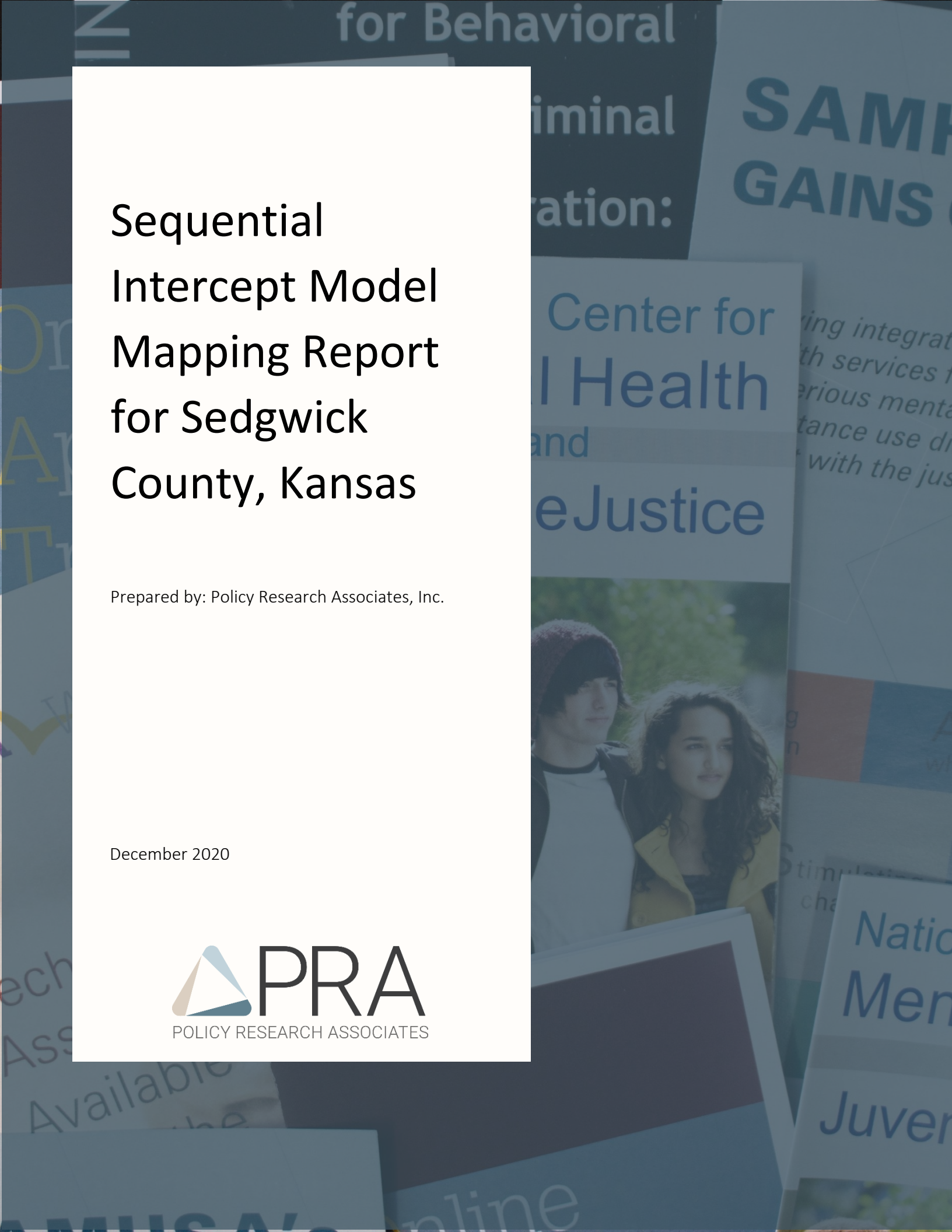
# Sequential Intercept Model Mapping Report for Sedgwick County, Kansas

Prepared by: Policy Research Associates, Inc.

December 2020




PRA
POLICY RESEARCH ASSOCIATES

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Final Report

December 2020

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## ACKNOWLEDGEMENTS

This report was prepared by Connie Milligan, Arnold Remington, and Carol Speed of Policy Research Associates, Inc. Policy Research Associates wishes to thank Jennifer Wilson, Behavioral Health Community Collaborator for Sedgwick County, for assisting with planning and organizing this effort, and all the local stakeholders who participated.

## RECOMMENDED CITATION

Policy Research Associates. (2020). *Sequential intercept model mapping report for Sedgwick County, Kansas.* Delmar, NY: Policy Research Associates, Inc.

# CONTENTS

# BACKGROUND

The Sequential Intercept Model (SIM), developed by Mark R. Munetz, M.D. and Patricia A. Griffin, Ph.D.,[1] has provides a conceptual framework for states and communities interested in exploring the intersection of criminal justice and behavioral health, assessing available resources, identifying gaps in services, and planning for community change. These activities are best accomplished by a diverse cross-system group of stakeholders that includes representation from mental health and substance use treatment providers, law enforcement, pretrial services, courts, jails, community corrections, housing, health, social services, people with lived experience, family members, and many others.

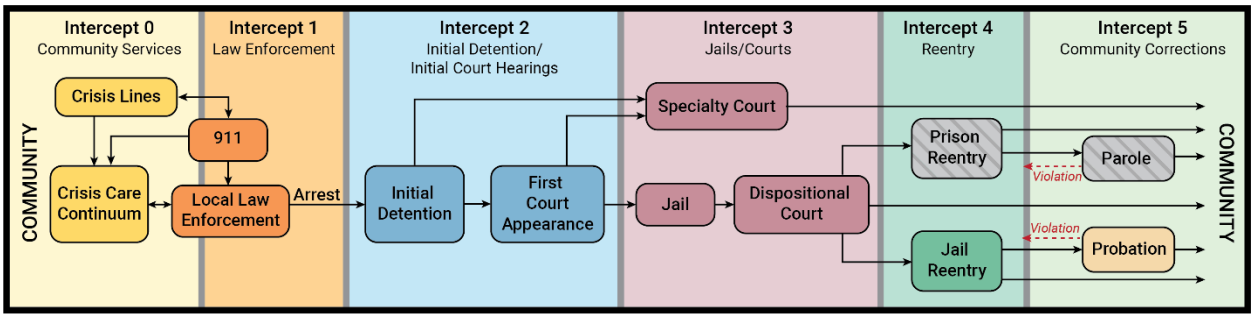
SIM Mapping is a process that results in the development of a map that illustrates how people with behavioral health needs come into contact with and move through the criminal justice system. Through the process, facilitators and participants identify opportunities for linkage to services and for prevention of further penetration into the criminal justice system.

SIM Mapping has three primary objectives:

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

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

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






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

# INTRODUCTION

On October 29, 2020, Policy Research Associates (PRA) convened a cross-system group of criminal justice and behavioral health system stakeholders from Sedgwick County for a virtual SIM Mapping Workshop. PRA delivered a presentation on the SIM and facilitated discussions focused on identifying available resources for responding to the needs of adults with mental and substance use disorders involved in the criminal justice system, as well as gaps in services. The discussions focused on all intercepts of the SIM. Following the initial meeting PRA coordinated a voting process to prioritize the identified gaps in services, which became the focus of strategic planning during a subsequent meeting.

On November 4, 2020, PRA convened the same group of stakeholders to review the results of the voting process and discuss the group's priority areas in more detail. PRA staff facilitated the development of strategic action plans to outline next steps for beginning to address the top priority areas.

# AGENDA (PART I - FOCUS GROUP MEETING)

**Sequential Intercept Model Mapping Workshop (Part I)**

**Sedgwick County, Kansas**

**October 29, 2020**
**9:00 a.m. – 4:00 p.m. Central Time**

## AGENDA

| | |
|---|---|
| 9:00 a.m. – 9:30 a.m. | **Registration and Networking** |
| 9:30 a.m. – 9:40 a.m. | **Welcome and Opening Remarks** |
| 9:40 a.m. – 10:00 a.m. | **Introductions** |
| 10:00 a.m. – 10:30 a.m. | **Sequential Intercept Model Presentation** |
| 10:30 a.m. – 10:45 a.m. | **Break** |
| 10:45 a.m. – 12:30 p.m. | **Concurrent Focus Groups**<br>• Intercepts 0/1<br>• Intercepts 2/3<br>• Intercepts 4/5 |
| 12:30 p.m. – 1:30 p.m. | **Lunch** |
| 1:30 p.m. – 2:45 p.m. | **Concurrent Focus Groups - Continued** |
| 2:45 p.m. – 3:00 p.m. | **Break** |
| 3:00 p.m. – 3:55 p.m. | **Facilitation Discussion of Priority Areas and Voting** |
| 3:55 p.m. – 4:00 p.m. | **Closing and Next Steps** |

