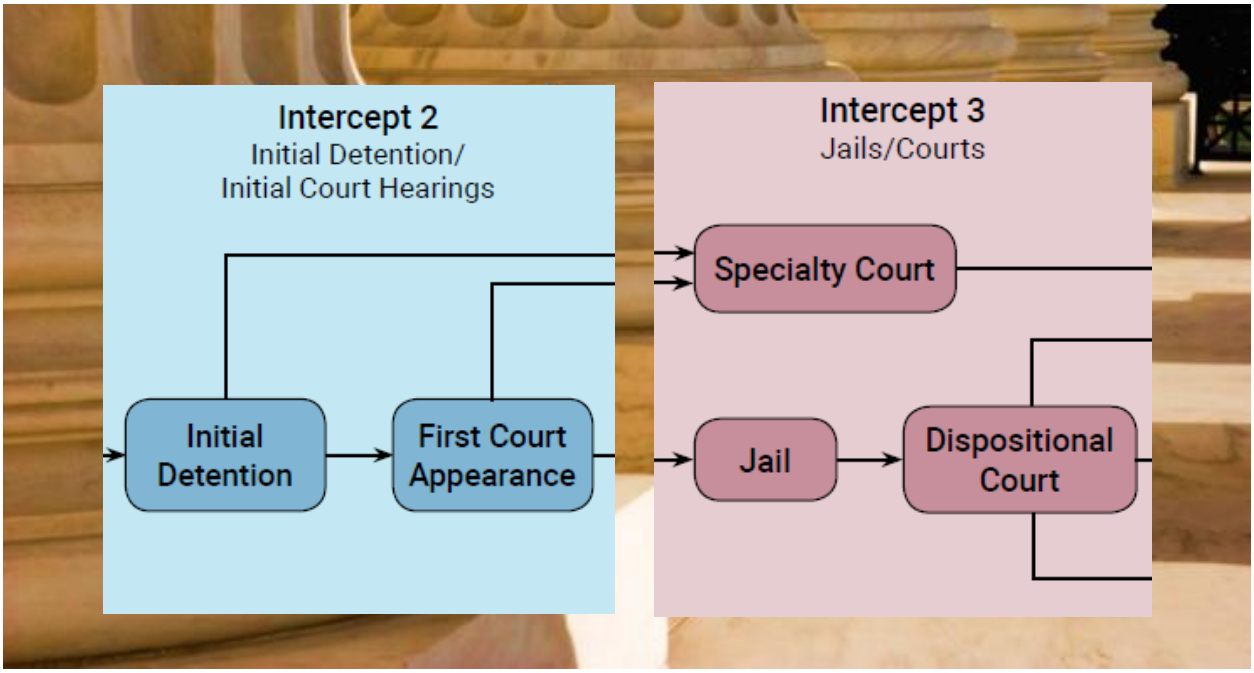
- There is a significant gap in affordable housing in Palm Beach County, including respite, supportive, and youth housing.

Peer Support

- There is a lot of competition locally for peer support staff positions.
- There is a lack of peer support staff at the local hospitals, since the end of a beneficial pilot project that bridged the hospital to community transition process.
- The Jerome Golden Center's Mobile Crisis Response Team could use additional peer support staff.

Collection and Sharing of Data

- There is a gap in front-end diversion information sharing and follow-up after crisis calls and referral to services. The PBSO's Behavioral Services Unit reported this gap in particular, as did the Public Defender's Office.



INTERCEPT 2 AND INTERCEPT 3

RESOURCES

Jail Structure and Personnel

- The two local jails are the Main Detention Center and West Detention Center. The average daily population (total for both facilities) is about 1,800, down from about 2,100 one year ago. The reduction is attributed to court policies, although specific causes were unclear.
    - The Main Detention Center has 2,100 beds and about 600 sworn staff members. The average daily population is about 1,250 individuals. Roughly 65% of correctional officers are trained in CIT. Within the jail, Wellpath contracts for two psychologists, three social workers, and three psychiatrists, as well as for additional per diem and part-time staff.
        - There are four designated mental health units (step down units) at the Main Detention Center, housing about 95 individuals. They are designed to function like an inpatient unit, and the goal is to strive for stabilization. The units are Acute (men who are suicidal or with psychotic issues), Delta (men, chronic, stabilized on medication), 2 Alpha (men who are less vulnerable but not able to "handle" being in the general population), and 3 Alpha (women) Individuals are housed in the infirmary if there are capacity issues.

- The West Detention Center has 850-900 beds and about 160-170 sworn staff members. The average daily population is about 550 individuals.

