# Sequential Intercept Model Mapping Report for Missoula County, MT

Prepared by: Policy Research, Inc.

Ashley Krider, MS, Senior Project Associate

Regina Huerter, MA, Senior Project Associate

April 23-24, 2019

Delmar, NY

POLICY RESEARCH, INC.

SAFETY+JUSTICE CHALLENGE

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

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Final Report

June 2019

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Policy Research, Inc.

## ACKNOWLEDGEMENTS

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## RECOMMENDED CITATION

Policy Research. (2019). *Sequential intercept model mapping report for Missoula County.* Delmar, NY: Policy Research, Inc.

# 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.

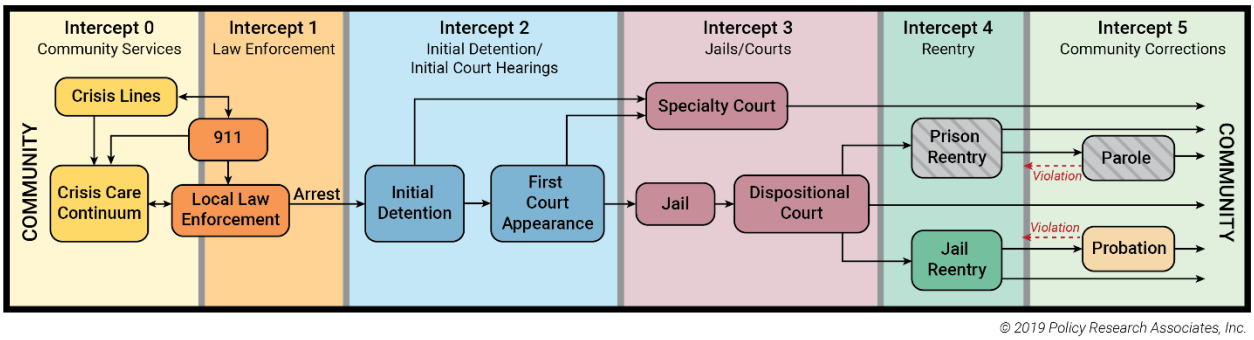
A Sequential Intercept Model mapping is a workshop to develop a map that illustrates how people with behavioral health needs come in contact with and flow through the criminal justice system. Through the workshop, facilitators and participants identify opportunities for linkage to services and for prevention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

# AGENDA

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## *Sequential Intercept Mapping*

Missoula, MT

April 23, 2019

**AGENDA**

**8:30** **Registration**

**9:00** **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.*

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# *Sequential Intercept Mapping*

## Missoula, MT

April 24, 2019

### AGENDA

**8:30** **Registration and Networking**

**9:00** **Opening**
- Remarks
- Preview of the Day

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

**Action Planning**

**Finalizing the Action Plan**

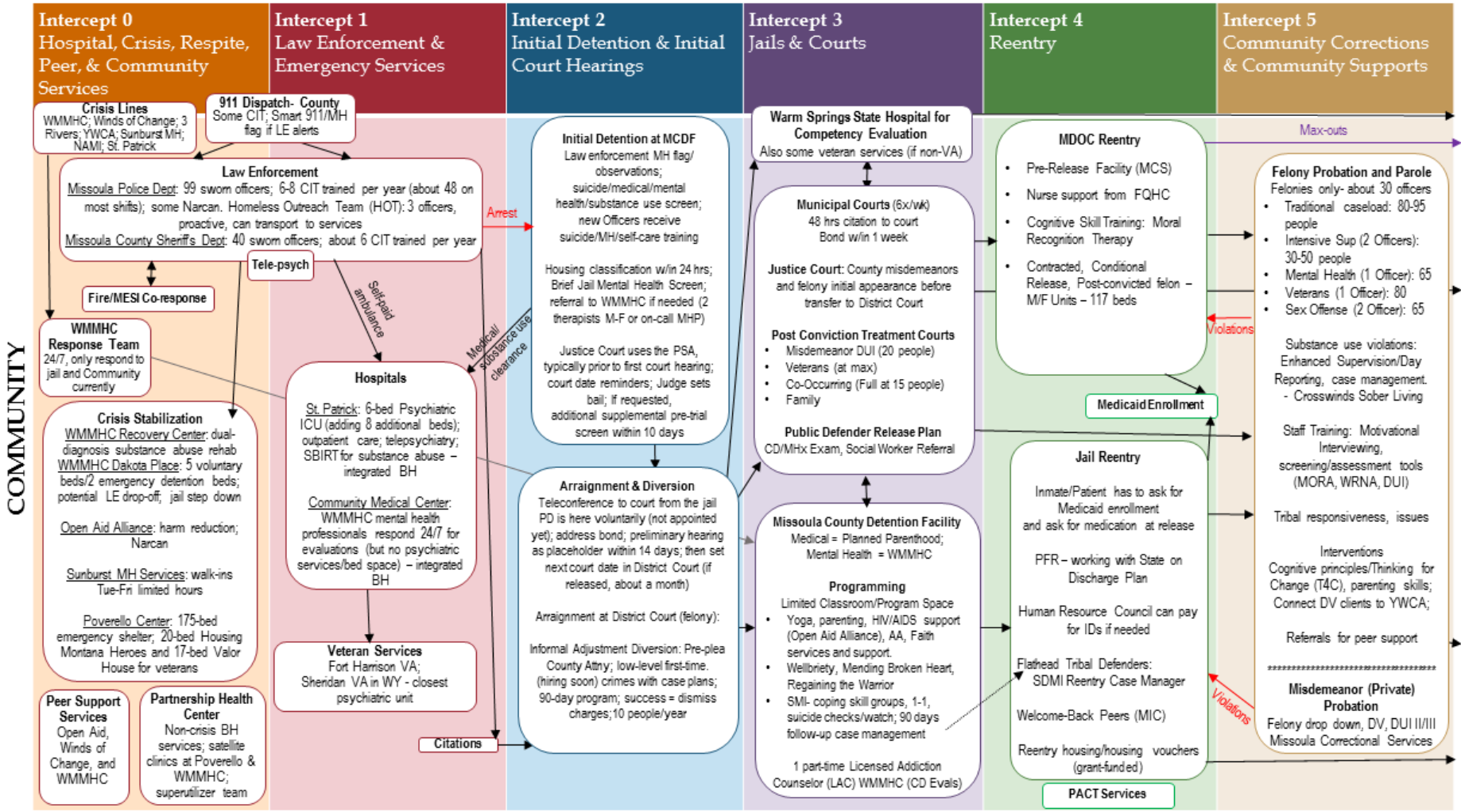
**Next Steps**

**Summary and Closing**

**12:00** **Adjourn**

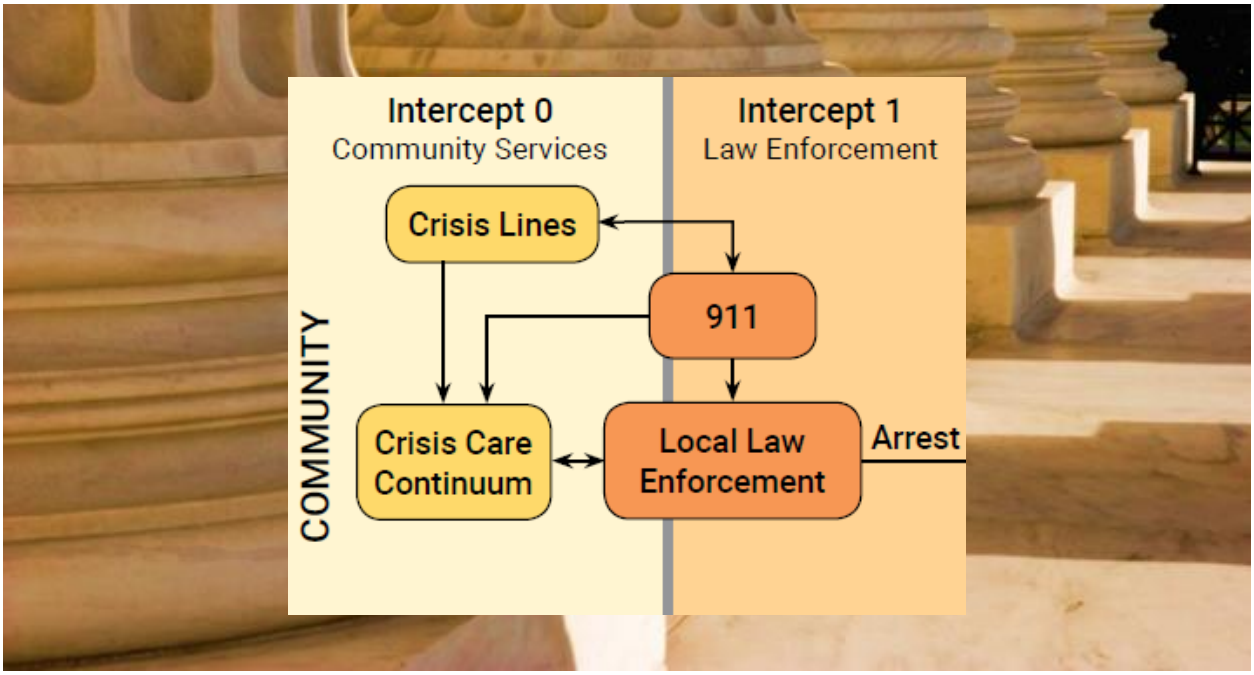
*There will be a 15 minute break mid-morning.*

# Sequential Intercept Model Map for Missoula County, MT




# 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 Call Lines/Community Resources

- Western Montana Mental Health Center (WMMHC) has a 24/7 crisis line available to all callers.
- Winds of Change has a crisis line for clients only.
- 3 Rivers Mental Health Center has a crisis line for clients only.
- Sunburst Mental Health Services has a crisis line.
- The YWCA operates a victims' call line.
- Some individuals call the NAMI line, although this often goes to a voicemail and is not ideal in crises. NAMI also has a resource guide.
- Project Tomorrow Montana has a mental health/suicide resource card, listing several call lines.
- Women's Opportunity and Resource Development, Inc. (WORD) also has a four-page local resource guide on their website.
- The Providence St. Patrick Urgent Mental Health Clinic's Youth Crisis Diversion Project helps fill the gap in services for youth.
- 2-1-1- is utilized for resource sharing Monday through Friday, 9am-5pm.

