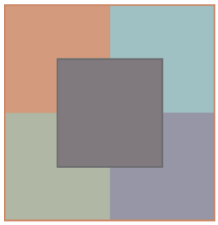


SAMHSA'S GAINS Center for Behavioral Health and Justice Transformation

Sequential Intercept Mapping Report – Missoula County, MT

Prepared by: Policy Research Associates, Inc.
Dan Abreu, M.S., C.R.C., L.M.H.C.
Patricia A. Griffin, Ph.D.

Acknowledgement

The GAINS Center wishes to thank Missoula Grants and Community Programs for the assistance with the coordination of this event.

Introduction:

SAMHSA's GAINS Center for Behavioral Health and Justice Transformation, operated by Policy Research Associates, Inc. (PRA), is known nationally for its work in regard to people with behavioral health needs involved in the criminal justice system. On October 29, 2014 the GAINS Center released a solicitation requesting applications from communities interested in developing integrated strategies to better identify and respond to the needs of adults with co-occurring mental health and substance use disorders in contact with the criminal justice system. This year's solicitation targeted communities that were focusing on Intercepts 1 and 2 as discussed below. The GAINS Center chose five of the 17 applicants to receive the Sequential Intercept Mapping (SIM) for Early Diversion Workshop, including Missoula County, MT.

Background:

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 five distinct intercept points: Law Enforcement and Emergency Services, Initial Detention and Initial Court Hearings, Jails and Courts, Re-entry, and 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.

The participants in the workshops represented multiple stakeholder systems including mental health, substance abuse treatment, health care, human services, corrections, advocates, individuals, law enforcement, health care (emergency department and inpatient acute psychiatric care), and the courts. Dan Abreu, M.S., C.R.C., L.M.H.C., Senior Project Associate and Patricia A. Griffin, Ph.D., Senior Consultant for SAMHSA's GAINS Center for Behavioral Health and Justice Transformation and Policy Research Associates, Inc., facilitated the workshop session.

Thirty-five (35) people were recorded present at the Missoula County, MT SIM.

Missoula County, MT SIM Agenda
Day 1: June 9, 2015

8:30 **Registration and Networking**

9:00 **Openings**

- Remarks – Mayor Engen
- 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
- Five Key Points for Interception

Cross-Systems Mapping

- Creating a Local Map
- Examining the Gaps and Opportunities

Establishing Priorities

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

Wrap Up

- Review
- Setting the Stage for Day 2

4:30 **Adjourn**

Missoula County, MT SIM Agenda
Day 2: June 10, 2015

8:30 **Registration and Networking**

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

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

Action Planning
- Identify Objectives and Action Steps for top priorities
- Determine who or what committees will be responsible
- Identify timelines

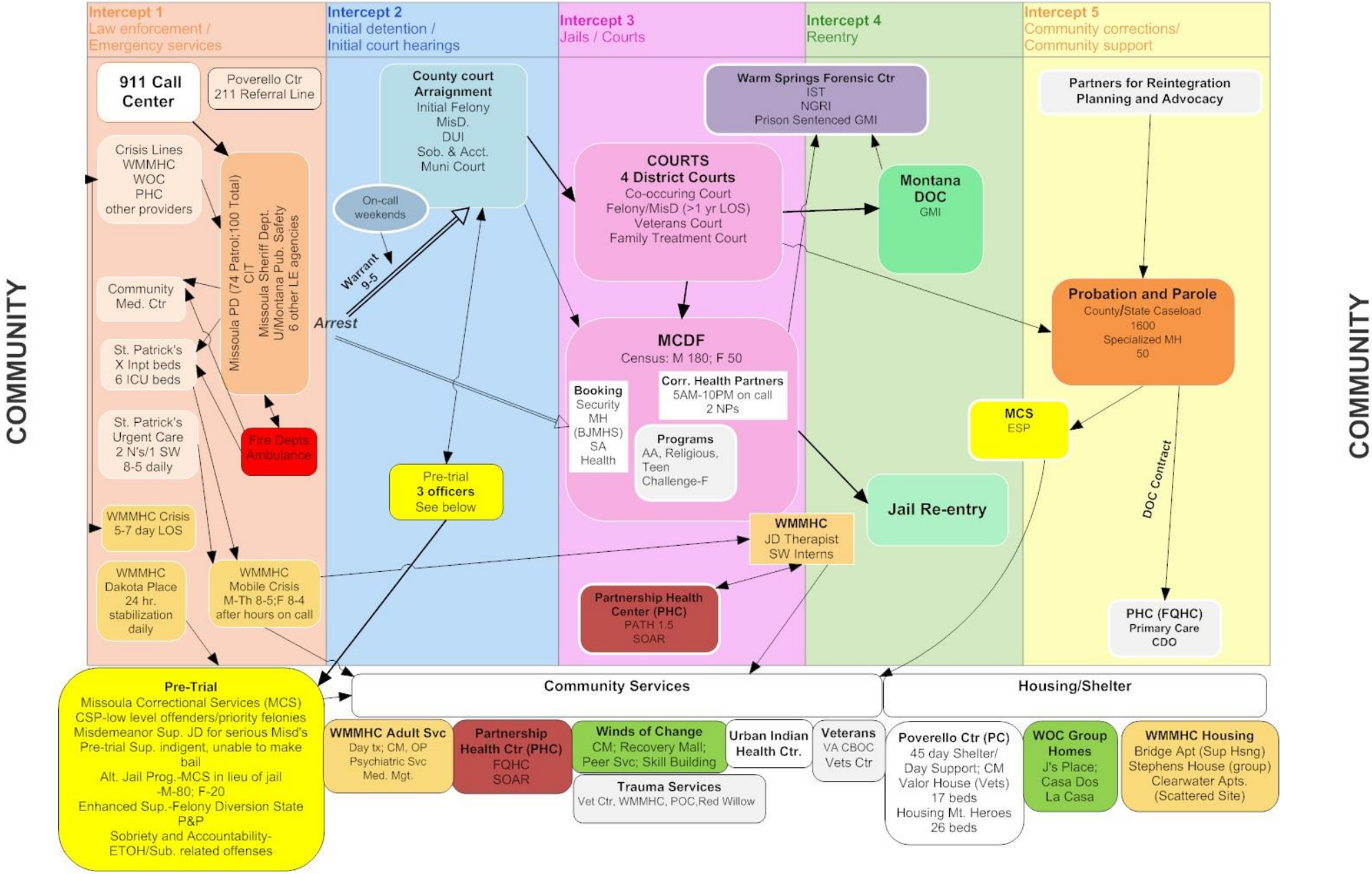
Finalizing the Action Plan
- Share Action Plan with the group