Jail Services

- Upon booking at Main Detention Center, a nurse (available 24/7) will conduct a medical/mental health screen. The Columbia-Suicide Severity Rating Scale (C-SSRS) is administered as well. Medications will be verified through prescribers, and referral to a psychiatrist will follow, if needed. There is a separate mental health unit to house individuals discontinuing medication that may result in suicidal ideation.
  - The process at West Detention Center is very similar, although individuals may be transferred to the mental health unit at Main Detention Center, if needed.
- Individuals are asked about veteran status early in the booking process.
- Jail programming includes GED prep, AA/NA, crisis intervention and Solution-Focused Brief Therapy (SFBT). Many providers do jail in-reach including NAMI, The Lord's Place, the Drug Abuse Foundation.
- There is a drug dorm at the West Detention facility called Another Way. It utilizes an evidence-based understanding of substance use to help participants gain insight into their use. The program is 60 days and has about 25 women and 60 men enrolled. There is an option for reduced incarceration time, for some who successfully complete the program.
- The jail is hoping to open a MAT program in September 2019, which will be a multi-agency and multi-system partnership.

First Appearance/Pre-trial Services

- Individuals must be seen within 24 hours of booking, and Public Defenders are present at First Appearance. The Public Defender's (PD's) Office receives a daily list of who is up for first appearance (about 35-40 people per day), in order to identify clients. The State's Attorney's Office contacts any victims, and assists the judge in setting bond.
- The PD's Office has a Mental Health Division with two attorneys and a Licensed Clinical Social Worker (LCSW).
- Pre-trial staff collect information at this point including employment, military experience, mental health/medical issues, and criminal history, then administer the Virginia Pretrial Risk Assessment Instrument (VPRAI-Revised), providing the information to the defense council, State's Attorney's Office, and the judge. The judge may consider this and release with monetary bond or to pre-trial supervision with no monetary bond.
- There are 23 pre-trial services staff, including 13 at the jail and 10 in supervision units. They serve about 675 clients on supervision.
- The DOC's Pretrial Intervention Program, a supervised program similar to probation, is available to some alleged felony offenders that, if successfully completed, results in the criminal charge being dismissed. Typical conditions of PTI supervision require monthly

reporting, payment of supervision fees, community service and appropriate counseling or treatment if deemed necessary after an evaluation.

Problem-Solving Courts

- The First Appearance attorney may flag competency for the PD's Office at this point. The court will appoint an expert to conduct a competency evaluation at the jail, if the person is in custody. The in-custody evaluations typically take 20 days or less. If ruled incompetent, the individual must be transferred to the state hospital within 15 days.
    - Outpatient (community-based) competency restoration begins immediately, but may experience a delay in finding an appropriate environment, and individuals may wait to be transferred to a surrounding county.
- For those part of Competency Court (aka Mental Health Court), competency restoration takes place either in a facility or upon a release to a community agency (most commonly South County Mental Health or Jerome Golden). Housing, medication, and competency restoration training are key services to this restoration process, which has been in existence for 10 years. Individuals may be deemed not guilty by reason of insanity (NGI) through a non-jury trial, also.
    - There are about 30 individuals awaiting a determination, five pending conditional release, and five pending hospitalization.
    - There is no competency restoration for individuals charged with misdemeanors.
- Palm Beach County has three Drug Courts (Family Drug Court, Delinquency- Juvenile-Drug Court, and Adult Drug Court).
    - Adult Drug Court is pre-plea and generally lasts for one year. Primarily outpatient based services are offered. There are approximately 96 people being served at any given time. Referrals typically come from First Appearance and Arraignment courts. The Court contracts with various agencies for substance use and co-occurring disorders services and has an approximately 14% recidivism rate. It has been in existence for over 20 years.
    - Delinquency (Juvenile) Drug Court is a minimum six-month program which targets youth (14- to 17-years-old) who have a history of substance abuse.
    - Family Drug Court has about 10 participants and helps parents stay with or gain custody of their children back.
- The Fifteenth Circuit's Domestic Violence Program is comprised of Circuit Judges, County Criminal Court Judges, and case managers.
- The Driving While License Suspended Court (DUS) has been in existence for three years.
- The Veterans Court has been in existence for eight years and collaborates with the local VA Hospital, which is a valuable resource for linkages to treatment and services.

Data Collection and Sharing

- Data is collected regarding persons in the jail who are taking psychotropic medications.

- Wellpath submits monthly data reports.

GAPS

Jail Structure and Personnel

- There are no designated mental health professionals at jail intake currently, although there is interest and providers are on call 24/7.

