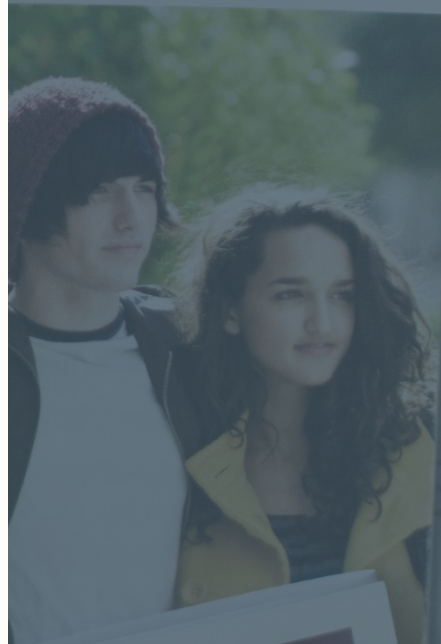


Sequential Intercept Model Mapping Report for Fulton County, GA

Prepared by: Policy Research Associates, Inc.
Travis Parker, M.S., L.I.M.H.P., C.P.C.
Patricia A. Griffin, Ph.D.

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Sequential Intercept Model Mapping Report for Fulton County, Georgia

April 25-26, 2017

Final Report: June 2017

Travis Parker, M.S., L.I.M.H.P., C.P.C.
Patricia A. Griffin, Ph.D.

Policy Research Associates, Inc.



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Introduction

The Superior Court of Fulton County contracted with Policy Research Associates (PRA) to develop a behavioral health and criminal justice system map focusing on the existing connections between behavioral health and criminal justice programs to identify resources, gaps, and priorities in Fulton County for adults with severe mental illness and co-occurring disorders.

Background

The Sequential Intercept Model, developed by Mark R. Munetz, M.D. and Patricia A. Griffin, Ph.D. in conjunction with SAMHSA’s GAINS Center¹, has been used as a focal point for states and communities to assess available resources, determine gaps in services, and plan for community change. These activities are best accomplished by a team of stakeholders that cross over multiple systems, including mental health, substance abuse, law enforcement, pre-trial services, courts, jails, community corrections, housing, health, social services, peers, family members, and many others.

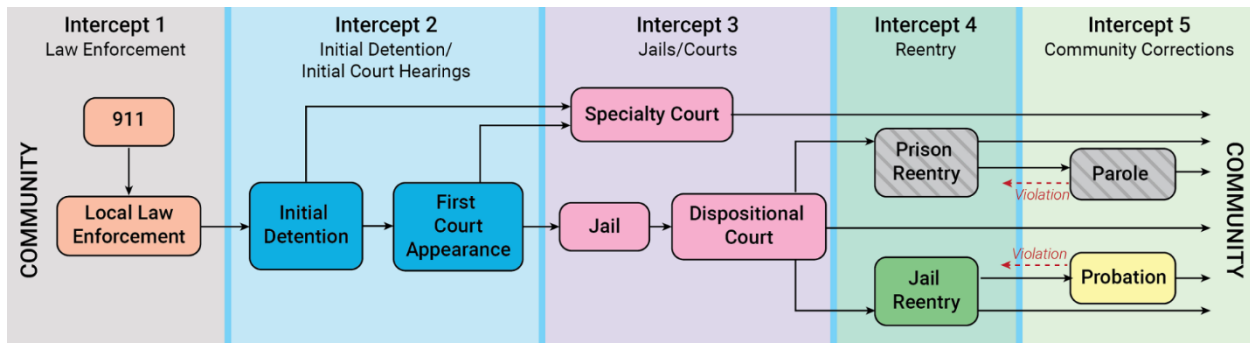
A Sequential Intercept Model mapping is a workshop to develop a map that illustrates how people with behavioral health needs come in contact with and flow through the criminal justice system. Through the workshop, facilitators and participants identify opportunities for linkage to services and for prevention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

The Sequential Intercept Mapping workshop has five 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: (1) Law Enforcement and Emergency Services, (2) Initial Detention and Initial Court Hearings, (3) Jails and Courts, (4) Reentry, and (5) Community Corrections/Community Support.
2. Identification of gaps, resources, and opportunities at each intercept for individuals in the target population.
3. Development of priorities for activities designed to improve system and service level responses for individuals in the target population
4. Develop of an action plan to implement the priorities
5. Nurture cross system collaboration

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

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Fifty people attended the Fulton County Sequential Intercept Mapping workshop. The participants represented multiple stakeholders including mental health, substance abuse treatment, health care (including emergency department and inpatient acute psychiatric care), human services, corrections, courts, reentry staff, advocates, housing, probation, and parole. Expert Consultant, Patricia A. Griffin, Ph.D. and Senior Project Associate, Travis Parker, M.S., L.I.M.H.P., C.P.C. of Policy Research Associates, facilitated the workshop session.

Superior Court Chief Judge Gail Tusan and Superior Court Judge Doris Downs welcomed participants to the workshop on the first day. Chief Judge Tusan shared with participants that a kickoff mental health consortium had previously been held at Atlanta Metropolitan State College. She emphasized that there is a clear need to continue the dialogue coming out of the mental health consortium and addressed the importance of the day-and-a-half workshop and its importance for the group to focus on how to better assist the citizens of Fulton County with mental health issues who are also in the justice system.

Judge Downs shared with participants that Judge Steve Leifman from Miami-Dade County had come to Atlanta to present at the mental health consortium. As a result of what she heard at the mental health consortium, Judge Downs concluded, “We aren’t dealing with the problem of mental health and addiction in Fulton County very well.” Judge Downs spoke not only of the importance of helping persons with mental illness, but also assisting these individuals in navigating systems that they need to access in order to receive help. Judge Downs emphasized to the participants that she was anxious for everyone “to get a lot accomplished and a map created.” She charged the group with the responsibility that, “We are here to connect and divert!”

This report contains:

- Background regarding the workshop
- Agendas for each day
- Fulton County Sequential Intercept Map developed by the participants
- Brief narrative of services at each intercept from information provided in the Community Collaboration Questionnaire developed in advance of the workshop

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- Resources and Opportunities along with Gaps and Challenges for each Intercept identified by the workshop participants
- Fulton County Priorities
- Action Plan developed during the workshop
- Recommendations
- Resources
- Appendices

AGENDA

Sequential Intercept Mapping

AGENDA

Fulton County, GA

April 25, 2017

8:30 Registration

9:00 Opening/Overview for Large Group

- Welcome and Introductions
 - Judge Doris Downs
- 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

10:30 Cross-Systems Mapping

- Creating a Local Map
- Examining the Gaps and Opportunities

Establishing Priorities

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

Wrap Up

- Review

4:30 Adjourn

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

There will be break for lunch at approximately noon.

Sequential Intercept Mapping

AGENDA

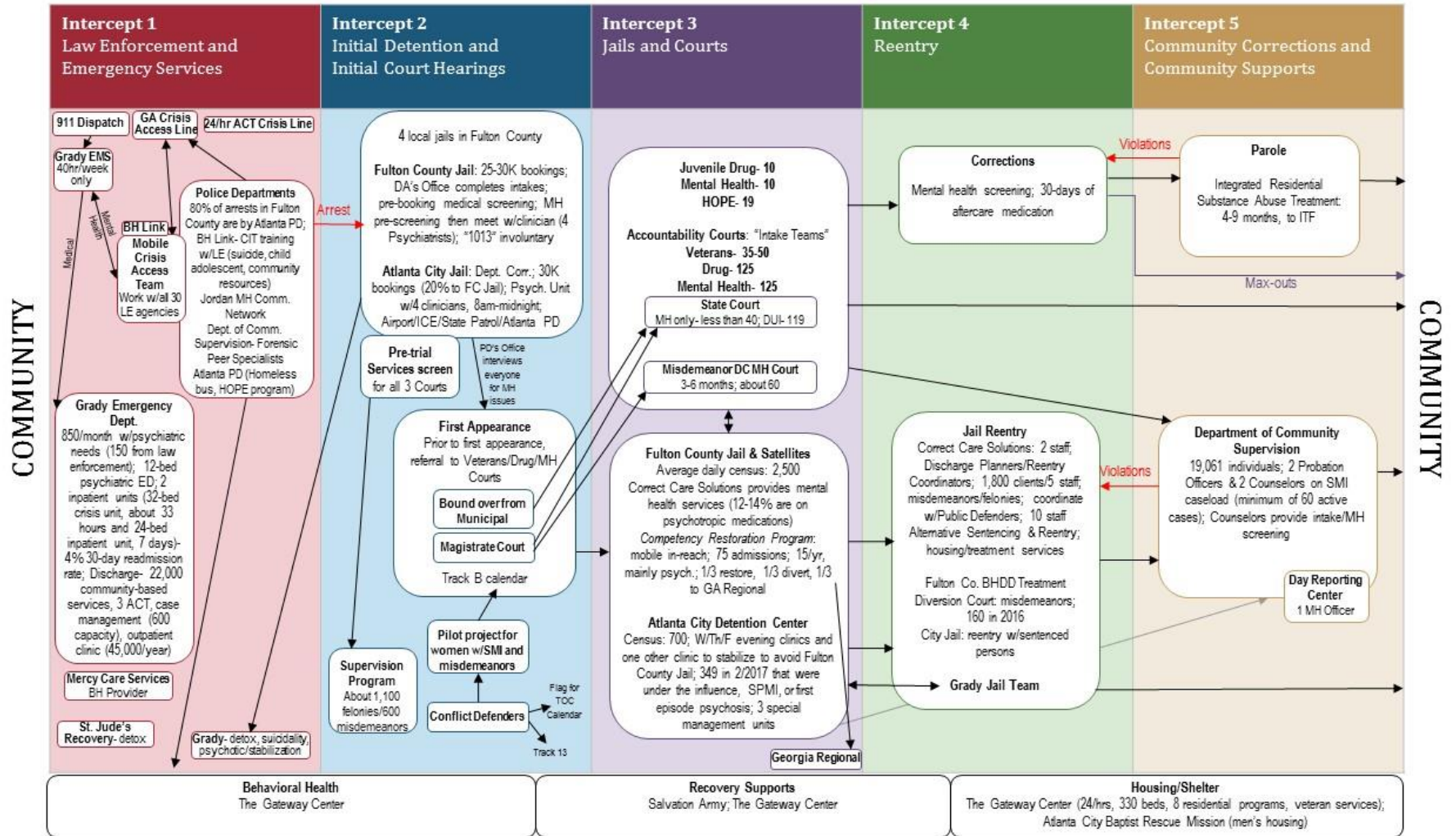
Fulton County, GA

April 26, 2017

- 8:30 Registration and Networking**
- 9:00 Opening**
- Remarks
 - Preview of the Day
- Review**
- Day 1 Accomplishments
 - Local County Priorities
 - Keys to Success in Community
- Action Planning**
- Finalizing the Action Plan**
- Next Steps**
- Summary and Closing**
- 12:30 Adjourn**

There will be a 15 minute break mid-morning.

SEQUENTIAL INTERCEPT MODEL MAP FOR FULTON COUNTY, GA





RESOURCES AND GAPS AT EACH INTERCEPT

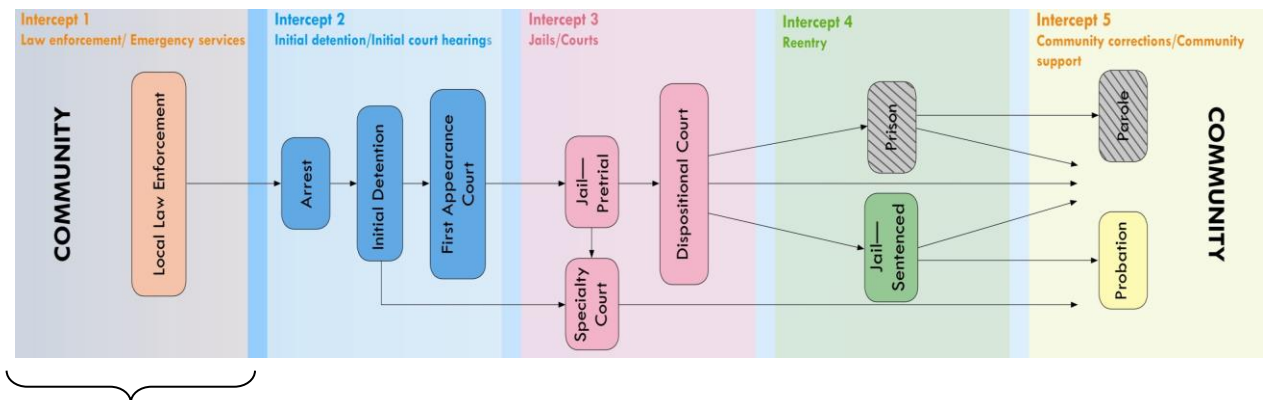
The centerpiece of the workshop is the development of a Sequential Intercept Model map. As part of the mapping activity, the facilitators work with the participants to identify opportunities, gaps, and challenges at each intercept. This process is important since the criminal justice system and behavioral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

Cross-System Collaborations

Fulton County has a number of existing cross-system collaborations including the:

- Criminal Justice Coordinating Council
- Justice and Mental Health Task Force --- Stepping Up Initiative
- Crisis Intervention Team training
- Emory University and Fulton County Sheriff's Office Jail-Based Competency Restoration Program
- Atlanta/Fulton County Pre-Arrest Diversion Project
- City of Atlanta Public Defender's Office MacArthur Safety and Justice Challenge
- Treatment Diversion Court
- Pilot Project for Women with Severe Mental Illness
- Accountability Courts
- Public Defender's Office/United Way Alternative Sentencing Initiative
- Mental Health Collaborative Meeting

Intercept 1: Pre-arrest Diversion



- The Racial Justice Action Center is leading collaborative efforts on a Pre-Arrest Diversion Project. The City of Atlanta Public Defender’s Office was recently awarded the MacArthur Safety and Justice Challenge grant to evaluate the Pre-Arrest Diversion Project. The program aims to redirect people out of the criminal justice system who would be better served by social services.
 - It seeks to reduce the number of people in the courts and jails whose involvement is primarily due to mental illness, drug and alcohol addiction, or extreme poverty.
 - By replacing detention with services, it aims to increase neighborhood safety, improve the quality of life in Atlanta’s communities, and expand the quantity and quality of needed social services in the city and the county.
 - The project holds regular meetings and subcommittees are formed.
 - This is a cross-system collaborative group that put together the pilot program set to start in the summer of 2017 in Atlanta Police Department (APD) Zones 5 and 6.
 - The project includes Care Navigators and Peer Specialists.
- By closing and reducing the state psychiatric bed capacity without transferring dollar for dollar into the community, the state has essentially shifted treatment for the mentally ill from its facilities to the jails. A central component of this initiative is to rally around the need for increased community capacity (including beds) to treat this specialized population.
- Due to a significant volume increase over the last 7 years, Grady built a dedicated Psychiatric Emergency Service within its general Emergency room. This dedicated 12 bed unit evaluates approximately 875 people per month, with 150 (15-20%) of those brought in by law enforcement. Approximately 45% of their total admissions are brought in by Emergency Medical Services while another 20 to 30% are walk-ins. Approximately 400 people a month (or 45% presenting to this service) require involuntary admission due to their psychiatric acuity.
- BH Link works with all 28 law enforcement agencies.