Next Steps

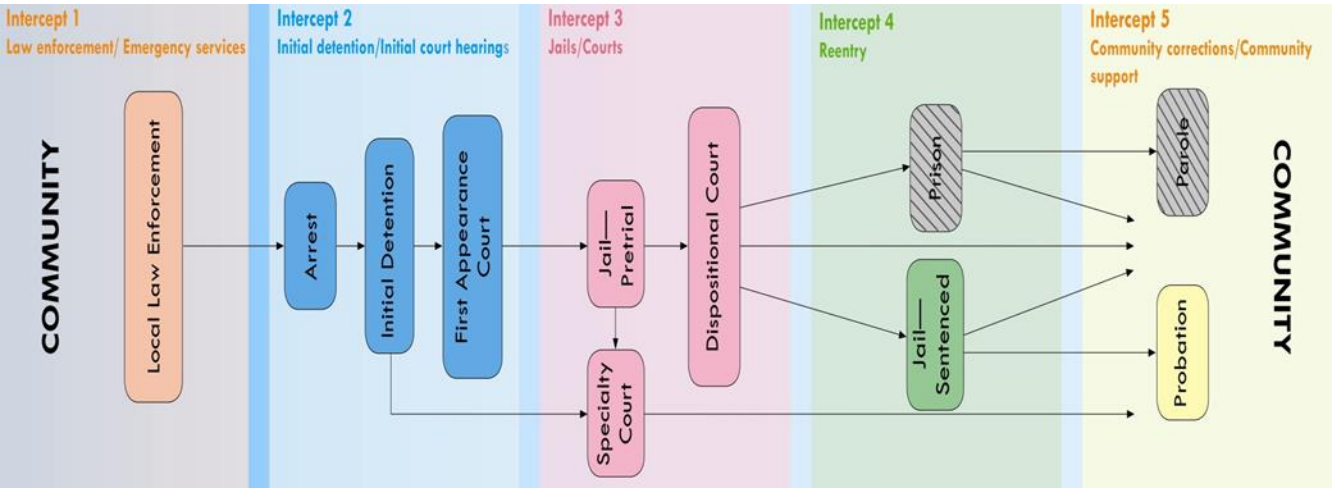
Summary and Closing

12:30 **Adjourn**

Missoula County, MT Sequential Intercept Map



Intercept 1



Resources

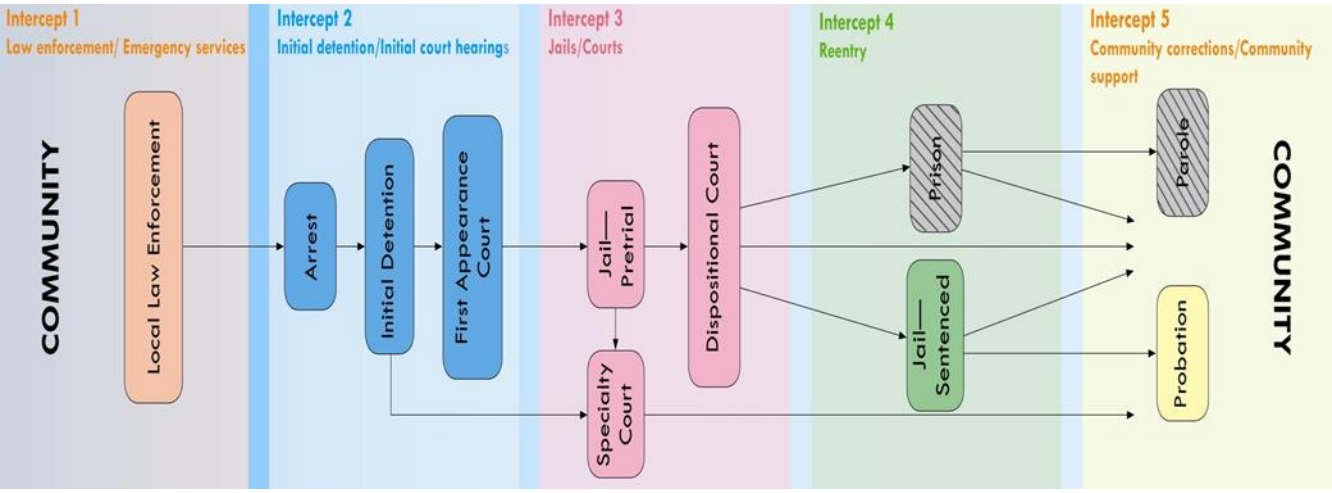
- It has been five years since the Sheriff's Department had Crisis Intervention Team (CIT) training, but they are planning to rectify this
- Mental Health First Aid available in Jefferson County
- Mobile Crisis (MHPs) goes to the detention center, but does not go on home visits
- Homeless outreach shelter staff have begun working with the police
    - Encampments
    - Hotline
- Business Improvement Officer (MPD)
- MHC crisis works with CIT
- "Downtown Ambassadors" (2-3)
- Educating consumers to request CIT
- Saint Patrick Hospital has three security staff to take custody of individuals dropped off by police, acting as central drop off
- The University of Montana Behavioral Intervention Team (BIT) program brings people together
- Western Montana Mental Health Center's (WMMHC) Dakota Place has short-term crisis stabilization facilities, serving as emergency room diversion
- Community Medical Center has limited detox