Jail Services

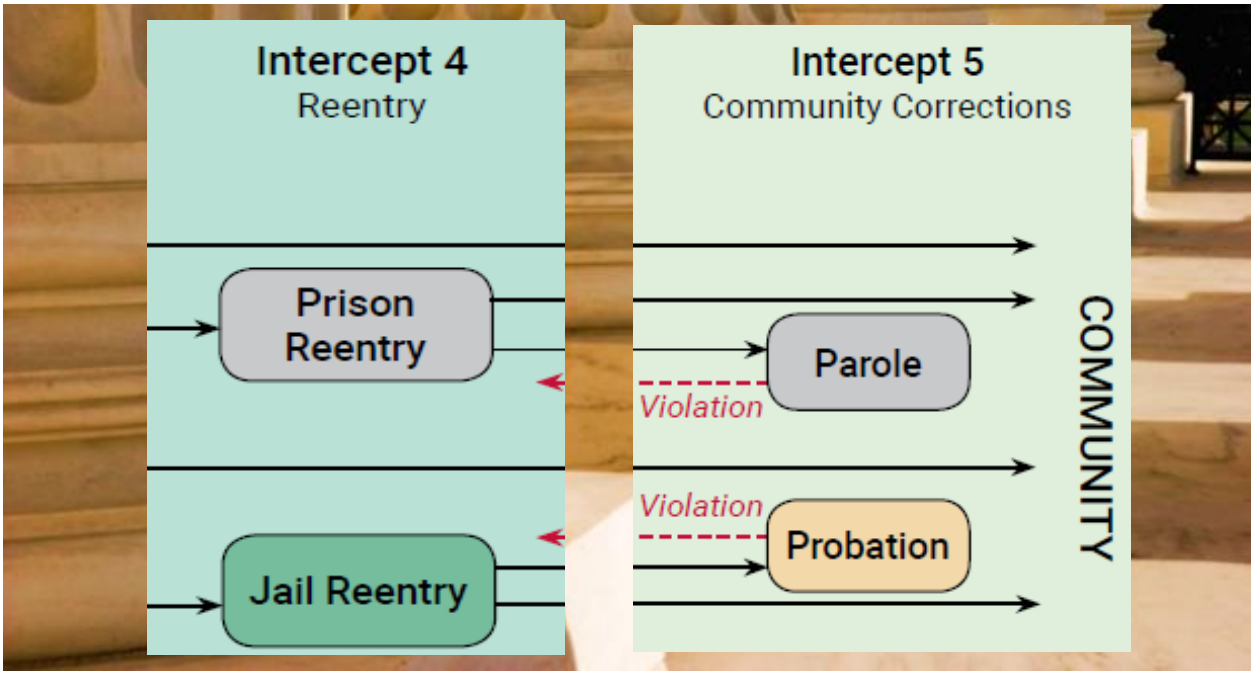
- From initial data tracking around March 2019, about 420-480 individuals per month are put on detox (of 1,600 total jail bookings). There is little community capacity to serve this need. Anyone entering the jail under the influence of alcohol or benzodiazepines is monitored through the withdrawal period using medication protocol.
- There is a limited formulary available at the jail. Newer generation psychotropic medications are not necessarily available.
- Medications cannot be brought in from outside of the jail, unless the individual is transferred from the state hospital.
- There may be a delay in medication delivery after booking, particularly when verification is an issue.
- There is no mental health unit at West Detention Center, and transfer to the Main Detention Center unit requires 50 miles of travel each way.
- Some individuals are in need of mental health services but do not disclose.

First Appearance/Pre-trial Services

- There has been no recent mental health training with pre-trial staff (since 2016).
- Identification of mental health needs is done on an ad hoc basis, based in many cases on if a person is on the mental health unit, but there is no formal information sharing with pre-trial staff. The pre-trial screen only consists of three questions covering history of mental health needs and substance abuse.
- Treatment and housing engagement may be used as conditions of bond/release, which can result in individuals waiting longer in jail than necessary.

Problem-Solving Courts

- There is a very high threshold to determine level of competency to move forward with court proceedings. Some persons are restored within months, others take years. There is language that says these proceedings can be dismissed after three years for non-violent offenses and after five years for more violent offenses if the person is not likely to be restored. Some people are reportedly waiting years for restoration, without resolution of their cases.



INTERCEPT 4 AND INTERCEPT 5

RESOURCES

Jail Services

- There are both in-reach and out-reach reentry services available at the jail.
- The Public Safety Department is responsible for jail-based reentry staff. There are three Palm Beach County Public Safety- Justice Services program coordinators, including two for adults and one for youth. They oversee the community providers' contracts.
- There are two prison-based and one jail-based reentry programs that receive county funding. All reentry services are voluntary and are broken down geographically.
- The Level of Service Inventory-Revised (LSI-R) is utilized for reentry planning.
- The Sago Palm Re-Entry Center, a specialized reentry prison, works well to get to people prior to release, but it does not have an inpatient mental health unit. It *does* have an outpatient substance use program. The program shows a recidivism rate of 11% for 2016.
- Individuals who have been taking medication are released from jail with a five- to seven-day supply of medication or a prescription, if none remains. Some of this may only be based on request, however.
- It is possible for released individuals to use the jail wage printout to access some services, such as SSA enrollment.