9-1-1/Dispatch

- Some dispatch staff have received Crisis Intervention Team (CIT) training.

- There is a mental health flag that can be placed through dispatch if they are alerted to the issue.
- There is a local CIT coordinating group, which is educating service providers around requesting CIT officers.
- SMART 9-1-1 allows citizens to opt-in to be flagged as needing a response from a CIT-trained officer.

## Healthcare

- Medicaid expansion will continue through 2025.
- Providence St. Patrick Hospital has a six-bed Psychiatric ICU, and is adding eight additional beds. They provide outpatient psychiatric care, medication management, and psychiatric consultations, as well as telepsychiatry and Screening, Brief Intervention, and Referral to Treatment (SBIRT) for substance abuse.
    - St. Patrick and Partnership Health Center have a shared electronic medical records (EMR) system.
    - St. Patrick uses a "Diversion Contract" as a cross-system approach with individuals who are high utilizers of services.
- WMMHC mental health professionals respond 24/7 to Community Medical Center to conduct evaluations, but the hospital has no psychiatric services or bed space.
- Area hospitals have a protocol for linking veterans to services. They may connect to Fort Harrison for inpatient treatment, fly the individual to Wyoming for the Sheridan VA's psychiatric unit, or refer non-VA eligible veterans to Warm Springs for services.
- The Health Department has both Prescription Drug and DUI Taskforces.

## Law Enforcement and First Responders

- The Poverello Center has a Homeless Outreach Team (HOT) with three staff members who proactively outreach with individuals in the community. They have specific resources for veterans and can provide transportation to services in some cases.
    - Businesses can also call the HOT to respond.
    - The Missoula Downtown Association's Downtown Ambassador does not provide crisis services, but will call the HOT, if needed.
    - There is one Missoula Police officer to serve the Business Improvement District (BID). This officers is proactive and responds to calls, with flexibility in the response. A second BID position has been approved but not yet filled.
- The goal is to have one CIT officer available on each shift. The Poverello Center reported that a CIT officer is available and responds when requested about 90% if the time.
- The Missoula Urban Indian Health Center has mental health services available, which law enforcement can connect to.

## Crisis Services

- WMMHC
    - The WMMHC Recovery Center offers dual-diagnosis substance abuse rehab. They have a VA contract for beds for veterans. Services include residential, outpatient, residential detoxification, outpatient methadone/buprenorphine or Vivitrol, outpatient day treatment or partial hospitalization, and regular outpatient treatment.
    - The WMMHC Response Team operates 24/7 but currently only responds to the jail and Community Medical Center, although they are exploring alternatives.
    - The WMMHC Dakota Place has five voluntary beds and a two-bed emergency detention unit, meant to serve law enforcement for drop-offs, and ultimately walk-ins. It can be used as a jail step-down program and provides medication support and assessment for up to five days, which can then be extended.
- Open Aid Alliance offers a clean needle exchange, Narcan, Fentanyl testing, family education, and other harm reduction services.
- Partnership Health Center provides non-crisis integrated behavioral health services during regular business hours. It has satellite clinics at Poverello and WMHHC, as well as a "super utilizer" care team. They share an electronic medical records (EMR) system with WMMHC.
- The Union Gospel Mission provides non-crisis long-term services for individuals who are homeless in particular.
- Sunburst Mental Health Services provides mental health and chemical dependency services Tuesday through Friday. Drop-in immediate services are provided if available.
- The University of Montana has its own crisis intervention team to meet the needs of students.

## Housing

- A "Homelessness and Housing Instability in Missoula" report was issued in 2010.
- Missoula is in Phase Three of their 10-Year Plan to End Homelessness (2012-2022). They are now using a vulnerability assessment (the VI-SPDAT); and the Poverello Center, 2-1-1, the YWCA, and the Salvation Army are all access points.
- The Poverello Center is a 175-bed adult emergency shelter and service center. They have a zero tolerance policy. They also have transitional housing (up to two years) with case management for eligible veterans through the Housing Montana Heroes (20-bed) and Valor House (17-bed) programs.
- Crosswinds Sober Living has 12 beds.
- The Salvation Army provides a winter warming shelter (although this is probably not permanent).

## Peer Support

- WMMHC, Winds of Change, and the Open Aid Alliance offer peer support services.

## GAPS

### Crisis Call Lines

- It would be helpful to have a substance use version of the Project Tomorrow Montana resource card.
- St. Patrick Hospital has a crisis line but receives many voicemails because staff are busy seeing clients. They receive about 3,000 to 4,000 calls per year, about 90% of which lead to assessment. Calls are returned, but the time delays are inconsistent.
- The 2-1-1 line also lacks staffing to answer in real time.

### 9-1-1/Dispatch

- There is not much mental health training provided to dispatch, other than some CIT-trained staff. It is unclear of dispatch is asking mental health questions during calls, and if the information is being passed on, if so.

### Healthcare

- If law enforcement needs to call an ambulance to transport someone to the hospital, the individual receives a bill for those services.
- The operation and purpose for the additional city ambulance was unclear.
- Some of the emergency departments will refuse services for individuals with behavioral health issues, and law enforcement must wait to provide security in these cases.

### Law Enforcement and First Responders

- The Missoula Police Department is short about 10 officers currently.
- Missoula Police Department officers carry naloxone (Narcan), but the cold temperatures frequently render the nasal medication unusable. There is resistance to equipping officers with injectable naloxone.
- Some people are cited and released, but they can get caught in the “revolving door” without engagement in services, particularly when in need of detox. Access to detox services is reportedly based on prior authorization.
- Fire and MESI (EMS) co-respond with law enforcement in some cases.

### Crisis Services

- The WMMHC Dakota Place emergency detention unit has been understaffed to date, although action is being taken to remedy these issues so that it is a viable diversion option for law enforcement. They also require medical clearance for non-clients.
- There is a population that has serious mental illness, but does not rise to the level of involuntary commitment acuity. These individuals are often high utilizers of services.

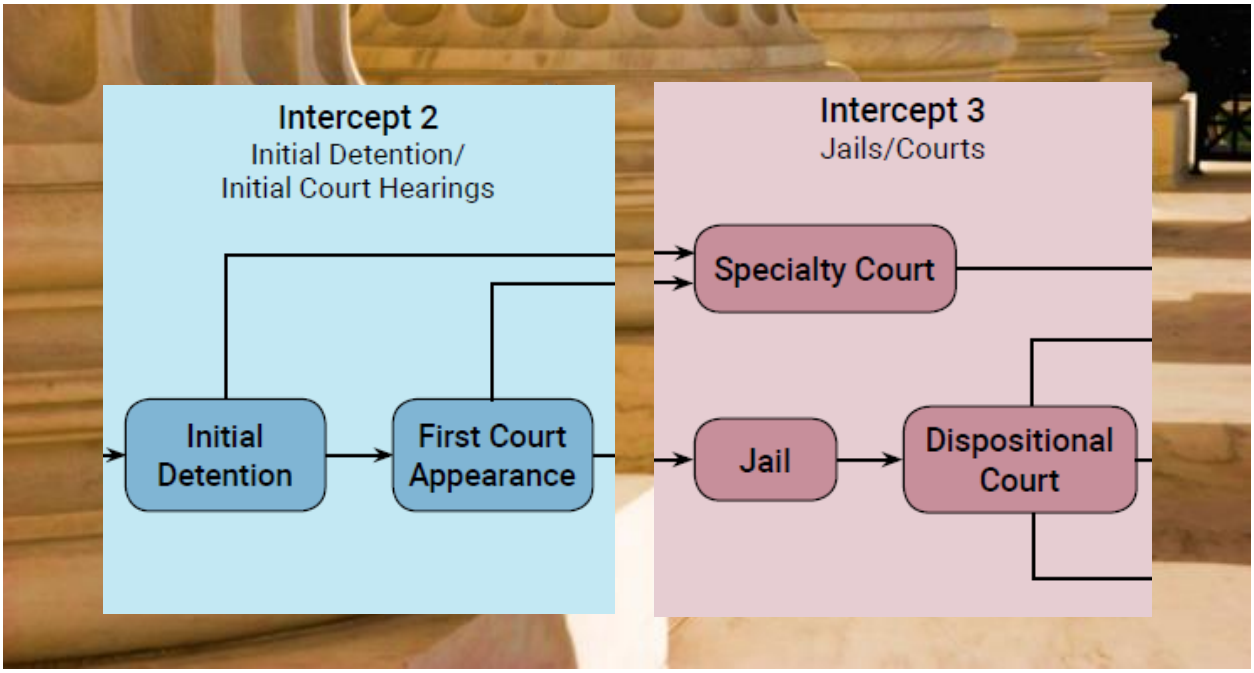
- There are limited detox beds and a waitlist at the WMMHC Recovery Center.
- Partnership Health Center has full service capacity.
- There is no psychiatric bed management system to determine what is available locally.
- Medical clearance was raised as a barrier several times during the SIM.
- There is a lack of community-based mental health services and support available in real time, and in particular services accessible to law enforcement.
- Conversations to expand co-responder services are taking place in a variety of agencies. Coordination and collaboration is needed.
- There is a gap in mobile crisis response services that are able to respond anywhere.
- Shelter providers can reportedly observe potential crisis situation arising, but have to wait until the acute crisis occurs to access services. Shelter beds are limited and non-traditional hours are not available in most cases.
- Early intervention crisis services are not generally available.
- There are several gaps around opioid and drug issues.
    - It is difficult to access Medication-Assisted Treatment (MAT) and some providers are reportedly more reliable than others.
    - There are Federal opioid-related funding streams that are not being maximized.
    - Law enforcement should have access to the injectable form of Narcan.
    - Resources to prevent and address fentanyl and methamphetamine are lacking.
    - There is a lack of daytime treatment intervention for DUIs.
    - Psycho-social education is not available across methadone and buprenorphine providers.

