SEQUENTIAL INTERCEPT MODEL MAPPING REPORT FOR SANTA CRUZ COUNTY, CALIFORNIA

Final Report
April 2019

Dan Abreu, MS CRC LMHC, Senior Project Associate
Jennifer Johnson, J.D., Senior Consultant

SAMHSA’s GAINS Center
Policy Research Associates
ACKNOWLEDGEMENTS

This report was prepared by Dan Abreu and Jennifer Johnson of Policy Research Associates, Inc., for SAMHSA’s GAINS Center for Behavioral Health and Justice Transformation. SAMHSA’s GAINS Center wishes to thank the Superior Court of California, Santa Cruz County, for organizing and hosting this event. SAMHSA’s GAINS Center also wishes to thank the Honorable Judge Paul Burdick, Honorable Judge John Salazar, and Collaborative Court Manager Katherine Mayeda for introducing and opening the workshop.

RECOMMENDED CITATION

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Introduction

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

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

On April 24-25, 2019, Dan Abreu and Jennifer Johnson of SAMHSA’s GAINS Center facilitated a Sequential Intercept Model Mapping Workshop for Santa Cruz County, California. The workshop was hosted by the Superior Court of California, Santa Cruz County, and was held at the Inn at Pasatiempo in Santa Cruz, CA. Approximately 54 representatives from Santa Cruz County participated in the 1½-day event.

The Honorable Judge Paul Burdick opened the workshop on April 24, 2019, with remarks regarding collaboration and partnership. He discussed the many challenges that Santa Cruz County has overcome, and also discussed how much work still needs to be done to improve services and decrease the number of people with mental and substance use disorders in the Santa Cruz County jails.

The Judge’s remarks were followed by a powerful and personal introduction to the workshop by Katherine Mayeda, the Collaborative Court Manager in Santa Cruz County. As the child of parents involved in the criminal justice system, Katherine’s passion and optimism for change served as a call to action for everyone in the room. She offered a vision that the system should be working for the people involved in it rather than against them, and that addressing the root causes of criminal behavior can and does change lives. She encouraged the group to focus on the goals of the workshop and posed a simple question: Where have we come and where are we going?

The Honorable Judge John Salazar opened the workshop on April 25, 2019, by honoring the community’s commitment to providing equal access to justice for those in need. While he acknowledged challenges such as funding, lack of housing, and lack of treatment beds, Judge Salazar reminded the group of the county’s firm commitment to interagency collaboration. He noted that when it comes to improving the
continuity of care for people with behavioral health challenges, the agencies represented in the room are “on the same page” and that Santa Cruz County has long supported problem solving courts. Santa Cruz County is the recipient of multiple awards for innovative programs and is part of the Stepping Up Initiative to reduce the numbers of people with mental illnesses in local jails. According to Judge Salazar, what the county needs is an action plan to better deliver justice.

Santa Cruz County has a proud tradition of working collaboratively across agencies and rallying together to solve problems in the community. The county has shown leadership in justice reform at both the juvenile and the adult levels. The workshop provided stakeholders an opportunity to look critically at their systems, to acknowledge gaps, and to create a path forward.
Background

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

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

The Sequential Intercept Mapping workshop has three primary objectives:

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

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

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

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Agenda (Day 1)

Sequential Intercept Mapping Workshop
Santa Cruz County, CA
April 24, 2019

AGENDA

8:30  Registration and Networking

9:00  Openings
- Welcome and Introductions
- Overview of the Workshop
- Workshop Focus, Goals, and Tasks
- Collaboration: What’s Happening Locally

What Works!
- Keys to Success

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

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

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

Wrap Up
- Review
- Setting the Stage for Day 2

4:30  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 Workshop

Santa Cruz County, CA
April 25, 2019

AGENDA

8:30  Registration and Networking

9:00  Opening
• Remarks
• Preview of the Day

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

Action Planning
Finalizing the Action Plan

Next Steps
Summary and Closing

12:00  Adjourn

There will be a 15 minute break mid-morning.
Sequential Intercept Model Map for Santa Cruz County
Resources and Gaps at Each Intercept

The centerpiece of the workshop is the development of a Sequential Intercept Model map. As part of the mapping activity, the facilitators work with the workshop participants to identify resources and gaps at each intercept. This process is important since the criminal justice system and behavioral health services are ever changing, and the resources and gaps provide contextual information for understanding the local map. Moreover, this catalog can be used by planners to establish greater opportunities for improving public safety and public health outcomes for people with mental and substance use disorders by addressing the gaps and building on existing resources.
INTERCEPT 0 AND INTERCEPT 1

INTERCEPT 0/1 RESOURCES

Crisis Lines

- United Way of Santa Cruz County operates 2-1-1 Santa Cruz County and staff are available 24/7 to provide information and referrals (Dial 211).
- Monarch Services operates a bilingual crisis line and staff are available 24/7 to talk confidentially regarding domestic violence, sexual assault, or human trafficking (Dial 1-888-900-4232).
- Family Service Agency of the Central Coast operates a multilingual suicide crisis line and staff are available 24/7 to provide support to individuals experiencing suicidal crisis or emotional distress (Dial 1-877-663-5433).
- The National Suicide Prevention Lifeline is also available 24/7 to provide support to individuals experiencing suicidal crisis or emotional distress (Dial 1-800-273-8255).
- A National Veterans Crisis Line is also available 24/7 and is staffed by the Veterans Administration Crisis Responders that specialize in supporting Veterans who are experiencing crisis (Dial 1-800-273-8255 and Press 1).

Mobile Crisis Response

- Santa Cruz County Behavioral Health operates a Mobile Emergency Response Team (MERT) that is able to assist individuals experiencing a serious mental health crisis. The team operates
Monday through Friday, from 8 a.m. to 5 p.m. and can be reached by calling 1-800-952-2335. There is an answering service that links callers to 911 during after-hours.

Law Enforcement and First Responders

- A Crisis Intervention Team (CIT) training program exists through a partnership between law enforcement and behavioral health that involves training for law enforcement officers on de-escalation skills and promotes officer safety while ensuring the safety of the individual experiencing a crisis. There are 200 law enforcement officers that have been trained in the county.
- A Mental Health Liaisons to Law Enforcement program has Mental Health Clinicians embedded within three law enforcement agencies in the county to provide co-response.
  - The following three jurisdictions have Mental Health Liaisons:
    - The Santa Cruz County Sheriff’s Office has two Mental Health Liaisons that work seven days per week from 8 a.m. to 7 p.m.
    - The Santa Cruz Police Department has a Mental Health Liaison that works seven days per week from 8 a.m. to 7 p.m.
    - The Watsonville Police Department has a Mental Health Liaison that works five days per week from 8 a.m. to 7 p.m.
  - Services can be requested by calling 911.
  - Referrals to mental health treatment providers for follow-up appointments are provided.
- Emergency Medical Services (EMS) will provide transport to the hospital if needed.
- Law enforcement is available to assist EMS with warm handoffs to hospital/crisis staff.

Crisis Care Continuum (see attachment)

- Crisis care referrals can be self-referral or 911 dispatch/law enforcement referral, including involuntary psychiatric care when it is determined that an individual meets Welfare and Institutions code 5150 criteria.
- Santa Cruz Behavioral Health operates a Crisis Stabilization Program
  - Each stay cannot exceed 24 hours.
  - There are 12 crisis beds available.
  - The program provides crisis assessments, interventions, and referrals.
  - The turnaround time for law enforcement officers is 15 minutes.
  - The program can provide adolescent beds when necessary.
- The Santa Cruz Behavioral Health also operates a Psychiatric Health Facility. The Psychiatric Health Facility is a 16 bed locked psychiatric inpatient treatment facility that serves individuals 18 and older who a serious mental health crisis.
- Encompass Telos Services operates a short-term crisis residential program that serves as a diversion to psychiatric hospitalization for individuals in crisis. There are 10 beds available.
- Santa Cruz Behavioral Health provides walk-in crisis services for adults and children Monday through Friday, from 8 a.m. to 5 p.m.
• Janus of Santa Cruz operates a detox Program that has 16 beds and accepts both insurance and private pay clients. Approximately 70% receive detox services through Medi-Cal and 30% are private pay.
• Janus of Santa Cruz also operates a Sobering Center.
  o Each stay cannot exceed 24 hours, and the average length of stay is five to seven hours.
  o There are 10 beds available.
  o The program provides discharge planning and referral to services.
  o The program is contracted through the Santa Cruz County Sheriff’s Office.
• The Watsonville Community Hospital Emergency Department is utilized for crisis stabilization for individuals located in the southern portion of the county.
• There is a Homeless Outreach Proactive Engagement Services (HOPES) multidisciplinary team.
• There is a Joint Powers Agreement (JPA) public/private partnership.
• There is a joint county regional center.

**Hospitals and Healthcare**

• The primary hospitals in the county are Dominican Hospital and Watsonville Community Hospital. Both hospitals have Emergency Rooms/Departments.
• There are Urgent Care services available that are operated by Sutter Health, Kaiser, and Doctors On Duty.
• The Santa Cruz Behavioral Health Access Team evaluates all requests for non-emergency services for anyone not currently receiving services from County Mental Health or community providers who are part of the mental health system. The Access Team is comprised of bilingual mental health clinicians and psychiatrists who conduct assessments, determine eligibility, and provide referrals.
• Santa Cruz County Integrated Behavioral Health (IBH) is a multidisciplinary team that seeks to bridge the gap between physical and behavioral health.
• The Palo Alto Medical Foundation (PAMF) is a medical group associated with Sutter Health that has physicians and patients throughout the county.
• The Homeless Persons Health Project (HPHP) Provides comprehensive health care and housing in an effort to eliminate homelessness in the county.
• Salud Para La Gente provides health care services in Watsonville.
• The East Cliff Family Health Center is available to serve the primary health care needs of adults and children.
• The Walnut Avenue Family and Women’s Center provides support and services to women, children, and families.
• Planned Parenthood operates a Westside Health Center in Santa Cruz.