Community Reentry

- The Re-entry Taskforce meets quarterly and has subcommittees surrounding housing, sex offenders, employment, sustainability, and youth. There are 12 voting members, but 40-50 people attend in an advisory committee manner. The group has been in existence since 2008.
- The Lord's Place is a homeless shelter with a strong focus on permanent supportive housing and reentry. They take a holistic approach and provide employment, mental health, physical health, substance abuse, reunification with family, SOAR, and other services. Each client is provided with a case manager.
    - They have 50 beds for men at the William H. Mann Place for Men (30 are transitional and 20 are supportive housing).
    - They also have a family campus that can accommodate 32-36 families.
    - Halle Place is a supportive housing program specifically designed for women who were formerly incarcerated, within the prior six months.
    - There is also a female reentry house (Burckle Place) that can hold 12 women.
    - Operation Home Ready provides long-term supportive housing for up to 55 chronically homeless individuals with disabilities.
- Gulfstream Goodwill Industries also has services at reentry. Employment, family reunification, housing assessments for coordinated entry, family reunification, and shelter services are all provided.
- South County Mental Health Center has an open clinic for medications on Thursday mornings.
- The Salvation Army Northwest Community Center offers reentry programming.
- The VA has a specialized reentry unit that does in-reach into the jail.
- Village for Change, an adult substance use program with 18 residential beds, provides dual-diagnosis treatment and assistance with housing and other community services.
- Rebel Recovery Florida provides reentry and pre-entry services through Certified Peer Support Specialists. They distribute Narcan and are focused on harm reduction.

Probation

- Misdemeanor probation serves approximately 1,800 people. There are three offices throughout the county, including 15 officers working in West Palm Beach. The average caseload is 225 people served per probation officer.
    - An internally developed risk/needs assessment is utilized with each person.
    - Seven officers cover court on a daily basis, with caseloads of about 120 each. Two officers see battery cases (about 195 persons) and one sees mental health cases (about 200 persons). The Mental Health Officer has a master's degree in mental health.
- The rest of the misdemeanor probation officers go through a basic mental health training (about 10 hours per year).
- Notices to Appear are often given in lieu of probation revocations/warrants.

GAPS

Jail Services

- All reentry services are voluntary.

Community Reentry

- Some individuals with cognitive or mental disorders, or serious physical health needs, are reportedly released from the jail and dropped off at the area hospitals.
- Some individuals are brought to The Lord's Place from the jail still wearing handcuffs.
- A person is typically released with five to seven days of medications, which is not enough prior to getting connected or re-connected with a prescribing provider. Individuals are not always released with prescriptions for additional medication.
- Identification is a barrier to service access for those coming out of incarceration.
- Housing is an area of significant need.
- Public transportation is difficult for people to use and access, especially when it is hot outside.

Probation

- Felony probation was not represented at the SIM.
- The misdemeanor probation risk assessment is homegrown. It is not a validated instrument.
- There is a need to access resources and services in a more rapid and effective way.
- There are no peers working with Probation at this time.

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 16, 2019. The top three priorities are highlighted in italicized text.

1. *Address the homelessness situation by increasing housing resources- 22 votes*
2. *Create a general receiving facility with capacity for mental health, substance abuse, and crisis emergency services- 9 votes*
    a. *Create a community-based option for detox and a secure addiction receiving facility- 20 votes*
3. *Create respite services/housing for those with mental health needs in particular- 10 votes*
4. Improve access to and continuity around medication- 9 votes
5. Increase cross-system coordination and communication- 8 votes
6. Implement a pre-arrest deflection/diversion program to reduce the number of people entering the jail- 8 votes
7. Create immediate early assessment and intervention pre-jail- 6 votes
8. Increase paid peer support services across the Intercepts- 5 votes
9. Create a step-down unit from crisis stabilization- 3 votes
10. Improve needs assessment and linkage to services between jail/hospital and the community- 2 votes

Action Plans

Priority Area #1: Increase housing resources and create step down unit(s) form crises stabilization and respite housing (incorporated Priorities #1, 3 and 9)			
Objective	**Action Step**	**Who**	**When**
Research models from other counties/states	"Living Room" model- mobile units to go where the homeless are (See Objective #3)		Now!
Educate the community and legislators about cost effectiveness of step down services vs. repeat jail/emergency services	Re-allocate funds from crisis services to step down Get community, hospitals, businesses involves	Palm FUSE	
More mobile care to make the first contact and start the process to help those who are homeless and save on crisis services	Contact Health Care District to coordinate a schedule with community policing Follow-up to see what is working and how to improve Expand mobile services to start substance abuse treatment and mental health meds, etc.	HCD Police	