Housing

- There is a general education gap regarding the Housing First model, particularly with Program for Assertive Community Treatment (PACT) teams and the Mental Health Center.
- Accessing behavioral health services, and in particular housing, is generally difficult for individuals convicted of sex offenses.
- Citations and fines can be barriers to accessing housing.

Collection and Sharing of Data

- There is a lack of data tracking around CIT calls.
- There is a data gap around potential diversion to detox, instead of jail.




INTERCEPT 2 AND INTERCEPT 3

## RESOURCES

Booking

- The Brief Jail Mental Health Screen is administered at classification, within 24 hours of booking. When need is indicated, additional services are offered.

Jail Structure and Personnel

- There is training on suicide, mental health, and self-care provided to new Detention Officers.
- About six Detention Officers are trained in CIT each year.

Jail Services

- The jail's new medical provider is Planned Parenthood. According to the Jail Diversion Master Plan Update (April 2018), this provider will improve access to prescription medications through an alternate formulary and add four hours a week of a medical provider specially trained in the diagnostics and prescribing of psychiatric medications for complex cases and provide a healthcare navigator who also performs reentry assistance through coordinating community resources for inmates upon release.
- Behavioral health staff are available on an on-call basis during off-hours.
- The jail has a new telepsychiatry program (within the last few weeks).
- An FQHC dentist does in-reach at the jail.

- Jail programming is group-based unless for individuals with serious mental illness (SMI). It includes case management with up to 90-day follow-up after reentry, peer supports, yoga, parenting classes, HIV testing through the Open Aid Alliance, Alcoholics Anonymous (AA), and Native American cultural programming.
- Community providers are able to perform education and in-reach as "professional visiting."

## Pretrial Services

- Justice Court uses the Public Safety Assessment (PSA), typically prior to first court hearing. At times, there are requests to have pre-trial (Missoula Correctional Services) conduct a pre-trial report. Court date reminders are used.
- There is a pre-plea prosecutor-led diversion program at arraignment at District Court that is currently being developed. The program would review low-level first-time felonies and misdemeanors and create case plans. The diversion program is 90 days and charges are dismissed if the individual is successful. The program has a service goal of 10 people per year, and is similar to the existing program in Billings.
- The Public Defender's Office has a Social Worker (and potentially a second) to help refer clients to resources. She receives referrals from attorneys and conducts a psycho-social interview and system navigation.
- Discretion exists regarding desired timelines around court processes.

## Problem-Solving Courts

- There are multiple Treatment Courts in Missoula County. Most are 18 months in length.
    - The grant-funded Family Drug Treatment Court began in 2017.
    - The Co-Occurring Treatment Court (2004) has a caseload of 15 and is at capacity.
    - The Veterans Treatment Court (2011) is full, with a grant to expand to 25 clients. It has about a 33% recidivism rate over 48 months.
    - The grant-funded Misdemeanor DUI Court (in Justice Court) began in March 2019 and has four clients, with a capacity of up to 20.
    - There is also a Youth Drug Court.
    - District Court (Judge Halligan) is interested in adding a felony Drug Court
- The defense and prosecution discuss the potential appropriateness of Treatment Courts.

## Data Collection and Sharing

- Data is accessible for ORs, bond, and releases to pretrial.
- Through Missoula County's MacArthur Safety and Justice Challenge Innovation Fund, they created the Native Outreach Project (NOP) from January 2017-March 2018, which sought to address the disproportionate representation of Native Americans in the local jail by instituting culturally relevant prerelease programming for incarcerated people and awareness training for jail staff.

# GAPS

## Booking

- The medical/suicide/mental health/substance use screen used has been developed internally, and may not be as valid as possible.
- On occasion, an individual needs medical clearance prior to booking into the jail, but the hospital won't accept the person due to behavioral/behavioral health issues, so law enforcement must wait at the hospital until the individual is stabilized.

## Jail Structure and Personnel

- Roughly 46% of individuals at MCDF are held at the jail's contracted 144-bed community corrections facility (Missoula Assessment and Sanction Center, or MASC). These individuals are currently ineligible for diversion services; however they can receive assistance enrolling in Medicaid, if they request it.

## Jail Services

- There is no bond review/jail population review team currently.
- The jail has a limited formulary, although this may change with the new provider (Planned Parenthood).
- Jail programming is voluntary, and space is limited.
- The jail's Narcotics Anonymous (NA) was twice "unsuccessful."
- There is no acute medical/mental health/detox care at the jail. Individuals with significant detox or mental health needs are sent to the local emergency room or the State Hospital.
- Over-the-counter medication is used to manage withdrawal symptoms, as opposed to buprenorphine.

## Competency

- There is a "months-long" wait for competency evaluation at Warm Springs State Hospital.
- Competency evaluation and restoration is rarely pursued for individuals charged with misdemeanors, as the City Attorney must pay for evaluation and treatment in this case. Charges are often dismissed, but these individuals cycle through the justice system repeatedly.
- Generally, judges must mandate involuntary medication with individuals who are involuntary committed. Even when this is done, only Warm Springs will forcibly administer medication.

## Pretrial Services

- The PSA information is sent from the jail to the state, who generally returns the PSA score within 24 hours. SIM participants noted that there are challenges with moving to

the risk-based pretrial process, as a supplement to judicial discretion and the previous tool(s). Linkage to services is also a concern.

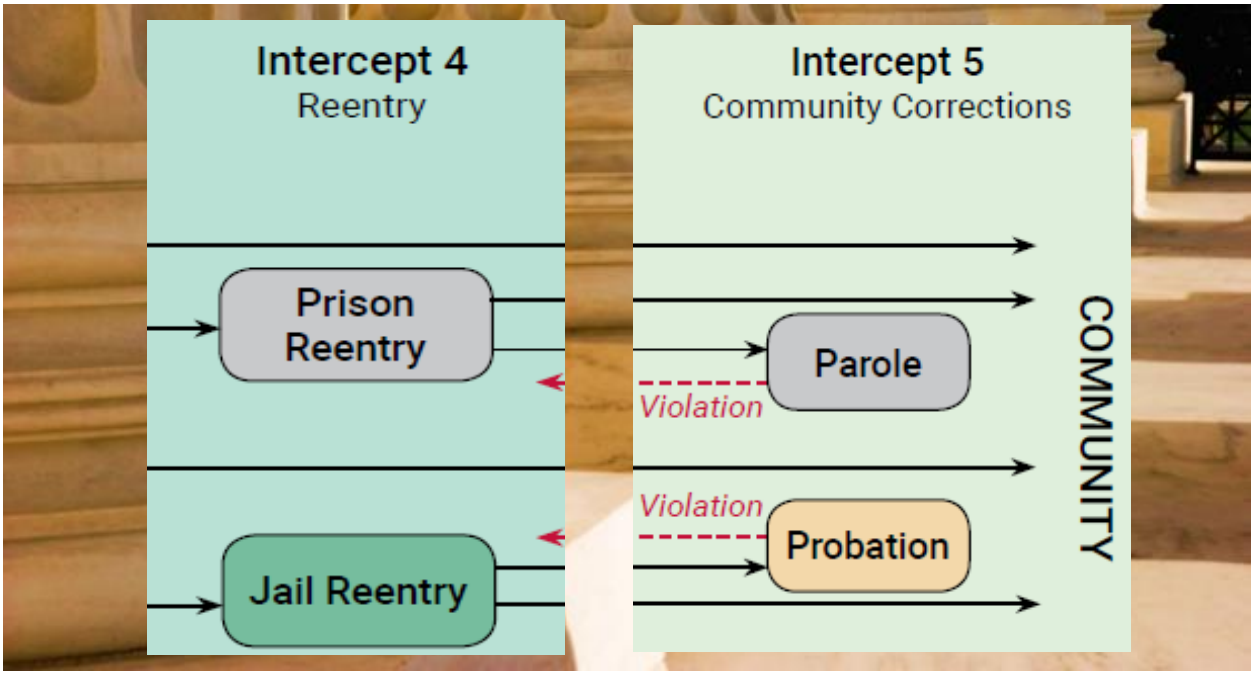
- There is little and inconsistent behavioral health screening at pretrial.
- Cash bonds are being used. Bail is still used as part of pretrial.
- There are a high number of failures to appear (FTAs), especially in Municipal Court. The court requires defendants to attend every court hearing, and there are many.
- Case processing, especially moving a client from Justice Court to District Court, is confusing, and can take over a month to complete. There is a recognition of the issue and work to address the process.
- Commonly, a requirement of inpatient treatment prior to issuing a guilty plea results in multiple continuances. This process relies on the Public Defender's Office to connect to treatment.
- There is only one Social Worker serving the Public Defender's Office, and utilization of this role is inconsistent.

<u>Problem-Solving Courts</u>

- Courts often require chemical dependency evaluations, and the responsibility for obtaining evaluations lies with the Public Defender's Office.
    - Unless for felony DUI charges, the Public Defender's Office does not consider Treatment Courts a viable option, as they are post-conviction models.
- There may be fidelity issues with some of the Treatment Courts.
- The Veterans Treatment Court is part of sentencing, and may lack standardization.