# AGENDA (PART II - COMMUNITY MEETING)

POLICY RESEARCH ASSOCIATES

**Sequential Intercept Model Mapping Workshop (Part II)**

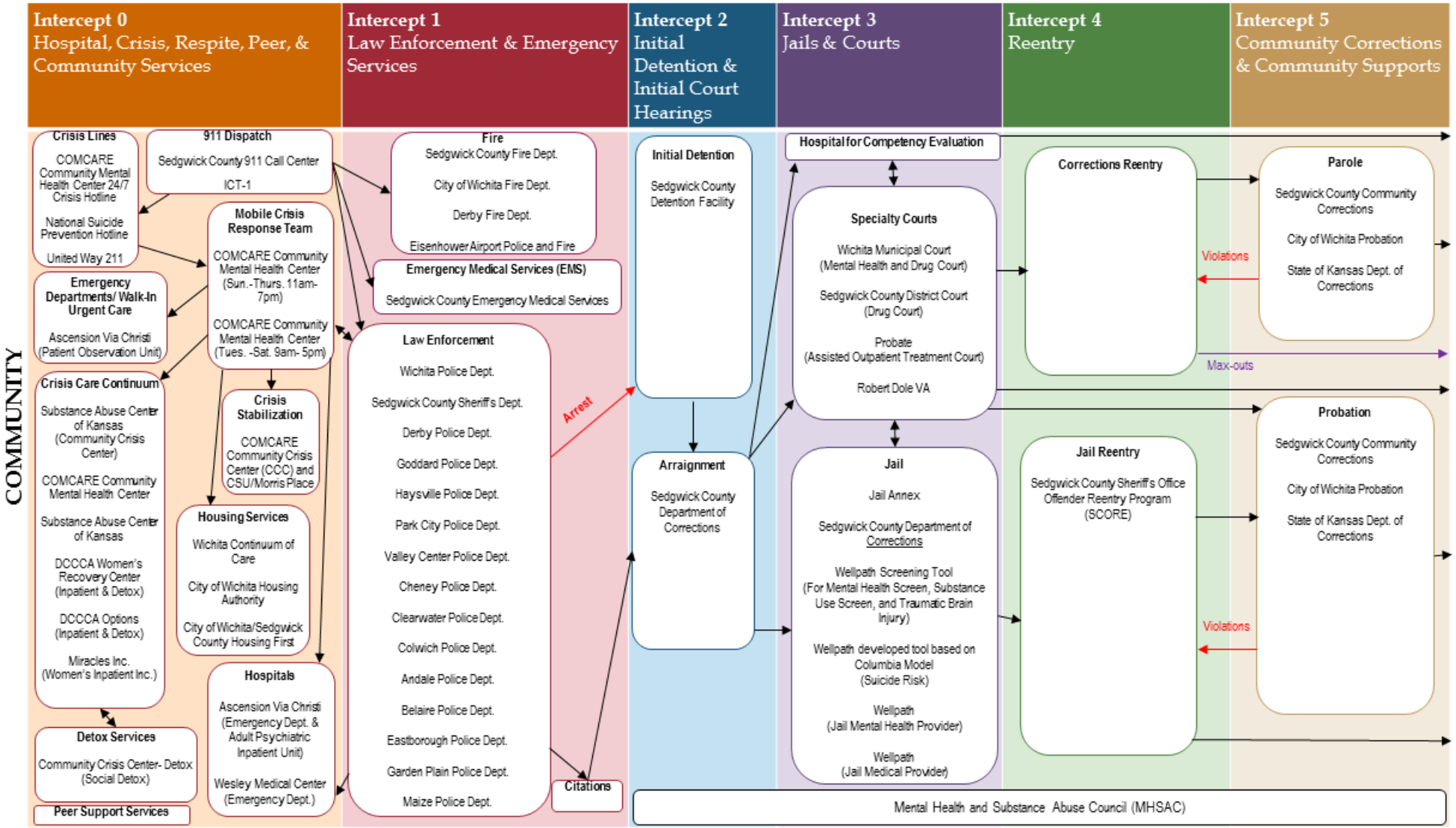
**Sedgwick County, Kansas**

**November 4, 2020**
**9:00 am – 1:00 pm CT**

## AGENDA

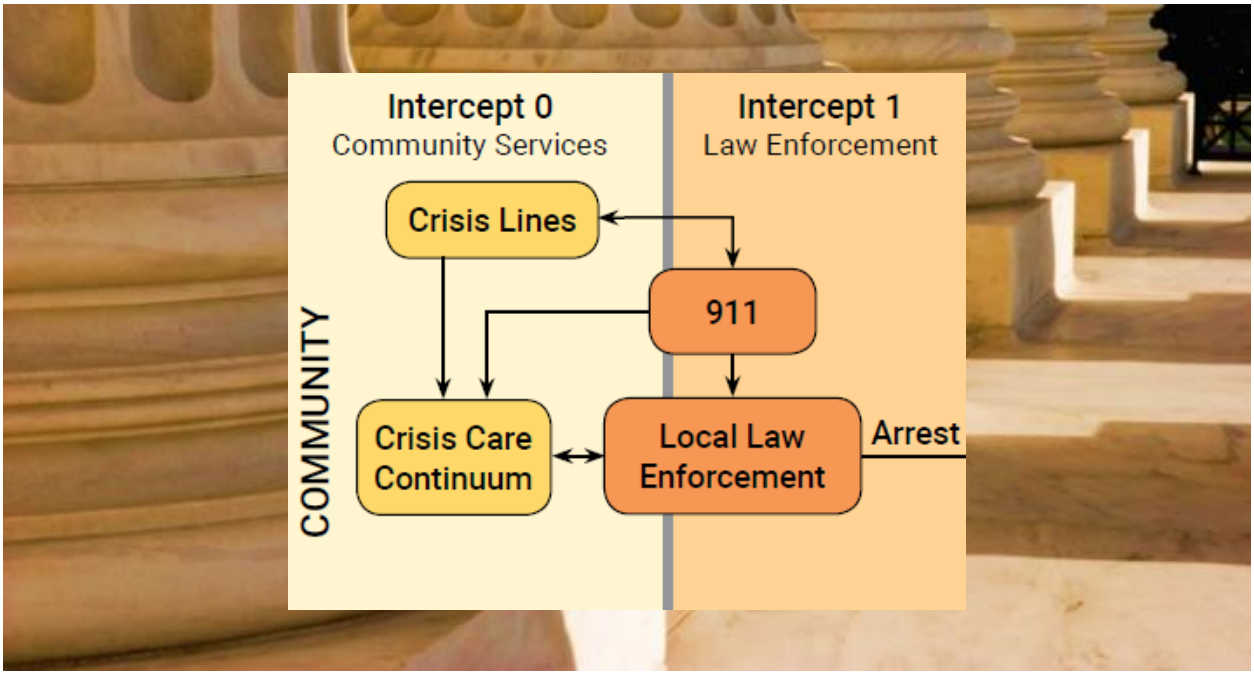
| | |
|---|---|
| 9:00 a.m. – 9:15 a.m. | **Registration and Networking** |
| 9:15 a.m. – 9:30 a.m. | **Roll Call** |
| 9:30 a.m. – 9:45 a.m. | **Community Updates** |
| 9:45 a.m. – 10:15 a.m. | **Review/Discuss Gaps, Voting Process, Priority Areas, and Group Discussion** |
| 10:15 a.m. – 10:20 a.m. | **Strategic Action Planning Overview** |
| 10:20 a.m. – 10:30 a.m. | **Break** |
| 10:30 a.m. – 11:45 a.m. | **Strategic Planning (Priority #1)** |
| 11:45 a.m. – 1:00 p.m. | **Strategic Planning (Priority #2)** |
| 1:00 p.m. | **Closing and Next Steps** |

# Sequential Intercept Model Map for Sedgwick 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

- There are a few Cross-System Groups that serve the Sedgwick County Region.
    - The Mental Health and Substance Abuse Coalition (MHSAC) was recently formed to enhance the response to behavioral health needs in the community. The county has approved a position, the Behavioral Health Community Collaborator funded in part by COMCARE. The role of the Behavioral Health Community Collaborator is to champion collaboration between community partners and carry out the MHSAC's mission. The MHSAC's Board of Directors includes the Sheriff, Chief of Police, District Attorney, Community Mental Health Center Director, Substance Abuse Center of Kansas Director, Director of Homeless Services, USD 259's Director of Safety, President of the local hospital, and leadership from the downtown private sector. The past year has been spent on completing research, gathering data, and developing strategic priorities for the MHSAC. Some of the data and research used for the strategic plan includes a High Utilizer Study completed by Wichita State University, a Comprehensive Facilities Study that was funded by a grant awarded to Ascension Via Christi, and Focus Groups

that included law enforcement and treatment and community service providers. From the data collected, the three priorities rose to the top: Access to Care, Coordination/Communication/Collaboration, and Workforce Development. The MHSAC has been using Bexar County, Texas as an example of cross-systems collaboration, which uses SIM in their Smart Justice Initiative. SIM would build on efforts already underway in Sedgwick County, improving collaboration between mental health and criminal justice agencies, while also improving the quality of lives of those served. Through the MHSAC strategic planning process, goals created to improve collaboration, communication, and coordination include: Identify a path that will allow universal healthcare plans, determine the feasibility of assigning a system navigator/liaison for assisting individuals in finding their way through services, build on the Return on Investment of pooling resources to solicit funds together, and deliver a patient-centric shared database among providers, emergency responders, and the court system.

- Crisis lines that serve the Sedgwick County Region.
    - United Way 2-1-1 is a free confidential service that can connect people in the Sedgwick county region to resources and services across Kansas. They have a trained call specialist available 24/7, with translation services available.
    - COMCARE is a Community Mental Health Center (CMHC) that operates a 24/7 crisis hotline. COMCARE has around 75-100 staff members dedicated to crisis services and case managers trained as call takers (4-5 taking calls at any given time). COMCARE tends to get around 65,000-75,000 calls per year. This service also answers calls to National Suicide Prevention.
    - Wichita Family Crisis Center Line (316-263-7501) provides immediate crisis intervention and access to referral services. Once safety and critical needs have been addressed, victims receive a wide range of services to help overcome the trauma they have experienced and start rebuilding their lives.
    - National Suicide Prevention Hotline (1-800-273-8255) is answered by the Community Crisis Center (CCC) and provides a 24/7 access.

- Mobile Crisis Unit
    - COMCARE has a Mobile Crisis Unit in Sedgwick County that is comprised of two staff - one master's level therapist and one case manager and they are available Sunday through Thursday (11 a.m.- 7 p.m.).
    - The COMCARE Community Mental Health Center is available 24/7.
- Crisis Stabilization
    - COMCARE Community Crisis Center (CCC) and COMCARE's Crisis Stabilization Unit (CSU) help provide crisis stabilization for Sedgwick county.
        - In 2015, COMCARE, the community mental health center in Sedgwick County, expanded crisis services and opened the Community Crisis Center (CCC). CCC provides 24-hour crisis intervention services, social detox, sobering, crisis observation and stabilization services, and longer-term support via emergency crisis housing services at Morris Place. The CCC has allowed law enforcement officers to divert calls to CCC for assessment, stabilization, or sobering/detox services, rather than booking them in jail for minor offenses.
        - At COMCARE's CSU, clients have access to clinicians and case managers who specialize in mental health crisis intervention. The twelve-bed facility is located at 1720 East Morris in Wichita and includes two living room areas, a dining area, a kitchen, bathrooms, and laundry facilities. The CSU is licensed as a Residential Care Facility by the Kansas Department of Aging and Disability Services.

          The average length of stay for clients at COMCARE's CSU is about 4 days. COMCARE also provides assessment and reentry services to clients in the detention facility.
- Detox/Withdrawal Management
    - COMCARE's Community Crisis Center (CCC) includes a 20-bed sobering unit and social detox unit operated by the Substance Abuse Center of Kansas.
        - There are 3 licensed addiction counselors, 17 staff part-time and fulltime and 10 peer mentors in detox.