**Residential Treatment**

• An overview of residential treatment facilities in Santa Cruz County is included in Appendix 3.
Collection and Sharing of Data

- Santa Cruz County and all contracted providers utilize a universal electronic medical record system called Avatar for shared treatment needs. The system is not easy to pull data from for analysis.
- Probation utilizes an electronic referral system for AB109 data.
- High users of mental health services are the subject of data collection by several providers, but there has been no analysis of all of the data that has been collected.
- HOPES data is collected to evaluate the homeless population.
- Quarterly data reports are prepared for co-responder teams.
- Health Improvement Partnership (HIP) is working with County Whole Person Care to develop a universal consent form and data sharing system for health care, substance use, and mental health. The collaborative courts are working to incorporate it in the criminal justice system.

INTERCEPT 0/1 GAPS

Crisis Call Lines

- Information about the crisis lines is not well known by the community.
- There are no established protocols between the crisis lines (i.e. suicide prevention calls 911).
- There is a high volume of mental health related calls and a high need for services.

9-1-1/Dispatch

- There is a need for CIT training for dispatchers.
- There is no designated CIT code for law enforcement officers.
- There is no specific CIT Code or recoding a call as a CIT call after a call is completed.
- Mental health calls are coded as “emotionally disturbed person” calls.

Healthcare

- The north county emergency rooms are over burdened with mental health visits.
- There is an overall lack of services in the south county.
- There are limited bilingual services.

Law Enforcement (LE) and First Responders

- Law enforcement officers need a place to take people when they are experiencing crisis.
- The MERT could benefit from more staff and better technology.
- The Mental Health Liaison to law enforcement program in Watsonville needs to be expanded.
  - The after-hours response is often not as effective and may result in the use of force, and more challenging situations.
  - After-hours guidance is needed for law enforcement officers responding to calls.
  - More staff/coverage is needed.
Because of the location, transportation time is lengthy and requires officers to be occupied for long periods of time.

The after-hours mental health response by law enforcement experiences a different call demand. The Safety of Mental Health Liaisons is implicated.

- Emergency Medical Services (EMS) staff are not CIT trained, and do not do medical clearance.
- Law enforcement lacks understanding of the law regarding involuntary commitment holds.
- There are gaps in services for law enforcement officers who are in crisis, and their families.

**Crisis Care Continuum**

- There are not enough detox beds to meet demand.
  - The beds are all full the majority of the time.
  - Medi-Cal beds are very difficult to access.
  - Medi-Cal plus mental health beds not accessible at all.
  - More cross training is needed in this area.
- The Behavioral Health Psychiatric Health Facility has some issues that need to be addressed.
  - There are inpatient capacity issues.
  - There are no services for the child/adolescent population.
  - It is rare that law enforcement will utilize the center.
  - Referrals from jail are told that everyone needs medical clearance, so they are not accepted.
  - What options are available for individuals who don’t meet 5150 criteria?
- There is no Assisted Outpatient Treatment (AOT) Program
- Santa Cruz Behavioral Health needs to educate community members on what they do collaboratively in the community.

**Housing**

- There is a major housing need in the county.
- The county is facing some “Not in My Backyard” issues.
- Need transitional housing options apart from SLEs so that people are not remanded and waiting for treatment in jail.
- Need harm reduction friendly housing.
  - Nearly all SLEs are abstinence only.
  - SLEs don’t have enough staff and are struggling.
  - The capacity of SLEs has gone down.
  - Need longer period for stability (Super SLE).
  - No training for SLE staff on medication management and mental illness.
  - Some SLEs don’t accept people who are receiving Medically Assisted Treatment (MAT) or mental health medication.
Peer Support

- Peer support is not evident across the continuum, and although it is embedded in the reentry process there is a lot of room for improvement in this area. In order to expand peer support services it will be important to ensure that individuals providing peer support are valued and compensated appropriately.

Collection and Sharing of Data

- Data comparing high utilizers throughout the community is not cross referenced to criminal justice data points.
- There is some information tracking around mental health but not enough.
- There are no data collected in the jail for people with a mental health disorder unless they are already a county mental health beneficiary.
- The data collected throughout the county do not include criminal justice involvement.
INTERCEPT 2 AND INTERCEPT 3

INTERCEPT 2/3 RESOURCES

**Booking**

- The booking staff conduct preliminary screening for any medical or mental health issues.
- Individuals who are Veterans are identified at booked by self-reporting.
  - A relationship exists with the local Veterans Justice Outreach Specialist.
  - There is also a Veteran liaison position.
- The booking information is matched with Santa Cruz Behavioral Health records.
- An individual’s Electronic Health Record provides a snapshot of their behavioral health treatment history.

**Jail Structure and Personnel**

- Santa Cruz County has four jail facilities and a total in-custody population of 490 men and women.
  - The Santa Cruz Main Jail houses 337 individuals.
  - The Blain Street Women Facility houses 18 women.
  - The Roundtree Medium Facility (which is located in South County) houses 75 individuals.
  - The Rehabilitation and Reentry Facility or R&R (also located in South County) houses 60 individuals.
There are approximately 136 individuals in the jail facilities who are receiving psychiatric medications.

Approximately 68% of women in the jail facilities have a mental health diagnosis and the majority of them are receiving psychiatric medications, however limited treatment programming is available in the jail facilities.

Santa Cruz County Sheriff’s Office provides staff for the jails. All jail staff receive a one-hour mental health training and two hour suicide prevention training. Some staff have also received CIT training.

Jail Healthcare is private and separate from mental health (California Forensic Medical Group, CFMG).

Mental Health Unit (O Unit)
- Staffed by specially trained officers.
- For individuals with acute mental health needs.
- 24-hour isolation protocols are followed.
- Administrative Restricted to Cell (RTC) policy.
- 12 watch rooms and 1 safety room are available (13 beds total).
- Individualized treatment plans.
- Medication is voluntary unless an individual is found Incompetent to Stand Trial and ordered to involuntarily take medication by the court.
- There are additional opportunities for programing at Roundtree and the R&R facility.

Jail Services
- Santa Cruz Behavioral Health (SCBH) provides mental health services at the jail.
- 2.25 full time psychiatric positions exist to handle prescribing medications.
- Jail Formulary:
  - The formulary is specific with some exceptions.
  - SCBH does influence formulary exceptions.
  - SCBH tries to maintain consistency with outside medications.
  - Medication is provided at the time an individual is released if jail staff know when an individual is being released in advance.
- SCBH has electronic health record access at the jail to review an individual’s treatment history in the community.
- SCBH has a formal screening tool for substance use screening and suicide screening that is used for all individuals coming into custody by medical and corrections staff, and the information is passed onto SCBH staff for further assessment.
- Mental health staff assess anyone who is referred or screened positive for mental health concerns.
- Medication Assisted Treatment (MAT) is available in the jail.
  - Methadone (JANUS) can be provided for people who are already receiving methadone when admitted, but if someone will be incarcerated for a long period of time they will be titrated off.
Vivitrol shot inductions are only provided for the AB109 population.
- Daily jail meetings with SCBH occur seven days per week.
- Law Enforcement Mental Health Liaison has good communication with the SCBH staff in the jail.
- There is integration of mental health and substance use treatment services.
- SCBH has integrated behavioral health (for individuals with mild to moderate needs) and physical health that is provided at and Integrated Behavioral Health (IBH) clinic.

**Competency**

- The new Mental Health Diversion program received a grant to begin treating the incompetent to stand trial population locally, and not sending a portion of the population to the state hospital.
- The court contracts with three outside forensic psychologist for competency evaluations and reports.

**Pre-trial Services**

- A Focused Intervention Team (FIT) habitual offender program exists.
  - It is a pilot program.
  - For the purposes of the program individuals are considered habitual offenders when they have three or more 647(f), recent arrests or a pattern or arrests, and resistance to intervention. Also misdemeanants with aggressive tendencies.
  - 30 individuals classified as habitual offenders were identified initially.
- The results of the pretrial assessment after booking (PSA Arnold Foundation risk tool) goes to the court with recommendations from probation. The District Attorney and Public Defender are involved.

**Problem-Solving Courts (for more information see appendix)**

- Behavioral Health Court (BHC)
  - BHC is a post-adjudication review court in partnership with Santa Cruz County Behavioral Health Service’s MOST Team, a forensic wraparound program.
  - Designed to address the complex needs of participants with severe mental health and co-occurring substance use disorders.
  - Must be on formal probation with mental health conditions.
- PACT Court
  - PACT Court is a pre-adjudication, post-plea review court that partners with Santa Cruz County Health Services Agencies - Homeless Outreach, Proactive Engagement & Services (HOPES Team).
  - Designed to address the needs of participants who struggle with homelessness, mental health and co-occurring substance use disorders.
- Reentry Court
- Designed to address the needs of people on parole who suffer with mental health, substance use disorders, or co-occurring disorders.

- **Veteran’s Court**
  - Peer-support based collaborative court program, operating under CA Penal Codes § 1170.9 and § 1001.80.
  - Provides alternative sentencing for veterans with service-related mental health and substance use issues.
  - The court’s mission is to connect justice system-involved veterans and their families with opportunities to access treatment and improve quality of life.

- **Mental Health Diversion in the Planning Process**
  - Pretrial diversion for those who were in a mental health state at the time of the alleged crime.

## INTERCEPT 2/3 GAPS

### Booking
- All mental health related questions are asked by law enforcement.
- There is no follow up on people who appear to have mental health concerns but do not self-report.
- There are screenings for mental health and substance use during intake, but no data collection for this population.
- Information gathered at booking is not communicated to the District Attorney, Public Defender, or judge.
- Medical and mental health services in the jail are separate, which can create barriers and miscommunication.

### Jail Structure and Personnel
- Retention and recruitment of qualified staff is a concern.
- There has been mandatory overtime for jail staff over the past two years.
- At the time of the workshop there was the Division of Reentry (DOR) which was a program operated by the Santa Cruz County Sheriff’s Office that helped link people who are incarcerated to services. DOR also coordinated screening of individuals struggling with substance use for release to a treatment program. As of September 2019, this program is no longer active and there is a backup of people waiting in jail who should be placed in treatment programs.