- Depending upon the designated level for each, mobile crisis may accompany law enforcement or go out on their own.
- BH Link and Grady partner to intervene when a 911 call is determined to reflect a behavioral health need. A paramedic and behavioral health clinician (and law enforcement as needed) perform an assessment in the field and attempt to divert from the Grady emergency room or jail.
- In addition to Grady’s 12 bed psychiatric Emergency Room that has a 6-hour length of stay, a temporary observation crisis unit provides capacity for 32 people who stay an average of 33 hours while a determination is made for the need for inpatient treatment. Finally, Grady operates a 24-bed inpatient unit with an average length of stay of 7 days. Grady is essentially the only resource for the uninsured, which constitute most people released from jail/prison.

Gaps/Challenges

- The Atlanta Regional Commission estimates that as many as 50,000 Fulton County residents have severe mental illness. With few resources to serve these individuals, mental health services in jail and the services offered at Grady provide approximately 80% of the care for those that do receive services. Clearly, more capacity needs to be developed for diversion to be successful.
- There were no street officers in the room during the SIM
 - Need to follow up, especially with Atlanta Police Department and the Sheriff’s Office
- 28 law enforcement agencies in the County
- Grady/BHL mobile assessment team is working with 911 and available 40 hours per week; outside those 40 hours, triage is backed up by the emergency room at Grady
- Grady prioritizes those who come into their ER. People being released from jail are typically more stable than others brought to ER so they receive a lower priority status. Additionally, people released from jail can be more stable than those being discharged from Grady’s inpatient services who receive priority at Grady’s outpatient clinic. Thus, care can be delayed.
- Many law enforcement officers have completed Crisis Intervention Team (CIT) training but need annual CIT refresher trainings
 - Officers can lose CIT de-escalation skills if they do not keep utilizing the skills
- Law enforcement have no real options for intoxicated people
 - Law enforcement is frustrated dealing with intoxicated people
 - St. Jude’s Recovery Center provides detox but services are limited and law enforcement typically do not transport people there
 - Law enforcement may take intoxicated people to Grady but some are released in a day and then law enforcement has to come back and transport them to jail
 - Some law enforcement believe CIT doesn’t work because there are almost no alternatives to jail for intoxicated people

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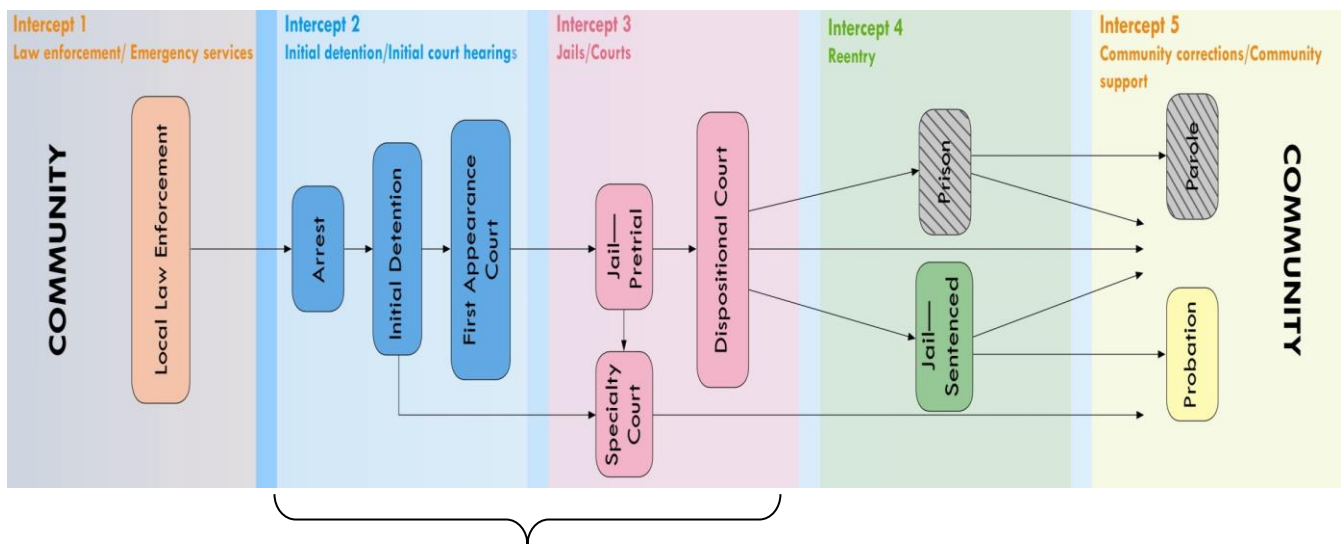
- No one seems to be alerted to behavioral health challenges until after the person is arrested
- Are there linkages to the VA and the Veterans Justice Outreach Specialists for veterans in crisis?
- No single point of access for behavioral health services in the community
 - While the state funds the GA Crisis and Access line run by BH Link, they focus on emergent and urgent cases. People with routine MH needs generally have to wait many weeks for an appointment.
- While the DBHDD maintains a significant amount of information about individuals with severe mental illness treated by providers funded by the state/Medicaid, this information is not utilized for purposes of care coordination and jail/hospital diversion.

Opportunities

- BH Link uses their participation in CIT training to build closer relationships with law enforcement
- Lots of CIT training
 - Law enforcement
 - District Attorneys supports
 - BH Link in communication with dispatcher
 - Corrections hosts
- NAMI CIT
 - Pat Strode keeps data about who has completed CIT training
- 24/7 mobile crisis services
- ACDC encourages families to ask for CIT officers when their family member is in crisis
- HOPE Program of Atlanta Police Department transports people off the street to services
- Law enforcement can contact the ACT Team's 24/7 crisis line if they know the person is served by an ACT Team
- Pre-arrest diversion, based in the Seattle Law Enforcement Assisted Diversion (LEAD) program, starts in July 2017
 - Two-year pilot
 - Started with a focus on people doing sex work
 - Focuses on behavior, not offense
 - Funding sources:
 - Open Society
 - Central Atlanta Progress
 - City of Atlanta
 - Fulton County
 - MacArthur Safety and Justice Challenge Grant
 - Public Defenders received this grant
 - Diversion program now in talks using of these funds to evaluate their program
- Faith-based organizations provide a variety of resources

- The Department of Community Supervision has Community Service Officers that work with the Atlanta Police Department to divert individuals
- Judge Downs requires her deputies to have CIT training
- Potentially, a state/county funded crisis unit with a primary focus on diversion

Intercepts 2 and 3: Court-Based Diversion/Jail Diversion



Fulton County Jail

- The Emory University Jail-Based Competency Restoration Program based in the jail restores competency to stand trial for incompetent defendants who require less intensive services than those provided in a forensic inpatient hospital unit or who can be diverted out of the criminal justice system into the mental health systems. NOTE: To be clear, this project is not a diversion program. Its aim is to restore competency so people can stand trial. It is a way to speed up the competency restoration process because of the long wait times to enter Georgia Regional for competency restoration.

Atlanta City Jail

- Grady provides clinical staff to evaluate and treat individuals who are screened as positive for Mental Illness. If hospitalization is necessary the individual is transferred to Grady.

Fulton County Courts

- The Office of the Public Defender holds a monthly Mental Health Collaborative Meeting with mental health providers to improve access to care/services for individuals in jail or in

treatment programs. The purpose is to remove barriers between community providers and the criminal justice system. The meeting is run by Kelly Prejean. It is an informal networking opportunity where particular cases, problems, and referrals are discussed.

- Emory University is conducting a Women’s Pilot Project in the Union City Jail in collaboration with the Magistrate Court and Grady. The purpose is to reduce the number of days in jail for female misdemeanor offenders with severe mental illness, who prior to the program were being released with no services. Individuals are sent to the Grady inpatient unit and followed by its Assertive Community Treatment team upon discharge.
- The Fulton County Magistrate Court Treatment Diversion Court is provided as part of the collaborative effort with the Fulton County Department of Behavioral Health and Developmental Disabilities (DBHDD). This program is designed to divert individuals arrested on misdemeanor offenses with a mental illness (and often co-occurring substance use disorders) in the pre-trial stage and prior to formal accusation in contact with the justice system from jail and to either connect or reconnect these individuals to community-based treatment and support services.
- The Fulton County Magistrate Court “Track B” is a jail-based program that results in misdemeanor cases being dismissed (over 85% dismissed), diverted to TDC, or proceeding as a typical case after the defendant’s competency is evaluated and/or restored. The program focuses on treatment and community supports for long-term improvements in lieu of competency restoration.
- Community Court is operated through the District Attorney’s Office, targeting mostly individuals with quality of life misdemeanor crimes. The DA is working to improve their service offerings to people with mental illness/substance abuse.
- The Superior Court’s Accountability Court Programs include:
 - Behavioral Treatment Court
 - Veterans Court
 - Adult Felony Court
- DUI Court is run by State Court.
- Public Defender’s Office/United Way Alternative Sentencing Initiative:
 - The Public Defender’s Office Alternative Sentencing Specialists (social workers) provide assistance to clients with substance abuse, medical, and/or various mental health problems. They receive placement requests from attorneys and the court to place clients in treatment facilities as soon as possible after arrest as an alternative to incarceration.
 - The referrals are instrumental in obtaining vital treatment and counseling for clients who, without such assistance, would otherwise remain incarcerated for longer periods of time.
 - Generally, placement providers of treatment programs are unwilling to accept clients of the Public Defender’s Office that do not have money for housing or other services upon entering their agencies.
 - The United Way has provided transitional housing services along with case management for seven to ten mental health clients of the Public Defender’s Office.

- A minimum of 30 to 40 inmates will receive mental health placements annually.
- The cost of housing mental health clients in this program is \$17.00 per day.
- United Way is currently developing a report on the progress and results of the individuals served.
- Fulton County has realized significant savings from the cost of housing and providing medical services at the jail while providing extensive community based services through the United Way for a fraction of the cost.
- Pretrial Services serves 1100 felony cases and 600 misdemeanors

Gaps/Challenges

- No detox alternatives besides what ACDC does
 - ACDC options: Send most intoxicated/not sure of specific substance to Grady “trip ticket” or dry out
- Process at ACDC is so fast that linkages with VA rarely happen
- Sometimes jail is used as a “gateway” to Gateway Center housing
- There are 15 to 17 cities in the county
- Fulton County Jail is the largest of three jails within the ACDC
- Police officers exercise discretion in where they take people
 - Processing through the Complaint Room can be time consuming
- The process from arrest to detention to initial hearing is complex
- There is a lack of data concerning persons in jail with SMI
- There is no formal Intercept 2 diversion other than the female pilot project and Magistrate Court’s Treatment Diversion Court and Track B calendar.
- Some key partners are not aware of the pilot project for females
- Staffing has been cut from the Treatment Diversion Court
- People coming into jail with SMI could benefit from ACT-like services if they aren’t linked to ACT already
- Individuals have to be able to cognitively participate in Pre-trial Services
- Repeat offenders who could benefit from treatment courts are not being referred to the courts for a multitude of reasons
- Intoxicated people cannot be booked into jail but instead go to Grady for medical clearance
 - Many refuse treatment when they are returned to jail
- There are gaps in communication between Municipal, Magistrate, State, and Superior Court
- State Court cannot send people anywhere - only process them through and give them a record
 - No resources to support the court for people served except DUI Court
- Multiple treatment courts
- Persons with severe mental illness stay in Fulton County Jail longer than persons without SMI

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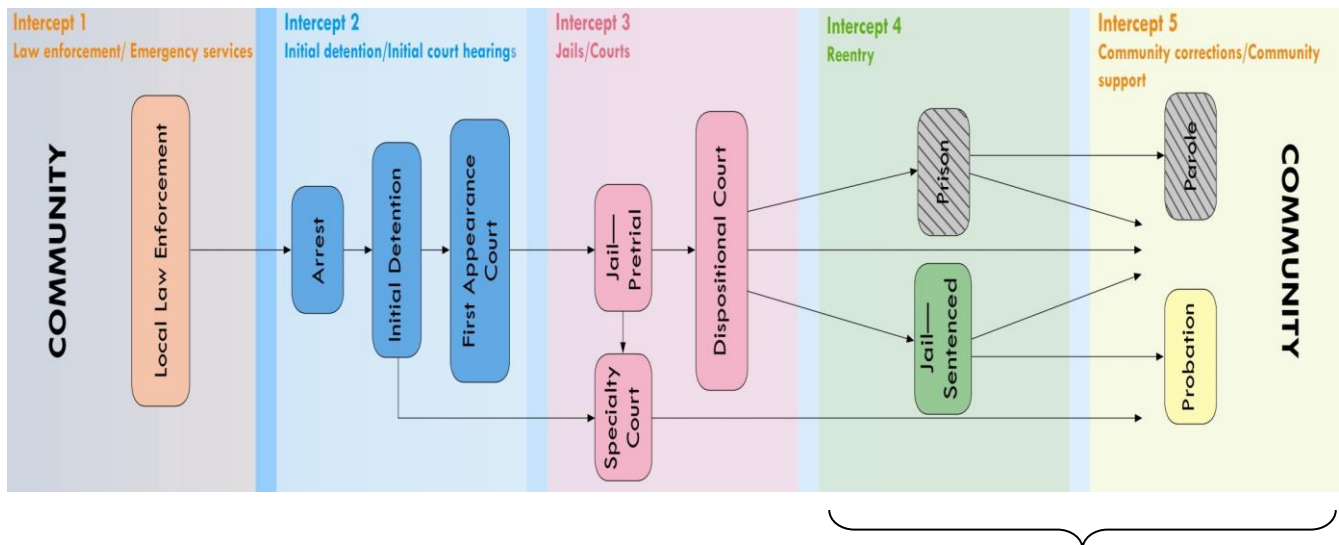
- Limited data on persons in jail with severe mental illness, co-occurring disorders, etc. --- need to “drill down” further
- Intake process can take 30 days or longer
- Need more effective screening on front end to get into treatment courts
- Capacity is limited in treatment court
- Misdemeanors from Municipal Court who are found Incompetent to Stand Trial access the same state hospital beds as those with felony charges with same long wait times
- Some refuse medication while in jail and are then found Incompetent to Stand Trial and end up in a state hospital beds
 - Could there be expanded mechanisms for involuntary medication while in jail in order to avoid the waiting list and time in state hospitals?