Priority Area #2: Create a general receiving facility with mental health, substance use, and crisis emergency services			
Objective	**Action Step**	**Who**	**When**
Develop/identify a facility or partner who can provide referral/delivery or multi-faceted services to address different consumer needs (regardless of insurance) at the same location -Provide emergency services at a location other than the jail	Identify location, funding (needs and sources), and providers Develop definition of services to be provided Form multi-disciplinary taskforce/workgroup to formalize action plan and budget Fund existing facilities/programs to provide additional services for referred consumers	CJC, MacArthur Foundation, County Commission, M.E., mental health providers, substance abuse providers, law enforcement, NAMI/MHA, hospitals/Health Care District, peer supports, housing providers (HUD), crisis service providers (211, etc.), courts (PD, SAO, judicial), DCF/AHCA	Seek funding: 2019 Pilot: 2020 Expand/implement: 2021

Priority Area #3: Implement an alternative to arrest and/or pre-arrest deflection/diversion program to reduce the number of people entering the jail			
Objective	**Action Step**	**Who**	**When**
Reduce the amount of individuals with misdemeanor charges going through the county jail	Research programs: -Do civil citations work (e.g., Leon County reduced by 80%)? Implement incentives: -Needs assessment -Holistic approach assessment -Mentorship programs/peer support Systems tracking across agencies Alternative to arrest programs created: -Probation	PBSO 33 law enforcement agencies Judicial, State's Attorney's Office City officials Churches Community-based programs	Now!

Priority Area #4: Increase paid peer support services across Intercepts			
Objective	**Action Step**	**Who**	**When**
Find precedents	Identify different points across the Intercepts where peers are needed	CJC, community service providers	CJC's discretion
Train peers to work in different Intercepts	Create job descriptions Create trainings	MHA	After identification of needs at each Intercept
Outline pilot	Identify funders, providers, peers Identify target Intercepts that have immediate need (small scope, like PalmFUSE)		

Priority Area #5: Improve access to and continuity around medication			
Objective	**Action Step**	**Who**	**When**
Ensure compatibility for those who are discharged from civil/forensic CSUs/hospitals, and jail settings -Coordination at jail discharge for the right medication (unrestricted formulary)	Supervised release to care manager, care coordinator/navigator/peer support Expand access for medication from pharmacies (community) Increase education of manufacturers medication vouchers Develop/improve internal systems for discharge regarding medication Peer support as a strategy to improve appointments (decrease no shows) Improve coordination of transportation (mobile pharmacy) Improve collaboration for discharge planning	Managing Entity (ME) Community health providers Drug companies, health care districts PBSO (jails) State hospitals Receiving facilities Foundations	Pilot with 30 consumers: 2019 2020

RECOMMENDATIONS

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

1. Identify Where this Work Will Live and a Champion to Move Forward.

PRI provided Palm Beach County with two formal products following facilitation of the SIM:

- A visual map (see page 5) that illustrates how people with mental and substance use disorders come in contact with and flow through the local criminal justice system.
- A full report (this document). The report includes local opportunities and gaps within each Intercept, a list of identified priorities for change, action planning work completed during the SIM, PRI's SIM facilitator recommendations, and additional topical resources.

The SIM report and map are meant to be "living documents," able to be revisited and updated by the community regularly. It is vital to identify where this ongoing work will "live." Many jurisdictions have a criminal justice advisory council, planning board, or representative body already in place for making decisions related to the justice system. Palm Beach County's CJC fills this role, and may be a natural group to absorb ongoing follow-up related to the SIM workshop and report.

In January 2018, SAMHSA's GAINS Center for Behavioral Health and Justice Transformation hosted a webinar in which three jurisdictions presented information on how members of their criminal justice coordinating councils (CJCCs) were supporting the creation of more robust continuums of behavioral health services in their communities. At that time, the GAINS Center released tip sheets for sheriffs, public defenders, judges, prosecutors, police chiefs, and chief magistrates who serve on CJCCs. Three additional tip sheets have subsequently been released for chief probation and parole officers, county commissioners, and trial court administrators.

It is also important to identify one or more individuals who may serve as "champions" to gain stakeholder buy-in and help move this work forward. Ideally, the champion should be mission-driven/goal-oriented; qualified to manage people and processes; skilled at communication; experienced at building relationships; respected by others; and committed to the diversion efforts in your community. Designate an individual on your task force to serve as a State Liaison or invite state office personnel to local meetings so the local concerns on key issues can be addressed at the highest levels.