### Jail Services
- SCBH has integrated behavioral health (for individuals with mild-moderate needs) and physical health that is provided at and Integrated Behavioral Health (IBH) clinic. There is a lack of referrals or linkage to these services for the jail population.
- There are no gender specific assessments used.
• There is a lack of ongoing mental health treatment in the jail.
• There are no paid peer support staff.
• There is a lack of services for individuals with mild to moderate mental health needs, and a need to expand referrals and linkage to the Integrated Behavioral Health (IBH) clinic.
• There is limited programing at Main jail and there are real benefits for people who attend programing. Through participation in programs at the medium security facilities people can receive milestone credits that may earn them early release from custody.
• There are more medical and mental health services at main jail which can limit people from being transferred to medium or low security facilities due to their medical and mental health needs.
• There are no contact visits at Main jail so people with severe mental illnesses and others incarcerated there cannot touch their children and other family members.
• Santa Crux County Behavioral Health staff in the jails do not provide some mental health medications without an approval process, which can take time and cause gaps in treatment for individuals who are already on those medications.

Competency
• In misdemeanor incompetent to stand trial cases treatment is ordered but is not available.
• Telecare facility will only assess individuals who are out of custody.
• There is no jail-based competency restoration.
• There is a population of people that may not be restored.

Pre-trial Services
• PACT program for repeated misdemeanants, explore funding for pre-filing diversion court
• Pretrial has limited information on mental health and substance use treatment needs.
• Service capacity is a barrier to expanding diversion opportunities at this intercept.
• Pretrial is considering looking at “START” needs and assessment tool to inform releases.
• Mental health and substance use services have different funding sources.
• The initial PSA has no connection to mental health.
• There are no paid peer support staff.

Problem-Solving Courts
• Planning is in the works for court liaison to assess, refer, and divert. The position will be funded by a grant. There is no bailiff to support clinicians in early screening.
• Looking into establishing Neighborhood Courts based on the San Francisco Model.
• There is a severe lack of housing and treatment beds:
  o Not enough detox beds in the community.
  o Funding for treatment but not long-term housing.
  o Individuals with mild to moderate mental health needs does not have a connection to services (IBH).
- No long-term placements.
- Lack of SLE housing for women with children.
- Lack of SLE placements for Severe Mentally Ill (SMI).
- No women specific substance use treatment beds.
- Lack of hospital crisis residential beds.
- Limited residential treatment.
- No women residential treatment beds in South County.
- Mental health beds only for individuals diagnosed with Serious Mental Illness (SMI)
  - 10 acute beds.
  - 16 sub-acute beds.
  - 12 co-occurring beds.
- Lack of transitional housing (e.g. after treatment program completion and upon release from custody).

- No services for people who do not qualify for system of care but are in custody with mental health needs.
- Lack of diversion opportunities for individuals diagnosed with Serious Mental Illness (SMI).
- Lack of Supported Employment (IPS Model).
- Cognitive Behavioral Therapy (CBT) targeted to criminogenic risk not implemented across all of the intercepts.
- All court positions are grant based and therefore time limited.

**Data Collection and Sharing**

- No data sharing plans exist.
- Timely information sharing is a challenge.
- Limited access of records due to HIPAA concerns.
- No consistent data validation meetings are occurring.
INTERCEPT 4 AND INTERCEPT 5

INTERCEPT 4/5 RESOURCES

Jail Services

- SCSO operates a Rehabilitation and Reentry Facility (R&R).
- The Division of Reentry is not currently staffed but may be staffed again in the future.
  - The Division of Reentry previously employed a director, five officers, and six civilians.
- Reentry services are available to everyone in jail, no specific diagnosis is required. These services are currently on hold until the Division of Reentry is back operational.
  - Reentry services were offered in four facilities.
  - Some of the individuals served were pretrial however the majority were sentenced.
  - There was an application process.
  - Attendance was mandatory.

Community Reentry

- Encompass operates the Successful Team Approach for Reentry Transition (START) program.
  - The START program provides case management, group therapy, and reentry services.
  - The Return Project focuses of providing case management to the AB109 population.

Probation

- The reentry process begins in the jail.
• Probation does in-reach to the CDCR.
• There is Post-Release Community Supervision (PRCS) population.
• A Probation Services Center funded with realignment money will be opening soon.
  o The center will include peer navigators, an onsite mental health provider, and staff from the Return Project.
• According to the latest Probation numbers there are currently:
  o 1600 active cases, not including misdemeanors, and 340 of those cases are misdemeanor cases.
  o Seven adult probation supervisors.
  o 33 Line Staff adult Probation Officers.
  o Specialized Caseloads (35 – 45, with exception of Domestic Violence):
    ▪ Realignment (AB109 – PRCS and 1170)
    ▪ MOST team/Whole Person Care
    ▪ Sex offenders
    ▪ Intensive (High Violence / Gang)
    ▪ Domestic Violence Caseloads (previously 80-100, now around 60)
  o Average supervision caseload for Moderate/High Level is 60.
• Pretrial Unit also screens 200 – 250 clients per month and provides information to the court daily; monitors an average of 150 clients at any given time in the community who are pending trial (most of whom are NOT also on supervision by any other probation officer, but a small portion are).
  o Pretrial will also play a small monitoring role in MH Diversion (AB1810), in select cases.

INTERCEPT 4/5 GAPS

Jail Services
• Medical discharge medications can be an issue.
• Timing of releases from the jails are unpredictable and problematic.
• Releases often occur on days and times when no community treatment intake services are available.
• When transferred to substance use treatment facilities medications are often not enough.
• Need to increase visits for children of incarcerated parents (contact visits).
• Need to provide coordination for providers to conduct substance use disorder screenings and to coordinate releases to treatment for people who qualify.
• Need to provide support for early clinician screening for people with mental health needs.

Community Reentry
• There is no capacity for placement after release from jail.
• Individuals released with credit for time served are not connected and transitioned to treatment.
- There are not enough treatment beds in the community.
- No funding exists for non-county contracted residential programs.
- No detox or residential programs exists for people who are 290 registered.

**Probation**

- Supervision is not often clear at the point of release from jail.
Priorities for Change

The priorities for change are determined through a voting process. Workshop participants are asked to identify a set of priorities followed by a vote where each participant has three votes. The voting took place on April 25, 2019. The top five priorities are highlighted in bold text followed by the number of votes for each priority area. Although priority number 2 garnered 15 votes, the group decided to focus on the other top four priorities for change. Clearly, funding is a critical issue for this community. However, when the moment came for action planning, very few people volunteered to be part of that small group so we settled on the remaining four priorities.

<table>
<thead>
<tr>
<th>Priority</th>
<th>Votes</th>
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<tbody>
<tr>
<td>1. Diversion for misdemeanor clients and felony clients with mental illness: diversion to where? Create options for where to take people</td>
<td>18</td>
</tr>
<tr>
<td>2. Funding for individuals and linkage to get people into treatment</td>
<td>15</td>
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<tr>
<td>3. Coordination around release to residential programs; communication between stakeholders and education about appropriate levels of care</td>
<td>13</td>
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<tr>
<td>4. Increase bed capacity at all mental health programs</td>
<td>9</td>
</tr>
<tr>
<td>5. Peer support groups, expanded funding for peer support over all</td>
<td>8</td>
</tr>
<tr>
<td>6. Step down housing</td>
<td>7</td>
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<tr>
<td>7. Cross training</td>
<td>6</td>
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<tr>
<td>8. Increase linkage to IBH programs</td>
<td>5</td>
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<tr>
<td>9. Staff recruitment and retention</td>
<td>5</td>
</tr>
<tr>
<td>10. Expand mental health team at the jail</td>
<td>4</td>
</tr>
<tr>
<td>11. Education and advocacy for the community, elected officials</td>
<td>3</td>
</tr>
<tr>
<td>12. Shared data between agencies and across systems</td>
<td>3</td>
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<tr>
<td>13. Better tools for law enforcement</td>
<td>3</td>
</tr>
<tr>
<td>14. Expand crisis support services to Watsonville PD</td>
<td>2</td>
</tr>
<tr>
<td>15. Housing for families and children</td>
<td>2</td>
</tr>
<tr>
<td>16. Standardized assessment tools across systems</td>
<td>1</td>
</tr>
<tr>
<td>17. Ongoing treatment for those with SUD</td>
<td>1</td>
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</tbody>
</table>
Quick Fixes

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

- Disseminate information about SB 1045.
- Health Improvement Project
  - Information sharing
  - Courts
- SCSO will distribute the mental health screening form they are using.
- Collaborative Court Manager will implement cross training based on San Francisco model.
- Parole will set up space at the new Probation Resource Center.
## Strategic Action Plans

### Priority Area 1: Mental Health Diversion

<table>
<thead>
<tr>
<th>Objective</th>
<th>Action Step</th>
<th>Who</th>
<th>When</th>
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</thead>
<tbody>
<tr>
<td>1. Implement diversion for misdemeanors (AB1810)</td>
<td>1. Implement diversion for felonies (AB1810)</td>
<td>2. Implement diversion for felonies (AB1810)</td>
<td>3. Create dedicated positions for assessments and recommendations</td>
<td>4. Create workgroup to explore community diversions</td>
</tr>
<tr>
<td>1a. Identify tools</td>
<td>1&amp;2: Subcommittee planning</td>
<td>1&amp;2: Existing members</td>
<td>4&amp;5: June</td>
<td></td>
</tr>
<tr>
<td>1&amp;2: Identify scale</td>
<td>4&amp;5: Identify possible locations providers for alternative to custody</td>
<td>4&amp;5: law enforcement, DA, CBO, BH, Probation, SUDs, CEEW</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1&amp;2: Identify workflow</td>
<td>4&amp;5: Identify possible locations providers for alternative to custody</td>
<td>4&amp;5: law enforcement, DA, CBO, BH, Probation, SUDs, CEEW</td>
<td></td>
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<tr>
<td>Develop peer services as part of program</td>
<td>4&amp;5: Identify possible locations providers for alternative to custody</td>
<td>4&amp;5: law enforcement, DA, CBO, BH, Probation, SUDs, CEEW</td>
<td></td>
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<tr>
<td>Diversion to where? Build adequate capacity across continuum</td>
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<td>PSA/community education</td>
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</table>
### Priority Area 2: Release of Information