Opportunities

- Emory Pilot project diverting women with most severe mental illness and misdemeanor charges via magistrate court judge was started one year ago
 - 12 persons served so far but capacity is limited to available Grady resources.
- Magistrate Court Treatment Diversion Court provides a diversion mechanism for people with mental illness in pre-trial/pre-accusation stage
- Magistrate Court Track B Calendar could provide roadmap for structural changes to how misdemeanor competency is addressed
- ACDC screens for mental health and veteran status
- ACDC diverts psychotic individuals to Grady – “get them where they should be”
- DC Supervisor: Day Reporting Center works with forensic peers
 - Peers sometimes have faster access to crisis services/detox
- ACDC tries to provide stabilization
- Fewer people coming from ACDC to Fulton County Jail
 - Dual charges
- Public Defender Office interviews everyone prior to First Appearance
 - Allows them to talk to judge about community alternatives
 - Can link to treatment in jail
- Pre-trial Services screens everyone at Fulton County Jail eligible for First Appearance
- Screening for Accountability Drug Court, MH Court, and Veterans Court prior to First Appearance
- ACDC offers CIT training several times a year and opens it at no cost to other agencies
- Community Court works in high impact communities
- Fulton County Jail has a competency restoration program which serves approximately 75 people annually
 - Approximately 15 are served via an outreach effort into the jail’s general population; they receive psycho-education to support competency restoration
- Grady comes into ACDC four times a week to conduct a mental health clinic
 - They get people back on their psychotropic medication within one week

- Juvenile Courts that serve families have capacity/availability
- People coming into jail already being served by ACT teams receive strong support services by ACT team while in jail and effective assistance in transitioning back into community
- Public Defender’s Alternative Sentencing Unit also works on those found Incompetent to Stand Trial - felony cases only

Intercepts 4 and 5: Reentry and Community Supervision



- The Sheriff’s Office jail-based contract provider, Correct Care Solutions, has a Discharge Planning Unit and utilizes jail diversion coordinators. The unit receives referrals from jail staff, the booking unit, conflict defenders, public defenders, medical staff, judges, etc.
 - The diversion coordinators develop a discharge plan.
 - They present their findings and recommendations at the inmate’s hearing in the presence of the court staff and the presiding judge for the State/Magistrate Treatment Diversion Court and the Superior Court’s Behavioral Health Treatment Court.
- The Sheriff’s Office was awarded the Smart Reentry grant through DOJ.
- The Department of Community Services supervises 19,061 on probation/parole.
 - Two probation officers focus on persons with severe mental illness along with two mental health counselors and have 1:60 caseloads.
 - A mental health officer works at Day Reporting Center.

Gaps/Challenges

- It can take months for a person to get out of jail and into the state prison system's RSAT program for people with co-occurring disorders
- Grady prioritizes who comes to them by level of need; Since those coming from the jail to Grady are more likely to be stable, they are often prioritized lower
- More people could benefit from ACT Team services but restrictive criteria limit who can be served by ACT
 - Need proactive case management from community providers (like ACT provides) into the jail that engages and links individuals to community services upon release
- Probation officers are overloaded by both the high numbers of probationers - caseloads can be as high as 1:120 - and the special conditions placed on probationers
- Many probationers lack housing, mental health services, and transportation
- Valuable information gained during Intercepts 1 through 4 are not shared with Community Supervision
- Not enough housing options for those returning to the community and/or under Community Supervision
- Need to start process of accessing Medical Assistance and other benefits prior to release from jail
- Currently 365 in jail waiting for a community plan; cannot be released to Community Supervision until plan is developed
- Drastic reduction in Treatment Diversion Court (TDC) staff
- People can be released from the Fulton County Jail in the middle of the night
 - Many sit in the lobby until daylight
 - Fulton County Jail starts release at 4 a.m.; Most releases occur between then and 6 a.m. but releases can go into the afternoon
- Many jail inmates with mental illness are released without aftercare medication; Some are released with 4 days of aftercare meds
 - Some treatment court judges issue an order for 30 days of aftercare medication
- "Uncoordinated" releases
- It can take a long time before individuals released from the jail are connected to community mental health services
- In some cases an individual needs to be given the option of jail or community based mental health services (i.e. conditional release). However, most providers of mental health services do not favor the coercive nature of what some may consider "forced treatment". Thus, there needs to be more programs dedicated to specialize in treating this population whose motivation can solely be to avoid incarceration.

Opportunities

- Grady provides a full array of outpatient community services, perhaps the richest array in the state
 - With over 350 discharges a month from its crisis and inpatient services, Grady's outpatient services are dedicated to serving the most in need and reducing return hospitalizations.
- Grady has lowered their 30-day readmission rate from its crisis services from 26% to 4% by focusing on accessible and stronger community aftercare
- Grady helps with reentry to Grady services from city jail
- Strong Alternative Sentencing Unit in Public Defender's Office
 - Criminal Justice Coordinating Council recently gave them funding for new staff
 - Alternative Sentencing submits organized plans; person is transported with aftercare medication
- IDCP provides in-reach into jail and takes person to the community provider
- Jail will provide 30 days of aftercare meds if the judge issues an order
- Department of Community Services' goal is to have all their probation officers CIT trained
- Dept. of Community Supervision (DCS) connects to VA and Veterans Resource Center for their probationers who are vets
- DCS can modify probation order to facilitate access to community services
- DCS works with faith-based organizations
- Sheriff's Office has received a Smart Reentry Program grant
- Georgia Department of Prisons has forensic peer specialists
- Georgia Department of Prisons provides 30 days of aftercare medications

Cross Intercepts:

- As part of the Stepping Up Initiative, which Fulton County has formally adopted, the County is in the process of establishing the Justice and Mental Health Task Force.
 - The kick-off meeting was on 1/27/17.
- The Fulton County Board of Commissioners authorized the Justice Reinvestment Initiative in January 2016 to develop a system-wide plan to drive better outcomes across justice agencies.
 - A Justice Coordinating Council was created out of Justice Reinvestment and began meeting in August 2016 to collaboratively build Fulton County’s capacity to govern the justice system and move the Justice Reinvestment Plan forward.
 - There is a Mental Health and Reentry Subcommittee led by Kelly Prejean.
- There are various groups working on legislative changes.

Gaps/Challenges

- “Fragmented “system with many programs working in their “bubbles”
- Need to pull together resources and share them
- Not enough capacity - many programs addressing this population but there are significant gaps
- Lack of data sharing on commonly served persons across BH/CJ system partners
- Could benefit from a Judicial Coordinating Council
- Disincentives for treatment because people can get out of the justice system now, but increase likelihood of recidivism because they forgo treatment
- Some people with mental illness do not recognize their own mental health issues
- Local agencies can compete against each other for limited resources --- Can create “in-fighting”
- Lack of understanding what services Fulton County funds
- See some people over and over again
- Lack of cross-system coordination, collaboration, and communication across CJ/BH partners
- As state psychiatric hospitals have closed or reduced their capacity, individuals with mental illness end up in Fulton Emergency Rooms and jails since the capacity/funding has not been fully transferred to the community

Opportunities

- CJ Coordinating Council
- MH Collaborative Committee
- Participants in workshop could benefit from a contact list of all participants along with a brief description of the services they provide
- Institute of Government's role:
 - Facilitate committees, workgroups, taskforces, whatever
 - Compile data --- wrangle data and makes sense of it
 - Help Fulton County to apply for the next stage of funding
 - Build from this planning grant
 - This workshop as a "jump start"
 - Their point of contact: Tiffany and Kristin

Priorities for Change

Following the completion of the *Sequential Intercept Mapping* exercise, the workshop participants began to define specific areas of activity that could be mobilized to address the gaps and opportunities identified in the group discussion about the cross-systems map. Listed below are the priority areas identified by the workshop participants and the votes received for each proposed priority. All participants made **one top priority** vote and **two general votes**.

- ❖ Develop pre-arrest diversion strategies (13 first priority votes, 3 other votes = 16 total)
 - Screening
 - Expand detox options
 - One-stop
 - Goal of avoiding jail
- ❖ Expand housing options (7 first priority votes, 7 other votes = 14 total)
- ❖ Improve collaboration between the courts (3 first priority votes, 6 other votes = 9 total)
- ❖ Refine and expand reentry (2 first priority votes, 11 other votes = 13 total)
 - Expand community options
- ❖ Develop a coordinated database to provide better information sharing regarding individuals with behavioral health disorders in the justice system (1 first priority vote, 10 other votes = 11 total)
- ❖ Expand options for jobs, benefits, and other income supports (1 first priority vote, 6 other votes = 7 total)
- ❖ Expand treatment capacity for people not receiving appropriate treatment at the current time (2 first priority votes, 2 other votes = 4 total)
 - Intervene as early as possible after arrest
 - People falling through the cracks or misdirected to inappropriate treatment
- ❖ Better coordination of behavioral health training for law enforcement (2 first priority votes, 1 other vote = 3 total)
- ❖ Develop and expand evidence-based interventions provided by well qualified staff (1 first priority vote, 1 other vote = 2 total)
- ❖ Develop data across intercepts (4 other votes)
- ❖ Develop a more strategic approach to funding and planning services (3 other votes)
 - Consider utilization of the Criminal Justice Council

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- ❖ Develop a list of existing initiatives in Fulton County (1 other vote)
- ❖ Develop a more comprehensive strategic plan (1 other vote)
- ❖ Family reunification (no votes)

Action Plans

Moving Forward				
Objective	Action Step	Who	When	
Develop a report summarizing the work of the mapping workshop	✓ Draft of Action Plan	PRA to Kristin who will share with whole group	Next week	
	✓ Draft of Map		2 weeks	
	✓ Feedback to PRA		3 weeks	
	✓ Contact list	Kristin	Next week	
	✓ Draft of report	PRA to Kristin who will share with whole group		
	✓ Feedback to PRA			
	✓ Final report			
Fulton County Justice & Mental Health Task Force will lead going forward	✓ Task Force meets regularly over 9 months <ul style="list-style-type: none"> ○ Quarterly 	<ul style="list-style-type: none"> ● Judge Downs – chair ● Mental Health – Vickie ● Jail --- Chief A ● Commissioner – TBD ● All workshop participants will be part of Task Force 	Next meeting: End of May	
	✓ Subcommittees --- based on priorities and action plans developed by workshop participants			
	✓ Share a calendar of Task Force and subcommittee meetings and other standing meetings			● Kristin
	✓ Interim report			● Carl Vinson Institute of Government

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	<ul style="list-style-type: none"> ✓ Apply for a federal Bureau of Justice Assistance MH & Justice Collaboration Implementation grant 		
<p>Consider who else needs to be involved</p>	<ul style="list-style-type: none"> ✓ Law Enforcement <ul style="list-style-type: none"> ○ Including FCPD, APD, Sheriff’s Office, Sandy Springs PD, and others ✓ Private probation for State Court ✓ Business community ✓ More treatment providers <ul style="list-style-type: none"> ○ ACT Teams ✓ Statewide DBHDD, including Housing Director (currently vacant) and Addictive Services ✓ Prosecutors ✓ 911 ✓ County and City Management <ul style="list-style-type: none"> ○ Decision makers ○ Departments that provide grants and specific funding ✓ People who receive services/involved in justice system <ul style="list-style-type: none"> ○ Graduates of Accountability Courts ✓ Housing, including Housing Authority, private developers, 		

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	<ul style="list-style-type: none"> landlords, Atlanta Real Estate Collaborative ✓ Continuum of Care <ul style="list-style-type: none"> ○ Homeless Teams ✓ United Way ✓ Other judges <ul style="list-style-type: none"> ○ Magistrate Court Judge ○ City Court Judge ○ M.C. Chief Judge ○ Community Court 		
Generate buy-in from local, state, and federal funding sources	<ul style="list-style-type: none"> ✓ Mayor <ul style="list-style-type: none"> ○ \$25 m bond for housing ✓ City Council ✓ Board of Commissioners ✓ County and City Managers ✓ Community itself 		
Invest in and expand cross system collaboration			
Develop data to support these planning efforts			
Take advantage of May as National Mental Health Month			
Create a similar planning process for Juvenile Courts			