<u>Data Collection and Sharing</u>

- There is a lack of data on individuals who are incarcerated and were previously homeless.
- While Native Americans constitute 3% of the total county population, 14-18% of individuals incarcerated in MCDF are Native American.
- There is a need to examine data around "failures to appear" and make system adjustments to approve outcomes.




INTERCEPT 4 AND INTERCEPT 5

## RESOURCES

Jail Services

- Probation will request individuals' remaining medication at discharge, if they are part of the mental health caseload.
- For individuals with serious mental illness, the grant-funded jail case manager can provide up to 90 days of follow-up after reentry.
- Group homes can request up to 30 days of medication from the jail.
- Sometimes the jail case manager will transport individuals to the group home or Dakota Place, if available.
- Detention Officers provide resource information at reentry.
- A mental health notification can be placed on individuals' booking sheets.

Community Reentry

- The Tribal Defenders Office does in-reach into the prison for tribal members, and assistance with reentry services.
- The Missoula Interfaith Collaborative has an advocacy group for returning citizens, the Welcome Back program. The program has a housing focus and offers peer support services.
- Partners for Reintegration (PFR) is a coalition of service providers, stakeholders, and returning citizens, providing general reentry advocacy, outreach, and education. The

group has a collaboration at the prison to develop case plans. They also an online resource guide focused on reentry.
- A reentry council is being explored.
- There is a new reentry housing grant for individuals charged with felonies at DOC.
- Partnership Health Center has a nurse embedded at the Missoula Prerelease Center. The Prerelease Center houses 117 individuals convicted of felonies.
- Missoula DOC has a reentry initiative site that provides resources. They are part of a Montana Reentry Initiative Task Force.
- The Human Resource Council has funding for identification post-incarceration, and can use a booking photo if necessary.
- There is some ad hoc transportation coordination between community providers.

### Probation and Parole

- Probation and Parole has a conditional prerelease program, which helps to create plans with individuals before they go before the Parole Board. Probationers are sent to DOC for treatment, which includes Moral Reconation Therapy (MRT) and life skills training.
    - Graduated sanctions are used within Probation and Parole, utilizing a grid.
- Missoula Correctional Services handles Misdemeanor Probation for those from the Municipal and Justice Courts. They have received risk need training and utilized graduated sanctions.

## GAPS

### Jail Services

- There are no reentry services generally for the population without a serious mental illness.
- Individuals must request their remaining medication at discharge (up to one month), and many are released without this.
- There are no tribal-specific tools utilized for needs assessment.

### Community Reentry

- There is a lack of community provider notification when an individual is discharged from jail.
- The Prerelease Center has a capacity issue.
- There is a transportation services gap generally.

### Probation and Parole

- Probation and Parole Officers spent a lot of time in the office due to paperwork, instead of out in the field. Tools used are electronic, and there are not laptops available for all officers.

- There are no mental health staff embedded at Probation and Parole, although there is a potential contract with Western Montana Addition Services, Turning Point to do evaluations.
- There are discrepancies around the amount of necessary revocations pursued through the Missoula Correctional Services Misdemeanor Probation program. There is no revocation grid used, as within Felony Probation, and there is disagreement about standardization and efficacy.

# 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 April 23, 2019. The top three priorities are highlighted in italicized text.

1. *Increase deflection from the justice system at Intercept 0- 19 votes*
    a. *Add a second BID staff person (officer or non-officer/social worker)*
    b. *Look at co-response and mobile crisis team models*
    c. *Access to crisis services for law enforcement drop-off*
    d. *Increase the collaboration with other first responders (Fire/EMS) at Intercept 0- 1 vote*
2. *Communication, coordination, information sharing, and data across systems- 16 votes*
    a. *Cross-training between criminal justice, primary care, and behavioral health systems- 1 vote*
    b. *Develop a relationship with the state hospital, especially around discharge- 1 vote*
3. *Increase timely access to chemical dependency evaluations and process- 10 votes*
4. Increase the court process efficiency (in process)- 7 votes
5. Build a relationship with state Medicaid- 5 votes
6. Increase CIT officer training and capacity- 3 votes
7. Expand pre-trial diversion for people with mental illness- 3 votes
8. Fill the gap in services/case management between fitness to proceed and involuntary commitment- 3 votes
    a. Navigation, both prior to and after this stage
9. Expand access to medication at the jail and across systems/continuity of care- 1 vote

10. Expand accessible transportation, especially to court dates- 1 vote
11. Increase the continuum of housing for this population, including the working poor- 1 vote
12. Increase buy-in and education about the move to a risk-based assessment at pre-trial

# ACTION PLANS

| **Priority Area #1:** Increase deflection from the criminal justice system at Intercept 0 | | | |
|---|---|---|---|
| **Objective** | **Action Step** | **Who** | **When** |
| Hire a second BID person | Meet with SW Dept. about MSW Practicum at MPD- pilot<br><br>-Student would research models, pros/cons of second person being contracted with a MH agency or MPD and create a proposal<br><br>-Student would gather stats<br><br>-Student will also look at sustainability of current BID position and review job description<br><br>-Stipend for practicum position<br><br>Hire second BID person | Theresa, Randy, Charlie, Kate Chapin<br><br>MPD, BID, ? | Fall 2019<br><br>May 2020 |
| Increase access to crisis service center and/or mobile | Facilitate a meeting of appropriate stakeholders (people who currently aren't at the table) | CJCC lead, Erin Kautz, WMMHC, PHC, St. Patrick's, MPD, County Commissioner, U of M | June 2019 |
| Increase law enforcement officer training around community resources and outreach best practices | Ask Chief to block out four hours of new officer training for "Community Resource and Outreach" | Randy | Today (4/24/19) |

| | | | |
|---|---|---|---|
| Expand CES efforts to LEO, Probation and Parole, and P.D.O. (Housing First focus) | Check with Implementation Team regarding concerns/questions around MOUs and HMIS access | Theresa | May 6 |

| **Priority Area #2:** Increase timely access to chemical dependency (CD)/mental health evaluation and process | | | |
|---|---|---|---|
| Objective | Action Step | Who | When |
| Comprehensive list of CD/MH evaluators | List of: funding/billing, sources, providers, addresses, hours, services | Erin Kautz, with help from the PD SW | By June 1 |
| Full-time LAC for Public Defender | Find funding | Jennifer Streano (PD) | By June 1 |
| Full-time LAC(s) at jail, or dual-licensed MSW LAC | Budget/grant | Cola Rowley and Erin Kautz | By September |
| Communicate with all judges regarding issues with obtaining CD evaluations | Agenda item for next judges meeting- deadline, challenges (revocations, timelines, & barriers), and leniency | Tim DeFors, Amy McGhee (JP judges) | By May 5 |
| Explore peer network utilization | OPD to use MT Peer for transportation, etc. | Jennifer Streano | By July 1 |

| **Priority Area #3:** Communication, coordination, information sharing, and data across systems | | | |
|---|---|---|---|
| **Objective** | **Action Step** | **Who** | **When** |
| MAH (meeting after hours) | Monthly meetings at facilities:<br><br>-An open house, discussing population serves and vectors of referral/entry, myth-busting, mock entry/resolution (simulation), discussing data/concerning issues, create list of talking point guidelines | Each agency<br><br>Coordination: Jenny, Erin Kautz/Leah F<br><br>1st: Poverello, YWCA, Winds of Change<br><br>2nd: County Attorney, Public Defender, Judiciary | Monthly (end of day- 4-6pm?) |
| Mental health MDT | Determine information sharing (CONNECT, HMIS, etc.)<br><br>Further explore mobile response (crisis/long-term)<br><br>Reduce barriers to data sharing created by HIPAA, CIIA, and MT statute<br><br>Create an advisory group<br><br>Create a group that can look at case-specific information/situations for problem solving<br><br>Create an ROI | Suzy B (sent out general survey) | By May 30 |

| | | | |
|---|---|---|---|
| | Orientation | | |
| Better utilize current systems (HMIS, case conferencing) | Grow partnerships | Theresa Williams, Elise | ASAP |
| Collect data | Establish who/what/wants/timing<br>Examine trends/gaps/areas of improvement<br>Patient/client perceptions/focus groups<br>Create a general questionnaire of all desired information | Data analyst<br>Focus groups/students- Drew | After MDT formation (after June) |
| Create a referral document/resource | Myth busting (added question to general survey) | Suzy B (send out survey) | By May 30 |
| Secondary trauma/self-care focus | | Andy Laue? | |
| Examine funding options for coordinator position in behavioral health and manage MDT | | Drew and Erin | |

# QUICK FIXES/LOW-HANGING FRUIT

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

- The Missoula Downtown Ambassador can be engaged and educated regarding local resources for this population.
- The Social Worker at the Public Defender's Office and shelter/housing/service providers can meet together and establish a process for information sharing. The Social Worker already has access to the HMIS database and St. Patrick Hospital has been engaged.
- Probation and Parole can be included in the coordinated entry meetings.

# PARKING LOT

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

- The restrictive HUD definition of homelessness makes it difficult to find housing for those reentering the community from jail.


# RECOMMENDATIONS

## Cross-Intercept Recommendations

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

A data-informed process is essential to identify system gaps and resource utilization. It can help us understand returns on our investments and improve outcomes. Individualized data is necessary to identify and stratify potential populations for alternative processing and inform strategies to build a more responsive system. Unfortunately, all too often criminal justice and other data systems are transactional or operational in nature, making them "data rich but analysis poor" with reporting functions limited to boilerplate reports. Also, stakeholders across all disciplines have their data systems, each with unique individual identifiers making data matching very limited.