<table>
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<tr>
<th>Objective</th>
<th>Action Step</th>
<th>Who</th>
<th>When</th>
</tr>
</thead>
<tbody>
<tr>
<td>Program/Housing/SLE</td>
<td><strong>Objective</strong>&lt;br&gt;Early identification  &lt;br&gt;• Communication  &lt;br&gt;• Individual  &lt;br&gt;• Program/solution/assessment  &lt;br&gt;• Reentry list  &lt;br&gt;• Services in place in timely manner</td>
<td>Jail, Division of Reentry, diversion and discharge planner, DAs office, probation, SUD (provider), QC</td>
<td>Weekly list of release dates, referral/assessment agreement</td>
</tr>
<tr>
<td></td>
<td><strong>Action Step</strong>&lt;br&gt;Language minute order flexibility  &lt;br&gt;• Modification  &lt;br&gt;• Plan  &lt;br&gt;• Specification</td>
<td>Sheriff, DA, Probation, Court, PD, MH, SUD</td>
<td>Weekly census</td>
</tr>
<tr>
<td></td>
<td><strong>Monitoring Plan</strong>&lt;br&gt;• Who  &lt;br&gt;• Disclosure  &lt;br&gt;• Cost benefit</td>
<td>Probation, SUD, discharge planner, DA, PD, QC</td>
<td></td>
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<tr>
<td></td>
<td><strong>Provider Training and Education</strong>&lt;br&gt;• For both client and provider</td>
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<tr>
<td></td>
<td><strong>Public Safety (both clt and public)</strong></td>
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<td></td>
<td><strong>Collaboration</strong></td>
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</table>
## Priority Area 3:
Expanding Housing and Bed Capacity

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<thead>
<tr>
<th>Objective</th>
<th>Action Step</th>
<th>Who</th>
<th>When</th>
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</thead>
</table>
| Increase Bed Capacity  
  • Transitional  
  • Harm reduction  
  • Co-occurring SLEs  
  • Women and children  
  • Acute treatment |
| 1. Eminent domain | Workgroup: MH, NAMI, probation, courts, DA, Defense counsel, non-profits, hospitals, peers, IBH, Human Services |
| 2. Lobbyist | |
| 3. Grant writer/researcher | |
| 4. Education: number of beds, eligibility criteria to understand limitations | |
| 5. County master planning: mapping of city owned buildings | |
| 6. Cost analysis: jail cost, ER cost, interagency data sharing workgroup | |
| 7. Outreach to faith based and Corp(?) | |
| 8. More contracts for transitional not acute step down | |
| 9. RFP Process | |
| 10. Present SIM results to CBS, City Con. | |

Triage center/day treatment to support SLE/family environment

Long-term program for MH clients

Workgroup: MH, NAMI, probation, courts, DA, Defense counsel, non-profits, hospitals, peers, IBH, Human Services

SIM Review: KM, Tara Jasmine, Pam, Sara F., Sara A, Cynthia, C(?), Rick
## Priority Area 4:
### Increased Peer Support Across all Intercepts

<table>
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<tr>
<th>Objective</th>
<th>Action Step</th>
<th>Who</th>
<th>When</th>
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</thead>
</table>
| Location in custody and out of custody | Develop training  
--CIT Community opts  
--Peer training | Naomi, James | Starting July |
| Advocacy for funding  
--Funding  
--Review past positions | Prop 47 Grant funding for position  
Groups at Building K Conference rooms  
--Look for other grant funding for paid positions at Building K  
--Volunteers begin group after check-ins | Applied for Natalie B and Robert A coordinate space (Sara Siegal) at probation office | Response due June 2019  
August, September |
| Collect data to support position long term | Review Schen.(?) Co. Probation Peer Video | Brenda C. | September/TBD |
| Support in court and advocate on their behalf | | | |
| Aftercare | | | |
| Training | | | |
| Develop transition plans | | | |
| Provide resources | | | |
| Rounds | | | |
Parking Lot

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

- Legislation regarding Welfare & Institutions Code 5150 needs to be expanded to include:
  - Traumatic Brain Injury
  - Alzheimer’s disease and dementia disorders
  - Developmental disabilities
  - Spectrum disorders
  - Drug induced psychosis
- Adjustment to sentencing to avoid release from custody at inconvenient times.
- Funding for peer support.
- Funding for linkage to treatment.
- Education and advocacy around siting of residential treatment programs.
Recommendations

Santa Cruz County, as demonstrated in their application for the SIM Workshop solicitation, has a long history of collaboration and multi-system coordination of services. There was broad cross-system participation in this Workshop with over 54 people representing stakeholders from across the six sequential intercepts, in addition to representation from county government as well as several people who have experience incarceration in Santa Cruz County jails. The Priorities identified promise to add significant enhancements to existing programs or address areas requiring new focus and program development.

Recommendations below address areas that were not identified as top Priorities but are offered as areas of additional focus in on-going efforts. These recommendations are informed by the following reports:

- “Gender Matters: A Profile of Women in Santa Cruz County Jail” (Greene, 2017) (http://sccwc.org/Portals/17/Gender%20Matters_%20A%20Profile%20of%20Women%20in%20SCC%20Jail_March%202017.pdf)

1. **Expand the Crisis Continuum of Care that is integrated with the City/County Police Crisis Intervention Team (CIT) initiative.**

Current Mobile Emergency Response Team (MERT) is designed to address calls that come in through the Crisis Line, not 911. The MH Liaisons are assigned peak response time and the Law Enforcement Liaison is a valued resource. Still there appeared to be a need for additional on scene support for Law Enforcement after hours, especially for the Watsonville P.D. Increasingly, communities across the country are augmenting crisis response by providing telephone or videoconference consultation to law enforcement.
Consider use of videoconferencing to expand access to the Mental Health consultation. Remington, A. (2016). Skyping During a Crisis? Telehealth is a 24/7 Crisis Connection (see Appendices). Also the Behavioral Health Response (BHR) provides Virtual Crisis Support to the St. Louis, MO police department.

Collecting data on hospital emergency room uncompensated care costs may help engage the hospitals in on-going participation as CIT program development stakeholders since it is likely that CIT program development and enhanced partnerships will reduce ER referrals and decrease uncompensated care costs. Virginia conducted an uncompensated care study to examine costs of behavioral health use of Emergency Rooms and offered remedies to address uncompensated care costs “Hospital Uncompensated Care Costs in Virginia”, Policy Brief. September 2015. (https://hbp.vcu.edu/media/hbp/policybriefs/pdfs/VCU_DHBP_HUCC_WEB.pdf).

2. Examine increasing utilization of the 24-hour crisis line and “warm hand-off” transfer of crisis calls from 911 to the Crisis Line

There was discussion about integration between the 911- and 24-hour Crisis Lines. One consumer noted he was not aware there was a crisis line and that he might prefer to utilize a crisis line and speak to a mental health professional rather than call 911. He noted that CIT officers do not always respond, and the experience is not always helpful.

There was discussion about consumer voluntary registration with 911 so that trained CIT officers respond.

The Georgia Crisis Access Line (GCAL) is a Statewide Crisis Line that has warm hand off capabilities to providers and accepts warm handoffs from 911 Dispatch to ensure that calls are not dropped. While this is a statewide crisis line, there are elements of the GCAL program that could be implemented at a county level. (https://www.csg.org/ssifiles/innovations/2008/2008Southapplications/08S22GACRISISANDACCESSLINE.pdf).

3. Expand substance use disorder (SUD) treatment options and integrate strategies with current initiatives.

Participants identified SUD treatment capacity and access as a significant gap. The facilitators note the following SUD initiatives and encourage stakeholders to expand and integrate SUD initiatives with other initiatives described in this report.

- The 2016 SAMHSA publication, Screening and Assessment of Co-occurring Disorders in the Justice System developed by Roger Peters and the SAMHSA GAINS Center (see Screening and Assessment section of the Resources), provides an overview of screening and assessment and treatment of individuals with co-occurring disorders in the criminal justice system. In addition, Screening and Assessment instruments for mental illness, substance use, co-occurring disorders, treatment motivation and trauma/PTSD.
• The SAMHSA publication, Detoxification and Substance Abuse Treatment. Treatment Improvement Protocol (TIP) Series, No. 4 SAMHSA Tip 45, provides communities with guidance on a continuum of inpatient and outpatient care for detoxification services and identifies best practices.

• Jails and prisons are increasingly utilizing Medication Assisted Treatment (MAT) at the point of reentry. See the Medication Assisted Treatment section of the Resources.

4. Improve in custody treatment, linkage and referrals to Integrated Behavioral Health (IBH) for individuals with mild to moderate mental illness who do not qualify for services or other collaborative court programs

The group repeatedly pointed to a gap in services for those people in jail suffering from mental health disorders who are “ill, but not ill enough.” Half of the people referred to the Behavioral Health Court, for example, were not admitted suggesting there is a sizeable population of people who present with symptoms and would benefit from treatment but are not receiving it. Also, there is a population of people diagnosed with SMI who do are not participating in Behavioral Health Court or other court programs but would benefit from treatment through IBH. Without a referral to a clinic or a plan upon release from custody, these individuals are at risk of not complying with court orders, failing to appear in court, and/or reoffending.