- Frequent User of Services Engagement (FUSE) process at Saint Patrick Hospital with Winds of Change Mental Health Center
- Saint Patrick's Urgent Care (inpatient care transition) has two Nurse Practitioner Licensed Clinical Social Workers (LCSWs) (8am-5pm, 7 days/week)
- EMT/Fire Department

Gaps

- Mental Health First Aid training for law enforcement
- Greater Native American and veteran inclusion in initiatives
- The Police Department underutilizes the Dakota Place crisis stabilization
- CIT integration with Community Services
- Limited Mobile Crisis Outreach/no linkage to Police.
- Emergency diversion can be jail
- Waiting list for funding and access to detox programs, and there is a conflicting priority list
- 911 is not trained in CIT
- The University of Montana Police have not received CIT training
- Saint Patrick Hospital's Frequent User Systems Engagement (FUSE) does not formally include the justice-involved population or justice partners (e,g., police/jail/probation)
- Urgent care is not linked to police and has a waitlist
- 911 alerts are "under construction" and do not include MH information
- Peers are underutilized within the systems
- Insufficient psychiatric beds in the community
- Need a secure crisis stabilization unit
- Police/prosecutors need statutory provisions for diversion from the state hospital

Intercepts 2 & 3



Resources

- There is local interest in restorative justice
- If a warrant exists, the Sheriff/Police take the individual directly to the nearest available judge. A lot of these situations occur on weekends when the judges are not available, but some are on call in Municipal Court
- Montana code 46-7-101- A person arrested, whether with or without a warrant, must be taken without unnecessary delay before the nearest and most accessible judge for an initial appearance (pg. 8) State law dictates officers must do this
- Municipal Court holds Jail Court on Sundays
- If a person is already receiving mental health services, there is an attempt to send the case manager to be with him/her and offer alternatives to incarceration, which usually results in community release
    - Ad hoc diversion
- For low-level misdemeanors, the judge asks, “Who is your case manager? Where to you get your help?” and makes a note in her files so she does a hearing for show cause instead of issuing a warrant
- Tim’s Missoula Urban Indian Health Center has resources
- Travis looks at the jail roster, which is online, every day to see who has been released; encourage all case workers to review daily
- They started using the Brief Jail Mental Health Screen (BJMHS) in the jail last week

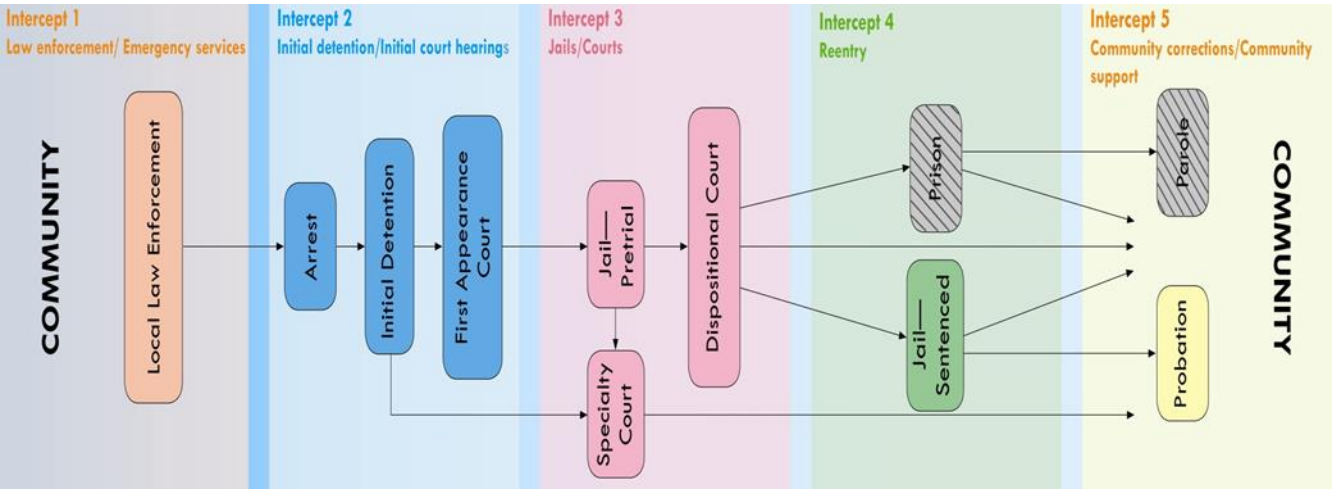
- Teresa jail based position is funded by a grant, HB 130
- MHSP can be used for people in jail, but they need significant documents for identification.
- The new administration is much more open, and the jail is willing to be flexible with allowing peers with criminal justice histories to enter the jail
- Graduates of co-occurring court
- In April 2015, Missoula County was selected to receive funding and technical support to advance and evaluate innovative models for success in addressing jail overcrowding at the Missoula County Detention Facility (Pay for Success)