SIM participants identified several areas where data was lacking, and was necessary to inform policy and practice. In particular:

a) Data regarding CIT and HOT response efforts. Tracking and analyzing this data can result in allocation of personnel and related supportive resources. Data can inform use of services and identify gaps in services. Data can also provide key information about the needs of vulnerable populations.
b) Data that informs discussions about client population needs and service/provider outcomes for those living with mental health and substance use disorders.

- Use data to inform detox needs and determine how many individuals would benefit from detox, rather than jail.
- Analyze service gaps to identify and sort the population and related needs, and to create intervention strategies and outcomes.

c) Data regarding court and case-processing

- Use observation data, including time-stamp information from arrest to closure, to create a case processing benchmark. Create alternatives and track outcomes.

- In particular, examine individuals released and detained pre-trial, failures to appear/warrants, and sentenced populations.
- Include race and ethnicity as well as gender and age in all data analyses.

SIM Participants identified Priority Area #2: communication, coordination, information sharing, and data across systems. Additional information related to this recommendation can be found in Recommendation #5.

### Definitions

Define key terms to improve accurate data collection, and create productive and focused discussions on issues and needs. Example behavioral health and criminal justice terms include: mental health/illness, crisis, substance use disorder, pre-arrest, diversion, pre-trial, technical violation, recidivism and others. The Stepping Up initiative provides an example.

Review Montana state statutes such as Title 33 and Title 53 for mental health and billing definitions.

### Understand Current Data Collection

Review existing current data usage and data systems including: fields/variables collected (or available but not used); data entry and integrity; data duplication within and across systems/disciplines; information-sharing practices, especially exporting and importing data; data storage for analysis and to create trends; data platforms; ability to make modifications to data systems; and overall capacity and report functions.

### Sharing Data

Answering the question "why should we track and share data" is an important place to start. National data and information-sharing expert, John Petrila, Vice President of Adult Policy at Meadows Mental Health Policy Institute, suggests interested parties answer the following questions:

- WHY do you want the share the information? To identify a target population? Geographic area? Evaluate program outcomes? Improve services? Data trends and analytics?
- WHAT types of information is needed to share? Identifying or non-identifying?
- WHO do you want to share it with? HIPAA covered entities v. business entities.
- WHO decides what, how, and with whom information can be shared?

Answering these questions will help shape an "information sharing framework." In addition:

- Are trends, interventions, costs, and outcomes tracked for specific populations?
- Are standard data fields across systems and disciplines defined and used?

**At the very least,** track data points recommended by Stepping Up.

Developing data and information strategies can seem overwhelming. More detailed information is available from PRA/PRI upon request.

**Stepping Up Key Data Points:**

1) Number of non-duplicated and duplicated people booked into jail; the number of people with serious mental illness (SMI) booked into jail
2) The number of non-duplicated and duplicated persons connected to treatment – by police, while in jail, from jail to community services, under court orders and probation
3) Length of time persons spend in jail
4) The number of persons returning to jail with a new offense, and by a technical violation, duplicated and non-duplicated

**TIPS:**

- Create a data dictionary that includes *shared definitions* and *defined terms* to ensure there is a standard definition of what populations/issues you are trying to understand; learn from each system how that data point is collected, entered, coded, and stored.
- Determine standard identifiers to match populations. Sometimes the best you will have is "name and date of birth."
- Add an "opt-out" clause to release of information about information collection for data sharing (as appropriate) and analysis purposes.
- Rather than tackle the entire system, start with integrating two or three parts of one system – such as pre-trial and detention/jail data, or emergency department, mobile crisis and triage center.
- Track *population-specific* data across a sample of cases to create a case-flow process by race/ethnicity, gender and age, identify areas of redundancy such as screening and assessments, unnecessary wait times, disparity and access to services. Include average time stamps between processes by type and level of offense, pre-trial and bond eligibility including holds (parole, other jurisdictions, and federal), time from eligibility to time of release, release volume by time of day and day of the week, sentencing outcomes, revocations by reason and results, diversion utilization and outcomes, and program and jail program access, capacity, and utilization.
- Work with state Human Services and Medicaid to understand what data would be helpful to collect to demonstrate resource needs.
- Develop a case-process flow analysis and data including race/ethnicity, gender, age, time to process each step, level of offense and risk, bond eligibility and status, the average length of stay for the general population, and for someone with a mental illness or a substance use disorder.
- Use data to understand trends. To the degree possible, use both charge-based and individual-based data and look historically at issues such as repeat offenders, common offense locations, system processing, and access to services. Historical data can reflect trends and target or illuminate issues.
- If possible, overlay access and utilization of mental health and substance use treatment and medication. Include failures to appear and lengths of stay in jail.
- Track racial and ethnic disparity across all programs. Examine criteria, acceptance, successful completion rates, and technical violations.
- Track technical violation data to understand the impact on jail and improve the use of sanctions and incentives.

- Add cost measures to the analysis.

Increase the common understanding of information sharing

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

| | |
|---|---|
| **Current State Laws Regarding Information Sharing** | |
| Montana DPHHS | Website |
| **Guidance on Applicable Federal Law** | |
| HIPAA.com | Website |
| Health Information Privacy Portal: Source: U.S. Department of Health and Human Services; Questions on HIPAA, maintained by HHS/Office of Civil Rights; HIPAA and law enforcement ; mental and behavioral health | Website |
| *Frequently Asked Questions: Applying the Substance Abuse Confidentiality Regulations to Health Information Exchange*. Source: Substance Abuse and Mental Health Services Administration (updates on 42 CFR Part 2) | PDF |
| *Disclosure of Substance Use Patient Records: How Do I Exchange Part 2 Data?* Source: Office of the National Coordinator for Health Information Technology | PDF |
| *Information Sharing in Criminal Justice-Mental Health Collaborations* by John Petrila and Hallie Fader-Towe | Article Link |
| **Homeless Management Information System** | |
| HUD Exchange Homeless Management Information System Guide and Tools | Website |
| McKinney-Vento Homeless Assistance Act Source: HUD Exchange | PDF |
| **Information Sharing Guidance** | |
| *Opportunities for Information Sharing to Enhance Public Safety Outcomes* Source: IJIS Institute, Urban Institute | PDF |
| *Prioritizing Justice-to-Health Exchanges Task Team Final Report* Source: Bureau of Justice Assistance | Website |
| *Corrections and Reentry: Protected Health Information Privacy Framework for Information Sharing.* Source: American Probation and Parole Association | PDF |
| *A Comparative Analysis of HL7 and NIEM: Enabling Justice-Health Data Exchange* Source: National Consortium for Justice Information and Statistics | PDF |
| *Information Sharing in Criminal Justice-Mental Health Collaborations: Working with HIPAA and Other Privacy Laws* | PDF |
| *When is consent required?* | Website |
| *Mental Health Information Systems.* Source: World Health Organizations | Website |

Data-sharing technology

Terms such as interface, integrated, and interoperability are used interchangeably; however, they may have different meanings. Refer to this quick guide on the differentiation between the terms. In many cases, levels of data integration can be achieved, but the ability to interface

systems is a tremendous leap forward. Interoperability, especially across disciplines, is often challenging and not necessary to improve system coordination and outcomes. A motto to keep in mind is "don't let great get in the way of good."

Across the United States, information on data-sharing is growing with a good deal of success. Some models to consider:

- Crisis Intervention Team (CIT) Methods for Using Data to Inform Practice: A Step-by-Step Guide
- In Johnson County, the data hub is built on a system called My Resource Connection (MyRC)
- Camden County Coalition of Healthcare Providers has done extensive work in data gathering and sharing

*Open source technology* can reduce system reliance on closed, proprietary systems. Open source consortiums like the Open Justice Broker's Consortium (OJBC) (PDF and Website) specialize in cross-system data. OJBC began their work in Hawaii to connect human service and criminal justice data systems; members are also in Pima County (AZ), Adams County (CO), and the States of Michigan, Massachusetts, Maine, and Vermont. In each case, the new county or state can benefit from the other systems' work, resulting in expediting the process and reducing costs.

Adams County (CO) offers the following lessons learned:

- Start with a survey to develop and document a unified vision, mission, and goals.
- Establish a governance structure to set policy and technical priorities, from what kind of data makes sense to share to who will have access and where it will reside.
- Set up the necessary protections, from data sharing and management control agreements to intergovernmental agreements and rules of access.
- Use project charters to align stakeholders, researchers, and technologists behind a unified set of goals and expectations for projects in development.
- Use justice information sharing standards provided by the National Information Exchange Model (NIEM) and Global Reference Architecture (GRA).
- Map data, build database and develop research, sharing, and analytics tools.
- Use local universities to help map your data tracking and information system. Some universities have specific departments that partner with counties and states. The Harvard School of Law, Government Performance Lab, and Code for America can be helpful partners in developing strategies and connection to others who are doing similar work.

Telling your story through internal and external dashboards

Dashboard indicators can show prevalence, demographics, and case characteristics of adults with mental and substance use disorders who are arrested, passing through the courts, booked into the jail, sentenced to prison, and placed on probation. Tools like Microsoft PowerBI are free and relatively easy to use. Louisville (KY) and Denver (CO) are among the jurisdictions with robust jail dashboards.

Mental health dashboards can monitor wait times, bed and service utilization in hospitals, crisis stabilization and other mental health service providers. The publication Data-Driven Justice Playbook: How to Develop a System of Diversion provides information on the development of data-driven strategies and use of data to develop programs and improve outcomes. See also the *Data Analysis and Matching* publications in the Resources section.

## 2. INCREASE CONTINUITY OF HEALTH CARE BETWEEN THE EMERGENCY ROOM AND JAIL

Convene a working group made up of local hospitals, the Sheriff's Department, and other care providers to discuss definitions, terms, conditions, and thresholds for "Medical Assessment" and "Medically Cleared."