In furthering this work, consider integrating the SIM and MacArthur Safety and Justice Challenge into other relevant national initiatives, such as the Council of State Governments (CSG) Justice Center's Stepping Up Initiative. Palm Beach County has passed a resolution in support of Stepping Up, there is current movement within Stepping Up to highlight "innovator counties," that are implementing a three-step approach to identify people in their jails who have serious mental illness, collect and share data to connect to treatment, and use this information to inform local policies and practices. Local expertise may be available to this county in particular through Chenise Bonilla, a former CSG staff member who is now focusing on reentry in Palm Beach and was present at the SIM.

2. Maximize Deflection/Diversion Strategies at Intercepts 0/1, including Expanding the Crisis Continuum of Care.

Increase Deflection and Diversion Strategies

The ability to increase individuals' stabilization through community-based alternative services and processes is at the heart of criminal justice deflection and diversion strategies. Law enforcement-based deflection requires system and public support for police to use their discretion, and immediate access to services, without barriers. In general, "deflection" occurs pre-arrest or with a citation, and refers to law enforcement utilizing non-criminal justice supports without any official criminal justice action. "Diversion" may be pre- or post-arrest, or pre-or post-booking. Diversion refers to alternative criminal justice 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 involvement of other criminal justice stakeholders, and offering an alternative to traditional case processing such as specialty/treatment court, deferred prosecution or judgement, or Law Enforcement Assisted Diversion (LEAD) are diversion strategies.

There was an expressed need during the SIM for additional early-intercept deflection and diversion options. While it was reported that there are at least some local resources for individuals with substance abuse, mental health services are lacking in the community. There is a particular gap in higher acuity resources for law enforcement diversion, especially after business hours and on weekends, for those who do not rise to the level of a Baker Act hold.

Document Deflection and Diversion Actions Taken to Understand Trends, Costs, and Populations

The importance of documenting "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 to services/where, referral to services; citation, arrest and detained. In addition, client demographic and location information should be tracked.

Increase Coordination and Access to Crisis Services

Strategies should be developed to streamline access to beds and increase the capacity of hospital resources.

- Explore the development and use of a bed registry across the crisis triage and the hospital networks to track bed availability.
- Improve discharge planning and "release-to-supports" to enhance stabilization and continuity of care including medication, housing, care navigation, and emotional supports.
- Coordinate with county and state crisis call centers and lines.
- 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.
- Periodically, conduct a case review of responses to crisis notification, and process and outcomes of deflection and diversion cases. Review the match of client risk and need to services. Based on the information received, formalize referral processes and forms, and increase knowledge of what services do and do not offer.
- Commit to having dedicated services and "slots" for justice-involved persons with medium- to high-risk and needs. Address concerns of service providers in accepting higher-risk offenders. Routinely address issues and make adjustments.

Over the past few years, the Substance Abuse and Mental Health Services Administration (SAMHSA) and many states have begun to identify a “Continuum of Care for Crisis Services.” In addition, states including Texas, New York, Virginia, and California have state-funded initiatives to enhance crisis services in communities.

3. Explore Creating New Positions at Intercepts 2 and 4 to Improve Linkage to Services.

There were several gaps discussed during the SIM that could be filled by modifying current positions and/or utilizing MacArthur SJC funding to create new capacity for warm-handoffs between the jail and community providers, both at the pre-trial stage and reentry.

This new staff member might be a social worker or service coordinator/navigator embedded at first appearance or the jail, or could be an employee of one of the local community treatment providers, and perform jail in-reach, then continue to provide services following release. Potential roles for this person could include increased and standardized identification of incarcerated individuals’ behavioral health needs, relevant information

sharing with pre-trial staff, medication access and continuity, and connection to community treatment services at discharge.

Several MacArthur SJC sites have explored this strategy in various ways, including Milwaukee County, WI; Tulsa County, OK; Mecklenburg County, NC; Missoula County, MT; and Spokane County, WA. Brief descriptions are below and PRI can facilitate connections for additional networking.