- Training for the staff includes Mental Health First Aid Training (MHFA), motivational interviewing, patient-centered care, and bi-annual confidentiality and ethics training.

- Around 3,500 people are admitted to the social detox yearly, with an average stay of 3-5 days.
- Around 1,500 assessments are done in jail, 1,000 in the hospital.
- Substance Abuse Center of Kansas has a regional reach and focuses on access to care.
- Approximately 40% of individuals who are admitted to the sobering unit are subsequently transferred to the social detox unit.
- Sedgwick County has approximately 15 detox beds (currently only 7 beds are available due to COVID-19 restrictions).
- Assessment and referral to the appropriate level of care based on ASAM (American Society of Addiction Medicine) criteria.
- There are three to five Substance Use Disorder (SUD) treatment providers that focus on the uninsured/underinsured population in Wichita, Kansas, and receive state block grant funding to support their efforts
- 60% of people served have a dual diagnosis, 95% are uninsured.

- Men's and women's groups in jail to keep individuals engaged in treatment in preparation for release.

- 9-1-1/ Dispatch
  - The Sedgwick County 911 Call Center is the Public Safety Answering Point (PSAP) for Sedgwick County.
    - The department has 106 total staff members, and 80-90 active operations staff.
    - There are 14-20 dispatchers on duty at any given time.
    - Dispatch can transfer callers to crisis lines when the caller requests.

        - There is a 5-week training academy that includes on-the-job training, dispatch training and Mental Health de-escalation and overdose protocols.
- EMS and Fire
    - Sedgwick County Emergency Medical Services (EMS)
        - Sedgwick County EMS has 200 employees.
            - 25% of the EMS staff are Emergency Medical Technicians (EMT) and 75% are Paramedics.
            - EMS can carry Narcan and are trained to administer.
- Co-Responder Team Pilot Program
    - The Integrated Care Team (ICT-1) pilot program monitors incoming calls to 911 and provides a targeted response.
        - August 1-October 31, 2019, ICT-1 was launched, which includes one law enforcement officer, one EMT, and one qualified mental health professional. The pilot has shown early success in that 8 county and city departments agreed to have members on the team and the 90-day data indicates ICT-1 was able to treat over 50% of calls in place, reducing the need for hospitalization and/or arrest and reducing the need for law enforcement and fire units to respond to these calls.
            - A case manager from COMCARE or another community-based treatment/service provider conducts a follow-up.
            - Additional models and team configurations are also being explored (e.g. law enforcement officer and clinician to follow up with “high utilizers” or “familiar faces”.
- There are multiple Law Enforcement agencies in Sedgwick County and its surrounding areas.
    - Sedgwick County Sheriff’s Department can contact the Mobile Crisis Team and ICT-1.

- Wichita Police Department has 465 officers and all of them are mental health first aid trained and 20% have received CIT training.
    - Wichita police has a Homeless Outreach Team (HOT) with four officers working from 8 a.m. – 5 p.m. to respond to 9-1-1 calls that involve unsheltered individuals.
- Many law enforcement agencies serve areas outside of the Sedgwick County Sheriff's Office including:
    - Andale Police Dept.
    - Belaire Police Dept.
    - Cheney Police Dept.
    - Clearwater Police Dept.
    - Colwich Police Dept.
    - Derby Police Dept.
    - Eastborough Police Dept.
    - Garden Plain Police Dept.
    - Goddard Police Dept.
    - Haysville Police Dept.
    - Maize Police Dept.
    - Mulvane Police Department
    - Park City Police Dept.
    - Valley Center Police Dept.

- There are a few hospitals and treatment providers that serve individuals with mental health and substance use disorders in or near Sedgwick County including Ascension Via Christi, Wesley Medical Center, Osawatomie State Hospital (out of county), Substance Abuse Center of Kansas (CCC), and COMCARE Community Mental Health Center.

- Ascension Via Christi offers an emergency room, trauma department, and adult psychiatric inpatient unit. Individuals can remain in the emergency department for multiple days.
    - The Emergency Department is staffed 24 hours a day, 365 days a year. Emergency Department services are provided by board-certified emergency medicine physicians and nursing staff certified in advanced cardiac life support.
- There are three methadone clinics in Sedgwick County.
    - Center for Change (316-201-1234) provides medication-assisted outpatient treatment for opioid addiction.
    - Metro Treatment Center Inc. (316-263-1623) provides family counseling regarding substance abuse and 24/7 emergency/crisis intervention support.
    - Wichita Treatment Center (316-617-0680) is a provider of medically supervised medication-assisted treatment for individuals aged 18 and older.
- DCCCA Women's Recovery Center (Inpatient and Detox)
    - DCCCA Women's Recovery Center has 80 beds total for patients (40 male and 40 female). Due to COVID-19, they currently have 20 available for males and 20 for females. The Center has inpatient as well as re-integration where clients can stay 30-60 days longer with the ability to leave the facility when they want. Every patient receives a physical by Healthcore to identify medical concerns. Healthcore can refer patients for MAT. The Center also has peer support services and a connection with the Oxford House after 28 days.
- Miracles Inc. is a residential women's only program for the Sedgwick County area.
    - This program is available 24/7. They provide dual diagnosis, justice system referrals, and referrals from other community providers.
    - They do not have a wait list.

- Hunter Health (316-262-2415) is a Federally Qualified Health Center (FQHC) that provides patient-centered services and tailor a treatment plan that best firsts the patient's lifestyle and goals. They are normally open from 8 a.m. to 8 p.m. on Monday through Wednesday but when their office is not open, they provide patients with extended hours for same-day appointments and health care needs instructions, giving patients 24-hour access to medical care.
- Healthcore (316-691-0249) is an FQHC that provides responsive preventative services, including research-based initiatives that will allow patients access to premier medical advances. They are normally open Monday-Thursday 8 a.m. to 7 p.m., Friday's 8 a.m. to 5 p.m., and Saturday's 8 a.m. to 12 p.m.
- GraceMed (316-866-2000) is an FQHC and is the clinic of choice for comprehensive, integrated healthcare encompassing the spiritual, emotional, and physical needs of individuals and families in the community.

- Sedgwick County has a few shelter/housing support opportunities for the community. Including Wichita Continuum of Care, City of Wichita Housing Authority, City of Wichita/Sedgwick County Housing First, and Human Kind, to include 4 shelter providers and 2 DV shelters.
  - City of Wichita/Sedgwick County Housing First serves 64 individuals at a time.
  - Human Kind has many beds for their clients.
  - There are SOAR case managers but not enough for the demand.
  - Union Rescue Mission also houses a lot of people and are a big player in the community.

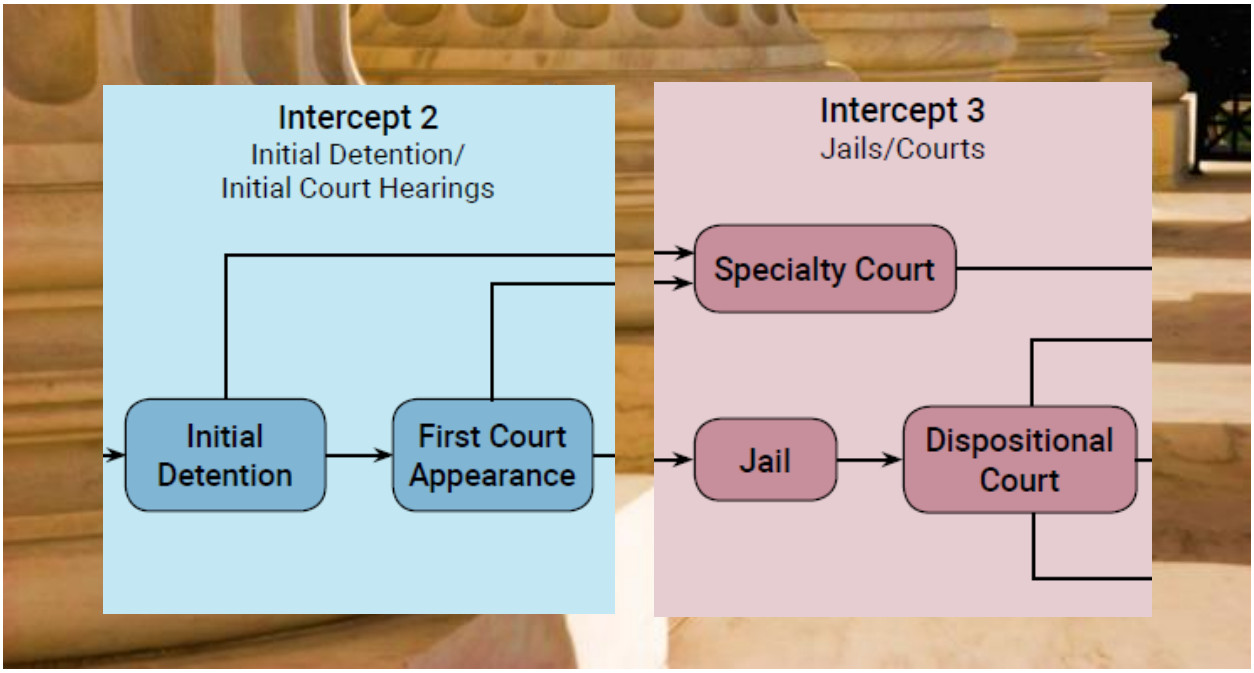
- Sedgwick County has a few peer support opportunities for the community.
  - COMCARE's CCC Social Detox employs peer support specialists that are both full time and part-time that assist with engagement navigation. COMCARE also promotes the use of Project Independence.
  - COMCARE's Crisis Observation Unit and Adult Rehab Services also employs Peer Support Specialists.