Gaps

- For Failure to Appears, are there alternatives to jail, as jail is not necessarily a disincentive?
- Some do not have money to post for bail
- Screening for pretrial supervision- felonies
- Screening can take up to two weeks, while the person waits in jail
- There is no independent jail project to interview and advocate for those at lower risk, and some groups fall through the gaps
- Some people do not disclose their case managers
- Some do not provide accurate information
- Prosecutors often are the last to receive information that would allow for diversion
- Saint Patrick Hospital could do more diversion work, but has limited resources
- Diversion misdemeanor statute by the County Sheriff, but it is not clear where to divert- need for services
- Involve the Public Defender's office-provide training on diversion and resources
- The Tribal population consists of at least 12% (could be up to 20%) of the jail, compared with only 2% of the general population
- "People shouldn't have to go to jail to get services"
- There is no mental health reimbursement funding for services in jail
- Theresa (jail diversion therapist), provides 7 groups/week; 200 contacts last month) is funded by HB money and student interns help with case management, but there is not a plan for after the funding ends
- Challenging conversation now regarding jail health services (5am-10pm in jail; on call 24/7) and Medical provider formulary
- There is a need for psychiatric hours in the jail, especially for starting medication and for those who have not taken medication recently

- There is a wait list for Warm Springs forensic evaluation/commitment, which is 15-20 individuals over capacity and not equipped to handle violent inmates
- There is a wait list to get into the maximum security (isolation) cell block for inmates with mental illness
- There is a need for a specialized unit for inmates with mental health
- The jail would like a peer recovery group, but there are restrictions on peers with criminal justice histories entering the jail. New administration is willing to revisit restrictions
- A co-occurring court is the “tip of the iceberg” to begin to serve the need
- Barriers to court ordered mandates
- PD office trial continuations keep people in jail as does tough sentencing on petty crimes

Intercepts 4 & 5



Resources

- HB-33 (effective July 2015) expanded mental health crisis intervention and jail diversion services to areas of the state that lack services
  - 3.5 million housing
  - 250,000 crisis services expansion
- Faith-based Missoula interfaith advocate network offers relevant resources
- Theresa (jail mental health) opens up increased continuity of care and treatment options under Western Montana Mental Health
- PATH program provides in-reach; “safety net”
  - Hoping to increase in FY 2017
- Travis and Theresa are working to revamp SOAR
  - They both, and Nicole, have completed the SOAR leadership training
  - They help support community alternatives
  - Missoula pays Human Resources $210,000/year to support Social Security access
- Taking advantage of Healthcare Navigators
- Partners for Reintegration from state prison: housing, mentorship, mental health, and employment task forces
  - Focusing on forums, communication, and advocacy

- Warrior Down Program in another county (Great Falls) as a possible model
- Large, interested inter-faith community
- Peer-to-peer programs can be very productive
- MHP sends staff to forensic state hospital for in-reach
- Federal Byrne grant money channeled by crime control board
- University of Montana behavioral health phone support
- Some providers are moving toward becoming trauma-informed
- Forensic case management is being developed
- Housing for veterans- The Housing Montana Heroes Program- men and women veterans, housed in semi-private rooms within the emergency shelter; also offers case management
- Aging working with veterans services
- University of Montana- veterans transition services
- Western Montana contract with the VA
- Veterans Center does Seeking Safety
- The Mental Health Probation Officer has a smaller caseload- 50 people
- Winds of Change staff look at the jail roster
- Probation and Parole often "intervene in a downward spiral" to offer treatment instead of jail
- Travis is hiring a new staff person who will be able to offer engagement and support
- Interested NAMI
- BH forum focuses on communication and advocacy
- State hospital works with Probation and Parole to fast-track admissions and hopefully decrease length of stay
- Justice Alliance on Mental Illness

Gaps

- The faith-based Missoula interfaith advocate network could benefit from a full time liaison
- The jail would like an FTE to help with case management and who can follow up for 90 days
- There is no coordinated effort to notify Theresa of a release
- Need for a dedicated SOAR case manager
- Theresa provides "soft" referrals to vocational rehabilitation and employment. More direct "warm hand-off" strategies are needed.
- Need for trauma training
- Jail Formulary

- Liaisons specific to support employment
- No specific reentry for Tribal population
- Reentry to motels is often not successful
- People can be released from the state hospital without notice
- Need for Seeking Safety training for females
    - Katherine is trained
    - Winds of Change developing?
- High collateral consequences: fines, warrants, inability to get jobs/housing/etc.
- Few resources for aging population with mental illness who need long-term care
    - "Waiting for people to get worse" medically or otherwise
    - Law enforcement/fire department providing "taxi service" looking for resources
- VA Hospital in Helena no longer provides inpatient services
- Montana's state-specific mental health expansion is waiting for Federal approval
- It is very difficult to get housing for persons with violent crimes or charged with sex offenses
- Violations of misdemeanor probation seem to come to jail faster than felony probation
    - Probationers monitored at higher levels?
    - "So much harder to be on misdemeanor probation"
- There is little data to illuminate problems and processes

Active Planning Groups

- Mayor's Downtown Advisory
- Quality of Life
- Housing First Group
- End Homelessness group
- CIT group
- Youth Crisis Intervention/Diversion- coordinator/facilitator
- At-risk Housing Coalition
- Partners for Re-Integration
- Homeless Advocacy
- Just Response Group- justice funding
- Interfaith Collaborative
- Local Advisory Council (LAC)
- Adult Protective Services

Priorities for Change as Determined by Mapping Participants

- Appropriate infrastructure for diversion efforts (21 votes)
    - Secure crisis
    - Expanded detox
    - One-stop for law enforcement
    - Wet housing
- Expand peer support and giving a voice to consumers (11 votes)
    - Empowerment
    - Expand recovery efforts and philosophy; person first language
    - Address community perceptions
        - Education and awareness
        - Legislature too
        - University population
    - See Resources:

        - SAMHSA's GAINS Center. *Involving Peers in Criminal Justice and Problem-Solving Collaboratives.* http://gainscenter.samhsa.gov/cms-assets/documents/62304-42605.peersupportfactsweb.pdf

        - SAMHSA's GAINS Center. *Overcoming Legal Impediments to Hiring Forensic Peer Specialists.* http://gainscenter.samhsa.gov/peer_resources/pdfs/Miller_Massaro_Overcoming.pdf

        - NAMI California. *Inmate Medication Information Forms*: LA NAMI Medication Form - English | LA NAMI Medication Form - Spanish

- Develop liaisons to support individuals across the criminal justice process- start-to-finish; one foot inside/one foot outside; outreach and engagement (9 votes)
- Sustainable funding to support diversion efforts (7 votes)
- Expand housing options, especially for violent offenders and sex offenders (6 votes)
    - Work with landlords
    - Affordable
    - "Rent well"
    - Oregon's "Ready to Rent" training as a model
        - Landlord guarantee program

  - Therapeutic foster homes
  - Group therapeutic homes
- Expand local inpatient psychiatric beds and substance abuse treatment (6 votes)
- Diversion for nonviolent offenders (5 votes)
  - Data to illustrate
  - Agreeing on definition of nonviolent offenders
- Strategies to support continuing collaboration (5 votes)
  - Build on these efforts
  - Fold together and coordinate all the various efforts (Ex: Sheriff's jail diversion Pay for Success)
- Develop data to inform our decisions (3 votes)
  - Research outcomes and clarify our goals
  - Across all intercepts
- Transition staffer in jail (Gallatin County model) (2 votes)
- Improve access and continuity of care for psychotropic medication- before, during, and after jail (2 votes)
  - Long acting medication- frequent users, state prisons, and jails
- Expand prevention and early intervention (1 vote)
- Outreach to our rural communities (1 vote)
  - Improve access to services
- Look systematically at how to better serve our Native American population (1 vote)
  - Across intercepts
  - Institutionalize screening and referral
- Address transient populations and gather data (0 votes)

Recommendations

1. **Formalize a countywide Planning Body to address the needs of justice involved persons with co-occurring mental health and substance use disorders.**

   Workshop participants expressed the need for on-going dialogue, joint planning and increasing awareness regarding system resources. Implementation of initiatives to increase diversion opportunities will require involvement of a broad group of stakeholders with sufficient authority to impact state, county and municipal level change.

   Bexar County (Texas), Memphis (Tennessee), New Orleans Parish (Louisiana), and Pima County (Arizona) are examples of counties and municipalities that have developed Criminal Justice Mental Health Planning Committees.

   - National Association of Counties. *Crisis Care Services for Counties: Preventing Individuals with Mental Illnesses from Entering Local Corrections Systems.* http://www.naco.org/newsroom/pubs/Documents/Health,%20Human%20Services%20and%20Justice/CrisisCarePublication.pdf

   - SAMHSA. *Crisis Services: Effectiveness, Cost-Effectiveness, and Funding Strategies.* http://store.samhsa.gov/product/Crisis-Services-Effectiveness-Cost-Effectiveness-and-Funding-Strategies/SMA14-4848

   - Texas Department of State Health Services. *Mental Health Substance Abuse Crisis Services Redesign Brief* (See Appendix 2).

2. **Explore expansion of Social Security Outreach Access and Recovery (SOAR) to include justice involved populations**

   Missoula County currently participates in SOAR Training and Implementation, and has a project implementation team which includes Theresa Williams, Marlene Disburg-Ross, Travis Mateer, Jennifer Nottingham, Nicole Gratch, and Heather Reeves. Policy Research Associates (PRA) operates both the SOAR Technical Assistance Center and SAMHSA's GAINS Center. There is additional support and expertise, through PRA to broaden SOAR focus to justice involved populations (see Appendix 4). Dan Abreu, of SAMHSA's GAINS Center can coordinate with Margret Lassiter, from the SOAR Technical Assistance Center to speak on monthly phone calls with the Missoula SOAR implementation team to address the inclusion of justice involved individuals and criminal justice partners in the SOAR initiative.

   - Information regarding SOAR for justice-involved persons can be found here: http://soarworks.prainc.com/article/working-justice-involved-persons

- The online SOAR training portal can be found here: http://soarworks.prainc.com/course/ssissdi-outreach-access-and-recovery-soar-online-training

- The SOAR Works contact for Florida is available through http://soarworks.prainc.com/states/florida

3. **Develop formal mechanisms to screen, identify and engage justice involved Native Americans. It will be important to reach out to local tribal leaders and resources.**

   Participants reported that the prevalence of the Native American population in the jail was between 12% and 20%, compared to 2% of the general population. Many justice involved Native Americans do not live on the reservations. As a group they are more likely to have high incidences of trauma and substance abuse yet still may require more culturally specific interventions. Those that do live on reservations are difficult to engage due to jurisdictional issues.

4. **Expand Intercept 2 diversion options for persons with mental illness.**

   Multiple priorities identified at the SIM workshop are related to expanding diversion. PRA recommends specifically focusing on Intercept 2 diversion strategies by improving screening for mental health and co-occurring disorders, service access and formalizing diversion activities at first appearance. Below are examples of Intercept 2 Diversion Programs. PRA acknowledges ad hoc efforts and best practice strategies already being used. For example, both the Poverello Center and Winds of Change check the jail roster to identify consumers who have been arrested. Formalizing this protocol and flow of information to the court and court partners can result in more timely diversion from jail and engagement into treatment.
   Below are links to two fact sheets describing Intercept 2 diversion programs.