- *Tulsa County, OK* (Innovation Site)- Tulsa County will implement a two-way text messaging tool aimed at reducing failure-to-appear rates by reminding clients of upcoming court dates. Additionally, the tool will link clients to vital social service providers that will assist in addressing underlying mental health and substance abuse disorders that have contributed to their entanglement in the criminal justice system. A social worker will be embedded in the Public Defender's office to provide direct client assistance as needed.
- *Milwaukee County, WI*- Milwaukee County will hire a Behavioral Health Liaison to conduct assessments in the jail and connect individuals to community resources and support. To prevent unnecessary cycling through the criminal and civil court systems, a Forensic Discharge Coordinator will be hired to engage local service providers and link persons who have competency hearings to community resources.
- *Mecklenburg County, NC*- Mecklenburg's original strategy included hiring a social worker within the Public Defender's Office, who would be referred defendants who are jailed on low-level charges, but who are assessed as high risk on the PSA, to coordinate referrals to local behavioral health services and/or local supportive services/resources. The County is currently reexamining strategies to determine whether a more comprehensive focus on populations impacted by criminal justice and mental health concerns is needed.
- *Missoula County, MT*- Missoula will add another full-time case manager who can work with inmates in the jail and for up to three months, post-release. Post-release support will include additional stabilization, including warm handoffs.
- *Spokane County, WA*- Spokane is continuing to implement a mental health diversion program. Through this program, participants with mental health diagnoses are matched with a case manager who assists with treatment and care coordination. Upon successfully following a treatment plan, prosecutors dismiss the charges. Additionally, Spokane is working to develop a social worker position in the Office of Pre-trial Services in order to provide case management for individuals, particularly those with behavioral health needs.

4. Increase and Improve Housing Options.

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

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

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

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

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

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

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

- Shifting the Focus from Criminalization to Housing

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

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

RESOURCES

Competency Evaluation and Restoration

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

Crisis Care, Crisis Response, and Law Enforcement

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

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

Data Analysis and Matching

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

Housing

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

Information Sharing

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

Jail Inmate Information

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

Medication Assisted Treatment (MAT)

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

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

Mental Health First Aid

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

Peers

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

Pretrial Diversion

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

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

Procedural Justice

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

Reentry

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

Screening and Assessment

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

Sequential Intercept Model

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

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

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

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

Transition-Aged Youth

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

Trauma-Informed Care

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

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

Veterans

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

APPENDICES

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

Appendix 1

NAME	AGENCY	TITLE	EMAIL
Barnes, Brittany	Mental Health America of Palm Beach County	Director of Program Impact	bbarnes@mentalhealthpbc.org
Bonilla, Chenise	PBC Reentry	Mangager of Criminal Justice Programs	CBonilla@pbcgov.org
Burnim, Ira	Bazelon Center	Director	irabster@gmail.com
Chand, Smita	Jerome Golden Center for Behavioral Health	Director of Outpatient Therapeutic and Reintegration Services	schand@goldenctr.org
Cleare, Thomas	Health Care District PBC	Vice President of Strategy	tcleare@hcdpbc.org
Collbath, Jeffery	Circuit Court Criminal Trial Division	Judge	JColbath@pbcgov.org
Collins, Karen	Veterans Administration	Mental Health Recovery Programs Supervisor	karen.collins@va.gov
Crossen, Kristin	PBSO 911 Dispatch	Communications Training Supervisor	rossenk@pbso.org
Cueto, Glenny	Probation – County vendor Professional Probation Services	Director of Operations	gcueto@ppsinfo.net
Davis, Darcy	Health Care District	Chief Executive Officer	ddavis@hcdpbc.org
Dudek, Dan	PBSO Sgt. Dan Dudek	Sgt.	DudekD@pbso.org
Fana, Armando	City of West Palm Beach	Assistant City Administrator	afana@wpb.org
Ferrante, Mark	Palm Beach County Community Services	FRS Professional	MFerrant@pbcgov.org
Foley, Randy	PBSO	Lt Behavioral Health	foleyr@pbso.org
Gauger, Mike	PBSO	Chief Deputy	gaugerm@pbso.org
Gray, Kenneth	PBSO (Parks/Community Policing)	Deputy Kenney Gray	GrayK@pbso.org
Hackley, Jonathan	PBC Criminal Justice Commission	Senior Criminal Justice Analyst	JHackley@pbcgov.org
Hammer, Kat	Gulfstream Goodwill	Lewis Center Senior Director	KHammer@lewiscenterpbc.org
Hayes, Latronda	Palm Beach County Public Safety	Manager Court Services	lhayes@pbcgov.org
Heneks, Natalie	PBSO 911 Dispatch	Section Manager	heneksn@pbso.org
Hulick, John	PBC Community Services	Senior Program Manager	JHulick@pbcgov.org
Kukec, Damir	PBC Criminal Justice Commission	Research and Planning Manager	DKukec@pbcgov.org
Lefton, Jeffrey	St. Marys Hospital	Director Behavioral Health Services	jeff.lefton@tenethealth.com
Lowe, Cathy	Drug Abuse Foundation	Clincial Director	EXECUTIVE_OFFICE@dafpbci.org
Loyless, Jennifer	Public Defender's Office	Project Coordinator	JLoyless@pd15.state.fl.us
Lugo, Wally	Community Services	CMIS Administrator	WLugo@pbcgov.org
Mackey, James	PBSO (Parks/Community Policing)	Deputy James Mackey	MackeyJ@pbso.org
Marcus, Ilana	Public Defender's Office	Assistant Public Defender	IMarcus@pd15.state.fl.us