## INTERCEPT 0/1 GAPS

- Additional state block grant funding and/or adjustments to current allocations to support local programs and services are necessary.
- There is a need for state Medicaid expansion.
- The involuntary commitment process is problematic since the moratorium on state hospitalization implemented 5 years ago. The state hospital level of care is no longer a viable option when someone is in crisis.
- There are limited resources for FQHCs, CMHCs, and non-profit/faith-based entities compared to private for-profit entities.
- The ability for FQHCs to transport individuals to locations other than their home should be expanded and there should be Medicaid reimbursement for transportation.
- Additional training for 911 dispatchers on how to navigate conversations with individuals experiencing a behavioral health crisis, particularly individuals who are contemplating suicide and/or the availability of trained clinicians to assist with handling those types of calls. 911 dispatchers currently only transferring callers to crisis line/mobile crisis unit in response upon request and more dispatcher discretion could be beneficial.
- The 911 system does not have a "divert" option. Calls go directly to the Law Enforcement, even when other providers would be better suited for the task, particularly with callers who are suicidal.
- Co-responder efforts (one team for each bureau) should be expanded to link "high utilizers" or "familiar faces" with treatment and other support services (e.g. individuals who frequently utilize 911, crisis services, hospital emergency department, and detention facility).
- Expansion of ICT-1 to offer 24/7 response (and multiple teams during peak periods).
- EMS are experiencing severe staffing shortage and low compensation for staff which creates a hiring barrier (this is needed to expand co-responder efforts).

- There is no medical detox (which would require a medical director and nurse available 24/7) and there is a need for expansion of social detox and sobering services. There is currently limited access to detox services, primarily due to high costs and lack of funding for providers.
- Education for public and primary care physicians around triaging and accessing an array of non-emergency services (alternatives to hospital emergency departments) could be enhanced.
- A high number of people are uninsured or underinsured (approximately 28-35% of COMCARE patients are uninsured and 90% of SACK detox clients patients are uninsured).
- There are long wait times for individuals who are uninsured seeking inpatient (and sometimes outpatient) substance use treatment. Normally longer for men rather than women.
- There is a shortage of behavioral health and substance use treatment professionals (including non-emergency physician prescribers) and a need for quicker access to medications.
- There is a need for continued engagement through "warm handoffs" or case manager follow-up to ensure continuity of care and reimbursement for these types of services.
- There are limited transportation options available for people in the community and sometimes long wait times to get people transported to crisis and detox service providers in the community (rely heavily on law enforcement for transportation).
- There is a need for access to "low barrier" shelter beds for individuals regardless of shelter access history, employment status, substance use, criminal history, etc. For both men and women (particularly single women who are not in a domestic violence situation). Immediate access during evenings/nights can be very challenging.
- There is a need for housing case managers to aid with accessing all levels of care.
- Access to Sober Living Units (Oxford Houses) for individuals who can't afford the cost and fidelity model could be enhanced.

- Expansion of peer support services across the intercepts is needed. There is a need for peer support workforce development (recruiting and training), peer support embedded in mobile responses, and peer support embedded in inpatient substance use treatment and detox services.
- The ability to proactively analyze available data and follow up on the "high utilizers" or "familiar faces" work done a number of years ago would enhance the work in the behavioral health and criminal justice systems.




# INTERCEPT 2 AND INTERCEPT 3

## INTERCEPT 2/3 RESOURCES

- Initial detention occurs at Sedgwick County Detention Facility.
- The facility has 1,407 beds and the average daily census is between 1,535 and 1,645.
- There are approximately 70 bookings daily (30,000 bookings per year).
- There are about 300 detention deputies plus additional staff in the jail including doctors, nurses, psychiatrists, med passers, case managers, re-entry staff, counselors, mental health nurses. Detention deputies receive 11 weeks of training at the academy followed by 12 weeks in the field. They receive training in mental health and substance abuse but not in trauma.
- A form developed by Wellpath is used for mental health screening, substance use, and traumatic brain injury. They also use a suicide risk assessment based on the Columbia Model.
    - Approximately 72% of people in the facility have substance abuse issues.
    - Approximately 30% of people in the facility have mental health issues.

- The facility provides Substance Evaluation through the Substance Abuse Coordinator. Substance Abuse Center of Kansas (SACK) provides an assessment at the jail for treatment services. There are no limits on the number of times a client can use SACK.
- The facility does not provide Medication Assisted Treatment (MAT).
- The jail has a mental health pod for people that meet certain criteria.
    - More severe cases comprise the mental health pod with the jail.
    - A three-tier step-down unit based on the severity of crime and risk.
    - WELLPATH provides full-time services to include individual groups
    - Medication is continued for clients entering the pod (a doctor within the jail will prescribe).
    - COMCARE is utilized by law enforcement and if someone is intoxicated or showing signs of mental health issues, they get sent to COMCARE and from there they will try to divert from the system.
- Initial appearances are made at the Detention Facility. They are sentenced to work release which is operated by the Sedgwick County Department of Corrections. The Sedgwick county DOC, Kansas DOC and the Sedgwick County Detention Facility are all ran by different entities.
    - SCOAP is a program that is used in the court system at arraignment. The program works with the courts to intercept those with mental illnesses who have encountered the legal system and connect them to services and medication rather than incarceration. Individuals must be documented as severely mentally ill by COMCARE and qualify for case management through COMCARE. This program will accept people with felonies but none with a violent history.
    - The average length of stay for the district court was 84 days in District Court and 59 days for Municipal Court in 2019.
    - Drug Court is offered through the city of Wichita to individuals on felony probation who have committed nonviolent crimes to include drug related property crimes and drug related offenses. Drug court has a capacity of around 120 people but with COVID-19 the capacity is down to 100. The

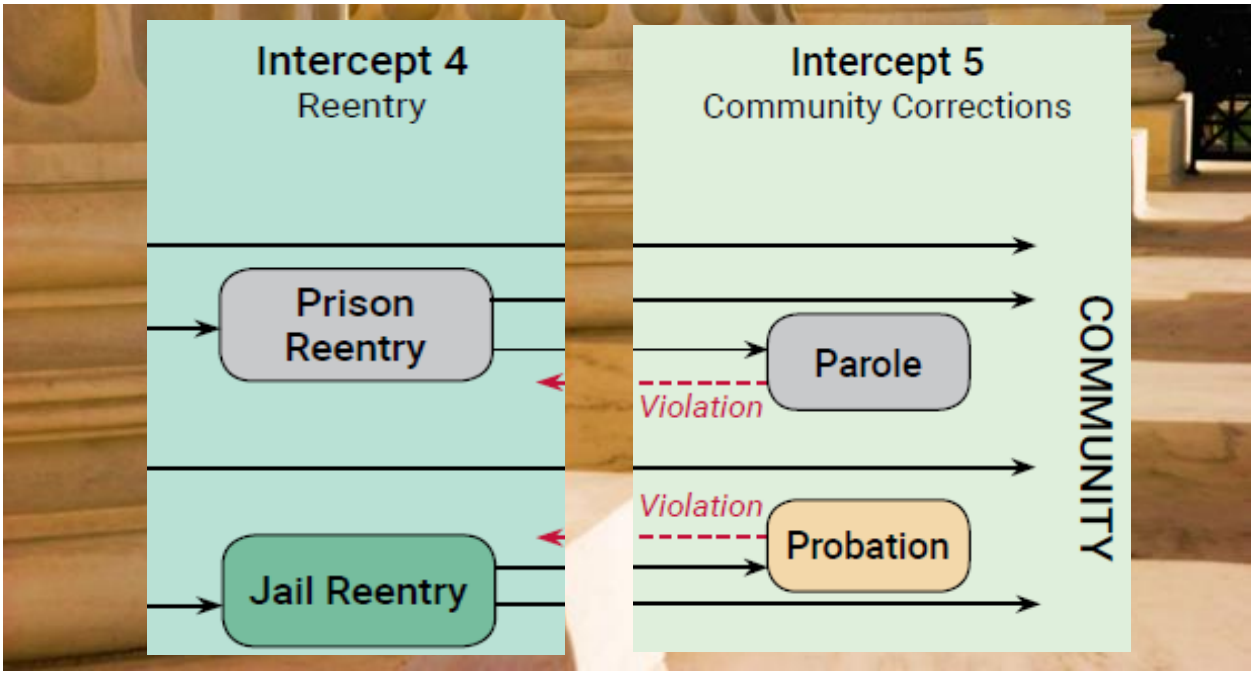
average length of the drug program is 18-24 months, but people can stay in longer and still graduate.

- The diversion program has a capacity of 60 people and the length of stay is up to 2 years.
- Mental Health Court is offered through the city of Wichita and is a post-conviction court, not a diversion. Mental Health Court has a capacity of 75 people normally but with COVID-19 the capacity is down to 50. Clients can stay in the program for up to 1 year.
- Probate Court has an Assisted Outpatient Treatment Court. The court targets people that are frequent users of the services and assessed by the Judge, COMCARE, and the case managers.
- Robert J. Dole VA Medical Center
    - The Medical Center serves over 30,000 Veterans living in 59 counties of the state. In addition to their main facility in Wichita, they offer six community-based outpatient clinics.
- The average wait time for Competency hearings is around 168 days. And there are currently 36 people waiting. Competency screening is done by COMCARE and takes about 2 weeks. The following is based upon court-ordered competency evaluations for the time frame of 4/1/2020 to 9/30/2020: 48 defendants involving 62 cases (1 Traffic Case, 61 Criminal Cases).
    - 2020 had 32 cases.
    - 2019 had 20 cases (1 Traffic, 19 Criminal).
    - 2018 had 8 cases.
    - 2017 had 2 cases.

## INTERCEPT 2/3 GAPS

- Judges could use a brief risk/needs assessment tool during the pre-trial process.

- Homeless and inmate populations do not have access to certain services due to health insurance barriers (inactive/unavailable).
- There is a need for more peer support services for substance abuse & mental health needs throughout court proceedings.
- The Jail could use assessment tools/resources to assist people with drug possession charges due to short length of stay.
- Could use more staffing with specific duties related to the steps in intercepts 2/3.
- Transportation for clients could be enhanced utilizing cab/Uber vouchers.
- There is a long waiting list for people going into the inpatient substance abuse treatment facility and limited available beds for psychiatric care.
- Upon release from jail, it is difficult to get clients with mental health issues to the services they need in the community.
- Clients leaving the jail and going directly to inpatient treatment, encounter a gap with no medicine for a couple of days until they get connected with services.
- Limited housing for people with mental health issues and if substance abuse is present, there are additional barriers.
- Education and prevention (i.e. Primary care physicians) for people in the community before the zero intercept could be better.
- There is no Veterans Court.