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❖ **Priority Area #1: Develop pre-arrest diversion strategies**

- Screening
- Expand detox options
- One-stop
- Goal of avoiding jail

Shedra Jones, Phenix Gaston-Ayers, Gwen Craddieth, Marshal Hodge, Andrew Taylor, Treva Jones, Rosalie Joy, Liz Markowitz, Shelly Spizuoco, Michael Claeys, Dr. Kelly Coffman, Kelly Prejean, Judge Patsy Porter

Objective	Action Step	Who	When
Develop working subcommittee of Task Force	✓ Call first meeting of the group	Shedra Jones	
Expand “divert to” options	<ul style="list-style-type: none"> ✓ Expand access to community resources instead of arrest ✓ Ensure community alternatives incorporate evidence-based practices ✓ Consider pursuing future DBHDD funding for a crisis stabilization unit <ul style="list-style-type: none"> ○ Requires significant collaboration at the local level 		
Develop buy-in with law enforcement	<ul style="list-style-type: none"> ✓ Explore: <ul style="list-style-type: none"> ○ Ride alongs ○ Citizen Academies 		
Identify and address “frequent utilizers”/”familiar faces”/”loyal customers”			
Build on new Prearrest Diversion Program	✓ Make it easy for law enforcement to participate		

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<ul style="list-style-type: none"> ▪ Based on Seattle Law Enforcement Assisted Diversion (LEAD) model ▪ Developing over past year ▪ July 1 start date 	<ul style="list-style-type: none"> ✓ Explore how to capture data for “non-events”; i.e., not being arrested <ul style="list-style-type: none"> ○ City of Atlanta Law Dept. working on forms now ✓ Continue to develop the network of services <ul style="list-style-type: none"> ○ List of resources/services funded/capacity/target population ○ Determine who will be lead treatment agency ✓ Consider: <ul style="list-style-type: none"> ○ How soon to intervene <ul style="list-style-type: none"> ▪ Social referrals vs. probable cause vs. Peace Officer ○ How voluntary <ul style="list-style-type: none"> ▪ Free to leave? ▪ Coerced treatment with safeguards ▪ Role of prosecutors/defense <ul style="list-style-type: none"> • Safeguards 		
<p>Explore possibility of building on Atlanta Police Dept.’s Project Hope</p>			
<p>Explore collaboration with 911</p>	<ul style="list-style-type: none"> ✓ Explore interventions with: <ul style="list-style-type: none"> ○ Frequent callers ○ Escalating crises 		
<p>Consider expanding Mental Health First Aid training to staff working at this intercept</p>			

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Integrate information about pre-arrest diversion resources/strategies into training opportunities	✓ Consider: <ul style="list-style-type: none"> ○ CIT training <ul style="list-style-type: none"> ▪ New CIT officers ▪ Experienced CIT officers ○ New officer orientation ○ Supervising officers <ul style="list-style-type: none"> ▪ Examine Miami-Dade CIT training approach ○ All officers 		
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Priority Area #2: Expand housing options.
 George Chidi, Kate Boccia, Mary Sidney-Harbert, Gwen Craddieth, Shedra Jones, Lynn Copeland, Marcus Carter, Kelly Prejean team

Objective	Action Step	Who	When
Develop working subcommittee of Task Force	✓ Call first meeting of group	George Chidi	
Develop list of housing resources	✓ Clarify: <ul style="list-style-type: none"> ○ Funder ○ Target population 		
Expand partnership with United Way			
Develop an in-county housing option			

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Develop and expand collaboration with other systems	<ul style="list-style-type: none"> ✓ VA ✓ DBHDD ✓ DCA ✓ HUD ✓ Housing Authorities ✓ Landlords ✓ Private developers <ul style="list-style-type: none"> ○ Build on work DCA and DBHDD are doing to reach out to developers ✓ City Government ✓ Atlanta Real Estate Collaborative ✓ DCP Reentry Housing Coordinators 		
Target expanded housing options for people leaving jail			
Explore the \$25 m housing bond to be matched by charitable contributions			
Address barriers to using housing vouchers			

Priority Area #3: Improve collaboration between the courts			
Judge Doris Downs, Marshal Hodge, LeNora Ponzio, Judge Belton, Violet Ricks, Phenix Gatson-Ayers, Bradley Jones, Omotayo Alli, Andrew Taylor, Judge Lillian Caudle Judge Cassandra Kirk, Liz Markowitz, Keith Lamar, Keith Gammage, Elaine McGruder			
Objective	Action Step	Who	When
Develop working subcommittee of Task Force	<ul style="list-style-type: none"> ✓ Call the first meeting ✓ Identify judges/staff working in this area who could be involved: <ul style="list-style-type: none"> ○ Chief J. Graves for City ○ In-custody judges: <ul style="list-style-type: none"> ▪ Herman Sloan ▪ Terrimee Gundy 	Judge Doris Downs	
Focus early collaboration on defining common goals	<ul style="list-style-type: none"> ✓ Consider framing in terms of Stepping Up Initiative 		
Consider using a mapping workshop to support discussion	<ul style="list-style-type: none"> ✓ identify: <ul style="list-style-type: none"> ○ Early pathways into justice system ○ Available behavioral health resources <ul style="list-style-type: none"> ▪ Limitations ○ Judicial resources 		

Priority Area #4: Refine and expand reentry

Violet Ricks, Felicia Pack, MonaLisa Newsome, Will Davis, Kelly Prejean, Rosalie Joy, Clinton Miles, Treva Jones, Charles Releford, Gwen Craddieth, Cassidy Crowder, Sharon Williams, Ida Thomas, Sheriff’s Smart Reentry initiative, Correct Care staff, Valencia Miller, social worker in Conflict Defender’s Office, Randy Sauls, Katy ?

Objective	Action Step	Who	When
Develop working subcommittee of Task Force	<ul style="list-style-type: none"> ✓ Call the first meeting ✓ 	Violet Ricks	
Inventory who is doing reentry	<ul style="list-style-type: none"> ✓ Including: <ul style="list-style-type: none"> ○ Georgia Prison Reentry Initiative ○ BH Treatment Court ○ MH Collaborative 	<ul style="list-style-type: none"> • Every other Friday 9 a.m. to 1 p.m. • 3rd Tuesday at noon (contact Kelly Prejean) 	
Ensure all people with mental illness receive “warm handoff” at release	<ul style="list-style-type: none"> ✓ Include: <ul style="list-style-type: none"> ○ Pick up at jail or ACDC ○ Gaps in aftercare medication ○ Explore use of long-acting injectables <ul style="list-style-type: none"> ▪ Grady using at ACDC ▪ Competency Restoration Program using ▪ Jails and prisons starting to use 		

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	<ul style="list-style-type: none"> more frequently at reentry ○ Consider Medication Assisted Treatment options 		
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Priority Area #5: Develop a coordinated database to provide better information sharing regarding individuals with behavioral health disorders in the criminal justice system

Phenix Gaston-Ayers, Renette Arnold , LeNora Ponzio, Carsandra Wiggins, Shedra Jones, Randy Sauls of Georgia DOC, Jonathan Tucker, Gwen Craddieth, Tange Johnson, Moki Macias, Bruce Taylor, Cory Beggs , Sue Jamieson

Objective	Action Step	Who	When
Develop working subcommittee of Task Force	✓ Call the first meeting	Phoenix	
Move beyond manual tracking			
Explore strategies for increased communication between jail based mental health provider (CCS) and community-based behavioral health providers			
Explore possibility of integrating with other databases	✓ Consider: <ul style="list-style-type: none"> ○ Pathways (Homeless Management Information System); specifically, Client Trac ○ Continuum of Care (COC) --- Catherine Marchman of City of Atlanta ○ Office of Administrative Courts 		

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Explore Health Information Exchange as a possible platform	✓ Include: <ul style="list-style-type: none"> ○ Cost ○ Design ○ Development 		
Address legal issues re information sharing			
Examine integrated database models	✓ Consider: <ul style="list-style-type: none"> ○ Local model: Dekalb MH Court ○ State examples: Texas, Illinois, Kentucky ○ Other localities: Pima County AZ 		
Also consider strategies to develop relevant aggregate data from a variety of data bases	✓ Build on Grady’s study on their high utilizers		

Recommendations

- Refine and strengthen the first draft of the action plan by reviewing the Gaps and Challenges along with the Resources and Opportunities developed during the mapping workshop and included in this report. Also, work to further refine the map developed during the workshop, especially the complex pathways in Fulton County from initial contact with law enforcement through the initial detention and initial hearings.
- As you plan for increased diversion alternatives at Intercept 1, consider the following suggestions:
 - Create a CIT Steering Committee involving partners from the hospitals, behavioral health, law enforcement agencies, 911 Communications, and advocates (NAMI, others) to meet regularly to review the ongoing development of CIT, review CIT calls, and see how well it is working to provide pre-booking diversion (track encounters, diversion numbers, arrests, etc.)
 - Continue to ensure that the front door of the system is user friendly for officers to make the drop off fast and easy
 - Consider use of Peers for follow up visits after a crisis
 - Determine who and how many individuals encounter law enforcement officers frequently and develop strategies to help them stay connected to treatment and reduce their repeated involvement with the criminal justice system
- Continue to build on the promising focus during the workshop on increasing attention to data collection and analysis at the intersection of your criminal justice and behavioral health systems.
 - The Carl Vinson Institute of Government is a significant resource to work with your county in improving data collection and analyses across intercepts.
 - The Stepping Up Initiative is strongly focused on the use of data to assist in lowering the numbers of people with mental illness in the jail. Take advantage of the resources on the Stepping Up website along with two or three relevant webinars each month that can benefit the work in Fulton County.
 - Montgomery County Pennsylvania has modified the four main Stepping Up goals to guide their county's efforts:
 - Reduce the number of people with severe mental illness admitted to jail
 - Reduce their length of stay while in jail
 - Increase their connections to community-based treatment and support upon release
 - Reduce their criminal recidivism
 - Consider developing similar goals for outcomes in Fulton County. It will help clarify and direct what data should be collected and how to use that data to further Fulton County's cross-systems efforts.
 - Creating a data match with information from local/state resources from time of arrest

to Pre-Trial can enhance diversion opportunities before and during the arraignment process. See below resources on Data Analysis/Matching and Information Sharing.

- Explore strategies to better coordinate the various Accountability Courts and diversion efforts in your county to more effectively and efficiently serve the needs of individuals involved in your justice system and expand access to community behavioral health services.
 - In recent years, the federal Substance Abuse and Mental Health Services Administration (SAMHSA) has funded grants supporting Behavioral Treatment Court Collaboratives (see <https://www.samhsa.gov/gains-center/grants-grantees/behavioral-health-treatment-court-collaboratives>). As a result, those counties have streamlined screening and assessment, enrollment, monitoring, and supervision practices in their jurisdictions.
 - See Appendix 6 for a description of a standardized triage process developed in one county.
 - Some of the learnings from that initiative include:
 - Judicial leadership is key
 - Regular meetings and close communication among the partners is necessary
 - Evidence-based practices take time to implement; Communities need a continuum of treatment resources
 - Paid peer staff can make a significant impact
 - Services and supervision need to effectively address co-occurring disorders
 - Flexibility and individual treatment/intervention plans are critical
 - Judge Steve Goss, Vice-Chair of the Council of Accountability Court Judges of Georgia, worked closely with SAMHSA’s GAINS Center in providing technical assistance to the grantees.
- Target strategies/interventions to address the arrest, incarceration, and re-arrest cycles of homeless individuals and other individuals that return to the healthcare and/or criminal justice system repeatedly.
 - The Center for Supportive Housing FUSE Resource Center describes supportive housing initiatives for super utilizers (frequent users) of jails, hospitals, healthcare, emergency shelters and other public systems. <http://www.csh.org/fuse>
 - Camden New Jersey has developed a promising collaboration of healthcare, social service, and law enforcement services to address their “complex care” populations that have frequent contact with their hospitals and sometimes police. They have been showing success in reducing repeated contact and improving health. <https://www.camdenhealth.org>
- Explore strategies to identify and link veterans involved in the justice system to appropriate services, including:
 - U.S. Department of Veterans Affairs’ Veterans Justice Outreach Program <https://www.va.gov/homeless/vjo.asp>

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- U.S. Department of Veterans Affairs Veterans Re-entry Search Service (VRSS): At the request of then-Secretary of Veterans Affairs (VA), Eric Shinseki, the Homeless Program Office developed an automated system called Veteran Re-entry Search Service (VRSS) to locate Veterans who are currently incarcerated in federal, state, city and county correctional facilities, or who are represented as defendants on court dockets. There are approximately 1,295 federal and state, 3,000 city/county correctional facilities, and 3,000 to 4,000 courts in the United States (US), but no automated method to identify charged, convicted, or incarcerated Veterans. Through comparison of records from Correctional Facilities and Court Systems and the Veterans Affairs/Department of Defense Identity Repository (VADIR), VRSS can be used to identify Veterans incarcerated or under supervision in the courts. Note: A record of military service is not the same as qualifying for benefits with the U.S. Department of Veterans Affairs. User Guide can be found at: https://vrss.va.gov/vrss_userguide.pdf
- Expand forensic peer support to promote recovery for justice-involved populations, from crisis-response strategies to reentry. Many communities have found that peer specialists with a personal history of involvement in the behavioral health and criminal justice systems have been effective in engaging individuals who have previously been unsuccessful in traditional behavioral health and/or criminal justice services. PRA recommends utilizing these services and also offers PRA Senior Project Associate LaVerne Miller as a resource for more assistance. Her contact information is below.