   - *Creating an Indigent Defense Diversion Team: The Manhattan Arraignment Diversion Project* http://gainscenter.samhsa.gov/cms-assets/documents/96362-788132.map-program-brief.pdf

   - *Successfully Engaging Misdemeanor Defendants with Mental Illness in Jail Diversion: The CASES Transitional Case Management Program* http://gainscenter.samhsa.gov/cms-assets/documents/73721-164186.casestcm.pdf

5. **Cross-intercept data should be developed to document the involvement of people with severe mental illness and often co-occurring substance use disorders involved in the criminal justice system.**

   Improving data collection was the ninth ranked priority, receiving three votes. Formalizing data collection will be useful to illustrate the scope and complexity of the problems discussed during the workshop. Efforts should be made to summarize important information on a regular basis and share with the larger planning group, other stakeholders, and funders.

   - "Mental Health Report Card" used by the King County, Washington Mental Health, Chemical Abuse and Dependency Services to document progress in meeting relevant client outcomes

  - For example, one outcome measure asks: Are we decreasing the number of times adults and older adults are incarcerated? http://www.kingcounty.gov/healthservices/MentalHealth/Reports.aspx

- The Illinois Jail Data Link Initiative cross references behavioral health data bases with jail data bases on a daily basis and provides for case management services to insure continuity of care and timely linkage to service upon release (See Appendix 3) https://sisonline.dhs.state.il.us/jaillink/home.asp

- Urban Institute. *Justice Reinvestment at the Local Level Planning and Implementation Guid*e http://www.urban.org/publications/412233.html

- Pennsylvania Commission on Crime and Delinquency. *Criminal Justice Advisory Board Data Dashboards* http://www.pacjabdash.net/Home/tabid/1853/Default.aspx

Missoula County, MT Strategic Action Plan

Priority Area 1: Expand the Crisis Care Continuum				
Objective		Action Step	Who	When
A	HB 33 allocates $1,000,000 for Crisis Services. Missoula County's application due at the end of July. Develop a plan for utilizing the allocation.	1. Inventory current Crisis Care Services to determine gaps, using the SAMHSA Crisis Case Continuum 2. Identify the agency and stakeholders that will determine how the money will be allocated 3. Identify additional CJ and SIM workshop participants to advise the planning group or join the planning group	Erin Kautz Erin	
B	Collect data to inform decision making	1. Share the cost of uncompensated care at St. Patrick's. 2. Develop a profile of the uncompensated care group 3. Refine and broaden strategies for the Frequent Users of Service (FUSE) group, involving more CJ and BH agencies.	Peter Peter Erin will coordinate	
C	Collect information about successful programs and models. Benchmark programs.	1. Visit Yellowstone County Community Crisis Center and review Fact Sheet. 2. Review resources provided by GAINS, and visit additional sites. 3. Review benefits of locked vs. unlocked facility or mixed security facility.	Erin will coordinate	

Priority Area 2: Expand Peer Support Services for Justice Involved Persons				
Objective		Action Step	Who	When
A	Review roles and capacity of existing peer work force to work in justice settings	1. Winds of Change will review deployment of re-hires from Consumer Direct to consider placement in justice settings. 2. Jail Administration/Probation will review current hiring/clearance practices to consider eliminating barriers to allowing peers with a history of justice involvement to provide transition services in the jail. 3. SAMHSA GAINS Center will provide Technical Support and program example of successful Forensic Peer Initiatives. 4. WOC is soliciting letters of support to expand peer initiatives.		
B	There is $250,000 available from State Funding to develop peer services develop plan to place peers in strategic diversion and justice settings.	1. Do needs assessment and prioritize where peers will be most effective. 2. Expand PATH services by utilizing peers		

Resources

Competency Evaluation and Restoration

- SAMHSA's GAINS Center. *Quick Fixes for Effectively Dealing with Persons Found Incompetent to Stand Trial.* http://gainscenter.samhsa.gov/pdfs/integrating/QuickFixes_11_07.pdf
- 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. http://onlinelibrary.wiley.com/doi/10.1002/bsl.890/abstract;jsessionid=5A8F5596BB486AC9A85FDFBEF9DA071D.f04t04

Crisis Response and Law Enforcement

- International Association of Chiefs of Police. *Building Safer Communities: Improving Police Responses to Persons with Mental Illness.* http://www.theiacp.org/portals/0/pdfs/ImprovingPoliceResponsetoPersonsWithMentalIllnessSummit.pdf
- Saskatchewan Building Partnerships to Reduce Crime. *The Hub and COR Model.* http://saskbprc.com/index.php/2014-08-25-20-54-50/the-hub-cor-model
- Suicide Prevention Resource Center. *The Role of Law Enforcement Officers in Preventing Suicide.* http://www.sprc.org/sites/sprc.org/files/LawEnforcement.pdf
- Bureau of Justice Assistance. *Engaging Law Enforcement in Opioid Overdose Response: Frequently Asked Questions.* https://www.bjatraining.org/sites/default/files/naloxone/Police%20OOD%20FAQ_0.pdf