5. Improve and expand in custody treatment for persons with mental health disorders using evidence-based practices.

SCBH provides Mental Health Services in the jail. There is a daily jail meeting to discuss new cases and case specific planning. Participants noted that other than clinic based treatment approaches, resources for more intensive mental health programming for individuals with serious mental illness were lacking. Of particular concern were increased treatment and out of cell program time for persons on the mental health unit or administrative segregation. Utilizing Peer Support (Appendix X) and may be a cost efficient way to improve engagement of persons in the unit and expand programming options. Also see, the Pennsylvania based Peerstar, LLC website to learn more about the role of Forensic Peers in Criminal Justice settings https://www.peerstarllc.com/.

The Division of Reentry is a valuable and needed resource for individuals being released from the jail and should be re-staffed and brought back operational. For information about best practice in jail reentry see resource below.

• SAMHSA’s GAINS Center. Guidelines for the Successful Transition of People with Behavioral Health Disorders from Jail and Prison.
6. **Expand use of technology**

Developing capacity to implement or expand use of technology across the justice system could help address many of the gaps identified. The Rural and Frontier Technology Technical Assistance Center (http://www.attcnetwork.org/home/) recently held a seminar on technology in criminal justice settings.

- Intercept 1 applications include using video conferencing to provide Crisis Worker consultation to field law enforcement in rural areas and to interview persons in crisis (Appendix 2)

- Intercept 2-3 applications include using video conferencing for follow-up court hearings to avoid taking time off from work, disrupting treatment programs or to address transportation barriers; tele psychiatry to provide consultation and treatment in hard to recruit locations; telephone consultation by local crisis centers to jails with limited mental health services. (Appendix 3)

- Intercept 4 applications include video conferencing detained individuals with prospective service and housing providers.

- Intercept 5 applications include probation substituting videoconferencing for direct report to avoid probationers taking time off from work, disrupting treatment or to address transportation barriers.

7. **Develop strategies to provide cross system training.**

Participants identified multiple mental health and substance abuse training needs. A training needs survey of stakeholders including, jail, magistrates and judges, probation might help to develop and target training focus.

Below is a link to a National Institute of Corrections Crisis Intervention Team training publication, which is specific to jail and prison corrections staff.


Also see “Mental Health First Aid” in the Resources section later in this report.

https://nicic.gov/crisis-intervention-teams-frontline-response-mental-illness-corrections-lesson-plans-and

Also see “Trauma Informed” in the Resources section of this report.

8. **At all stages of the Sequential Intercept Model, gather data to document the processing of people with mental health and substance use disorders through the criminal justice system locally.**

Improving cross system data collection and integration is key to identifying high user populations, justifying expansion of programs, and measuring program outcomes and success. 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.

Data collection does not have to be overly complicated. For example, some 911 dispatchers spend an inordinate amount of time on comfort and support calls. Collecting information on the number of calls, identifying the callers and working to link the callers to services has been a successful strategy in other communities to reduce repeated calls. In addition, establishing protocols to develop a “warm handoff” or direct transfers to crisis lines can also result in directing calls to the most appropriate agency and result in improved service engagement.

Dashboard indicators can be developed on the prevalence, demographics, and case characteristics of adults with mental and substance use disorders who are being arrested, passing through the courts, booked into the jail, sentenced to prison, placed on probation, etc.

A mental health dashboard can also be developed to monitor wait times in hospitals for people in mental health crises and transfer times from the emergency department to inpatient units or other services to determine whether procedures can be implemented to improve such responses. These dashboard indicators can be employed by a county planning and monitoring council to better identify opportunities for programming and to determine where existing initiatives require adjustments.

Join the Arnold Foundation and National Association of Counties (NACo) Data Driven Justice Initiative (DDJ). The publication “Data-Driven Justice Playbook: How to Develop a System of Diversion” provides guidance on development of data driven strategies and use of data to develop programs and improve outcomes.

See also the Data Analysis and Matching publications in the Resources section.

9. Enhance Jail Mental Health Screening

Participants discussed a lack of a standardized mental health screening instrument and there was mention of delays in instituting treatment. There has been discussion about placing a full-time mental health clinician in the jail but funding has been an issue.

The guidance to enhance standardized jail mental health screening is available on the Stepping Up website: https://stepuptogether.org/

Formalizing screening protocols at arraignment and at the jail is the first step in expanding and implementing diversion strategies and initiating prompt treatment. Many screens, such as the Brief Jail Mental Health Screen, are in the public domain.

Additional brief mental health screens include the:

- Correctional Mental Health Screen
- Mental Health Screening Form III
Brief alcohol and drug screens include the:

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

For screening veterans, consider utilizing the U.S. Department of Veterans Affairs Veterans Re-Entry Search Services (VRSS). 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.


10. Develop more formal and coordinated screening and diversion strategies for arraignment diversion (Intercept 2) and pre-plea diversion (Intercept 3).

Formalizing screening protocols at arraignment and at the jail is the first step in expanding and implementing diversion strategies. Many screens, such as the Brief Jail Mental Health Screen, are in the public domain. See examples of other standardized screening instruments in Recommendation 6 above.

Essential elements of Intercept 2 diversion can be found in the SAMHSA Monograph, “Municipal Courts: An Effective Tool for Diverting People with Mental and Substance Use Disorders in the Criminal Justice System.” The monograph identifies four essential elements of arraignment diversion programs. Improving screening, clinical assessment, and behavioral health disorders who are released without referral or follow-up. The CASES Transitional Case Management and the Manhattan Arraignment Diversion Program are two examples.

11. Consider implementing a Social Security Outreach Access and Recovery training (SOAR) program. Social Security Disability (SSD) and Social Security Supplemental Income (SSI) provide medical benefits and income which can improve access to housing and other services. Social Security Outreach Access and Recovery training (SOAR) can improve successful enrollments and reduce approval times from months to as soon as 60 days. Training is offered through on-line portal. [https://soarworks.prainc.com/topics/criminal-justice](https://soarworks.prainc.com/topics/criminal-justice)

12. Implement gender-specific protocols as detailed in the “Gender Matters: A Profile of Women in Santa Cruz County Jail”

According to the Gender Matters report referenced above, more than two-thirds of the women (68%) in the Santa Cruz County jail reported that they have, at some point in their lives, been diagnosed with a mental illness, and nearly a third (61%) have been treated for a mental health issue. Many women
reported having received multiple diagnoses over the years including anxiety, bipolar disorder, post-traumatic stress disorder (PTSD), depression, and schizophrenia. (P.15) The women in this study who had been diagnosed with a mental illness were booked and released 62% more often than those with no mental health diagnosis. (P.36)

- Select and implement a validated, gender-specific classification tool that will accurately assess risk of recidivism and will collect information on factors known to be important to women including histories of abuse, mental illness, and issues related to their children.
- Train staff in gender-responsive, trauma-informed practices. Staff should be invited to participate in identifying institutional practices that could be improved so they are not simply being taught how to change but are also able to help prioritize areas of reform and initiate related efforts.

13. **Improve protocols for children of parents incarcerated in the Santa Cruz County Jail as detailed in the “Gender Matters: A Profile of Women in Santa Cruz County Jail”**

An estimated 10 million children in the U.S. have a parent who is or has been incarcerated. For many, the incarceration of a parent puts additional pressure on families already living at the margins. This is true in Santa Cruz County and improving communication, visitation and continuity of care for children with incarcerated parents will benefit the family unit and improve chances for successful reentry upon release from custody.

- Review and improve visiting and communication policies to provide for easier, less expensive communications between an incarcerated parent and his or her child.
- Consider contact visits as incentives and provide a child-friendly visitation area that promotes positive interactions between parents and children.
- Reexamine policies for pregnant women. Expand access to prenatal care for pregnant women in custody and employ the least restrictive alternative housing options.
- Reexamine and enhance coordination with child welfare systems.
Resources

COMPETENCY EVALUATION AND RESTORATION

- SAMHSA’s GAINS Center. Quick Fixes for Effectively Dealing with Persons Found Incompetent to Stand Trial.

CRISIS CARE, CRISIS RESPONSE, AND LAW ENFORCEMENT

- Substance Abuse and Mental Health Services Administration. Crisis Services: Effectiveness, Cost-Effectiveness, and Funding Strategies.
- International Association of Chiefs of Police. Building Safer Communities: Improving Police Responses to Persons with Mental Illness.
- Suicide Prevention Resource Center. The Role of Law Enforcement Officers in Preventing Suicide.
- Saskatchewan Building Partnerships to Reduce Crime. The Hub and COR Model.
- International Association of Chiefs of Police. One Mind Campaign.
- Optum. In Salt Lake County, Optum Enhances Jail Diversion Initiatives with Effective Crisis Programs.
- The Case Assessment Management Program is a joint effort of the Los Angeles Department of Mental Health and the Los Angeles Police Department to provide effective follow-up and management of selected referrals involving high users of emergency services, abusers of the 911 system, and individuals at high risk of death or injury to themselves.

- National Association of Counties. Crisis Care Services for Counties: Preventing Individuals with Mental Illnesses from Entering Local Corrections Systems.

- CIT International.

- National Action Alliance for Suicide Prevention: Crisis Services Task Force. Crisis now: Transforming services is within our reach. Washington, DC: Education Development Center, Inc.

DATA ANALYSIS AND MATCHING

- Data-Driven Justice Initiative. Data-Driven Justice Playbook: How to Develop a System of Diversion.


- Corporation for Supportive Housing. Jail Data Link Frequent Users: A Data Matching Initiative in Illinois (See Appendix 1)


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.

- Corporation for Supportive Housing. *NYC FUSE – Evaluation Findings*.
- Corporation for Supportive Housing. *Housing is the Best Medicine: Supportive Housing and the Social Determinants of Health*.
- Corporation for Supportive Housing. *Guide to the FUSE Model*.

**INFORMATION SHARING**

- Legal Action Center. *Sample Consent Forms for Release of Substance Use Disorder Patient Records*.

**JAIL INMATE INFORMATION**

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

**MEDICATION ASSISTED TREATMENT (MAT)**

- 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)*.
MENTAL HEALTH FIRST AID

- Mental Health First Aid.
- 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*.
- Laura and John Arnold Foundation. *The Hidden Costs of Pretrial Diversion*.