INTERCEPT 4 AND INTERCEPT 5

## INTERCEPT 4/5 RESOURCES

- Prison
    - There are eight facilities throughout the state.
    - Discharged with 30-day supply of medications- could add additional days if needed.
    - Special P.O. officer for release. They reach into the prisons 6-18 months prior to release.
    - At 6 months prior to d/c they work on the release plan.
    - They work with residential providers and bus transport.
    - SPMI population is transported to residential facilities
    - They enter through the prison through the RDU (receiving and diagnostic unit) where they go through an assessment.
    - For someone identified as having an illness, they have a choice to receive medication or not. Compliance with medication determines whether they are

released with a 30-day supply of their medication. It is possible to add a 15-day supply from the facility if a person is running out of medicine.

- Jail
    - Detention facility has a MH pod (53 people) and a reentry specialist that works with individuals win the pod. (employed by Wellpath, who is the mental health and medical provider in the jail.) The reentry specialist can assist three to four people per day.
    - Receive a pamphlet with a map of housing, food, resources available if they ask for it.
    - If d/c date is known they leave with 3 days' worth of meds.
    - Some care coordinators in the healthcare agencies.
    - Upon being discharged from the MH pod, many clients will get assessed by a reentry specialist employed by WellPath (the jail mental health and medical provider).
    - If requested, clients are given access to housing, food, and other resource pamphlets upon release. They can take a picture of a map with information on where resources are located and public transportation.
    - Jail has the ability to ask the judge for certain times/days for release of the special need's population.
        - Coordinated with Wellpath, a follow-up appointment is scheduled with safety-net clinics the same day as release. MOU and Universal release are signed between Wellpath and the safety net clinics to coordinate care.
    - Connections with community resources are all made after release.
    - Healthcore has "navigators" who know all resources and can help guide clients to all available services.

    - The jail tries to facilitate a warm handoff and introduce the person to the resources they are being handed off to like shelters.
    - Bus service in town.

- 1 male homeless shelter- Union Rescue Mission (30 day stay)
- 1 female shelter – Humankind.
    - Humankind also has a main shelter that is for men, women, and families.
- 2 DV shelters- Wichita Family Crisis Center and Harbor House
- VASH vouchers available through the Veterans program.
- Bus system for seniors.
- Para transport for qualifying disabilities.
- Juvenile system has lots of great incentives and money.
- Giving the Basics (resource for basic supplies-free).
- Union Rescue Mission is the lone men's homeless shelter in Sedgwick County.
    - The shelter has a 30-day rotation (30 days in and 30 days out).
- United Methodist Open Door has a day shelter available.
- There is a female homeless shelter through the Salvation Army and Humankind.
- Education and prevention (i.e. Primary care physicians) for people in the community before the zero intercept could be better.

- COMCARE is available to work with individuals in the detention facility. ComCare coordinates release services and resources for the prison but not for the jail unless they've interacted with them in the past. There is an existing case manager to assist with services in the Jail.
- Additional preliminary contactless drug screening technology (Pathpoint machine) to be implemented by end of 2020 to screen before additional UA (urinalysis) testing.

- Goodwill and Wichita State University technical college working with the County to provide vocational training for offenders.
    - Wellbeing program launched this past August.
- Workforce Alliance links unemployed clients to opportunities within the community.
- Sedgwick County offers on-call bus transportation through Senior Services (exclusive to the target population in rural Sedgwick County) and is looking to expand to Wichita.
- VA is very active in the Jail and often assists with veteran discharge.
- Kansas no longer terminates Medicaid during incarceration so it can resume upon release.
- Approximately 30% of the population at the Sedgwick County Detention Facility has a mental illness.
- Probation
    - Breakdown of probation departments:
        - Probation: moderate to very high-risk clients
        - Court: low to moderate risk
        - City: misdemeanor (low risk) only from city court-usually traffic violations.
    - 6 levels of probation caseloads:
        - Intensive. supervision (30-35 per caseload)
        - SP123 (40-50)
        - Level 2 & 3 offenders
        - High risk team (lowest caseload about 20)
        - PO in residential and reentry team (20-25)
        - Work release
        - Pretrial services (70-80)

- All PO's receive training on LSIR, motivational interviewing, some have gone through CIT training
- Some teams have a peer mentor, case manager and a therapist.
- New Ocular testing for drugs (Passpoint) will offset the expense of UA's.

- Parole
  - KSHOP hands out vouchers for housing at release from prison
  - LSIR is assessment used by DOC.
  - Same assessment and basically offer the same services as probation.
  - Phoenix- Sober gym (need 48 hours of sobriety to access) FREE for anyone.
    - This is a non-profit branch of Koch. The non-profit name is "Stand Together Foundation."

- Sedgwick County Community Corrections for Parole and Probation are one entity that manages individuals in the community separately.
- State of Kansas Department of Corrections has an adult residential and work release program in addition to their correctional facilities.
  - 5-7% of those released from prison each year have a serious mental illness and 40-45% have a less severe mental illness that has been diagnosed or is being treated while incarcerated.
  - The first step of release is finding shelter for clients upon release before the coordination of services.
- Sedgwick County has a KSHOP program to link individuals to resources upon release.
- Kansas Department of Corrections provides bus passes for those released from the prison and planning occurs depending on how much time is provided before release. For those with serious mental illness or disability, they may be transported by a corrections officer or parole officer.
- LSIR (Level of Service Inventory) is used to assess the risk level of clients and services needed while on probation and how a plan is developed for the client.

## INTERCEPT 4/5 GAPS

- Prison

- COVID has a huge impact.
- Could take up to 3 months for a follow up appointment.
- More people are released to Sedgwick County because of the abundance of resources. (which lowers resources for those being discharged)

- **Probation**
  - Currently do not have the 211 app. Working on establishing it and adding to the information.
  - No transportation available for discharging from jail. Few and far between.
  - Juvenile system has an expediter position that helps with coordination, housing, appointments, benefits, etc. No such position for the adult system.
  - Available staff to assist with reentry is very limited.
  - No resource book at discharge. Limited benefits available.
  - Don't have a great tracking system for populations (homeless, Veteran's, MH, etc.).
  - Need longer term treatment beds.
  - Need more supportive housing.
  - Probation caseload is high due to understaffing (6-8 positions down)
  - Housing is limited- hard to find landlords willing to rent to special populations. Federal regulations also a challenge.
  - There is a need for an increase in vocational training.
  - Wichita Transit is not being included in conversations. Could help create programs to fill gaps if they were.
  - There is a need to help increase partnerships for homeless populations.
- Parole
  - County resources very limited due to COVID. Currently not doing UA's.
  - Currently working off crisis and fires. At one time was up and being proactive with lots of programs and engagements.

- If a client's release is not planned, they are not provided with medication or additional clothing.
- Jails try to coordinate releases with Judges, but it is difficult to coordinate transportation when release time is indefinite.
- Inmates are not screened or asked about veteran status and inmates do not always self-disclose.
- Upon intake, the records management system is outdated and does not record veteran population size or assess for homelessness.
- Benefit coordinators do not interact with inmates during detention.
- There is a substantial amount of people who linger and become homeless in the region after being released from this jail.
- If clients are not taking medication during their incarceration, they will not be released with it.
- No peer support groups in the prison and clients with serious mental illness are not eligible to participate in the mentoring program.
- There are no specific teams in Sedgwick Community Corrections for those with mental health issues, which results in bundling those people into high-risk groups.
- Client to Probation Officer ratio is currently higher than preferred.
- There are staffing issues and high caseload ratios in Sedgwick County.
    - Sedgwick Co has higher populations across the board, so service ratios are high.
    - Pretrial services have about 70-80 person caseloads.
- There is a large homeless population in Sedgwick County, which affects supervision and stability.
- Affordability and the landlord's willingness to work with formerly incarcerated individuals are both issues in the area.

- More vocational training is needed in the Sedgwick County area.

- All agencies say they collaborate very well, but, they don't. Could be meeting monthly to share resources.
- No residential program unless they enter a correctional residential program post-release.
- The Sedgwick County community lacks funding and available housing.
- Shelter residents do not always disclose if clients are on probation or parole, so there are no stats gathered.
- There is a gap in cross-system communication post-release, arrival to homeless shelters, and resources.
- There is a need for support for individuals to receive treatment and support resources after release.
- The transportation system needs to educate and provide more passes to detention facilities and educate facility staff on resources, bus operation schedules, and services.
- Wichita Transit lacks partnerships with appropriate entities to provide bus passes and access to individuals in need.

# 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 November 4th, 2020. The top three priorities are highlighted in bold text.

1. **Expand co-responder model efforts to link "high utilizers" or "familiar faces" with treatment and other support services (49% of the vote).**
2. **No medical detox and expansion of social detox and sobering services (37% of the vote).**
3. **Create navigator roles to help connect people to all the resources they need and foster cross-resource collaboration (29% of the vote).**
4. Long wait times for individuals who are uninsured seeking inpatient (and sometimes outpatient) substance use treatment (27% of the vote).
5. High number of people are uninsured or underinsured (25% of the vote).
6. Shortage of behavioral health and substance use treatment professionals and quicker/low barrier access to medications including through education about workarounds that exist (25% of the vote).
7. Access to "low barrier" shelter beds for individuals regardless of shelter access history, employment status, substance use, criminal history, etc. (22% of the vote).
8. Expansion of peer support services across all intercepts (10% of the vote).

9. Ability to proactively analyze available data and develop a list of “high utilizers” or “familiar faces” of/in the behavioral health and criminal justice systems (10% of the vote).
10. Additional training for 9-1-1 dispatchers on how to navigate conversations with individuals experiencing a behavioral health crisis, particularly individuals who are contemplating suicide and/or the availability of trained callers to crisis lines/mobile crisis unit in response upon request and more dispatcher discretion could be beneficial (8% of the vote).
11. Continued engagement through “warm handoffs” or case manager follow-up to ensure continuity of care and reimbursement for these types of services (8% of the vote).
12. Homeless and inmate populations do not have access to certain services due to health insurance barriers (8% of the vote).
13. Intercept 4/5 staffing issues due to funding and hiring and retention issues (limited capacity to provide extensive services in-house due to funding as well as high supervision caseloads) (8%of the vote).
14. Limited EMS staff and compensation for the staff (5% of the vote).
15. Limited transportation and sometimes long wait times to get people transported to crisis and detox service providers in the community (5% of the vote).
16. Housing case managers to provide assistance with accessing all levels of care (5% of the vote).
17. Judges could use a brief risk/needs assessment tool during pre-trial process (5% of the vote).
18. Upon release from jail, it is difficult to get clients with mental health issues to the services they need in the community (5% of the vote).
19. Limited homelessness services. Limited residential programs; designated residential post-release housing (5 % of the vote).
20. Establish a LSA-type meeting to foster connections and collaboration among correctional facilities, probation/parole services and community resources (5% of the vote).
21. Identifying and collecting data on individuals booked into the jail who are experiencing homelessness and/or Veterans (2.5% of the vote).
22. Could use more staffing with specific duties related to the steps in intercepts 2/3 (2.5% of the vote).
23. Education for public and primary care physicians around triaging and accessing array of non-emergency services (0% of the vote).