Data Analysis/Matching

- Urban Institute. *Justice Reinvestment at the Local Level Planning and Implementation Guide.* http://www.urban.org/publications/412233.html
- The Council of State Governments Justice Center. *Ten-Step Guide to Transforming Probation Departments to Reduce Recidivism.* http://csgjusticecenter.org/corrections/publications/ten-step-guide-to-transforming-probation-departments-to-reduce-recidivism/
- New Orleans Health Department. *New Orleans Mental Health Dashboard. http://www.nola.gov/getattachment/Health/Data-and-Publications/NO-Behavioral-Health-Dashboard-4-05-15.pdf/*
- Pennsylvania Commission on Crime and Delinquency. *Criminal Justice Advisory Board Data Dashboards.* http://www.pacjabdash.net/Home/tabid/1853/Default.aspx
- Corporation for Supportive Housing. *Jail Data Link Frequent Users: A Data Matching Initiative in Illinois* (See Appendix 3)

Information Sharing

- American Probation and Parole Association. *Corrections and Reentry: Protected Health Information Privacy Framework for Information Sharing*. http://www.appa-net.org/eweb/docs/APPA/pubs/CRPHIPFIS.pdf

Mental Health First Aid

- Illinois General Assembly. *Public Act 098-0195: "Illinois Mental Health First Aid Training Act."* http://www.ilga.gov/legislation/publicacts/fulltext.asp?Name=098-0195
- Mental Health First Aid. http://www.mentalhealthfirstaid.org/cs/
- Pennsylvania Mental Health and Justice Center of Excellence. *City of Philadelphia Mental Health First Aid Initiative.* http://www.pacenterofexcellence.pitt.edu/documents/Session10_Piloting_the_Public_Safety_Version_of_MHFA.ppt

Reentry

- SAMHSA's GAINS Center. *Guidelines for the Successful Transition of People with Behavioral Health Disorders from Jail and Prison*. http://gainscenter.samhsa.gov/cms-assets/documents/147845-318300.guidelines-document.pdf
- Community Oriented Correctional Health Services. *Technology and Continuity of Care: Connecting Justice and Health: Nine Case Studies* http://www.cochs.org/files/HIT-paper/technology-continuity-care-nine-case-studies.pdf

Resources/Funding

- Justice Reinvestment at the Local Level Planning and Implementation Guide. http://webarchive.urban.org/publications/412233.html

- The Sustainability Curve. http://gainscenter.samhsa.gov/cms-assets/documents/144667-141965.the-sustainability-curve.pdf

- The Sustainability Checklist: Guidelines for Federal Grantees. http://gainscenter.samhsa.gov/cms-assets/documents/190941-834517.sustainability-checklist-final.pdf

Screening and Assessment

- SAMHSA's GAINS Center. *Screening and Assessment of Co-Occurring Disorders in the Justice System.* http://gainscenter.samhsa.gov/topical_resources/cooccurring.asp
- 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. http://gainscenter.samhsa.gov/pdfs/jail_diversion/Psychiatric_Services_BJMHS.pdf

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. http://ps.psychiatryonline.org/doi/10.1176/ps.2006.57.4.544
- 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. https://global.oup.com/academic/product/the-sequential-intercept-model-and-criminal-justice-9780199826759?cc=us&lang=en&
- SAMHSA's GAINS Center. *Developing a Comprehensive Plan for Behavioral Health and Criminal Justice Collaboration: The Sequential Intercept Model.* http://gainscenter.samhsa.gov/cms-assets/documents/145789-100379.bh-sim-brochure.pdf

Trauma Informed Care

- SAMHSA, SAMHSA's National Center on Trauma-Informed Care, and SAMHSA's GAINS Center. *Essential Components of Trauma Informed Judicial Practice.* http://www.nasmhpd.org/docs/NCTIC/JudgesEssential_5%201%202013finaldraft.pdf
- SAMHSA's GAINS Center. *Trauma Specific Interventions for Justice Involved Individuals.* http://gainscenter.samhsa.gov/pdfs/ebp/TraumaSpecificInterventions.pdf
- SAMHSA. *SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach.* http://gainscenter.samhsa.gov/cms-assets/documents/200917-603321.sma14-4884.pdf

Tribal

- Bureau of Justice Assistance. *Risk Need Responsivity: Turning Principles into Practice for Tribal Probation Personnel*. https://www.appa-net.org/eweb/docs/APPA/pubs/RNRTPPTPP.pdf
- Center for Court Innovation. *State and Tribal Courts: Strategies for Bridging the Divide*. http://www.courtinnovation.org/sites/default/files/documents/StateAndTribalCourts.pdf
- State Health Reform Assistance Network. *Implications of Health Reform for American Indian and Alaska Native Populations*. http://www.rwjf.org/en/library/research/2012/02/implications-of-health-reform-for-american-indian-and-alaska-nat.html
- National Tribal Judicial Center. *Walking on Common Ground: Tribal-State-Federal Justice System Relationships*. https://www.walkingoncommonground.org/files/Background%207%20WOCG%202010.pdf
- Bureau of Justice Assistance. *Improving the Administration of Justice in Tribal Communities through Information Sharing and Resource Sharing*. https://www.bja.gov/Publications/APPA_TribalInfoResourceSharing.pdf
- Bureau of Justice Assistance. *Tribal Probation: An Overview for Tribal Court Judges*. https://www.appa-net.org/eweb/docs/appa/pubs/TPOTCJ.pdf

- Office of Justice Programs. *Healing to Wellness Courts: A Preliminary Overview of Tribal Drug Courts*. http://www.tribal-institute.org/download/heal.pdf

Veterans

- SAMHSA's GAINS Center. *Responding to the Needs of Justice-Involved Combat Veterans with Service-Related Trauma and Mental Health Conditions.* http://gainscenter.samhsa.gov/pdfs/veterans/CVTJS_Report.pdf

- Justice for Vets. *Ten Key Components of Veterans Treatment Courts.* http://justiceforvets.org/sites/default/files/files/Ten%20Key%20Components%20of%20Veterans%20Treatment%20Courts%20.pdf