PROCEDURAL JUSTICE

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

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.*

**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.*

**SEQUENTIAL INTERCEPT MODEL**


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

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

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

**TRANSITION-AGED YOUTH**

- National Institute of Justice. *Environmental Scan of Developmentally Appropriate Criminal Justice Responses to Justice-Involved Young Adults*.
- 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*.

**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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<td>100,000 Homes/Center for Urban Community Services. Housing First Self-Assessment: Assess and Align Your Program and Community with a Housing First Approach.</td>
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<td>Remington, A.A. (2016). Skyping During a Crisis? Telehealth is a 24/7 Crisis Connection.</td>
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<td>SAMHSA. Reentry Resources for Individuals, Providers, Communities, and States.</td>
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<th>First Name</th>
<th>Last Name</th>
<th>Agency</th>
<th>Job Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sara</td>
<td>Anderson</td>
<td>Encompass</td>
<td>Director of IBH, Adult Services</td>
</tr>
<tr>
<td>Edwin</td>
<td>Ayala</td>
<td>Santa Cruz Community Health Centers</td>
<td>IBH Care Coordinator</td>
</tr>
<tr>
<td>Lavada</td>
<td>Beard</td>
<td>Sobriety Works</td>
<td>IOT AB109/FPC Tx counselor</td>
</tr>
<tr>
<td>Cyrus &quot;Bo&quot;</td>
<td>Benck</td>
<td>Person with Lived experience</td>
<td>Disabled</td>
</tr>
<tr>
<td>Jennifer</td>
<td>Buesing</td>
<td>Santa Cruz Probation</td>
<td>Adult Division Director</td>
</tr>
<tr>
<td>William</td>
<td>Burnett</td>
<td>Santa Cruz Sheriff's Office</td>
<td>Service Division Director</td>
</tr>
<tr>
<td>Alex</td>
<td>Byers</td>
<td>Santa Cruz District Attorney</td>
<td>Assistant District Attorney</td>
</tr>
<tr>
<td>Francine</td>
<td>Byrne</td>
<td>Judicial Council of California</td>
<td>Principal Manager, Criminal Justice Services</td>
</tr>
<tr>
<td>Alex</td>
<td>Calvo</td>
<td>Santa Cruz Superior Court</td>
<td>Court Executive Officer</td>
</tr>
<tr>
<td>Brenda</td>
<td>Campbell</td>
<td>Santa Cruz Behavioral Health</td>
<td>Mental Health Supervising Client Specialist</td>
</tr>
<tr>
<td>Cynthia</td>
<td>Chase</td>
<td>Santa Cruz Sheriff's Office</td>
<td>Santa Cruz Sheriff's Office</td>
</tr>
<tr>
<td>Nicole</td>
<td>Coburn</td>
<td>County Administrative Office</td>
<td>County Administrative Office</td>
</tr>
<tr>
<td>Robert</td>
<td>Craig</td>
<td>Person with Lived experience</td>
<td>Veteran Advocate</td>
</tr>
<tr>
<td>Travis</td>
<td>Deyong</td>
<td>Veteran Service Office</td>
<td>Probation Officer</td>
</tr>
<tr>
<td>Sarah</td>
<td>Fletcher</td>
<td>Santa Cruz Probation</td>
<td>Chief Deputy District Attorney</td>
</tr>
<tr>
<td>Cassandra</td>
<td>Gazipura</td>
<td>Santa Cruz Public Defender</td>
<td>Deputy Public Defender</td>
</tr>
<tr>
<td>Tara</td>
<td>George</td>
<td>Santa Cruz District Attorney</td>
<td>Chief Deputy District Attorney</td>
</tr>
<tr>
<td>Fernando</td>
<td>Giraldo</td>
<td>Santa Cruz Probation</td>
<td>Chief Probation Officer</td>
</tr>
<tr>
<td>Susan</td>
<td>Greene</td>
<td>UCSC</td>
<td>Research Associate</td>
</tr>
<tr>
<td>Mimi</td>
<td>Hall</td>
<td>Santa Cruz County Health Services</td>
<td>HSA Director</td>
</tr>
<tr>
<td>Donald</td>
<td>Hunt</td>
<td>Person with Lived experience</td>
<td>Lived Experience</td>
</tr>
<tr>
<td>Yolanda</td>
<td>James-Sevilla</td>
<td>Santa Cruz County Probation</td>
<td>Assistant Division Director</td>
</tr>
<tr>
<td>James</td>
<td>Johnston</td>
<td>Person with Lived experience</td>
<td>Lived Experience</td>
</tr>
<tr>
<td>Nicole</td>
<td>Keadle</td>
<td>Encompass</td>
<td>Counselor II/Employment Specialist</td>
</tr>
<tr>
<td>Monica</td>
<td>Martinez</td>
<td>Encompass</td>
<td>Chief Executive Officer</td>
</tr>
<tr>
<td>Rick</td>
<td>Martinez</td>
<td>Santa Cruz Police Department</td>
<td>Santa Cruz Police Department</td>
</tr>
<tr>
<td>Katie</td>
<td>Mayeda</td>
<td>Santa Cruz Superior Court</td>
<td>Collaborative Court Manager</td>
</tr>
<tr>
<td>Jim</td>
<td>McMillan</td>
<td>Santa Cruz Public Defender</td>
<td>Attorney</td>
</tr>
<tr>
<td>Heather</td>
<td>Morse</td>
<td>Superior Court</td>
<td>Assigned Judges program</td>
</tr>
<tr>
<td>Rosie</td>
<td>Murillo</td>
<td>Santa Cruz County SUDS</td>
<td>Service Coordinator</td>
</tr>
<tr>
<td>Jasmine</td>
<td>Najera</td>
<td>Santa Cruz County Adult Behavioral Health</td>
<td>Forensic Services Program Manager</td>
</tr>
<tr>
<td>Tim</td>
<td>Newman</td>
<td>Superior Court</td>
<td>Director of Operations-Criminal+Traffic</td>
</tr>
<tr>
<td>Brian</td>
<td>Orr</td>
<td>Person with Lived experience</td>
<td>Sud Counselian</td>
</tr>
<tr>
<td>Hadley</td>
<td>Owen</td>
<td>Superior Court</td>
<td>Collaborative Court Case Manager</td>
</tr>
<tr>
<td>Stacey</td>
<td>Palau</td>
<td>New Life Community Services</td>
<td>Administrative Director</td>
</tr>
<tr>
<td>Anna</td>
<td>Phillips</td>
<td>New Life Community Services</td>
<td>Executive Director</td>
</tr>
<tr>
<td>Erik</td>
<td>Riera</td>
<td>Santa Cruz Behavioral Health</td>
<td>Behavioral Health Director</td>
</tr>
<tr>
<td>Pam</td>
<td>Rogers-Wyman</td>
<td>Santa Cruz County Behavioral Health</td>
<td>Director of Adult Behavioral Health Services</td>
</tr>
<tr>
<td>Jeff</td>
<td>Rosell</td>
<td>Santa Cruz District Attorney's Office</td>
<td>District Attorney- Police Administrator</td>
</tr>
<tr>
<td>James</td>
<td>Russell</td>
<td>Santa Cruz County Adult Behavioral Health</td>
<td>Supervisor MH</td>
</tr>
<tr>
<td>Sarah</td>
<td>Saulnier</td>
<td>Encompass</td>
<td>Case Manager</td>
</tr>
<tr>
<td>Sara</td>
<td>Siegel</td>
<td>Santa Cruz County Probation</td>
<td>Probation Officer</td>
</tr>
<tr>
<td>Robert</td>
<td>Vickers</td>
<td>Santa Cruz Behavioral Health</td>
<td>Jail Discharge Planner</td>
</tr>
<tr>
<td>Crystina</td>
<td>Ybarra</td>
<td>Superior Court</td>
<td>Court Case Manager</td>
</tr>
<tr>
<td>Jorge</td>
<td>Zamora</td>
<td>Watsonville Police Department</td>
<td>Watsonville PD Captain</td>
</tr>
</tbody>
</table>
Appendix 2
## Santa Cruz County Collaborative Courts

The Collaborative Justice System of Santa Cruz County aims to improve treatment outcomes, reduce recidivism, respond to public safety and victims’ rights concerns, and more effectively utilize public resources. These problem-solving courts are designed to improve participants’ lives by increasing their support networks, helping them to avoid unhealthy patterns and assisting in achievement of goals.

<table>
<thead>
<tr>
<th>Program</th>
<th>Judge</th>
<th>Description</th>
<th>Qualifying Criteria</th>
<th>Referral Process</th>
<th>Contact Person</th>
<th>Day and Time of Court</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral Health Court (BHC)</td>
<td>Judge Denine Guy</td>
<td>BHC is a supportive post-adjudication review court in partnership with Santa Cruz County Behavioral Health Services designed to address the complex needs of participants with <strong>severe mental health</strong> and co-occurring substance use disorders through an integrated multidisciplinary team.</td>
<td>1. Diagnosed with a significant &amp; persistent mental health disorder. 2. Experiences significant impairment in functioning as a result of their mental health disorder. 3. Eligible to have an assigned county case coordinator after completing an access assessment. 4. Amenable to psychiatric treatment and taking medication as prescribed. 5. Santa Cruz County Medi-Cal beneficiary 6. Amenable to participate. 7. Be on a Formal Mental Health Probation with Mental Health Terms.</td>
<td>• Client fills out BHC referral packet and signs all Releases of Information (ROI) attached (packet found in courtroom). • If client has any additional mental health records, including out of Santa Cruz County records, please include supportive documentation with referral packet. • Request that the court conduct a Behavioral Health Court Assessment. • The clerk will enter the event code (BHCA).</td>
<td>Katie Mayeda</td>
<td>Day: Every Thursday</td>
</tr>
<tr>
<td>PACT Court</td>
<td>Judge John Salazar</td>
<td>PACT Court is a supportive pre-adjudication review court that partners with Santa Cruz County Health Services Agencies - Homeless Outreach, Proactive Engagement &amp; Services (HOPES Team) to address the complex needs of participants who struggle with homelessness, mental health and co-occurring substance use disorders through an integrated multidisciplinary team.</td>
<td>1. The majority of participants are homeless. 2. Not connected to services. 3. Low criminality (infractions &amp; misdos), High need (SUD, MH, Homeless, No support etc.), and High reoffending (multiple police contacts). 4. Struggles with Substance Use or Mental Health. 5. Has an open criminal case. 6. Amenable to participate</td>
<td>• Client fills out PACT referral packet and signs all Releases of Information (ROI) attached (packet found in courtroom). • Request that the court conduct a PACT Court Assessment. • The clerk will enter the event code (PACTA). • Clients can be referred by the DA, Public Defender or the city attorney office.</td>
<td>Katie Mayeda</td>
<td>Day: Every other Tuesday</td>
</tr>
</tbody>
</table>
Santa Cruz County Collaborative Courts

The Collaborative Justice System of Santa Cruz County aims to improve treatment outcomes, reduce recidivism, respond to public safety and victims' rights concerns, and more effectively utilize public resources. These problem-solving courts are designed to improve participants' lives by increasing their support networks, helping them to avoid unhealthy patterns and assisting in achievement of goals.