The process of medical clearance to be accepted into jail is a common issue. The National Commission on Correctional Health Care (NCCHC) and the CHC Guidelines provide good information about standards of care.

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

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

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

## 3. HOMELESS AND HOUSING INTERVENTION STRATEGIES

Create a comprehensive housing inventory. Include program, location, target population, eligibility criteria, type, services, funding support, capacity, and availability.

- Types of housing to inventory: hotels/lodging that accept justice-involved individuals, group homes, board and care homes, and nursing care facilities. Emergency shelters, rapid rehousing, Permanent Supportive Housing, Housing First, supported housing/partial rent subsidies, transitional housing, affordable rental housing, and homeownership Include landlord liaisons/support and intervention services, housing operated by disability and mental health providers and half-way houses. Also

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.

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 critical steps for communities to take to expand housing options for persons with mental illness.
- The Corporation for Supportive Housing FUSE Resource Center describes supportive housing initiatives for super-utilizers (frequent users) of jails, hospitals, healthcare, emergency shelters, and other public systems.
- Camden New Jersey has developed a promising collaboration of healthcare, social service, and law enforcement services to address their "complex care" populations that have frequent contact with their hospitals and, sometimes, police. They have been showing success in reducing repeated contact and improving health.

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

- Address shelter/housing criteria that limit or exclude individuals with criminal justice, or mental health or substance use issues. Work collaboratively to improve access and physical state of the accommodations to promote safety and stabilization.
- Prioritize and coordinate access to housing, especially Housing First and Permanent Supportive Housing models. Access to "coordinated housing" results from client scores such as the Vulnerability Index and Service Prioritization Decision Assistance Tool (VI-SPDAT).
- Diversify housing options such as transitional, supportive, and supported housing. Improve the ability of shelters to connect persons with longer-term housing services. Discussions with shelter providers and persons who have experienced homelessness could result in expanded thinking and repurposing of some of the shelter beds.
- Review current housing/zoning codes to understand what rules or statutes preclude sex offenders from living in the area. Shared Living Arrangements (SLA) have been shown to increase accountability for sex offenders and reduce recidivism among sex offenders.
- Similar to Permanent Supportive Housing, consider combining affordable housing with access to supportive services to increase housing stability.
- Programs that promote housing, life skills, and employment (such as The Doe Fund Ready to Work, TOSA, and Delancey St) creates alternatives to jail/prison and include housing, employment, and life-skills training.
- Landlord liaison and navigation increase the likelihood that landlords will accept individuals with justice system involvement and who have higher needs.
- Develop financial support, including Housing Transition Services and Housing and Tenancy Sustaining Services to support move in, make deposits, and address any damage and repair costs.
- Utilize various housing funding streams available at the state, county and federal level:
  - State and Federal housing vouchers and public housing options, Veterans Affairs Supportive Housing (VASH), Family Unification Program (FUP), Emergency Solutions

Grants (ESG), Home Purchase Assistance Program (HPAP), Tenant-based Rental Assistance (TBRA), Permanent Supportive Housing (PSH) and PHS Bonus, PSH Shelter Plus Care (PSH(S+C))

- Coordinate with your local HUD CoC - Continuum of Care
  - Understand the U.S. Department of Housing and Urban Development (HUD) definitions to access various housing options.
  - Understand HUD rules and compare to local housing authority rules
  - Work to prioritize criminal justice housing under your CoC and housing authority.
- The following resources may help inform strategy development. See also *Housing* under Resources below.
  - GAINS Center. Moving Toward Evidence-based Housing Program for Person with Mental Illness in Contact with the Justice System
  - Housing Toolbox for Massachusetts Communities
  - Connect Our Future Community Based Housing Strategies
  - Housing Development Toolkit
  - 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) Coordinated by Community Solutions.
  - U.S. Department of Housing and Urban Development (HUD)
  - National Alliance to End Homelessness
  - Supportive Housing Program
  - Federal Medical Assistance Percentages (FMAP)

## 4. CREATE A COMPREHENSIVE BEHAVIORAL HEALTH SCREEENING STRATEGY: IMPROVE POPULATION SCREENING AND IDENTIFICATION

SIM participants identified the need to "increase timely access to chemical dependency (CD)/mental health evaluation and process" as a Priority Area and Action Plan #2. In addition to focusing on chemical dependency for court action, the county may want to consider moving toward using a *behavioral health screening suite* (BHSS) (brief mental health, substance use, and trauma screening; basic demographic information; and consent to administer and share the

screens), to improve screening coordination, improve data collection and analysis based on coordinated screening.

For example, in under 20 minutes the Brief Jail Mental Health Screen (BJMHS), TCUDS-V, and PC-PTSD-5 could be used as the BHSS. The BHSS screens could be administered by detox, crisis stabilization centers, homeless outreach, and others as the initial point of contact, and the information passed on to the next level of care, such as hospitals, county detention/jail medical staff, pre-trial, courts, treatment providers who would do the next level of *assessment* – or more specific screening as indicated by the BHSS tools. Screening outcomes could be entered into a database as jointly agreed by the stakeholders for the purposes of analysis, planning, and developing population-specific services.

This Stepping Up article outlines the importance of universal mental health screening at jail. Similar outcomes and rational for using BHSS in intercepts 0-1 apply.

*Medication-Assisted Treatment (MAT)*

Jails and prisons are increasingly utilizing Medication Assisted Treatment (MAT) at the point of reentry. The American Society of Addiction Medicine has established a National Practice Guideline to provide information on evidence-based treatment for opioid use disorder.

- The American Academy of Addiction Psychiatrists has established a clinical support system for providers, including prescribers working with justice-involved individuals. Education and training are available through the following web-portal.
- The National Sheriffs' Association and the National Commission on Correctional Health Care have established promising practices and guidelines for jail-based Medication-Assisted Treatment.
- Several curricula can be helpful to use within the facility. See Jail-Based Substance Abuse Treatment Literature Review for details.
  - General cognitive curricula such as Thinking for a Change (TFC) and Moral Reconation Therapy (MRT) are effective, but can be lengthy to administer.
  - The SMART Recovery curriculum is shorter in length to administer. InsideOut is a SMART Recovery program for substance abuse treatment in correctional settings.
- The Matrix Model is a curriculum for persons suffering from methamphetamine use disorder.
- Hill, R. (2015). *Evidence-based practices for treatment of methamphetamine dependency: A review*. Guelph, ON: Community Engaged Scholarship Institute.

*Developing (MAT) protocols in the jail and community*

Review your current Medication-Assisted Treatment (MAT) processes in the community and jail. Many jails are only giving Vivitrol or Suboxone to women who are pregnant.

- Ensure support, especially peer support, to help persons maintain MAT and their recovery.
- MAT strategies can be used across the justice system. Some examples include treatment on demand, post-emergency co-responder follow-up, access to methadone, buprenorphine, and Vivitrol, harm reduction/syringe exchange, and first responders carrying naloxone and jail release with naloxone.

- Consider a collective impact process to bring together harm reduction, prevention, treatment, and enforcement strategies. The work needs to include process, and individual, policy, and place-based strategies.
- A full jail/criminal justice facility MAT for opioid use disorder includes:
  - Screening for use and withdrawal (Clinical Opiate Withdrawal Scale, or COWS)
  - Withdrawal management on Buprenorphine
  - Maintenance dosing and induction on Methadone and Buprenorphine paired with appropriate psychoeducational classes
  - Peer support in the facility and upon release
  - Inmates leaving with Naloxone (Narcan)
- Approximately 1% of the over 3000 county jails are offering a full spectrum of MAT protocols. Dr. Rai at Denver County Jail is open to discussing their model, which provides all levels of MAT: maintenance, induction, withdrawal management, psych/social education, and Narcan at release. In addition, see *Jail-Based Medication-Assisted Treatment: Promising Practices, Guidelines, and Resources for the Field*, October 2018, National Sheriffs' Association, National Commission on Correctional Health Care.

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

- Seeking Safety is a non-clinical curriculum.
- Basic post-traumatic stress disorder screening tools:
  - The Abbreviated PCL-C is a shortened version of the PTSD Checklist-Civilian version.
  - The Primary Care PTSD Screen for DSM-5 (PC-PTSD -5) is a quick but comprehensive trauma screen designed for use in primary care settings.

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

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

## Intercept-Specific

### 5. IMPROVE INTENSITY AND AVAILABILITY OF CARE; DEVELOP A COORDINATED CRISIS AND CRISIS SERVICE DELIVERY CONTINUUM

Location, access, and availability of resources is challenging in a jurisdiction as geographically large as Missoula County. Location of services, hours of operation, transportation, treatment match, and costs are just some of the barriers needed to be addressed within the county. Access and availability of services is also limited due to siloed funding and eligibility criteria, and in part, capacity due to staffing and trained workforce availability. Furthermore, consider client need and treatment levels as individuals with lower needs may be inadvertently engaging in a higher level of treatment services.

Maximize capacity and availability of services: Think coordination and collaboration! The following two models may be helpful to consider: 1) the "Hub and Spoke," where acute services are centralized and less acute services are available across geographic locations; or 2) "Pie" where replication of services occurs in each "slice of the pie." A robust service delivery model is based on a continuum of service options with a variety services and intensity, and adoption of the "air traffic control (ATC)" model where there are intentional hand-offs between services and providers and removal of barriers to access services. Care coordination and access to services is limited when siloed funding streams and criminal justice criteria such as "felony" or "misdemeanor" are the basis for access versus client need. It is important to consider virtual telehealth and telepsychiatry, peer support, and co-location of resources as options to maximize and leverage resources.