24. Access to “low barrier” shelter beds for individuals regardless of shelter access history, employment status, substance use, criminal history, etc. Immediate access during evenings/nights is very challenging (0% of the vote).

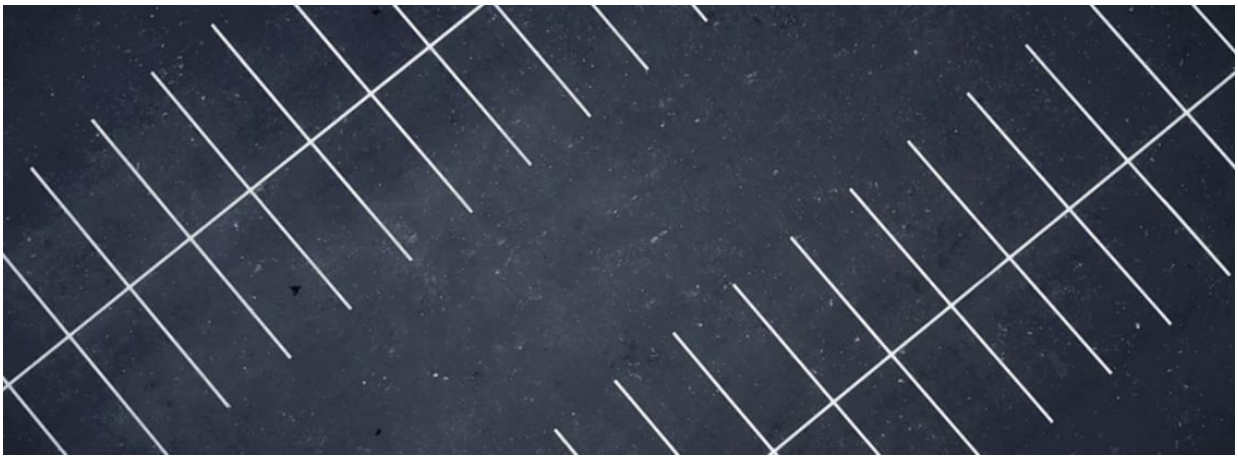
# STRATEGIC ACTION PLANS

| **Priority Area #1:** Expand Co-Responder Efforts | | | |
|---|---|---|---|
| **Objective** | **Action Step** | **Who** | **When** |
| Expand ICT-1 (Integrated Care Team) program to operate 7 days/week with multiple teams (4 teams would be enough) | • Gather and analyze available data to justify public safety tax and expansion of ICT-1 (look at cost savings, results of high utilizer study and workforce study, and availability of community-based services)<br>• Development of impact statement based on findings | • MHSAC<br>• Sedgwick Co. EMS<br>• Wichita State PPMC<br>• Safe Place | May 2021 |
| | • Hold community forum to get feedback from public | • Community members | May 2021 |
| | • Develop proposal for public safety tax to increase compensation and recruitment in public safety departments (look at what other jurisdictions have done) | • MHSAC (develop proposal and campaign)<br>• City Council<br>• County Commissioners | By September 2022 |
| | • Increase number of paramedics, clinicians, and law enforcement officers (4.3 FTEs required for each but need to go beyond minimum needed) | • Dr. John Gallagher?<br>• MHSAC Workforce Group | September 2022 (partially based on outcome of above action steps) |
| | • Develop operating schedule and staffing rotations for law enforcement officers, clinicians, and paramedics | • MHSAC Workforce Group | September 2022 (partially based on outcome of |

| | | | |
|---|---|---|---|
| | | | above action steps) |
| Implement additional co-responder team program (1 2-person team in each bureau) – pilot program currently in development with plans to implement in one bureau (south?) | • Planning for pilot program in progress<br>• Staffing and funding issues need to be explored | • Wichita Police Department<br>  ○ Homeless Outreach Team<br>  ○ DIVERT Team<br>• COMCARE | January 2021 |
| Convene follow-up meeting to continue to develop plan and discuss next steps | • Add to agenda for next MHSAC meeting | • MHSAC Workforce Group?<br>• Who needs to be added to the council? More community members? | November 16, 2020 |

| **Priority Area #2:** Development of Acute Detox Services | | | |
|---|---|---|---|
| **Objective** | **Action Step** | **Who** | **When** |
| Identify physical space and finalize design/construction<br><br>35-40 bed facility (within new crisis facility)<br>• 15-bed medical detox beds<br>• Acute detox beds<br>• Social detox beds<br>• Sobering beds | Identify physical space (currently looking at several existing buildings) | MHSAC<br>Sedgwick Co. | Ongoing |
| | Finalize design | Architect | Ongoing |
| | Construction | Bid | TBD |
| Identify funding needs (900k/year) and mechanism | Gather and analyze available data to justify need and cost savings (a lot exists already from prior efforts)<br>• Cost saving analysis should be ongoing | Joan Tammany<br>Harold Casey<br>Wichita State<br>Ascension | January 2021 |
| | Explore bringing on additional partners<br>• Initiate conversations<br>• Identify dates for upcoming meetings and get added to agendas<br>• Explore how partnerships would be mutually beneficial | • Lobbyists (Rhonda Walker will reach out)<br>• Wesley Medical Center (continue trying to engage but not essential) | ASAP |

| | | | |
|---|---|---|---|
| | Finalize funding mechanisms<br>• Medicaid and private insurance<br>• Block grant funding<br>• Donated staff (i.e., Medical Director or RN)<br>• Grant funding<br>• Explore Problem Gambling and Addiction Fund and how the funds could be accessed | • Private sector<br>• City of Wichita<br>• KS Dept. of Aging and Disability<br>• KU School of Medicine<br>• Lobbyists<br>• Legislators | Ongoing |
| | Staffing (Medical and Acute require .3 FTE Medical Director, RN 40hrs/week, and LPNs) | | |
| Continued expansion of community-based programs and services | • Develop inventory of programs and services (in progress)<br>• Integration of Kansas Health Information Network (KHIN), homeless database, etc. to improve information sharing | MHSAC | Ongoing |
| Convene follow-up meeting to continue to develop plan and discuss next steps | | BH Community Collaborator (Jennifer)<br>MHSAC | Quarterly? |



# PARKING LOT

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

- The need for Medicaid expansion to help fund services to this vulnerable, high treatment needy and medically fragile population.
- Reopen beds in the State Hospital system to assist with the care of this high risk and high need population. It has created a fiscal crisis as communities try to develop services at the local level.


# RECOMMENDATIONS

Sedgwick County has several exemplary programs that address criminal justice/behavioral health collaboration. Still, the mapping exercise identified areas where programs may need expansion or where new resources and programming must be developed.

1. **Address the Incompetent to Stand Trial (IST) population.** Participants discussed the IST population who are retained in jail while waiting transfer to a state forensic hospital. In Sedgwick County the screening process occurs within two weeks, but individuals can wait up to 168 days for a state hospital bed. The IST issue is a challenge for states across the country, but strategies have emerged to reduce the number of individuals found IST, provide outpatient restoration alternatives and reduce IST inpatient length of stay. In addition, coordinating strategies within the state forensic leadership will be a critical pathway toward reducing this challenge. This may include coordinating across other activities as well, including thinking through how an IST patient may be eligible for AOT services, or able to be diverted through crisis services and then longer term supports. For cases in which charges are minor, legal standards, such as the American Bar Association standards from 2016, point to consideration of diversion strategies for the misdemeanant who is incompetent to stand trial (see standard 7.4-8(e)).
   In general, restoration settings from most restrictive to least include inpatient (usually at a state mental health hospital, jail-based, and community-based outpatient. Consider convening a working group to review the current state of competency and competency restoration, including frequency of raised competency over the past several years, type of charges, evaluation/restoration outcomes, and individual information including mental health and substance use history/treatment, housing status, insurance status, and natural supports, if known. The American Academy of Psychiatry and Law has created guidelines for competency evaluation. Stakeholder meetings from the local jurisdiction and the state to focus on this population can be helpful. Outpatient competency-related

programs can also be considered. Also see SAMHSA's GAINS Center's *Quick Fixes for Effectively Dealing with Persons Found Incompetent to Stand Trial* (2007).

2. Implement the Brief Jail Mental Health Screen. The Jail currently does not use the Brief Jail Mental Health Screen (BJMHS) however the use of this effective quick, simple, and free resource is a powerful booking tool to screen incoming detainees in jails and detention centers for the need for further mental health assessment. The BJMHS assesses incoming detainees for the possibility of having a serious mental illness such as schizophrenia, bipolar disorder, or major depression. The process takes less than 3 minutes and is easily incorporated by corrections officers into the booking process. The entire screen consists of only eight yes/no questions. The information gathered from this tool could be passed on with the person as they move through Intercepts 2/3 providing valuable information that can assist with decision making and diversion opportunities. Johnson County Kansas is currently using this model and would be a recommended site to review.

3. Explore strategies to identify and link veterans involved in the justice system to appropriate services. The U.S. Department of Veterans Affairs' Veterans Justice Outreach Program U.S. Department of Veterans Affairs Veterans Re-entry Search Service (VRSS). At the request of then-Secretary of Veterans Affairs (VA), Eric Shinseki, the Homeless Program Office developed an automated system called Veteran Re-entry Search Service (VRSS) to locate Veterans who are currently incarcerated in federal, state, city and county correctional facilities, or who are represented as defendants on court dockets. There are approximately 1,295 federal and state, 3,000 city/county correctional facilities, and 3,000 to 4,000 courts in the United States (US), but no automated method to identify charged, convicted, or incarcerated Veterans. Through comparison of records from Correctional Facilities and Court Systems and the Veterans Affairs/Department of Defense Identity Repository (VADIR), VRSS can be used to identify Veterans incarcerated or under supervision in the courts. Note: A record of military service is not the same as qualifying for benefits with the U.S. Department of Veterans Affairs.