LaVerne D. Miller, Esq.
Policy Research Associates, Inc.
345 Delaware Avenue
Delmar, NY 12054
(518) 439-7415 x 5245
LMiller@prainc.com

- Consider screening for psychosis and thought disturbance symptoms with the young adult population throughout the intercepts.
 - First episode psychosis refers to when a person first shows signs of beginning to lose contact with reality. Early intervention can significantly change the course, severity, and length of illness an individual endures. The average age of first episode psychosis is between 18 and 24.
 - NIMH *Coordinated Specialty Care* overview.
 - University of Maryland Medical School *Maryland First Episode Clinic and Recovery After Initial Schizophrenia Episode (RAISE) Connection Program*
 - University of Massachusetts Medical School video. *Altering the Course: First Episode Psychosis Intervention*

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- Increase trauma training for justice involved personnel. Trauma training that specifically targets personnel involved in the criminal justice system addresses the unique issues related to traumatization and its impact on recidivism. This may be helpful in changing cultural attitudes and lead to increased diversion efforts. One example is the *How Being Trauma-Informed Improves Criminal Justice System Responses* training available through PRA and the SAMHSA’s GAINS Center (see http://gainscenter.samhsa.gov/trauma/trauma_training.asp). Also see below resources on Trauma-Informed Care.



RESOURCES

Crisis Care, Crisis Response, and Law Enforcement

- Substance Abuse and Mental Health Services Administration. [*Crisis Services: Effectiveness, Cost-Effectiveness, and Funding Strategies.*](#)
- Suicide Prevention Resource Center. [*The Role of Law Enforcement Officers in Preventing Suicide.*](#)
- Saskatchewan Building Partnerships to Reduce Crime. [*The Hub and COR Model.*](#)
- Bureau of Justice Assistance. [*Engaging Law Enforcement in Opioid Overdose Response: Frequently Asked Questions.*](#)
- International Association of Chiefs of Police. [*Improving Police Response to Persons Affected by Mental Illness: Report from March 2016 IACP Symposium.*](#)
- International Association of Chiefs of Police. [*One Mind Campaign.*](#)
- Optum. [*In Salt Lake County, Optum Enhances Jail Diversion Initiatives with Effective Crisis Programs.*](#)
- The [*Case Assessment Management Program*](#) is a joint effort of the Los Angeles Department of Mental Health and the Los Angeles Police Department to provide effective follow-up and management of selected referrals involving high users of emergency services, abusers of the 911 system, and individuals at high risk of death or injury to themselves.
- National Association of Counties. [*Crisis Care Services for Counties: Preventing Individuals with Mental Illnesses from Entering Local Corrections Systems.*](#)
- [*CIT International.*](#)

Data Analysis and Matching

- Data-Driven Justice Initiative. [*Data-Driven Justice Playbook: How to Develop a System of Diversion.*](#)

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- Urban Institute. [Justice Reinvestment at the Local Level Planning and Implementation Guide.](#)
- The Council of State Governments Justice Center. [Ten-Step Guide to Transforming Probation Departments to Reduce Recidivism.](#)
- New Orleans Health Department. [New Orleans Mental Health Dashboard.](#)
- Pennsylvania Commission on Crime and Delinquency. [Criminal Justice Advisory Board Data Dashboards.](#)
- Vera Institute of Justice. [Closing the Gap: Using Criminal Justice and Public Health Data to Improve Identification of Mental Illness.](#)
- Salt Lake County, Utah: [A County Justice and Behavioral Health Systems Improvement Project.](#)

Diversion --- Law Enforcement Assisted Diversion (LEAD)

- [The LEAD National Support Bureau.](#)
- [Law Enforcement Assisted Diversion \(LEAD\) in King County, WA.](#)

Engagement

- National Alliance on Mental Illness. [Engagement: A New Standard for Mental Health Care.](#)

Evidence-Based Practices

- SAMHSA’s GAINS Center. [A Checklist for Implementing Evidence-Based Practices and Programs for Justice-Involved Adults with Behavioral Health Disorders.](#)
- SAMHSA’s GAINS Center. [Forensic Assertive Community Treatment: Updating the Evidence.](#)
- SAMHSA’s GAINS Center. [Illness Management and Recovery.](#)
- SAMHSA’s GAINS Center. [Supported Employment for Justice-Involved People with Mental Illness.](#)
- SAMHSA’s GAINS Center. [Housing Options for Adults with Mental and Substance Use Disorders Involved with the Criminal Justice System.](#)

Families of Incarcerated Individuals

- Child Welfare Information Gateway. [Supporting Children and Families of Prisoners.](#)
- Annie E. Casey. [Children and families with incarcerated parents.](#)
- Youth.gov. [Children of incarcerated parents tools, guides, and resources for law enforcement, parents, caregivers, and providers.](#)
- RISE. [Ensuring the success of children with incarcerated parents program overview.](#)

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- NAMI California. [Arrested Guides and Inmate Medication Forms.](#)

Housing

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

Information Sharing

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

Jail Inmate Information

- NAMI California. [Arrested Guides and Inmate Medication Forms.](#)

Medication Assisted Treatment (MAT)

- American Society of Addiction Medicine. [The National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use.](#)
- American Society of Addiction Medicine. [Advancing Access to Addiction Medications.](#)
- Substance Abuse and Mental Health Services Administration. [Federal Guidelines for Opioid Treatment Programs.](#)
- Substance Abuse and Mental Health Services Administration. [Medication for the Treatment of Alcohol Use Disorder: A Brief Guide.](#)
- Substance Abuse and Mental Health Services Administration. [Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction \(Treatment Improvement Protocol 40\).](#)
- Substance Abuse and Mental Health Services Administration. [Clinical Use of Extended Release Injectable Naltrexone in the Treatment of Opioid Use Disorder: A Brief Guide.](#)

Mental Health First Aid

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

Peers

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

Pretrial Diversion

- CSG Justice Center. *[Improving Responses to People with Mental Illness at the Pretrial State: Essential Elements](#)*.
- National Resource Center on Justice Involved Women. *[Building Gender Informed Practices at the Pretrial Stage](#)*.
- Laura and John Arnold Foundation. *[The Hidden Costs of Pretrial Diversion](#)*.
- Haney, C., Johnson, J.K., Lacey, K., and Romano, M. *[Justice That Heals – San Francisco District Attorney's Office](#)*.

Procedural Justice

- Center for Alternative Sentencing and Employment Services. *[Transitional Case Management for Reducing Recidivism of Individuals with Mental Disorders and Multiple Misdemeanors](#)*.
- Hawaii Opportunity Probation with Enforcement (HOPE). *[Overview](#)*.

Public Defenders/Social Services Strategies

- Legal Aid Society Manhattan Arraignment Diversion project (MAP), the largest such program in the country with 90 social workers (<https://www.legal-aid.org/en/criminal/criminalpractice/map.aspx>) or contact Regina Schaefer, Director of Social Work for Legal Aid's Criminal Defense and Civil Practices, for additional information

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- [Shelby County Public Defender Jericho Project](#) or <https://www.facebook.com/JerichoMemphis/>

Main contact: Clifford Abeles, Shelby County, TN Public Defender’s Office (901) 222-2800

Reentry

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

Screening and Assessment

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

Sequential Intercept Model

- Munetz, M.R., and Griffin, P.A. (2006). [Use of the Sequential Intercept Model as an Approach to Decriminalization of People with Serious Mental Illness.](#) *Psychiatric Services*, 57, 544-549.
- Griffin, P.A., Heilbrun, K., Mulvey, E.P., DeMatteo, D., and Schubert, C.A. (2015). [The Sequential Intercept Model and Criminal Justice.](#) New York: Oxford University Press.

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- SAMHSA’s GAINS Center. [*Developing a Comprehensive Plan for Behavioral Health and Criminal Justice Collaboration: The Sequential Intercept Model.*](#)

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

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

- Information regarding [SOAR for justice-involved persons](#).
- The online [SOAR training portal](#).
- Additional information about [SSI/SSDI Outreach, Access, and Recovery \(SOAR\) in Georgia](#)

Transition-Aged Youth

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

Trauma-Informed Care

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

Veterans

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

Appendices

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- Appendix 1** Sequential Intercept Mapping Workshop Participant List
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- Appendix 2** Policy Research Associates. *The 21st Century Cures Act and the Sequential Intercept Model*.
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- Appendix 3** Dennis, D., Ware, D., and Steadman, H.J. (2014). Best Practices for Increasing Access to SSI and SSDI on Exit from Criminal Justice Settings. *Psychiatric Services, 65*, 1081-1083.
-
- Appendix 4** 100,000 Homes/Center for Urban Community Services. *Housing First Self-Assessment: Assess and Align Your Program and Community with a Housing First Approach*.
-
- Appendix 5** SAMHSA. *Reentry Resources for Individuals, Providers, Communities, and States*.
-
- Appendix 6** SAMHSA’s Adult Treatment Court Collaborative Evaluation. *Enhancing Specialty Courts through a Standardized Triage Process: Eau Claire, Wisconsin*.
-
- Appendix 7** Johnson, J.K. Ethical Issues for Defense Attorneys, Judges, Prosecutors (series of three briefs).

Appendix 1: Participant List

Participant	Agency	Email Address	Specific Division (if known or applies)	Title
Judge Doris Downs (CHAIR)	Superior Court of Fulton County Atlanta VA Medical Center	doris.downs@fultoncountyga.gov	* Veteran Justice Outreach Program	Superior Court Judge Veteran Justice Outreach Specialist
Byron Tinsley	Atlanta VA Medical Center	byron.tinsley@va.gov	Veteran Justice Outreach Program	Veteran Justice Outreach Specialist
Thindwia Cabiness	Behavioral Health Link Mobile Crisis Center	Thindwia.Cabiness@va.gov	Veteran Justice Outreach Program	Veteran Justice Outreach Specialist
Reinette Arnold	Carl Vinson Institute of Government	rarnold@ihrcorp.com	* Facilitation and Research	Community Collaborator Director
David Tanner	Carl Vinson Institute of Government	dtanner@uga.edu	Facilitation and Research	Director
Holly Lynde	Carl Vinson Institute of Government	lhlynde@uga.edu	Facilitation and Research	Fiscal Analyst
Sid Johnson	Carl Vinson Institute of Government	sidj@uga.edu	Facilitation and Research	
Lisa Maye	Carl Vinson Institute of Government	lisa.maye@uga.edu	Facilitation and Research	Project Coordinator
George Chidi	Progress	gchidi@atlantadowntown.com	* City of Atlanta Public Defender's Office Center	Social Impact Director Interim Director
Rosalie M. Joy	City of Atlanta	rjoy@atlantaga.gov		
Treva Jones	City of Atlanta	tjones@atlantaga.gov		
Andrew Taylor	Solicitor's Office	astaylor@atlantaga.gov	* Fulton County Jail	Deputy Solicitor
Clementine Wiggs	Solutions Correct Care	clwiggs@correctcaresolutions.com		Behavioral Health Manager
Donna Carter	Solutions	DSCarter@Correctcaresolutions.com	Jail Medical Services Office of the Director	Manager
Charles Releford	DBHDD	charles.releford@fultoncountyga.gov	Court	Manager
Clinton Miles	DBHDD	clinton.miles@fultoncountyga.gov		
Dr. Denis Zavodny	DBHDD	Denis.Zavodny@dbhdd.ga.gov	Statewide Hospital	Asst. State Director of Forensic Services
Dr. Don Hughey	DBHDD	don.hughey@dbhdd.ga.gov	Forensic Services	Forensic Director
Dr. Karen Bailey	DBHDD	karen.bailey@dbhdd.ga.gov		State Director

Gwen Craddieth <i>DBHDD</i>	Gwen.Craddieth@dbhdd.ga.gov	Region 3-Behavioral Health Field Office Misdemeanor Treatment Diversion	Regional Services Administrator Coordinator
Ida Thomas <i>DBHDD</i>	ida.thomas@fultoncountyga.gov		
MonaLisa <i>DCS Atlanta Day Newsome Reporting Center</i>	Monalisa.newsome@dcs.ga.gov		
Marcus Carter <i>Department of Corrections</i>	marcus.carter@dcs.ga.gov	Community Supervision *	Rehabilitative Health Counselor ADA
Keith Lamar <i>Office Public Defender</i>	keith.lamar@fultoncountyga.gov		
Tange Johnson <i>Office Emory School of Medicine, Psychiatry</i>	Tange.Johnson@fultoncountyga.gov	Community Court Jail-based Competency Restoration	Director
Victoria Roberts <i>Emory School of Medicine, Psychiatry</i>	vrober3@emory.edu	Program/Forensic Psychiatry	Associate Program Director
Dr. Kelly Coffman <i>Emory School of Medicine, Psychiatry</i>	kerwin@emory.edu	Psychiatry and Law Service	Director
Dr. Peter Ash <i>Medicine, Psychiatry</i>	pash01@emory.edu		Director
Violet Travis Ricks <i>Fulton County Conflict Defender's Office</i>	violet.ricks@fultoncountyga.gov	County Manager's Office	Officer
Marshall Hodge <i>Office</i>	marshal.hodge@gapublicdefender.com	Conflict Defender	Asst. Conflict Defender
Lt. Col Derrick Singleton <i>Fulton County Sheriff's Office Health Consumer Network</i>	derrick.singleton@fultoncountyga.gov	Jail Forensic Peer Specialists Training w/ DBHDD Behavioral Health	Lt. Col. Coordinator-Forensic Peer Mentor Project Executive Director
Sharon Williams <i>Health Intervention</i>	sltucker@gmhcn.org		
Michael Claeyes <i>Health Intervention</i>	mclaeyes@GMH.EDU		
Lola Swaby <i>Education Programs Juvenile Court of Fulton County</i>	lswaby@interventioned.com	*	President Behavioral Health Program Manager
Shelly Spizuoco <i>Mental Health America of Georgia Incarceration Association</i>	shelly.spizuoco@fultoncountyga.gov	Juvenile Court	
Jewell Gooding <i>America of Georgia Incarceration Association</i>	jewell@mhageorgia.org	*	Executive Director
Kate Boccia <i>Association</i>	kate@joinNIA.com	Communities for Justice Reform	CEO