Improve identification of mental health issues at the earliest time: a) Train dispatch/call takers in Mental Health First Aid (MHFA) or CIT; b) Utilize standardized mental health-related 9-1-1/dispatch questions (see box) and track the data for analysis; c) Standardize key information about callers' mental health information relayed from dispatch to first responders; and d) Similar to Harris County (TX), consider embedding a licensed clinician in 9-1-1 call centers to help manage and triage behavioral health calls.

**Suggested 9-1-1 Behavioral Health Questions:**

Does this call involve anyone with mental health issues? If No, proceed with routine call processing.

If "Yes", ask the following questions:

- Does the individual appear to pose a danger to him/herself or others?
- Does the person possess or have access to weapons?
- Are you aware of the person's mental health or substance use history?

Improve access, availability, and capacity of programs and resources within the county. If not already completed, inventory existing programs including eligibility criteria, exclusions, capacity, utilization, hours of operation, numbers served, client demographics, client engagement and treatment outcomes, treatment match (intensity, duration, and frequency) to client needs, barriers to access and availability, and funding. Geo-code/map service locations to identify gaps

across the county.  Look also for opportunities to co-locate programs and services to maximize access and availability.

Explore implementing a universal screening process to identify clients for services at the earliest point in time. Access to appropriate treatment should be based on client treatment needs and occur regardless of offense status or related eligibility due to funding streams.

Coordinate with providers to understand the use of screening and assessments, and the referral process. Determine if referrals are following the assessed needs of the client. Explore continuity of care regardless of what system the client is in, or will be involved with. Determine and address funding and program siloes and their disparate impact on communities of color.

Consider using "outcome-based contracts" and standardized reviews of core treatment providers.

Create follow-up to crisis services. Law enforcement can address immediate issues; however, access and availability of options that can increase client stabilization are crucial. Generally, individuals with high-needs require comprehensive services: health, legal, housing, positive social connections, transportation, integrated primary health, substance use, and mental health care. See Recommendation #6 below for an exploration of deflection and diversion strategies.

## 6. MAXIMIZE, AND INCREASE COUNTY-WIDE DEFLECTION AND DIVERSION STRATEGIES

SIM participants prioritized the need to “Increase deflection from the criminal justice system at Intercept 0” and began developing Action Plan #1.

*Increase Deflection and Diversion Strategies*

The ability to increase client 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.

*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.

- Determine how to identify or “flag” repeat/frequent individuals for law enforcement to promote proactive action.
- Track the total number of dispatch calls to persons with behavioral health issues and sort by actions: de-escalation, citation issued, arrested/detained, deflected/diverted, and “No Probable Arrest,” “Probable Misdemeanor Arrest,” or “Probable Felony Arrest.”
- Establish costs of various actions to determine the return on deploying multiple strategies.

## DEFLECTION

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

*Increase Coordination and Access to Crisis Services, Especially Psychiatric Beds*

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.
    - Call crisis call lines, review websites, billboards, and public information about crisis services to understand the consumers’ experience and advocate for changes and updates as necessary. Colorado Crisis Services can serve as a resource regarding their robust statewide referral database.
- 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.
    - Review any existing contracts or agreements to understand current expectations.
- 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.

*Clinical Co-Response Strategies*

SIM participants expressed the need for a clinical co-response model, and the need for additional BID Homeless Outreach Officer resources. A combined approach, including braided funding across provider groups, can make this possible.

Joint clinical mental health and law enforcement/first responder response is known as "co-responder” or “clinical co-response.” Although co-response strategies vary from community to community, the general framework entails a licensed clinician who rides along with law enforcement, or is requested to arrive at the scene of a mental health crisis. Once law

enforcement has secured the scene, the co-responder assists law enforcement in determining the best clinical course of action, including de-escalating the crisis, establish a warm hand-off to services, and providing proactive follow-up to improve the likelihood of long-term services engagement. Some law enforcement departments have specific co-response teams or units. In some cases, regular patrol requests a co-responder, while other departments have officers and co-responders proactively working specific areas known for "high-need" calls.

Regardless of the model, to be effective, community-based crisis response must be adequately staffed to respond promptly to crisis calls. Communities are coordinating mobile crisis/co-response team responses with law enforcement especially during peak call hours and co-locating services or embedding clinicians in police district headquarters. It is important to: a) Ensure and formalize coordination, access to services, communication, consistency, data collection, and standards within the clinical co-response and specialized first responder position(s); b) Improve the ability of co-response and specialized first responder teams to identify clients that utilize multiple crisis teams to identify common system issues related to accessing services and to improve coordination; c) Create standards of work where appropriate, such as client release of information, core intake information, standard data points, and tracking; and d) Improve overall understanding of mental health by providing Mental Health First Aid (MHFA) training as a core and supplemental training to law enforcement, dispatch, and community members.

Often co-response services are augmented by providing telephone or videoconference consultation to law enforcement. The Crisis Now report offers a comprehensive overview of crisis services and a crisis framework. Some states with advanced crisis frameworks include Colorado, Texas, New York, Virginia, and California. Also consider the viewpoints and experiences of individuals with lived experience and family members when designing deflection and diversion programs.

- Explore the use of virtual crisis response strategies such as video conferencing and telehealth to support law enforcement officers and other first responders responding to crises. Use of video conferencing to expand access to the mental health consultation is increasingly being used to connect law enforcement with mental health professionals. Counties with varying populations, from large counties (e.g., Harris County, TX), medium counties (Lancaster County, NE), and lesser populated counties (Yuma County, AZ), have employed this technology to improve response times of mental health co-responders.
- Additional crisis response strategies for consideration:
    - Expand CIT training and coordinate across each of the law enforcement entities and 9-1-1 call takers in the surrounding municipalities.
    - Offer Mental Health First Aid (MHFA) training to 9-1-1/Dispatch call takers, first responders including EMS/Fire and other justice system stakeholders.
    - Increase coordination with Probate Court regarding guardianship and outpatient commitment.
    - Explore using a Social Impact Bond. Reference the Urban Institute report on Denver's (CO) experience with expansion of Supportive Housing.

- Explore a county or state tax to ensure funding and increase the availability of services. Some of the counties with a tax include Bernalillo County (NM) and Denver (CO).

*Crisis Stabilization Unit/Beds*

Crisis Stabilization Units (CSU) are a valuable resource, however without cross-system coordination, comprehensive services, and low- or no-barrier access and availability for law enforcement, law enforcement utilization will be poor at best. CSU design and development includes, but is not limited to: design, services and licensure; staff and staffing pattern; food service; capital and operational funding; coordination and expectations between hospitals, detox, law enforcement, and other provider systems; and other operational considerations. Develop standards of work and agreements including response times, program criteria and eligibility, hours of operation, metrics and data collection, public-facing messaging, employee training, and client forms including release of information.

Across the country, many Crisis Stabilization Unit models have been developed and are worth reviewing. Consider talking with Harris County (TX), King County (WA), Pima County (AZ), and Colorado for models. Also, see the aforementioned Crisis Now report.

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

The following is information addressing the "familiar face," or high utilizer population. It is an extension of data and information, and deflection and diversion strategies.

Differentiate between a) identifying a "familiar face" population (which, at some level, is static); b) understanding the reasons for frequent use of jail, behavioral health, and medical services; and c) using information to inform strategies to proactively identify people at risk to be "familiar faces," and develop interventions to improve outcomes for those who are high system utilizers.

### General High Utilizer Identification Process

While other data sets can be used, court data includes citations, detention/jail, and failure to appear information. Sort the data identifying individuals rather than charge types; finalize any cleaning of the data and share the identified list (name and date of birth at a minimum) with first responders: police, fire, EMS, hospital, detox, criminal justice (sheriff, courts, prosecution, defense), supportive and public services (park and recreation, library), homeless providers, Medicaid, mental health providers, and other agencies who can compare the list utilizers of their services.

Thinking in terms of a Venn diagram, develop cross-discipline and cross-system strategies to improve outcomes for this highly-vulnerable population.

- Determine data points and seek agreements to analyze and share data at the aggregate and individual level.
- Map current system flow, frequency, and costs for various populations.

- Define, identify, stratify, and create strategies to meet the needs of various high-utilizing populations. Some populations to consider are:
    - Emergency services such as fire, EMS and emergency rooms for non-emergency issues
    - Calls for police services which involve mental health or intellectual disability
    - Individuals repeatedly evaluated as incompetent to stand trial, who are charged with low level, non-violent offenses
    - Repeated use of withdrawal management and police contact
    - Repeated overdose of substance use disorders resulting in emergency care and the use of naloxone (Narcan)
    - Repeated technical violators of probation services
    - Failures to appear and high court utilization for low-level offenses
    - Parents whose child abuse/neglect was substantiated and who are frequently arrested or cited for charges related to substance use or mental health disorders
- Track strategy outcomes and impact
- Track outcomes of police contact. The importance of documenting pre-booking actions including citation, arrest, hospitalization, de-escalation, and referral, cannot be overstated.
    - Determine how to flag individuals for police so they can initiate the deflection or diversion process.
    - Create a baseline and track by deflection and diversion strategy.
    - Fairfax (VA) and Miami-Dade County (FL) law enforcement use a simple check-box to document actions taken.
    - Track the total number of dispatch calls to persons with behavioral health issues and sort by actions: arrest, deflect/divert, or "No Probable Arrest," "Probable Misdemeanor Arrest," and "Probable Felony Arrest."
    - Track the percentage and type of calls that specialized police units/officers are responding to and prioritize calls, if necessary.
- Develop a dashboard to track the prevalence, demographics, and case characteristics of adults with mental and substance use disorders who are being arrested, passing through the courts, booked into the jail, sentenced to prison, placed on probation. Systems such as Microsoft Power BI allow flexibility in presenting the information.
    - A mental health dashboard can also be developed to monitor wait times in hospitals for people in mental health crises and transfer times from the emergency department to inpatient units or other services to determine whether procedures can be implemented to improve such responses. These dashboard indicators can be employed by a county planning and monitoring council to identify opportunities for programming and to determine where existing initiatives require adjustments.