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

   A strong housing continuum includes emergency shelters, landlord support and intervention, rapid rehousing, Permanent Supportive Housing (with or without Housing First but including supportive services such as case management, treatment,

employment, etc.), Supported Housing (partial rent subsidies), transitional housing, affordable rental housing, and home ownership. In addition, consider how dependent care, institutional care, home-based services such as FACT, FUSE and ACT, halfway houses, and respite care can support specific populations needs.

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

- GAINS Center. Moving Toward Evidence-based Housing Program for Person with Mental Illness in Contact with the Justice System.
- Stefancic, A., Hul, L., Gillespie, C., Jost, J., Tsemberis, S., and Jones, H. (2012). Reconciling Alternative to Incarceration and Treatment Mandates with a Consumer Choice Housing First model: A Qualitative study of Individuals with Psychiatric Disabilities. Journal of Forensic Psychology Practice, 12, 382–408.
- Tsemberis, S. (2010). Housing First: The Pathways Model to End Homelessness for People with Mental Illness and Addiction. Center City, MN: Hazelden Press.
- Stefancic, A., Henwood, B. F., Melton, H., Shin, S. M., Lawrence-Gomez, R., and Tsemberis, S. (2013). Implementing Housing First in Rural Areas: Pathways Vermont, *American Journal of Public Health*, *103*, 206–209.
- Shifting the Focus from Criminalization to Housing
- Lehman, M.H., Brown, C.A., Frost, L.E., Hickey, J.S., and Buck, D.S. (2012). Integrated Primary and Behavioral Health Care in Patient-Centered Medical Homes for Jail Releases with Mental Illness. *Criminal Justice and Behavior* published online.
- Built for Zero (formerly Zero: 2016) is a rigorous national change effort working to help a core group of committed communities end veteran and chronic homelessness. Coordinated by Community Solutions, the national effort supports participants in developing real time data on homelessness, optimizing local housing resources, tracking progress against monthly goals, and accelerating the spread of proven strategies.

5. **Conduct additional data analysis.** Examine, update and reanalyze the data from the frequent users/friendly faces study for the purpose of documenting the cost of recidivation to the entire system of care. Use this information to justify and substantiate the local funding needs for the crisis system of care. Consider a "crisis care safety tax" to help underwrite the staffing and development needs for mobile co-responder crisis services in community.

# RESOURCES

## Competence Evaluation and Restoration

- Policy Research Associates. Competence to Stand Trial Microsite.
- Policy Research Associates. (2007, re-released 2020). Quick Fixes for Effectively Dealing with Persons Found Incompetent to Stand Trial.
- Finkle, M., Kurth, R., Cadle, C., and Mullan, J. (2009) Competency Courts: A Creative Solution for Restoring Competency to the Competency Process. *Behavioral Science and the Law, 27,* 767-786.

## Crisis Care, Crisis Response, and Law Enforcement

- National Association of State Mental Health Program Directors. Crisis Now: Transforming Services is Within our Reach.
- National Association of Counties. (2010). Crisis Care Services for Counties: Preventing Individuals with Mental Illnesses from Entering Local Corrections Systems.
- Abt Associates. (2020). A Guidebook to Reimagining America's Crisis Response Systems.
- Urban Institute. (2020). Alternatives to Arrests and Police Responses to Homelessness: Evidence-Based Models and Promising Practices.
- Open Society Foundations. (2018). Police and Harm Reduction.
- Center for American Progress. (2020). The Community Responder Model: How Cities Can Send the Right Responder to Every 911 Call.
- Vera Institute of Justice. (2020). Behavioral Health Crisis Alternatives: Shifting from Policy to Community Responses.
- National Association of State Mental Health Program Directors. (2020). Cops, Clinicians, or Both? Collaborative Approaches to Responding to Behavioral Health Emergencies.
- National Association of State Mental Health Program Directors and Treatment Advocacy Center. (2017). Beyond Beds: The Vital Role of a Full Continuum of Psychiatric Care.
- R Street. (2019). Statewide Policies Relating to Pre-Arrest Diversion and Crisis Response.

- Substance Abuse and Mental Health Services Administration. (2014). Crisis Services: Effectiveness, Cost-Effectiveness, and Funding Strategies.
- Substance Abuse and Mental Health Services Administration. (2019). Tailoring Crisis Response and Pre-Arrest Diversion Models for Rural Communities.
- Substance Abuse and Mental Health Services Administration. (2020). Crisis Services: Meeting Needs, Saving Lives.
    - Substance Abuse and Mental Health Services Administration. (2020). National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit.
- Crisis Intervention Team International. (2019). Crisis Intervention Team (CIT) Programs: A Best Practice Guide for Transforming Community Responses to Mental Health Crises.
- Suicide Prevention Resource Center. (2013). The Role of Law Enforcement Officers in Preventing Suicide.
- Bureau of Justice Assistance. (2014). Engaging Law Enforcement in Opioid Overdose Response: Frequently Asked Questions.
- International Association of Chiefs of Police. One Mind Campaign: Enhancing Law Enforcement Engagement with People in Crisis, with Mental Health Disorders and/or Developmental Disabilities.
- Bureau of Justice Assistance. Police-Mental Health Collaboration Toolkit.
- Policy Research Associates and the National League of Cities. (2020). Responding to Individuals in Behavioral Health Crisis Via Co-Responder Models: The Roles of Cities, Counties, Law Enforcement, and Providers.
- International Association of Chiefs of Police. Improving Police Response to Persons Affected by Mental Illness: Report from March 2016 IACP Symposium.
- Optum. (2015). In Salt Lake County, Optum Enhances Jail Diversion Initiatives with Effective Crisis Programs.
- The Case Assessment Management Program (CAMP) 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.

### Brain Injury

- National Association of State Head Injury Administrators. (2020). Criminal and Juvenile Justice Best Practice Guide: Information and Tools for State Brain Injury Programs.
- National Association of State Head Injury Administrators. Supporting Materials including Screening Tools and Sample Consent Forms.

## Housing


- Alliance for Health Reform. (2015). The Connection Between Health and Housing: The Evidence and Policy Landscape.
- Economic Roundtable. (2013). Getting Home: Outcomes from Housing High Cost Homeless Hospital Patients.
- 100,000 Homes. Housing First Self-Assessment.
- Community Solutions. Built for Zero.
- Urban Institute. (2012). Supportive Housing for Returning Prisoners: Outcomes and Impacts of the Returning Home-Ohio Pilot Project.
- Corporation for Supportive Housing. Guide to the Frequent Users Systems Engagement (FUSE) Model.
    - Corporation for Supportive Housing. NYC Frequent User Services Enhancement – Evaluation Findings.
- Corporation for Supportive Housing. Housing is the Best Medicine: Supportive Housing and the Social Determinants of Health.
- Substance Abuse and Mental Health Services Administration. (2015). TIP 55: Behavioral Health Services for People Who Are Homeless.
- National Homelessness Law Center. (2019). Housing Not Handcuffs 2019: Ending the Criminalization of Homelessness in U.S. Cities.


## Information Sharing/Data Analysis and Matching


- Legal Action Center. (2020). Sample Consent Forms for Release of Substance Use Disorder Patient Records.
- Council of State Governments Justice Center. (2010). Information Sharing in Criminal Justice-Mental Health Collaborations: Working with HIPAA and Other Privacy Laws.
- American Probation and Parole Association. (2014). Corrections and Reentry: Protected Health Information Privacy Framework for Information Sharing.
- The Council of State Governments Justice Center. (2011). Ten-Step Guide to Transforming Probation Departments to Reduce Recidivism.
- Substance Abuse and Mental Health Services Administration. (2019). Data Collection Across the Sequential Intercept Model: Essential Measures.
- Substance Abuse and Mental Health Services Administration. (2018). Crisis Intervention Team (CIT) Methods for Using Data to Inform Practice: A Step-by-Step Guide.
- Data-Driven Justice Initiative. (2016). Data-Driven Justice Playbook: How to Develop a System of Diversion.
- Urban Institute. (2013). Justice Reinvestment at the Local Level: Planning and Implementation Guide.

- Vera Institute of Justice. (2012). Closing the Gap: Using Criminal Justice and Public Health Data to Improve Identification of Mental Illness.
- New Orleans Health Department. (2016). New Orleans Mental Health Dashboard.
- The Cook County, Illinois Jail Data Linkage Project: A Data Matching Initiative in Illinois became operational in 2002 and connected the behavioral health providers working in the Cook County Jail with the community mental health centers serving the Greater Chicago area. It quickly led to a change in state policy in support of the enhanced communication between service providers. The system has grown in the ensuing years to cover significantly more of the state.

### Jail Inmate Information/Services

- NAMI California. Arrested Guides and Medication Forms.
- NAMI California. Inmate Mental Health Information Forms.
- Urban Institute. (2018). Strategies for Connecting Justice-Involved Populations to Health Coverage and Care.
- R Street. (2020). How Technology Can Strengthen Family Connections During Incarceration.

### Medication-Assisted Treatment (MAT)/Opioids/Substance Use

- American Society of Addiction Medicine. Advancing Access to Addiction Medications.
- American Society of Addiction Medicine. (2015). The National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use.
    - ASAM 2020 Focused Update.
    - Journal of Addiction Medicine. (2020). Executive Summary of the Focused Update of the ASAM National Practice Guideline for the Treatment of Opioid Use Disorder.
- National Commission on Correctional Health Care and the National Sheriffs' Association. (2018). Jail-Based Medication-Assisted Treatment: Promising Practices, Guidelines, and Resources for the Field.
- National Council for Behavioral Health. (2020). Medication-Assisted Treatment for Opioid Use Disorder in Jails and Prisons: A Planning and Implementation Toolkit.
- Substance Abuse and Mental Health Services Administration. (2019). Use of Medication-Assisted Treatment for Opioid Use Disorder in Criminal Justice Settings.
- Substance Abuse and Mental Health Services Administration. (2019). Medication-Assisted Treatment Inside Correctional Facilities: Addressing Medication Diversion.
- Substance Abuse and Mental Health Services Administration. (2015). Federal Guidelines for Opioid Treatment Programs.

- Substance Abuse and Mental Health Services Administration. (2020). Treatment Improvement Protocol (TIP) 63: Medications for Opioid Use Disorder.
- Substance Abuse and Mental Health Services Administration. (2014). Clinical Use of Extended-Release Injectable Naltrexone in the Treatment of Opioid Use Disorder: A Brief Guide.
- Substance Abuse and Mental Health Services Administration. (2015). Medication for the Treatment of Alcohol Use Disorder: A Brief Guide.
- U.S. Department of Health and Human Services. (2018). Facing Addiction in America: The Surgeon General's Spotlight on Opioids.