Shedra Jones <i>Pre-Arrest Diversion Initiative</i>	shedra@prearrestdiversion.org	Pre-Arrest Diversion Project of Atlanta	Director
Elizabeth Markowitz <i>Public Defender</i>	elizabeth.markowitz@fultoncountyga.gov	*	Supervising Attorney
Kelly Prejean <i>Public Defender</i>	kelly.prejean@fultoncountyga.gov	Alternative Sentencing	Manager
Vernon Pitts <i>Public Defender</i>	vernon.pitts@fultoncountyga.gov	*	Public Defender
Walter Harris <i>Saving Our Society</i>	walterharris@yahoo.com	*	Executive Director
Monica Benning <i>Solicitor General</i>	monica.benning@fultoncountyga.gov	*	Asst. Solicitor
Mary Sidney- Harbert <i>Southern Center for Human Rights</i>	mskelly@schr.org	Impact Litigation Unit	Investigator/Paralegal
Judge Patsy Porter <i>County</i>	patsy.porter@fultoncountyga.gov	*	State Court Judge
LeNora Ponzo <i>County Superior Clerk of</i>	lenora.ponzo@fultoncountyga.gov	Clerk's Office	Administrator
Che Alexander <i>Fulton County Chief Judge</i>	che.alexander@fultoncountyga.gov	Clerk's Office	Chief of Court Bureau's
Gail Tusan <i>Superior Court of Fulton County</i>	gail.tusan@fultoncountyga.gov	*	Chief Judge
DeAndria Owens <i>Superior Court of Fulton County</i>	deandria.owens@fultoncountyga.gov	Accountabilty Courts	Therapist
Felicia Pack <i>Superior Court of Fulton County</i>	felicia.pack@fultoncountyga.gov	Pretrial Supervision	Pretrial Services Manager
Phenix Gaston <i>Superior Court of Fulton County</i>	phenix.gaston@fultoncountyga.gov	Accountabilty Courts	Accountability Court Interim Director
Will Davis <i>Superior Court of Fulton County</i>	will.davis@fultoncountyga.gov	Pretrial Intake District Court Administrator	Intake Manager District Court Administrator
Yolanda L. Lewis <i>United Way of Fulton County</i>	yolanda.lewis@fultoncountyga.gov	Commission on Homelessness	Director of Homelessness
Elizabeth Danley <i>Greater Atlanta Viewpoint Health</i>	EDanley@unitedwayatlanta.org	Reentry Services	Reentry Case Manager
Cassidy Crowder <i>Viewpoint Health</i>	cassidy.crowder@vphealth.org		

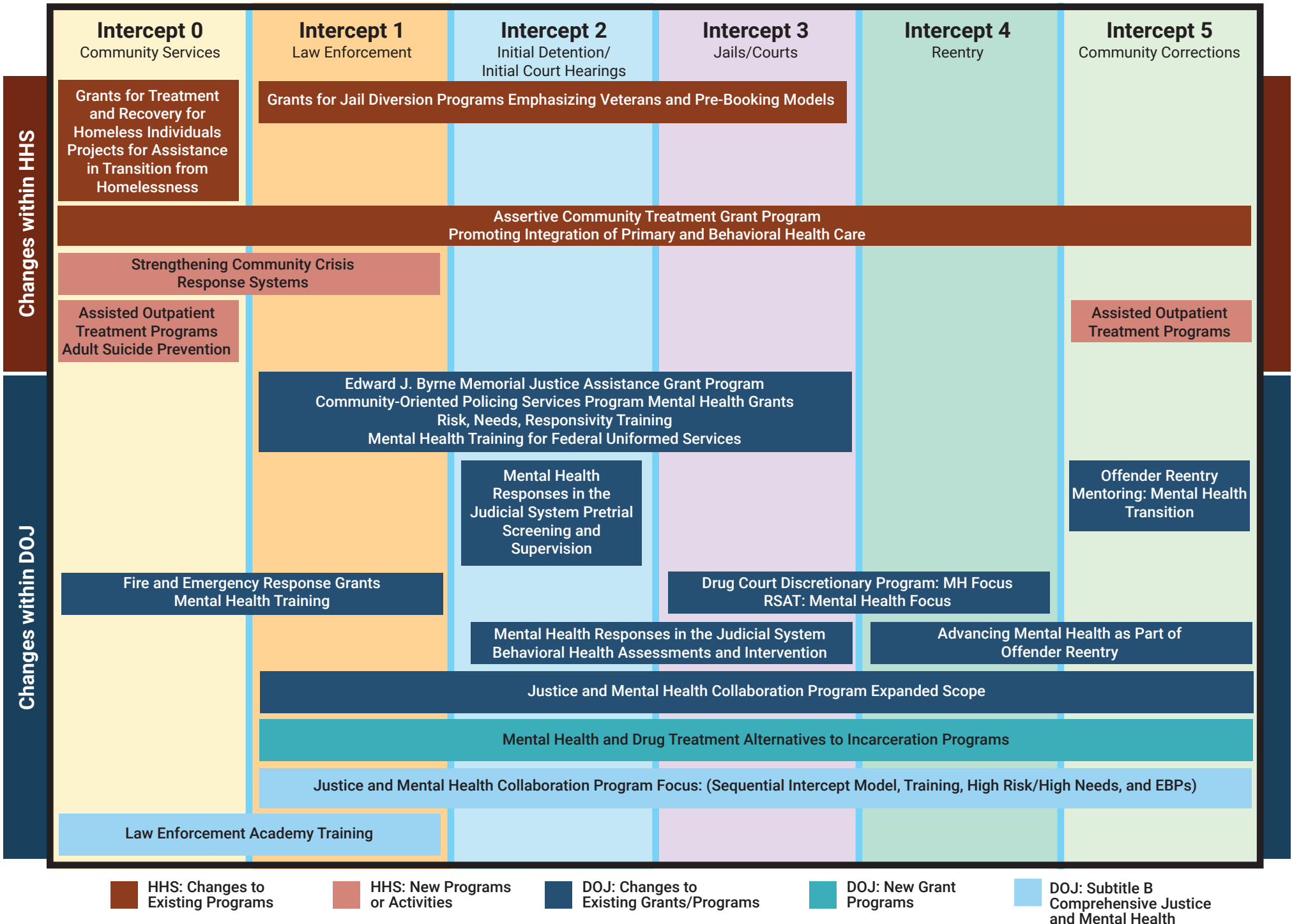
Overview	Workshop Day #1	Workshop Day #2
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Present Present	Present Present	Present Present
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Appendix 2:
21st Century Cures Act
and the SIM

The 21st Century Cures Act and the Sequential Intercept Model



HHS: Changes to Existing Programs

HHS: New Programs or Activities

DOJ: Changes to Existing Grants/Programs

DOJ: New Grant Programs

DOJ: Subtitle B Comprehensive Justice and Mental Health

**Appendix 3:
Best Practices for
Increasing Access to SSI
and SSDI on Exit from
CJ Settings**



SSI/SSDI Outreach, Access and Recovery

for people who are homeless

January 2013

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

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

Introduction

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

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

SOAR training can help local corrections and community transition staff negotiate and integrate benefit options with community reentry strategies

for people with mental illness and co-occurring disorders to assure successful outcomes. This best practices summary describes:

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

Mental Illness, Homelessness, and Incarceration

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

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

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

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

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

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

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

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

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

- In 2011 Sandra received SSI based on her mental illness. She was on probation, with three years remaining, when she violated the terms of probation by failing to report to her probation officer. As a result, Sandra was incarcerated in a state prison. Because she was incarcerated for more than 12 months, her benefits were terminated. Sandra received a tentative parole month of

September 2012 contingent on her ability to establish a verifiable residential address. The parole board did not approve the family address she submitted because the location is considered a high crime area. Unfortunately, Sandra was unable to establish residency on her own as she had no income. Thus, she missed her opportunity for parole and must complete her maximum sentence. Sandra is scheduled for release in 2013.

- Sam was released from prison after serving four years. While incarcerated, he was diagnosed with a traumatic brain injury and depression. Sam had served his full sentence and was not required to report to probation or parole upon release. He was released with \$25 and the phone number for a community mental health provider. Sam is 27 years old with a ninth grade education and no prior work history. He has no family support. Within two weeks of release, Sam was arrested for sleeping in an abandoned building. He was intoxicated and told the arresting officer that drinking helped the headaches he has suffered from since he was 14 years old. Sam was sent to jail.
- Manuel was arrested for stealing from a local grocery store. He was homeless at the time of arrest and had a diagnosis of schizophrenia. He was not receiving any community mental health services at the time. Manuel has no family. He was sent to a large county jail where he spent two years before being arraigned before a judge. His periodic acute symptoms resulted in his being taken to the state hospital until he was deemed stable enough to stand trial. However, the medications that helped Manuel's symptoms in the hospital weren't approved for use in the jail, and more acute episodes followed. Manuel cycled between the county jail and the state hospital four times over a two-year period before being able to stand before a judge.

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

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

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

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

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

Incarceration and SSA Disability Benefits

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

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

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

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

Role of Transition Services in Reentry for People with Mental Illness

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

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

Access to Benefits as an Essential Strategy for Reentry

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

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

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

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

The positive outcomes produced by SOAR pilot projects within jail and prison settings around the country that link people with mental illness to benefits upon their release should provide impetus for more correctional facilities to consider using this approach as a foundation for building successful transition or

reentry programs.¹⁰ Below are examples of SOAR collaborations in jails (Florida, Georgia, and New Jersey) and prison systems (New York, Oklahoma, and Michigan). In addition to those described below, new SOAR initiatives are underway in the jail system of Reno, Nevada and in the prison systems of Tennessee, Colorado, Connecticut, and the Federal Bureau of Prisons.

SOAR Collaborations with Jails

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

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

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

⁹ Dennis et al., (2011). *op cit*.

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

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

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

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

Prior to this pilot project, neither behavioral health care provider involved had assisted with SSI/SSDI applications for persons re-entering the community from the county jail. After participating in the pilot project, both agencies remain committed to continuing

such assistance despite the difficulty of budgeting staff time for these activities.

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

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

SOAR Collaborations with State and Federal Prisons

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

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

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

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

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

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

office where their release status is verified and their SSI/SSDI benefits are initiated.

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

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

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

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

- Collaboration
- Leadership
- Resources
- Commitment
- Training

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

¹¹ See <http://www.prainc.com/soar/criticalcomponents>.

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

- **Identify stakeholders.** Potential stakeholders associated with jail/prisons include
 - ✓ Judges assigned to specialized courts and diversion programs
 - ✓ Social workers assigned to the public defenders' office
 - ✓ Chief jailers or chiefs of security
 - ✓ Jail mental health officer, psychologist, or psychiatrist
 - ✓ County or city commissioners
 - ✓ Local reentry advocacy project leaders
 - ✓ Commissioner of state department of corrections
 - ✓ State director of reintegration/reentry services
 - ✓ Director of medical or mental health services for state department of corrections
 - ✓ State mental health agency administrator
 - ✓ Community reentry project directors
 - ✓ Parole/probation managers
- **Collaborate with SSA to establish prerelease agreements.** SSA can establish prerelease agreements with correctional facilities to permit special procedures when people apply for benefits prior to their release and will often assign a contact person. For example, prerelease agreements can be negotiated to allow for applications to be submitted from 60 to 120 days before the applicant's expected release date. In addition, SSA can make arrangements to accept paper applications and schedule phone interviews when necessary.
- **Collaborate with local SOAR providers to establish continuity of care.** Given the unpredictability of release dates from jails and prisons, it is important to engage a community-based behavioral health provider to either begin the SSI/SSDI application process while the person is incarcerated or to assist with the individual's reentry and assume responsibility for completing his or her SSI/SSDI application following release. SOAR training can help local corrections and community transition staff assure continuity of care by determining and coordinating benefit options and reintegration strategies for people with mental illness. Collaboration among service

providers, including supported housing programs that offer a variety of services, is key to assuring both continuity of care and best overall outcomes post-release.

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

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

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

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

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

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

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

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

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

Commitment. Developing and implementing an initiative to access SSI/SSDI as part of transition planning requires a commitment by the jail or prison's administration for a period of at least a year to see results and at least two years to see a fully functioning program. During the start up and early implementation period, competing priorities can often derail the best intentions. We have seen commitment wane as new administrations took office and the department of corrections commissioner changed. We have seen

staff struggle without success to find time to assist with applications as part of the job they are already doing. We have seen many facilities, particularly state departments of corrections, willing to conduct training for staff, but unwilling or unable to follow through on the rest of what it takes to assist with SSI/SSDI applications.

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

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

Conclusion

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

For More Information

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

Appendix 4:
Housing First Self-
Assessment

Housing First Self-Assessment

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

**100,000
HOMES**



HIGH PERFORMANCE SERIES

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

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

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

Housing First Self-Assessment

Assess and Align Your Program with a Housing First Approach

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

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

What is Housing First?

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

Why is this Toolkit Needed?

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

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

How Should My Community Use This Tool?

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

Who Does This Well?

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

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

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

Related Tools and Resources

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

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

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

Housing First Self-Assessment for Outreach Programs

1. Does your program receive real-time information about vacancies in Permanent Supportive Housing?

- **Yes** = 1 point
- **No** = 0 points

Number of Points Scored:

2. The entire process from street outreach (with an engaged client) to move-in to permanent housing typically takes:

- More than 180 days = 0 points
- Between 91 and 179 days = 1 point
- Between 61 and 90 days = 2 points
- Between 31 and 60 days = 3 points
- 30 days or less = 4 points
- Unknown = 0 points

Number of Points Scored:

3. Approximately what percentage of chronic and vulnerable homeless people served by your outreach program goes straight into permanent housing (without going through emergency shelter and transitional housing)?