## 8. INCREASE COURT CASE PROCESSING EFFICIENCY, REDUCE FAILURE TO APPEAR OF INDIVIDUALS

The SIM discussion identified a high number of failures to appear (FTAs), especially in Municipal Court, and delays in moving clients from Justice Court to District Court. It was also noted that

work is being done to improve case processing from Justice Court to District Court. This is critical as the amount of time defendants are detained due to system processing is several weeks.

For Municipal Court, consider, mapping the current process and either consolidating case processing into fewer court hearings, or determine what hearings really require a defendant to appear in person, or at all. Consider use of technology as a way to appear virtually.

Examine the feasibility and need for alternatives to detention and pre-adjudication diversion options for people with mental disorders at Intercept 2. Defendants with mental disorders remanded to pretrial detention often have worse public safety outcomes than defendants released to the community pending disposition of their criminal cases.

## Proportional Responses

Consider proportional responses based on the severity of a defendant's criminal risk and behavioral health treatment needs.

- Defendants with pending cases are released to pre-trial services as an alternative to detention. These may be cases with moderate criminal risk but where the individuals would benefit from community-based services that are not available while in pretrial detention and pretrial failure can be avoided.
- A deferred prosecution approach with a low-risk defendant who is directed to participate in a short-term community-based treatment program. Successful completion of the program results in dismissal of the charges while failure results in remand to custody and continuation of the criminal case. The Milwaukee County (WI) Pre-trial Diversion program offers diversion opportunities using restorative justice and other accountability models.
- Consider a competency court docket, such as was established by the Seattle Municipal Court, to reduce time spent in jail during the competency process. Refer to the journal article by Finkle and colleagues (2009) and the 2013 report on the Seattle Municipal Court Mental Health Court, which houses the competency docket.
- Explore implementing a detention Population Review Team (PRT) process similar to the one in Lucas County (OH). Weekly meetings are held with the prosecutor, public defender, jail representatives, mental health professionals, and others when appropriate. The team reviews a list of individuals in pre-trial custody to determine why a person is detained and if he or she can be safely released before trial or have his/her case resolved quickly. For example, some individuals are released to mental health services as part of pre-trial conditions. In other situations, if the case during the ordinary course of action would result in a plea, the plea offers expedited rather than waiting to set a trial date.
- Consider including peers at initial court appearances. They can encourage treatment engagement and adherence to pre-trial terms and conditions, and assist with Medicaid applications and general outreach and navigation.

# 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

| | |
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| **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 | Title | Agency | Address | Phone | Email |
|---|---|---|---|---|---|
| Alexandra Hall | Lieutenant | Missoula County Detention Facility | 2340 Mullan Road | 406-258-4067 | ahall@missoulacounty.us |
| Abby Gruber | Probation and Parole Officer | Department of Corrections | 1801 Stephens Ave, Missoula, 59801 | 406-542-7126 | agruber@mt.gov |
| Victoria Ventaloro | Social Worker | Office of State Public Defender | 610 Woody St, 59802 | 406-523-5771 | vventaloro@mt.gov |
| Randy Krastel | Downtown Police Officer | Missoula Police Department | | | KrastelR@ci.missoula.mt.us |
| Theresa Williams | Reaching Home Coordinator - 10 Year Plan to End Homelessness | City of Missoula Housing and Community Development | | | WilliamsT@ci.missoula.mt.us |
| Peter Snyder | Regional Director of Pyschiatric Services | Providence/St. Patrick Hospital | 902 N. Orange, 59802 | 406-327-3208 | peter.snyder@providence.org |
| Shelly Scotti | Program Manager | Mountain Home Montana | 2606 South Ave W, 59804 | 406-541-0451 | shelly@mountainhomemt.org |
| Nicole "Cola" Rowley | Missoula County Commissioner | Missoula County | 200 W. Broadway, 59802 | 406-258-4877 | nrowley@missoulacounty.us |
| Jordan Kilby | County Attorney | Missoula County Attorney | 200 W. Broadway, 59802 | 406-258-4737 | jkilby@missoulacounty.us |
| Ivan MacDonald | Cultural Liaison | Missoula Urban Indian Health Center | | | imacdonald@MUIHC.org |
| Jennifer Streano | Regional Deputy Public Defender | Office of State Public Defender | 610 Woody St, 59802 | | Jstreano@mt.gov |
| Elise Watts | Shelter Manager | Poverello Center | 1110 W. Broadway, 59802 | 406-532-6682 | ewatts@thepoverellocenter.org |
| Jenny Daniel | JUST Response Coordinator | Relationship Violence Services | 200 W. Broadway, 59802 | 406-258-3831 | jdaniel@missoulacounty.us |
| Charlie Wellenstein | Assistant Director | Center for Children, Families, and Workforce Development, University of Montana | 32 Campus Dr, 116 Rankin Hall, 59812 | 406-552-3149 | charlie.wellenstein@mso.umt.edu |

| | | | | | |
|---|---|---|---|---|---|
| Tim DeFors | Senior Law Clerk to Judge Leslie Halligan | State of Montana, Fourth Judicial District Court, Department 1 | 200 W. Broadway, 59802 | 406-258-3494 | tdefors@mt.gov |
| Shane A. Vannatta | District Court Judge | Fourth Judicial District | 200 W. Broadway, 59802 | 406-258-4765 | Shane.Vannatta@mt.gov |
| Amanda Springer | SLD-Adult Services Substance Abuse Prevention Coordinator | Western Montana Mental Health Center | | 406-532-9114 | aspringer@wmmhc.org |
| Leah Fitch | | Missoula City-County Health Department | | | lfitch@missoulacounty.us |
| Kari Auclair | Area Director | Western Montana Mental Health Center | 140 N. Russell, 59801 | 406-207-4411 | kauclair@wmmhc.org |
| Lizzy Gillespie | Program Development Manager | Partnership Health Center | 323 W. Alder St, 59802 | 406-258-4367 | gillespiel@phc.missoula.mt.us |
| Monique Casbeer | Vice President | NAMI Missoula Board | PO Box 5413, 59806 | 406-880-1013 | mcasbeer@centurylink.net |
| Terry Kendrick | Consultant | Partnership Health Center | 600 Cleveland St, 59801 | 406-459-9440 | terrykendrick5@gmail.com |
| Michelle Cares | City Councilor | Missoula City Council | | 509-844-8708 | MCares@ci.missoula.mt.us |
| Becca Goe | Program Development Manager | Partnership Health Center | 401 Railroad St W, 59802 | 406-258-4278 | goer@phc.missoula.mt.us |
| Amy McGhee | Justice Court Administrator | Missoula Justice Court | 200 W. Broadway, 59802 | 406-258-3216 | amcghee@missoulacounty.us |
| Bonnie Bishop | | University of Montana | | | bonnie.bishop@umconnect.umt.edu |
| Keithi Worthington | City Attorney | Missoula City Attorney's Office | 435 Ryman, 59082 | 406-552-6021 | worthingtonk@ci.missoula.mt.us |
| Jackie Merritt | VJO (Veteran's Justice Outreach) Social Worker | VHA | 3687 Veterans Dr, Fort Harrison, MT 59636 | 406-447-6027 | Jackie.Merritt@va.gov |
| Sue Wilkins | Director | Missoula Correctional Services | 2350 Mullan Rd, 59808 | 406-541-9200 | SWilkins@m-c-s-inc.org |

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|---|---|---|---|---|---|
| Suzy Boylan | Deputy County Attorney | Missoula County Attorney | 200 W. Broadway, 59802 | 406-258-4737 | sboylan@missoulacounty.us |
| Drew Colling | SARC Director and Cmapus Assault Prevention Coordinator | Student Advocacy Resource Center (SARC) | Curry Health Center Room 108 - University of Montana | 406-243-4429 | drew.colling@mso.umt.edu |
| Ken Bumke | Assistant Clinical Administrator | Winds of Change | 1120 Cedar St, 59802 | | kbumke@windsofchangemontana.com |
| John Wood | Program Administrator | Winds of Change | 1120 Cedar St, 59802 | | jwood@wocmt.com |
| Todd Clear | Consultant | JFA Institute | | | tclear@scj.rutgers.edu |
| Robin Wosje | Senior Program Manager | Justice Management Institute | 3033 Wilson Boulevard, Ste 700, Arlington, VA, 22201 | 703-879-2842 | robinw@jmijustice.org |
| Erin Kautz | Grants Administrator | Missoula County | 200 W. Broadway, 59802 | 406-258-4904 | ekautz@missoulacounty.us |

# 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:

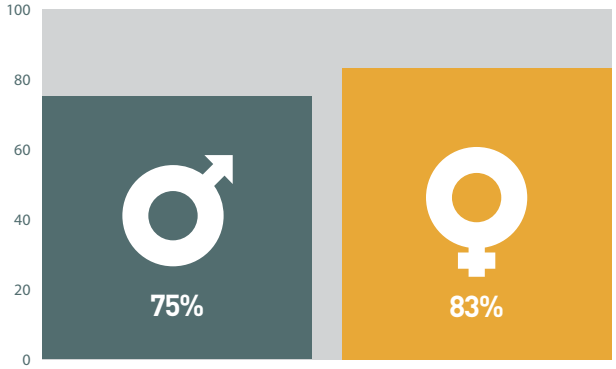
- Behavioral Health Providers & Criminal Justice Practitioners
- Individuals Returning From Jails & Prisons
- Communities & Local Jurisdictions
- State Policymakers

## 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

All publications are available free through SAMHSA's store

**http://store.samhsa.gov/**

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