<table>
<thead>
<tr>
<th>Program</th>
<th>Judge</th>
<th>Description</th>
<th>Qualifying Criteria</th>
<th>Referral Process</th>
<th>Contact Person</th>
<th>Day and Time of Court</th>
</tr>
</thead>
</table>
| **Reentry Court** | **Judge**     | **RC** is a supportive review court designed to address the complex needs of people on parole who suffer with mental health, substance use disorders, or co-occurring disorders through an integrated multidisciplinary team. | 1. Be on an active Parole  
2. Has a documented history of a substance use and/or mental health disorder.  
3. Has committed or at-risk of committing a violation of their Parole.  
4. Experiencing high level of need, has a history of criminal justice involvement, and high risk to recidivate.  
5. Be amenable to participate in RC. | •Majority of cases are referred from their parole officer.  
•Clients can fill out RC referral packet and sign all Releases of Information (ROI) attached (packet found in court).  
•Request that the court conduct a Reentry Court Assessment.  
•The clerk will enter the event code (RCA). | Crystina Prieto-Ybarra  
Email: crystina.prieto-ybarra@santacruzcourt.org  
Ph: (831) 420-2496 | Day: Every other Tuesday  
Time: 11:00 a.m.  
Location: Dept. 6 |
| **Veteran’s Court (VC)** | **Judge** | VC is a peer-support based collaborative court program, operating under CA Penal Codes § 1170.9 and § 1001.80, which provides alternative sentencing for veterans with service-related mental health and substance use issues. The mission is to connect justice system-involved veterans and their families with opportunities to improve the quality of life and to access treatment that addresses health concerns through an integrated multidisciplinary team. | 1. Served in the US military or current active service (no minimum service time or combat required).  
2. Have a service connected diagnosis of Post-Traumatic Stress Disorder (PTSD), Traumatic Brain Injury (TBI), military sexual trauma, substance use, or other mental health diagnosis.  
3. Amenable to participation in treatment and VC. | •Client fills out VC referral packet and signs all Releases of Information (ROI) attached (packet found in court).  
•If client has any additional mental health records not related to the VA, please include supportive documentation with referral packet.  
•Request that the court conduct a Veteran’s Court Assessment.  
•The clerk will enter the event code (VTCA). | Katie Mayeda  
Email: Katherine.mayeda@santacruzcourt.org  
Ph: (831) 420-2498 | Day: Every 3rd Friday of the month  
Time: 2:30 a.m.  
Location: Dept. 4 |
Appendix 3
## Santa Cruz County Residential Programs for the Criminal Justice Involved Population

<table>
<thead>
<tr>
<th>Agency Name</th>
<th>Program Name</th>
<th>Type of Service (SUD Res, MH Res, Shelter, SLE, Detox)</th>
<th># of Beds</th>
<th>Serves CJ (Yes, No)</th>
<th>Program focus (men, women, Co-ed, Perinatal)</th>
<th>Eligibility Criteria</th>
<th>Funding Sources</th>
<th>Referral Process or Contact</th>
<th>Additional Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Janus of Santa Cruz</td>
<td>RTC</td>
<td>SUD Res</td>
<td>24</td>
<td>Yes</td>
<td>Co-ed</td>
<td>Meets Res ASAM LOC</td>
<td>DMC, AB109, Collaborative Courts, FCS, Self-Pay, INS</td>
<td>831-462-1060 xt 290</td>
<td>No 290 reg, sexual or violent charges. Participation in day services required.</td>
</tr>
<tr>
<td>Janus of Santa Cruz</td>
<td>SCU</td>
<td>Detox</td>
<td>16</td>
<td>Yes</td>
<td>Co-ed</td>
<td>Meets detox ASAM LOC</td>
<td>DMC, AB109, Collaborative Courts, FCS, Self-Pay, INS</td>
<td>831-462-1060 xt 290</td>
<td>No 290 reg, sexual or violent charges. Participation in day services required.</td>
</tr>
<tr>
<td>Janus of Santa Cruz</td>
<td>Perinatal</td>
<td>SUD res</td>
<td>10</td>
<td>Yes</td>
<td>Woman</td>
<td>Meets Res ASAM LOC</td>
<td>DMC, AB109, Collaborative Courts, FCS, Self-Pay, INS</td>
<td>23-9015 xt 510 or 831-2398</td>
<td>No 290 reg, sexual or violent charges. Participation in day services required.</td>
</tr>
<tr>
<td>Janus of Santa Cruz</td>
<td>17 th</td>
<td>SLE</td>
<td>11</td>
<td>Yes</td>
<td>Co-ed</td>
<td>In Recovery and able to meet house guidelines</td>
<td>Self-Pay, Collaborative Courts, AB109,</td>
<td>831-462-1060 xt 252</td>
<td>No 290 reg, sexual or violent charges. Voluntary, transitional. Mid level mobility. bunk beds.</td>
</tr>
<tr>
<td>Janus of Santa Cruz</td>
<td>Derby</td>
<td>SLE</td>
<td>8</td>
<td>Yes</td>
<td>Male</td>
<td>In Recovery and able to meet house guidelines</td>
<td>Self-Pay, Collaborative Courts, AB109,</td>
<td>831-462-1060 xt 252</td>
<td>No 290 reg, sexual or violent charges. Voluntary, transitional. Mid level mobility. bunk beds.</td>
</tr>
<tr>
<td>Janus of Santa Cruz</td>
<td>El Derado</td>
<td>SLE</td>
<td>10</td>
<td>Yes</td>
<td>Male</td>
<td>In Recovery and able to meet house guidelines</td>
<td>Self-Pay, Collaborative Courts, AB109,</td>
<td>831-462-1060 xt 252</td>
<td>No 290 reg, sexual or violent charges. Voluntary, transitional. Mid level mobility. bunk beds.</td>
</tr>
<tr>
<td>Encompass</td>
<td>Si Se Puede</td>
<td>SUD Res</td>
<td>23</td>
<td>Yes</td>
<td>men</td>
<td>Meets Res ASAM LOC</td>
<td>DMC, AB109, Collaborative Courts, FCS, Self-Pay, START</td>
<td>831-226-3728</td>
<td>Co-occurring disorder, on-stie MAT services</td>
</tr>
<tr>
<td>Encompass</td>
<td>River St. Shelter</td>
<td>Shelter</td>
<td>32</td>
<td>Yes</td>
<td>Co-ed</td>
<td>Currently Homeless</td>
<td>CBH (27 beds for specialty MH) AB109 (2 beds), open to community (3 beds)</td>
<td>831-4596644</td>
<td>Participation in day services, required</td>
</tr>
<tr>
<td>Encompass</td>
<td>Weeks</td>
<td>SLE</td>
<td>8</td>
<td>Yes</td>
<td>Co-ed</td>
<td>In Recovery</td>
<td>Self-Pay, Collaborative Courts, AB109, START</td>
<td>831-226-3728</td>
<td>Voluntary, Long-term</td>
</tr>
<tr>
<td>Encompass</td>
<td>Freedom</td>
<td>SLE</td>
<td>12</td>
<td>Yes</td>
<td>Co-ed</td>
<td>In Recovery</td>
<td>Self-Pay, Collaborative Courts, AB109, START</td>
<td>831-226-3728</td>
<td>Voluntary, Long-term</td>
</tr>
<tr>
<td>Agency Name</td>
<td>Program Name</td>
<td>Type of Service (SUD Res, MH Res, Shelter, SLE, Detox)</td>
<td># of Beds</td>
<td>Serves CJ (Yes, No)</td>
<td>Program focus (men, women, Co-ed, Perinatal)</td>
<td>Eligibility Criteria</td>
<td>Funding Sources</td>
<td>Referral Process or Contact</td>
<td>Additional Information</td>
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<tr>
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<td>----------------</td>
<td>-----------------------------</td>
<td>------------------------</td>
</tr>
<tr>
<td>Encompass</td>
<td>Cleveland</td>
<td>SLE</td>
<td>6</td>
<td>Yes</td>
<td>Co-ed</td>
<td>In Recovery</td>
<td>Self-Pay, STOP, Collaborative Courts, AB109, START</td>
<td>831-226-3728</td>
<td>Voluntary, Long-term</td>
</tr>
<tr>
<td>Encompass</td>
<td>Miles Lane</td>
<td>SLE</td>
<td>4</td>
<td>Yes</td>
<td>Co-ed</td>
<td>In Recovery</td>
<td>Self-Pay, STOP, Collaborative Courts, AB109, START</td>
<td>831-226-3728</td>
<td>Voluntary, Long-term</td>
</tr>
<tr>
<td>Encompass</td>
<td>El Dorado Center</td>
<td>MH Res</td>
<td>16</td>
<td>Yes</td>
<td>Co-ed</td>
<td>Specialty MH coordination</td>
<td>CBH/Medical</td>
<td>831-479-9494</td>
<td>30 day MH stabilization</td>
</tr>
<tr>
<td>Encompass</td>
<td>Telos</td>
<td>MH Res</td>
<td>10</td>
<td>Yes</td>
<td>Co-ed</td>
<td>Acute MH Crisis, enrollment determined by CBH, Andrea Turnbull</td>
<td>CBH/Medical</td>
<td>831-226-3930</td>
<td>15 day Crisis stabilization</td>
</tr>
<tr>
<td>Encompass</td>
<td>2nd Story</td>
<td>MH Res</td>
<td>6</td>
<td>Yes</td>
<td>Co-ed</td>
<td>Specialty MH coordination</td>
<td>CBH/Medical</td>
<td>831-688-0967</td>
<td>14 day peer respite</td>
</tr>
<tr>
<td>New Life Community Services</td>
<td>New Life Community Services</td>
<td>SUDS Res and Outpatient</td>
<td>38, plus children</td>
<td>Yes</td>
<td>Co-ed and parents with children</td>
<td>Res or OP ASAM LOC with mild to moderate MH, focus on reentry services</td>
<td>Self-Pay, STOP, Collaborative Courts, START</td>
<td>831-440-3037 (intake) 831-427-1007 (main line)</td>
<td>up to 6 months, children may stay free of charge with parents, aftercare and OP support available, vocational emphasis</td>
</tr>
<tr>
<td>New Life Community Services</td>
<td>New Life Community Services</td>
<td>Gemma House</td>
<td>6</td>
<td>Yes</td>
<td>women, transitional housing</td>
<td>CJ identified, commonly while in Blaine St.</td>
<td>Co HSA, AB109, Core grant, RSAT grant</td>
<td>831-706-6560</td>
<td>up to 18 months transitional housing, reentry focus</td>
</tr>
</tbody>
</table>