APPENDIX INDEX

Appendix 1:
SIM Participant List

Sequential Intercept Mapping Participant List

Name	Agency	Street Address	City	Phone	Title	Email
Theresa Williams	Western Montana Mental Health/Missoula County Detention Facility			406-258-	Jail Diversion Therapist	twilliams@wmmhc.org
Jean Curtiss	Missoula County Commissioner	200 W. Broadway	Missoula		County Commissioner	jcurtiss@co.missoula.mt.us
Stacey Wheeler	Winds of Change	2685 Palmer St, #C	Missoula	721-2038x248	Program Administrator	swheeler@wocmt.com
Katherine Isaacson	Western Montana Mental Health - Adult Services	1315 Wyoming	Missoula	532-9700	Director	kisaacson@wmmhc.org
Andrea Wirshing	Partnership Health Center	401 Railroad St	Missoula	258-4449	Behavioral Health Director	wirshinga@phc.missoula.mt.us
Tim Payne	Missoula Urban Indian Health Center	830 W. Central	Missoula	829-9515x117	Behavioral Health Clinical Supervisor	tpayne@micmt.com
Barbara Kuzmic	Western Montana Addiction Services	1325 Wyoming St	Missoula	532-9814	Executive Director	bkuzmic@wmmhc.org
Kevin Stewart	Western Montana Addiction Services	1325 Wyoming St	Missoula	532-9815	Clinical Director	kstewart@wmmhc.org
Sue Wilkins	Missoula Correctional Services	2350 Mullan Rd	Missoula	541-9200	Executive Director	swilkins@m-c-s-inc.org
Peter Snyder	Providence Saint Patrick Hospital	902 N. Orange	Missoula	327-3208	Regional Director of Psychiatric Services	Peter.snyder@providence.org
Travis Mateer	Poverello Center	1110 W Broadway St	Missoula	728-1809	Homeless Outreach Coordinator	Tmateer19@montana.com
Rob Scheben	Missoula Police Department	435 Ryman	Missoula	552-6335	Crime Prevention Officer	rscheben@ci.missoula.mt.us

Officer Ben Slater	Missoula Police Department	435 Ryman	Missoula	552-6300	Crisis Intervention Team Coordinator	BSlater@ci.missoula.mt.us
Mike Frost	Curry Health Center - University of Montana	634 Eddy Ave	Missoula	243-4711	Director, Counseling Services	mfrost@mso.umt.edu
Patti Bower	Missoula County Attorney's Office	200 W. Broadway	Missoula	258-4737	Deputy County Attorney	pbower@co.missoula.mt.us
Brenda Desmond	Fourth Judicial District Court	200 W. Broadway	Missoula	258-4728	Standing Master	bdesmond@mt.gov
Karen Orzech	Justice Court II	200 W. Broadway	Missoula	258-3219	Justice of the Peace	korzech@co.missoula.mt.us
Karen Ward	NAMI		Missoula			Karenward514@gmail.com
Hannah Halden	Missoula Co-occurring Court	200 W. Broadway	Missoula	258-4641	Coordinator	hhalden@mt.gov
Connie Bowman	Co-occuring court				Consumer	nyexile@bigsky.net
Lauren Pope	Co-occuring court			214-6983	Consumer	Lpope.jobs@gmail.com
Tim Myers	WMMHC - Missoula Adults Crisis Services	1315 Wyoming	Missoula	532-8948	Program Manager	tmyers@wmmhc.org
Dave Stenerson	Office of the State Public Defender	610 Woody St	Missoula	523-5140	Regional Deputy Public Defender	davestenerson@mt.gov
Samantha Erpenbach	Montana Board of Crime Control	5 S. Last Chance Gulch	Helena	444-2947	Program Specialist	SErpenbach@mt.gov
Emily Bentley	Missoula City Council	140 W. Pine	Missoula		City Councilmember	EBentley@ci.missoula.mt.us
Sheryl Ziegler	Missoula County Detention Facility	2340 Mullan Rd	Missoula	258-4000	Jail Diversion Supervisor	sziegler@co.missoula.mt.us
Erin Kautz	Grants and Community Programs	200 W. Broadway	Missoula	258-3637	Grants Administrator	ekautz@co.missoula.mt.us
Jackie Merritt	Veteran's Court	3687 Veterans Drive	Fort Harrison	447-6021	Veteran Justice Outreach Specialist	Jackie.Merritt@va.gov

Landee Holloway	Dept of Corrections - Office of Offender Reentry	2415 Mullan Rd	Missoula	542-7132	Probation Officer	lholloway@mt.gov
Abby Gruber	MT DOC Adult Probation and Parole	2415 Mullan Rd	Missoula	542-7126	Probation and Parole Officer	agruber@mt.gov
Jason Johnson	Missoula County Sheriff's Office	200 W. Broadway	Missoula	258-4810	Undersheriff	jpjohnson@co.missoula.mt.us
Kim Lahiff	MT DOC Adult Probation and Parole	2415 Mullan Rd	Missoula	542-7130	Region 1 Administrator	klahiff@mt.gov
Scott Newell	Missoula County Sheriff's Office	200 W. Broadway	Missoula	258-3302	Patrol Lt.	snewell@co.missoula.mt.us
Rosie Jennings	Aleph P.C./Winds of Change	2685 Palmer St	Missoula		VP Operations	
Daniel Ladd	Aleph P.C./Winds of Change	2685 Palmer St, #A	Missoula	721-2038		dladd@jenningsmt.com

Appendix 2:
Crisis Services

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:
CSH Jail Data Link

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:

Best Practices for Increasing Access to SSI/SSDI

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

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