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

Number of Points Scored:

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

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

Checked Five = 5 points

Checked Four = 4 points

Checked Three = 3 points

Checked Two = 2 points

Checked One = 1 point

Checked Zero = 0 points

Total Points Scored:

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

Total Housing First Score:

If you scored: 13 points or more

- ✓ Housing First principles are likely being implemented ideally

If you scored between: 10 – 12 points

- ✓ Housing First principles are likely being well-implemented

If you scored between: 7 – 9 points

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

If you scored between: 4 - 6 points

- ✓ Housing First principles are likely being poorly implemented

If you scored between: 0 – 3 points

- ✓ Housing First principles are likely not being implemented

Housing First Self-Assessment For Emergency Shelter Programs

1. Does your program receive real-time information about vacancies in Permanent Supportive Housing?

- **Yes** = 1 point
- **No** = 0 points

Number of Points Scored:

2. Approximately what percentage of chronic and vulnerable homeless people staying in your emergency shelter go straight into permanent housing without first going through transitional housing?

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

Number of Points Scored:

3. Indicate whether priority consideration for shelter at your program is given to potential program participants with following characteristics. Check all that apply:

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

Checked Five = 5 points

Checked Four = 4 points

Checked Three = 3 points

Checked Two = 2 points

Checked One = 1 point

Checked Zero = 0 points

Total Points Scored:

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

Total Housing First Score:

If you scored: 10 points or more

- ✓ Housing First principles are likely being implemented ideally

If you scored between: 6 – 9 points

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

If you scored between: 3 - 5 points

- ✓ Housing First principles are likely being poorly implemented

If you scored between: 0 – 2 points

- ✓ Housing First principles are likely not being implemented

Housing First Self-Assessment for Permanent Housing Programs

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

a) Active Substance Use

- Yes = 1 point
- No = 0 points

b) Chronic Substance Use Issues

- Yes = 1 point
- No = 0 points

c) Untreated Mental Illness

- Yes = 1 point
- No = 0 points

d) Young Adults (18-24)

- Yes = 1 point
- No = 0 points

e) Criminal Background (any)

- Yes = 1 point
- No = 0 points

f) Felony Conviction

- Yes = 1 point
- No = 0 points

g) Sex Offender or Arson Conviction

- Yes = 1 point
- No = 0 points

h) Poor Credit

- Yes = 1 point
- No = 0 points

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

- Yes = 1 point
- No = 0 points

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

2. Program participants are required to demonstrate housing readiness to gain access to units?

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

Total Points Scored:

3. Indicate whether priority consideration for housing access is given to potential program participants with following characteristics. Check all that apply:

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

Checked Five = 5 points

Checked Four = 4 points

Checked Three = 3 points

Checked Two = 2 points

Checked One = 1 point

Checked Zero = 0 points

Total Points Scored:

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

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

Checked Six = 0 points

Checked Five = 1 points

Checked Four = 2 points

Checked Three = 3 points

Checked Two = 4 points

Checked One = 5 point

Checked Zero = 6 points

Total Points Scored:

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

Total Housing First Score:

If you scored: 21 points or more

- ✓ Housing First principles are likely being implemented ideally

If you scored between: 15-20 points

- ✓ Housing First principles are likely being well-implemented

If you scored between: 10 – 14 points

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

If you scored between: 5 - 9 points

- ✓ Housing First principles are likely being poorly implemented

If you scored between: 0 – 4 points

- ✓ Housing First principles are likely not being implemented

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

1. Does your community set outcome targets around permanent housing placement for your outreach programs?

- Yes = 1 point
- No = 0 points

Number of Points Scored:

2. For what percentage of your emergency shelters does your community set specific performance targets related to permanent housing placement?

- 90% or more = 4 points
- Between 51% and 89% = 3 points
- Between 26% and 50% = 2 points
- 25% or less = 1 point
- Unknown = 0 points

Number of Points Scored:

3. Considering all of the funding sources for supportive housing, what percentage of your vacancies in existing permanent supportive housing units are dedicated for people who meet the definition of chronic and/or vulnerable homeless?

- 90% or more = 4 points
- Between 51% and 89% = 3 points
- Between 26% and 50% = 2 points
- 25% or less = 1 point
- Unknown = 0 points

Number of Points Scored:

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

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

Number of Points Scored:

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

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

Number of Points Scored:

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

- Yes = 1 point
- No = 0 points

Number of Points Scored:

7. Does your community have a Coordinated Housing Placement System or Single Point of Access into permanent supportive housing?

- Yes = 1 point
- Partial = ½ point
- No = 0 points

Number of Points Scored:

8. Does your community have a Coordinated Housing Placement System or Single Point of Access into permanent subsidized housing (e.g. Section 8 and other voucher programs)?

- Yes = 1 point
- Partial = ½ point
- No = 0 points

Number of Points Scored:

9. Does your community have different application/housing placement processes for different populations and/or different funding sources? If so, how many separate processes does your community have?

- 5 or more processes = 0 points
- 3-4 processes = 1 point
- 2 processes = 2 points
- 1 process for all populations = 3 points

Number of Points Scored:

10. The entire process from street outreach (with an engaged client) to move-in to permanent housing typically takes:

- More than 180 days = 0 points
- Between 91 and 179 days = 1 point
- Between 61 and 90 days = 2 points
- Between 31 and 60 days = 3 points
- 30 days or less = 4 points
- Unknown = 0 points

Number of Points Scored:

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

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

Number of Points Scored:

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

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

Number of Points Scored:

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

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

Number of Points Scored:

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

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

Number of Points Scored:

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

a) Active Substance Use

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

b) Chronic Substance Use Issues

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

c) Untreated Mental Illness

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

d) Young Adults (18-24)

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

e) Criminal Background (any)

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

f) Felony Conviction

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

g) Sex Offender or Arson Conviction

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

h) Poor Credit

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

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

- Over 75% = 5 points

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

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

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

Total Housing First Score:

If you scored: 77 points or more

- ✓ Housing First principles are likely being implemented ideally

If you scored between: 57 – 76 points

- ✓ Housing First principles are likely being well-implemented

If you scored between: 37 – 56 points

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

If you scored between: 10 – 36 points

- ✓ Housing First principles are likely being poorly implemented

If you scored under 10 points

- ✓ Housing First principles are likely not being implemented

Appendix 5: Reentry Resources



KEY ISSUE: REENTRY

REENTRY RESOURCES FOR INDIVIDUALS, PROVIDERS, COMMUNITIES, AND STATES

LEARN ABOUT SAMHSA REENTRY RESOURCES FOR:

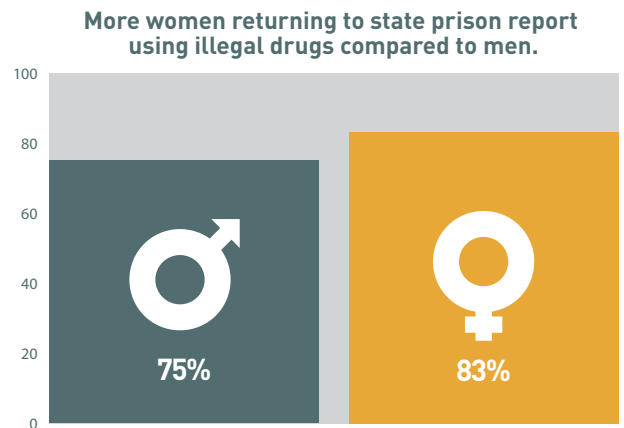
- Behavioral Health Providers & Criminal Justice Practitioners
- Individuals Returning From Jails & Prisons
- Communities & Local Jurisdictions
- State Policymakers

AT A GLANCE

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

The Office of National Drug Control Policy reports:

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



ISSUE DATE 4.1.16

Behavioral health is essential to health.

Prevention works.

Treatment is effective.

PEOPLE RECOVER.



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

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

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

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

SAMSHA RESOURCES

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



RESOURCES FOR BEHAVIORAL HEALTH PROVIDERS AND CRIMINAL JUSTICE PRACTITIONERS

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

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

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

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

Trauma Informed Response Training

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

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



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

SOAR TA Center

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

RESOURCES FOR INDIVIDUALS RETURNING FROM JAILS AND PRISONS

SAMHSA's Behavioral Health Treatment Locator

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

Self-Advocacy and Empowerment Toolkit

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

Obodo

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

SecondChanceResources Library

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

Right Path

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

RESOURCES FOR COMMUNITIES AND LOCAL JURISDICTIONS

Establishing and Maintaining Medicaid Eligibility upon Release from Public Institutions

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

Providing a Continuum of Care and Improving Collaboration among Services

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

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

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

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

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

SAMHSA's Offender Reentry Program

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

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

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

RESOURCES FOR STATE POLICYMAKERS

Behavioral Health Treatment Needs Assessment for States Toolkit

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

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

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



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<http://store.samhsa.gov/>



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Appendix 6: ATCC Evaluation

Innovations from the ADULT TREATMENT COURT COLLABORATIVE EVALUATION — GRANTEE CASE STUDY BRIEF

Enhancing Specialty Courts through a Standardized Triage Process

2014

The National Cross-Site Evaluation of the Adult Treatment Court Collaborative (ATCC) program was funded by SAMHSA to describe the strategies used by the 11 grantees to support infrastructure and community — level treatment system transformation to expand and enhance access to treatment for justice-involved adults with behavioral health conditions.

Case Study Methods

Sites were selected through an analysis of process evaluation site visit data, and the alignment of grantee features with ATCC program goals. Ultimately, four grantees were selected that exemplified an important aspect of the ATCC program: enhanced court and treatment collaboration through system structures; enhanced court and community collaboration through service practices; unified cross-court screening and referral processes; and enhanced court and program services through meaningful peer involvement. The data for the case studies were collected in June and July 2014 through in-person and telephone interviews with key stakeholders at the grantee sites. The goal of this document is to share key learnings from this first cohort of innovators with future ATCC grantees and the field.

Eau Claire County, Wisconsin

Eau Claire County Treatment Courts Collaborative

The Eau Claire County Treatment Courts Collaborative (ECCTCC) enhances four pre-existing specialized courts: the Drug Court, Mental Health Court, Alternatives to Incarcerating Mothers (AIM) Court and Veterans Court. The main goals of ECCTCC include: enhancing services by making evidence-based treatment available to all treatment court participants; expanding the population served to include a broader array of individuals with mental health diagnoses; and improving coordination among the four courts, such as through universal referral, screening and assessment procedures. Rather than referring participants to an individual treatment court, potential participants are screened and assessed for appropriateness for any of the courts by a multi-disciplinary Triage Team. Once enrolled, participants may be eligible for Integrated Dual Diagnosis Treatment (IDDT), Dialectical Behavioral Therapy (DBT), Thinking for a Change (T4C), and/or the Trauma Recovery and Empowerment Model (TREM), among other services. The focus for this case study is on Eau Claire County's universal referral, screening and assessment process, or Triage Process.

This case study addresses two of the primary goals of SAMHSA's ATCC initiative: to reach a wider population of court-involved adults with behavioral health needs than has traditionally been met through specialty courts; and to prevent and interrupt the cycle of offense and recidivism through diversion into appropriate treatment and services. Its purpose is to explore the ways in which Eau Claire County's universal referral, screening and assessment procedures affected access to services, impacted client and court outcomes, and strengthened collaboration across courts.

Court Procedures Prior to Implementing the Triage Process

Prior to receiving the ATCC grant, the four specialized courts in Eau Claire County had separate referral, screening and assessment procedures and policies. This was problematic for several reasons. First, each court had its own referral form, so potential referral sources had to assess which court would best serve their clients and complete the referral form for that specific court. Oftentimes, referral sources did not know which court was most appropriate, so they completed forms for multiple courts. Second, there was no standard for responding to referral sources with information about the outcomes of the referrals. Third, each court had different screening and assessment policies and tools. The process was inefficient and resulted in duplication of effort.

The Triage Process: Standardized Intake and Screening Procedures

The goal of the Triage Process is to centralize the referral process by creating standard guidelines and policies to better meet the needs of participants and the courts. This centralized process is more efficient and ensures that a participant is placed in the most appropriate court based on his/her needs.

Attorneys and other referral sources refer an individual to the Eau Claire County Treatment Courts by submitting a completed Treatment Court Referral Form. These forms are reviewed by a multi-disciplinary team during weekly Triage Team Meetings, using a standardized evaluation process to determine if a referred person is eligible and appropriate for one of the four treatment courts. Triage Team members include the Drug, Mental Health, and AIM Court Coordinators and representatives from the District Attorney's Office, Public Defender's Office, Sheriff's Department, the Department of Corrections (DOC), and Corporation Counsel (county legal services department). The former Veterans Court Coordinator initially served on the Triage Team; however, that role is currently vacant. The Triage Team reviews referrals as described below, and votes on the eligibility of and appropriateness of referrals for treatment court admission. The Project Director's role at Triage Meetings is to provide guidance on policy and procedures; she does not vote.

At the initial review, the District Attorney's representative helps determine the referred person's legal eligibility for each court, and Corporation Counsel advises on residency. Based on this and other preliminary information, the Triage Team determines the most likely treatment court designation and assigns a Lead Coordinator (one of the treatment court coordinators) to assume responsibility for coordinating the screening and assessment activities. If the Treatment Court Referral Form indicates that the individual does not meet preliminary criteria for any of the courts, the referral source is notified of the reason for denial through a Referral Disposition Form.

The Lead Coordinator is responsible for obtaining all releases and ensuring that the approved screening instruments are administered by the Assessment Coordinator (e.g., TCU Drug Screen II, Correctional Mental Health Screen (NIJ Mental Health), PTSD Checklist-Civilian (PCL-C), TCU Criminal Thinking Scales, University of Rhode Island Change Assessment (URICA) and Correctional Offender Management Profiling for Alternative Sanctions (COMPAS), a risk-needs assessment). In addition, the AIM Court Coordinator may administer the Women's Risk Needs Assessment (WRNA) to prospective female participants. The Lead Coordinator also may request other relevant records for prospective participants, such as mental health or substance abuse records. Once the Assessment Coordinator administers the screening and assessment tools, she sends a completed Screening Results Form with attached screens to the Lead Coordinator. Additionally, the Sheriff's Department representative determines whether any past convictions, pending charges or warrants may impact the individual's eligibility, and Corporation Counsel and the DA's representative also advise on eligibility and appropriateness of referred persons in relation to the violent offender restrictions imposed by the state Treatment Alternatives and Diversion (TAD) Grant.