Martino, Marsha	NAMI PBC	Executive Director	marshamartino@namipbc.org
Mooney, Sarah	West Palm Beach Police DepartmentAssistant Chief		SMooney@wpb.org
Morse, Jeremy	PBC Mental Health Association	Chief Executive Officer	jmorse@mhapbc.org
Murray, Rosalind	PBC Criminal Justice Commission	Senior Criminal Justice Analyst	RMurray@pbcgov.org
Osborne, Ruth	Wellpath, PBC Detention Center	Mental Health Director	rosborne@armorcorrectional.com
Ouellette, Danielle	PBSO	Licensed Clinical Therapist	OuelletteD@pbso.org
Pasquarelli, Paulina	Court Administration	Mental Health Case Manager	PPasquarelli@pbcgov.org
Pinkney, Tyrina	Frontline Staff TLP	CARE Coordinator	TPinkney@thelordsplace.org
Putnam, Guy	The Lord's Place	Peer Specialist	gputman@thelordsplace.org
Ramos, Daniel	Community Services	Senior Program Manager	DRamos@pbcgov.org
Rodriguez, Krystal	Center for Court Innovation	Coordinator for Training and Technical Assistance	krodriguez@nycourts.gov
Roman, Linda	211 Palm Beach/Treasure Coast	Vice President of Operations	linda.roman@211pbtc.org
Schoenfeld, Jacqueline	PBC Criminal Justice Commission	PalmFUSE Program Coordinator	jschoenfeld@pbcgov.org
Shover, Katherine	PBC Criminal Justice Commission	Senior Criminal Justice Analyst	KShover@pbcgov.org
Speicher, Joe	South County Mental Health Center	Chief Executive Officer	Speicherj@scmhcinc.org
Stanley, Diana	The Lord’s Place	Chief Executive Officer	dstanley@thelordsplace.org
Starling, Alfonso	PBSO	Major	StarlingA@pbso.org
Taylor, Rose	Jerome Golden Center for Behavioral Health	CARE Coordinator	trose@goldenctr.org
Tippett, Wendy	Palm Beach County Community Services Department	Director of Human Services	WTippett@pbcgov.org
Williams, Craig	State Attorney’s Office	Chief Assistant	cwilliams@sa15.org
Wilpidio Pinto	West Palm Beach police department WPB Officer		wpinto@wpb.org
Wims, William	South County Mental Health Center	Director of Acute Care	Wimsw@scmhcinc.org
Winkler, Bert	PBC Criminal Justice Commission	Manager of Criminal Justice Programs	BWinkler@pbcgov.org
Woodley, George	Southeast Florida Behavioral Health Network	Behavioral Health Contractor	George.Woodley@sefbhn.org
Zuchman, Lauren	Bewell PBC	Executive Director	lzuchman@bewellpbc.org

Appendix 2

TEXAS Department of State Health Services

Crisis Services

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

The 80th Legislature

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

Crisis Funds

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

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

Competitive Funds Projects

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

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

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

The 81st Legislature

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

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

Appendix 3

Jail Data Link Frequent Users
A Data Matching Initiative in Illinois

Overview of the Initiative

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

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

Target Population for Data Link Initiatives

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

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

Legal Basis for the Data Matching Initiative

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

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

Sample Data at a Demo Web Site

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

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

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

Program Partners and Funding Sources

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

Partnership Between Criminal Justice and Other Public Systems

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

Managing the Partnership

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

About CSH and the Returning Home Initiative

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

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

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

Appendix 4

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

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:

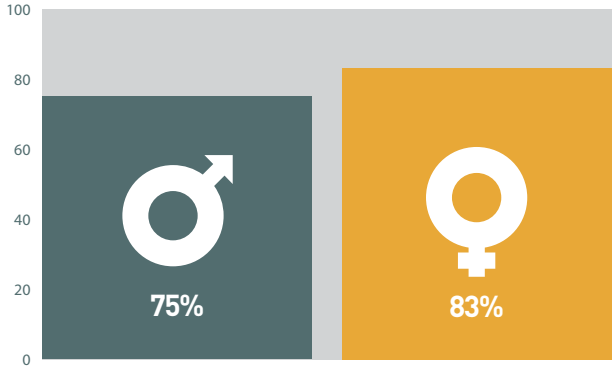
- Behavioral Health Providers & Criminal Justice Practitioners
- Individuals Returning From Jails & Prisons
- Communities & Local Jurisdictions
- State Policymakers

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

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http://store.samhsa.gov/

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