October 1, 2019
Appendix 4
Crisis Services

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

The 80th Legislature
$82 million was appropriated for the FY 08-09 biennium for improving the response to mental health and substance abuse crises. A majority of the funds were divided among the state’s Local Mental Health Authorities (LMHAs) and added to existing contracts. The first priority for this portion of the funds was to support a rapid community response to offset utilization of emergency rooms or more restrictive settings.

Crisis Funds

- **Crisis Hotline Services**
  - Continuously available 24 hours per day, seven days per week
  - All 37 LMHAs and NorthSTAR have or contract with crisis hotlines that are accredited by the American Association of Suicidology (AAS)

- **Mobile Crisis Outreach Teams (MCOT)**
  - Operate in conjunction with crisis hotlines
  - Respond at the crisis site or a safe location in the community
  - All 37 LMHAs and NorthSTAR have MCOT teams
  - More limited coverage in some rural communities

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

Competitive Funds Projects

- **Crisis Stabilization Units (CSU)**
  - Provide immediate access to emergency psychiatric care and short-term residential treatment for acute symptoms
  - Two CSUs were funded

- **Extended Observation Units**
  - Provide 23-48 hours of observation and treatment for psychiatric stabilization
  - Three extended observation units were funded

- **Crisis Residential Services**
  - Provide from 1-14 days crisis services in a clinically staffed, safe residential setting for individuals with some risk of harm to self or others
  - Four crisis residential units were funded

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

• Crisis Step-Down Stabilization in Hospital Setting
  • Provides from 3-10 days of psychiatric stabilization in a psychiatrically staffed local hospital setting
  • Six local step-down stabilization beds were funded

• Outpatient Competency Restoration Services
  • Provide community treatment to individuals with mental illness involved in the legal system
  • Reduces unnecessary burdens on jails and state psychiatric hospitals
  • Provides psychiatric stabilization and participant training in courtroom skills and behavior
  • Four Outpatient Competency Restoration projects were funded

The 81st Legislature
$53 million was appropriated for the FY 2010-2011 biennium for transitional and intensive ongoing services.

• Transitional Services
  • Provides linkage between existing services and individuals with serious mental illness not linked with ongoing care
  • Provides temporary assistance and stability for up to 90 days
  • Adults may be homeless, in need of substance abuse treatment and primary health care, involved in the criminal justice system, or experiencing multiple psychiatric hospitalizations

• Intensive Ongoing Services for Children and Adults
  • Provides team-based Psychosocial Rehabilitation services and Assertive Community Treatment (ACT) services (Service Package 3 and Service Package 4) to engage high need adults in recovery-oriented services
  • Provides intensive, wraparound services that are recovery-oriented to address the child's mental health needs
  • Expands availability of ongoing services for persons entering mental health services as a result of a crisis encounter, hospitalization, or incarceration
Appendix 5
Overview of the Initiative

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

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

Target Population for Data Link Initiatives
This project targets people currently in a county jail who have had contact with the Illinois Division of Mental Heath.

- **Jail Data Link – Cook County:** Identifies on a daily basis detainees who have had documented inpatient/outpatient services with the Illinois Division of Mental Health. Participating agencies sign a data sharing agreement for this project.

- **Jail Data Link – Cook County Frequent Users:** Identifies those current detainees from the Cook County Jail census who have at least two previous State of Illinois psychiatric inpatient hospitalizations and at least two jail stays. This will assist the jail staff in targeting new housing resources as a part of a federally funded research project beginning in 2008.

- **Jail Data Link – Expansion:** The Illinois Criminal Justice Information Authority provided funding to expand the project to Will, Peoria, Jefferson and Marion Counties, and the Proviso Mental Health Commission for Proviso Township residents.

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

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

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

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

- [https://sisonline.dhs.state.il.us/JailLink/demo.html](https://sisonline.dhs.state.il.us/JailLink/demo.html)
  - UserID:    cshdemo
  - Password:  cshdemo
  - PIN:        1234
Program Partners and Funding Sources

- **CSH’s Returning Home Initiative**: Utilizing funding from the Robert Wood Johnson Foundation, provided $25,000 towards programming and support for the creation of the Jail Data Link Frequent Users application.

- **Illinois Department of Mental Health**: Administering and financing on-going mental health services and providing secure internet database resource and maintenance.

- **Cermak Health Services**: Providing mental health services and supervision inside the jail facility.

- **Cook County Sheriff’s Office**: Assisting with data integration and coordination.

- **Community Mental Health Agencies**: Fourteen (14) agencies statewide are entering and receiving data.

- **Illinois Criminal Justice Authority**: Provided funding for the Jail Data Link Expansion of data technology to three additional counties, as well as initial funding for three additional case managers and the project’s evaluation and research through the University of Illinois.

- **Proviso Township Mental Health Commission (708 Board)**: Supported Cook County Jail Data Link Expansion into Proviso Township by funding a full-time case manager.

- **University of Illinois**: Performing ongoing evaluation and research

Partnership Between Criminal Justice and Other Public Systems

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

Managing the Partnership

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

About CSH and the Returning Home Initiative

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

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

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

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. Each year an estimated 725,000 persons are released from federal and state prisons, 125,000 with serious mental illness. More than 20 percent of people with mental illness were homeless in the months before their incarceration compared

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with 10 percent of the general prison population. 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.

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 offenses 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. At least three-quarters of incarcerated individuals with mental illness have a co-occurring substance use disorder.

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

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

- In 2011 Sandra received SSI based on her mental illness. She was on probation, with three years remaining, when she violated the terms of probation by failing to report to her probation officer. As a result, Sandra was incarcerated in a state prison. Because she was incarcerated for more than 12 months, her benefits were terminated. Sandra received a tentative parole month of September 2012 contingent on her ability to establish a verifiable residential address. The parole board did not approve the family address she submitted because the location is considered a high crime area. Unfortunately, Sandra was unable to establish residency on her own as she had no income. Thus, she missed her opportunity for parole and must complete her maximum sentence. Sandra is scheduled for release in 2013.

- Sam was released from prison after serving four years. While incarcerated, he was diagnosed with a traumatic brain injury and depression. Sam had served his full sentence and was not required to report to probation or parole upon release. He was released with $25 and the phone number for a community mental health provider. Sam is 27 years old with a ninth grade education and no prior work history. He has no family support. Within two weeks of release, Sam was arrested for sleeping in an abandoned building. He was intoxicated and told the arresting officer that drinking helped the headaches he has suffered from since he was 14 years old. Sam was sent to jail.

- Manuel was arrested for stealing from a local grocery store. He was homeless at the time of arrest and had a diagnosis of schizophrenia. He was not receiving any community mental health services at the time. Manuel has no family. He was sent to a large county jail where he spent two years before being arraigned before a judge. His periodic acute symptoms resulted in his being taken to the state hospital until he was deemed stable enough to stand trial. However, the medications that helped Manuel’s symptoms in the hospital weren’t approved for use in the jail, and more acute episodes followed. Manuel cycled between the county jail and the state hospital four times over a two-year period before being able to stand before a judge.

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

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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. 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. 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 approval.

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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 Women. 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. 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

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 7
Housing First Self-Assessment
Assess and Align Your Program and Community with a Housing First Approach

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

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
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**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
   \[\text{Number of Points Scored:}\]

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
   \[\text{Number of Points Scored:}\]

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
   \[\text{Number of Points Scored:}\]
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
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

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

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
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

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 point
   - 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 point
   - 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 point
   - 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

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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 8
When Nebraska law enforcement officials encounter people exhibiting signs of mental illness, a state statute allows them to place individuals into emergency protective custody. While emergency protective custody may be necessary if the person appears to be dangerous to themselves or to others, involuntary custody is not always the best option if the crisis stems from something like a routine medication issue.

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

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

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

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

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

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

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

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

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

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

SKYPING DURING A CRISIS?

Telehealth is a 24/7 Crisis Connection
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.
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)**


**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](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**


**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](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](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](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](http://store.samhsa.gov/shin/content//SMA13-4757/SMA13-4757.pdf)

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


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