The prospective participant is also required to observe a treatment court session to learn more about the process and determine his/her level of interest in participating. The Triage Team reviews the screening results and other applicable information as a group. A final decision regarding the individual's eligibility and appropriateness is reached by vote. The Assigned Coordinator notifies the referral source of the final determination via the Referral Disposition Form.

The individual is considered admitted after reviewing and signing the standard Participation Agreement, Release(s) of Information (ROI) and any other required documents. However, actual admission is determined by the sentencing judge or DOC. For example, the Triage Team may find a person eligible and appropriate for a treatment court, but the sentencing judge may choose to impose a prison term instead. Likewise, probation revocation by the DOC would make a person unavailable for treatment court participation.

Impact of the Triage Process

The Triage Process had a positive impact on many aspects of the Eau Claire County Treatment Court Collaborative (ECCTCC).

- ***The Triage Process does not leave*** decisions ***to a single individual or court***. It is a collaborative process with checks and balances; decisions are not made in a vacuum. The process facilitates an informed, integrated discussion with representatives from a variety of systems based on established policies and procedures. Greater consistency and clearer expectations are the result.
- ***Leadership embraced a consensus model of decision-making to facilitate collaboration***. The grant enhanced the overall level of collaboration among the key players. At Triage Meetings, everyone's comments are taken seriously and discussed. Individual team members understand that they have a forum to discuss their views and to voice their concerns. The team recognizes the autonomy of the different organizations at the table and helps break down walls between Treatment Court Coordinators. Through this process, the coordinators work together as a team in the best interest of the participant.
- ***The Triage Process is easier for participants to understand, does a better job matching participants to the appropriate court and treatment services, and participants have access to a full array of services***. The streamlined approach makes the referral process simpler and more efficient for referral sources. Using standardized screening and assessment tools provides a clearer picture up front of participant treatment and service needs,
- ***Success of the Triage Process relied, at least partially, on developing and cultivating commitment to the ATCC Collaborative Workgroup (CW) and the Implementation Team (IT)***. The CW provides broad project oversight and fosters collaboration among various system partners. The IT addresses project implementation needs and, along with several subcommittees, reports to the CW. Leadership believes that without commitment to these two groups, the Triage Process would have faltered. The grantee plans to continue the Workgroup and various subcommittees after SAMHSA funding ends, sustaining a venue for all players from various systems to collaborate on treatment courts operation. This is a testament to county stakeholders' long tradition of working together.

Key Lessons Learned

The grantee faced a range of challenges in implementing the new Triage Process. The ability to work through these challenges and keep the change process moving forward is a testament to the commitment and hard work of all those involved. Some key lessons learned included the need to clearly define the role of the Triage Team for stakeholders, key partners, and the general public; and to recognize the autonomy of treatment court judges and secure their buy-in.

The Triage Team is tasked with determining potential participants' eligibility and appropriateness for each court. The sentencing judge and DOC also play key roles in determining whether an individual will be admitted to a specialty court. Early in the process, there was a lack of clarity about the role of the Triage Team, and misunderstandings about responsibilities created some tension among court team members. Therefore, the Team is mindful of its role in the process and ensures that all parties have a clear understanding of the Team's role. Clarity about the Team's role may have helped judges and court team members understand that their responsibilities were not being usurped and may have mitigated misunderstandings. Educating attorneys, judges, referral sources, and other stakeholders about the process and its goals helped address this issue; continued education is necessary.

Not everyone will be engaged in the change process. Securing buy-in, particularly from judges, partially stems from education, but getting buy-in from all judges can be challenging. Although one court is not fully on board with the Triage Process, leadership did not let this inhibit their ability to make positive changes in the other treatment courts. Education and engagement efforts continue.

“One of the reasons it’s [The Triage Process] successful now is because of the buy-in from all of the partners...this came together probably easier in some ways than any other piece of the project, because I think everybody had a vested interest in improving efficiency and the effectiveness of the triage process.”

Advice to Other Courts

Involve major players from the beginning. Get buy-in from every office that is represented at the triage meetings. Buy-in from a single staff person carries little weight if (s)he leaves his/her position. You need more than one person from each system, department, or office to be knowledgeable about the process. Keep judges and other key leaders informed and solicit their input during systems change efforts.

It helps to have an outside facilitator brainstorm with a large group of stakeholders early on. Bring in someone who is not entrenched in local politics and allow yourself to be very open to a lot of thoughts and ideas before narrowing your focus. This is one way you can involve key players from the very beginning of the change process.

Develop training for various stakeholder groups on policy and procedures before implementing the Triage Process. This helped smooth the way for implementation and served as a clear kick-off for the process.

Place emphasis on your project as a treatment process rather than a court process. There has to be a real sense that the Triage Team serves the best interests of participants, not the individual treatment courts. If you identify your project as a court process, you run into complications related to due process and public record.

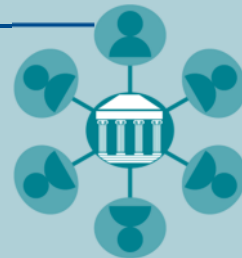
Have an integrated data collection system in place from the beginning. It is very important to have a working data collection system in place for quality improvement purposes, reporting, monitoring outcomes, and sharing information. Establishing standard outcome measures that all courts and providers collect and report on helps determine if you are meeting your goals, and can be used to demonstrate success for sustainability purposes.

The Triage Team should have voting members from all of the treatment courts. All courts should have equal representation on the Triage Team. In addition to each Treatment Court Coordinator, the other members of the Triage Team, such as representatives from the District Attorney’s Office, Public Defender’s Office, DOC, etc., should be associated with a variety of treatment courts.

CONTACT INFORMATION

Melissa Ives, Eau Claire County Project Director
integratedprojects@charter.net

Kristin Stainbrook, Ph.D., Cross-Site Evaluation Director
kstainbrook@ahpnet.com



Appendix 7: Ethical Issues Briefs

Ethical Issues for Defense Attorneys in Collaborative Courts

Jennifer K. Johnson, J.D.
San Francisco Behavioral Health Court

Critics of collaborative justice programs often claim that the roles of prosecutor and defense lawyer in a problem solving court are interchangeable. This is not the case. Having a shared goal in a treatment court does not mean that lawyers abdicate their traditional responsibilities or abandon their ethical duties.

Treatment courts take a longterm approach to both public safety and individual liberty by addressing the mental health and substance use disorders at the heart of so much criminal behavior. In this discussion, we focus on the role of the defense lawyer in a treatment court and highlight some of the challenges they face, particularly in courts that serve clients with serious mental illness.

First, a collaborative court cannot function without a team approach that involves sharing sensitive and confidential mental health information. Defense lawyers are not accustomed to sharing such information and are precluded from doing so by the attorney client privilege. Without clear and unequivocal agreements between the parties that shared information will not be used against a client in current or future criminal prosecutions, defense attorneys will be reluctant to participate.

Second, the coercive flavor of collaborative court programs goes against the ethical duties and the natural instincts of a criminal defense attorney. The idea that mental health courts are voluntary is often more fiction than fact—the choice between state prison and treatment in the community is hardly a choice. Client choice should be at the center of criminal defense practice and lawyers strive to find solutions that reflect a client’s autonomy.

Third, because of the widespread decimation of our mental health system, treatment in the community is scarce. It is not unusual for clients in need of dual diagnosis residential treatment beds to wait in jail for a vacancy in a program. This challenges the ethical duty of a defense attorney to find a solution with the least restriction on a client’s liberty. Without a tangible legal benefit from a longer stay in jail, courts will have difficulty convincing clients to stay in jail waiting for treatment.

Finally, treatment courts have the ability to use jail or the threat of jail as a therapeutic intervention. Incarcerating a person because they are showing symptoms of mental illness is the very definition of criminalization of the mentally ill. Defense lawyers are understandably reluctant to subject clients to the threat of incarceration for non-compliance with medication or for lack of insight into their mental health disorder.

Defense lawyers have a duty to “zealously advocate” for a client, to respect a client’s choice and to limit the time a client spends in jail or prison. However, they are often faced with a case resolution that will release a mentally ill client to the street with no access to treatment services and no structured plan. This virtually guarantees

failure and a return to the criminal justice system. Just as the prosecutor must consider the longterm safety of the public, defense attorneys should provide holistic representation and consider the longterm liberty interest of a client.

The courts and jails are inundated with people who, in another era, would have been treated for behavioral health conditions rather than left on the streets. The ethical duties of judge, prosecutor and defense attorney are being pushed to adapt to this new legal landscape so that our communities can provide just, humane and sensible solutions for clients with mental health and substance use disorders. Attorneys need to be aware of the ethical challenges that are part of this evolving criminal justice system.

Ethical Issues for Judges in Collaborative Courts



This article is the first in a series of articles focusing on legal ethics and therapeutic jurisprudence written by Jennifer Johnson, JD, of the San Francisco Office of the Public Defender. In this month's e-Newsletter we explore some of the challenges that judges face in collaborative court systems.

The ABA Model Code of Judicial Conduct sets the ethical standards for the judiciary. A judge must strive to maintain independence and impartiality, inspire confidence in the bench, and apply the law with integrity. The collaborative justice movement, now a central part of our criminal justice system, challenges those ethical responsibilities.

A collaborative court cannot function without broad information sharing, cross agency treatment planning, and individualized justice delivered in a non-adversarial courtroom setting. The essential elements of a treatment court may be at odds with the judge's traditional role in the courtroom and call into question the perception of judicial impartiality and independence. In this discussion, we highlight a few potential areas of concern for judges.

First, direct communication between a judge and a client—once unheard of in a criminal courtroom—is central to the success of a treatment court. The open dialog allows for a therapeutic relationship to develop between the judge and client. However, to the outside observer in a courtroom, the judge may not appear to be neutral. Beyond that, communication between the judge and defendant may bring up psychological issues of transference and counter transference that could affect a judge's neutrality. Second, many courts in this country operate on a "harm reduction" model with regard to substance abuse. While the long-term goal for each client is abstinence, courts and treatment programs may tolerate a certain amount of substance use on the way to that end goal. The judge is then in the awkward position of ignoring illegal behavior, condoning substance use, or allowing clients to appear in court under the influence. This conflicts with the judge's duty to apply the law and to maintain an atmosphere of dignity and decorum in the courtroom.

Third, in addition to dealing with clients that may be under the influence of substances, many courts treat people with serious mental illness. Courts cannot order clients to take medication, and people with mental illness have a right to refuse treatment. Often these clients are deregulated and exhibit symptoms of psychosis or mania in court. It may look like a judge is not maintaining proper decorum when, in fact, the judge is very appropriately navigating those symptoms of mental illness.

Finally, treatment courts are often the subject of media attention. Criminal courts have proactively stepped in to reverse decades of bad public policy that resulted in an era of mass incarceration in this country. The system is overwhelmed with people with mental illness, substance abuse problems, and other high social service needs that have become the focus of these specialized courts. The high visibility of these programs may unwittingly act as an external influence on a judge's impartial decision making. The collaborative justice movement is one of the most dynamic and hopeful areas of criminal law. What was once a novelty in the criminal justice system is becoming best practice as problem-solving courts proliferate throughout the country. In this changing legal landscape, judges are being asked to adopt a new role and should be aware of the ethical tensions that these collaborative programs necessarily invite.

Ethical Issues for Prosecutors in Collaborative Courts



This article is the second in a series of articles focusing on legal ethics and therapeutic jurisprudence written by Jennifer Johnson, JD, Criminal Defense Attorney in the San Francisco Behavioral Health Court. In this month's e-Newsletter we explore some of the challenges that prosecutors face in collaborative court systems.

According to the American Bar Association, the prosecutor in a criminal case has a duty to seek justice, not merely to convict. Our criminal justice system places great discretion in the hands of a prosecutor and with that discretion, tremendous power and responsibility. The role of the prosecutor is to serve the community, protect public safety, and punish criminal behavior.

Collaborative courts take a long term approach to public safety by addressing the mental health and substance use disorders at the heart of so much criminal behavior in our communities. The emphasis on treatment over incarceration redefines the roles of the lawyers in those courtrooms. In this discussion, we focus on prosecutors and highlight some of the ethical challenges they face, particularly in courts that serve clients with serious mental illness.

First, a collaborative court cannot function without a cross-agency, team approach with shared treatment goals for participants. Many criminal cases that are accepted into collaborative courts could easily be decided by a jury—a process that involves much less risk for the office of the prosecutor. In agreeing to an alternative court, the prosecutor must cede some decision making power and opt for a case disposition that gives deference to a treatment team.

Second, the decision to allow a person to participate in treatment in lieu of incarceration may go against the desire of a victim in a case. While a prosecutor is not bound by the wishes of a complaining witness, the public holds the office to a high standard. Ignoring the wishes of the very people the office seeks to protect invites both risk and criticism.

Third, many courts in this country operate on a “harm reduction” model with regard to substance abuse. While the long-term goal for each client is abstinence, courts and treatment programs may tolerate a certain amount of substance use on the way to that end goal. Although that may be in the best treatment interest of a particular person, it puts the prosecutor in the awkward position of turning a blind eye to illegal behavior in a public forum.

Finally, public safety is a primary concern for any prosecutor's office. Treatment courts, particularly mental health courts, are increasingly expanding eligibility criteria to include crimes of violence and felony charges. In agreeing to work with this population, the prosecution takes on additional risk. Why would a prosecutor support a collaborative court given the minefield of ethical issues outlined above?

The collaborative justice movement shows great potential for helping reverse decades of misguided criminal justice and mental health policy. Treatment courts represent an expanded view of the prosecutor's duty to the community and a recognition that public safety is enhanced when people with mental illness and substance use disorders have access to treatment. In this changing legal landscape, prosecutors are being asked to seek justice in a non-traditional way and should be aware of the ethical tensions that these collaborative programs necessarily invite.