### Mental Health First Aid

- Mental Health First Aid. Mental Health First Aid is a skills-based training course that teaches participants about mental health and substance-use issues.
- Illinois General Assembly. (2013). Public Act 098-0195: Illinois Mental Health First Aid Training Act.
- Pennsylvania Mental Health and Justice Center of Excellence. City of Philadelphia Mental Health First Aid Initiative.

### Peer Support/Peer Specialists

- Policy Research Associates. (2020). Peer Support Roles Across the Sequential Intercept Model.
- Department of Behavioral Health and Intellectual disability Services. Peer Support Toolkit.
- University of Colorado Anschutz Medical Campus, Behavioral Health and Wellness Program (2015). DIMENSIONS: Peer Support Program Toolkit.
- Local Program Examples:
    - People USA. Rose Houses are short-term crisis respites that are home-like alternatives to hospital psychiatric ERs and inpatient units. They are 100% operated by peers.
    - Mental Health Association of Nebraska. Keya House is a four-bedroom house for adults with mental health and/or substance use issues, staffed with Peer Specialists.
    - Mental Health Association of Nebraska. Honu Home is a peer-operated respite for individuals coming out of prison or on parole or state probation.
    - MHA NE/Lincoln Police Department REAL Referral Program. The REAL referral program works closely with law enforcement officials, community corrections officers and other local human service providers to offer diversion from higher levels of care and to provide a recovery model form of community support with the help of trained Peer Specialists.

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- Actionable Intelligence for Social Policy. (2020). A Toolkit for Centering Racial Equity Throughout Data Integration.
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### Screening and Assessment

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### Sequential Intercept Model

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- Urban Institute. (2018). Using the Sequential Intercept Model to Guide Local Reform.

### 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.

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### Telehealth


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# APPENDICES

| | |
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| **Appendix 1** | Sequential Intercept Model Mapping Workshop Participant List |
| **Appendix 2** | Results of Community Self-Assessment |
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| **Appendix 7** | Corporation for Supportive Housing. *Jail Data Link Frequent Users: A Data Matching Initiative in Illinois.* |

# Appendix 1

POLICY RESEARCH ASSOCIATES

# PARTICIPANT LIST

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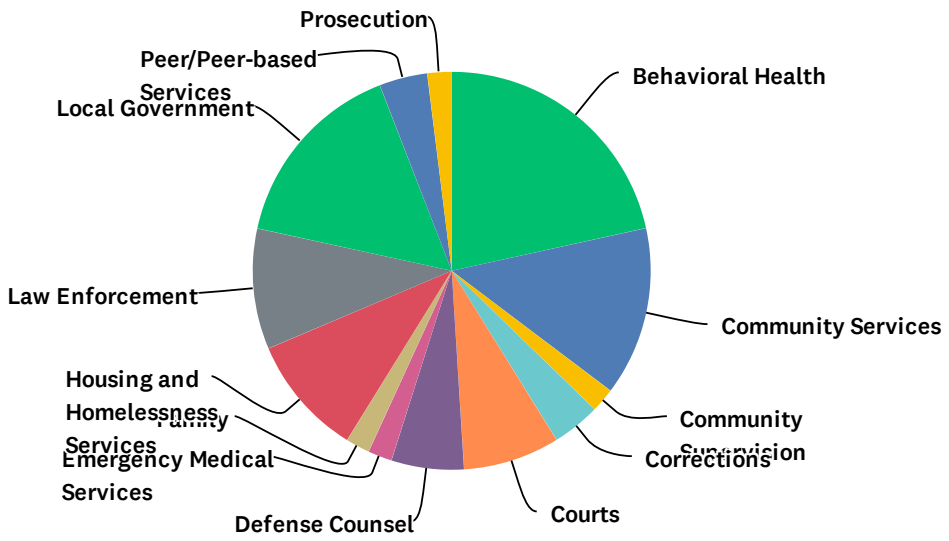
# Appendix 2

# Q1 What field do you represent?

Answered: 51 Skipped: 0




| ANSWER CHOICES | RESPONSES | |
|---|---|---|
| Behavioral Health | 21.57% | 11 |
| Community Services | 13.73% | 7 |
| Community Supervision | 1.96% | 1 |
| Corrections | 3.92% | 2 |
| Courts | 7.84% | 4 |
| Defense Counsel | 5.88% | 3 |
| Emergency Medical Services | 1.96% | 1 |
| Family | 1.96% | 1 |
| Housing and Homelessness Services | 9.80% | 5 |
| Law Enforcement | 9.80% | 5 |
| Local Government | 15.69% | 8 |
| Peer/Peer-based Services | 3.92% | 2 |
| Prosecution | 1.96% | 1 |
| Veterans Healthcare/Services | 0.00% | 0 |
| TOTAL | | 51 |

# Q2 CollaborationIn order to appropriately and effectively respond to adults with mental and substance use disorders, agencies should collaborate across the Sequential Intercept Model.Please indicate your level of agreement with the statements below as they relate to your community.

Answered: 45 Skipped: 6

| | STRONGLY DISAGREE | DISAGREE | NEITHER AGREE OR DISAGREE | AGREE | STRONGLY AGREE | DON'T KNOW | TOTAL | WEIGHTED AVERAGE |
|---|---|---|---|---|---|---|---|---|
| 2.01 There is cross-system recognition that many adults involved with the criminal justice system are experiencing mental disorders and substance use disorders. | 0.00%<br>0 | 4.44%<br>2 | 2.22%<br>1 | 35.56%<br>16 | 57.78%<br>26 | 0.00%<br>0 | 45 | 4.47 |
| 2.02 There is cross-systems recognition that responsibility for responding to these adults with mental and substance use disorders lies with all systems. | 2.22%<br>1 | 22.22%<br>10 | 11.11%<br>5 | 42.22%<br>19 | 20.00%<br>9 | 2.22%<br>1 | 45 | 3.57 |
| 2.09 Based on research evidence and guidance on best practice, stakeholders are willing to change beliefs, behaviors, practices, and policies relating to justice-involved adults with mental disorders and substance use disorders. | 4.65%<br>2 | 18.60%<br>8 | 25.58%<br>11 | 41.86%<br>18 | 2.33%<br>1 | 6.98%<br>3 | 43 | 3.20 |
| 2.08 Stakeholders focus on overcoming barriers to implementing effective programs and policies for justice-involved adults with mental disorders or substance use disorders. | 2.27%<br>1 | 25.00%<br>11 | 20.45%<br>9 | 34.09%<br>15 | 4.55%<br>2 | 13.64%<br>6 | 44 | 3.16 |
| 2.03 The criminal justice and behavioral health systems are engaged in collaborative and comprehensive efforts to foster a shared understanding of gaps at each point in the justice system. | 0.00%<br>0 | 31.82%<br>14 | 27.27%<br>12 | 27.27%<br>12 | 6.82%<br>3 | 6.82%<br>3 | 44 | 3.10 |
| 2.06 Stakeholders have established a shared mission and common goals to facilitate criminal justice and behavioral health collaboration. | 0.00%<br>0 | 31.82%<br>14 | 25.00%<br>11 | 29.55%<br>13 | 4.55%<br>2 | 9.09%<br>4 | 44 | 3.08 |
| 2.07 Stakeholders engage in frequent communication on criminal justice and behavioral health issues, including opportunities, challenges, and oversight of existing initiatives. | 2.27%<br>1 | 31.82%<br>14 | 18.18%<br>8 | 27.27%<br>12 | 6.82%<br>3 | 13.64%<br>6 | 44 | 3.05 |
| 2.10 Criminal justice and | 4.55% | 31.82% | 27.27% | 25.00% | 4.55% | 6.82% | | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| behavioral health agencies share resources and staff to support initiatives focused on adults with mental disorders or substance use disorders in the justice system. | 2 | 14 | 12 | 11 | 2 | 3 | 44 | 2.93 |
| 2.12 Criminal justice and behavioral health agencies engage in cross-system education and training to improve collaboration and understanding of different agency priorities, philosophies, and mandates. | 6.82%<br>3 | 31.82%<br>14 | 22.73%<br>10 | 20.45%<br>9 | 2.27%<br>1 | 15.91%<br>7 | 44 | 2.76 |
| 2.05 People with lived experience of mental disorders, substance use disorders, and the justice system are engaged as stakeholders on criminal justice and behavioral health collaborations, such as committees, task forces, and advisory boards. | 4.44%<br>2 | 37.78%<br>17 | 22.22%<br>10 | 22.22%<br>10 | 0.00%<br>0 | 13.33%<br>6 | 45 | 2.72 |
| 2.11 Criminal justice and behavioral health agencies share data on a routine basis for the purposes of program planning, program evaluation, and performance measurement. | 2.27%<br>1 | 36.36%<br>16 | 34.09%<br>15 | 13.64%<br>6 | 0.00%<br>0 | 13.64%<br>6 | 44 | 2.68 |
| 2.04 Family members people with mental disorders or substance use disorders are engaged as stakeholders on criminal justice and behavioral health collaborations, such as committees, task forces, and advisory boards. | 6.67%<br>3 | 33.33%<br>15 | 24.44%<br>11 | 17.78%<br>8 | 0.00%<br>0 | 17.78%<br>8 | 45 | 2.65 |

## Q3 IdentificationThe behavioral health needs of adults in the justice system should be identified on a systematic basis at each point within the criminal justice system.Please indicate your level of agreement with the statements below as they relate to your community.

Answered: 42 Skipped: 9

| | STRONGLY DISAGREE | DISAGREE | NEITHER AGREE OR DISAGREE | AGREE | STRONGLY AGREE | DON'T KNOW | TOTAL | WEIGHTED AVERAGE |
|---|---|---|---|---|---|---|---|---|
| 3.09 Information obtained through screening and assessments is never used in a manner which jeopardizes an adult's legal interests. | 7.14% 3 | 7.14% 3 | 33.33% 14 | 16.67% 7 | 7.14% 3 | 28.57% 12 | 42 | 3.13 |
| 3.05 There are procedures in place to access crisis behavioral health services for adults at any point of contact with the criminal justice system. | 2.44% 1 | 26.83% 11 | 21.95% 9 | 26.83% 11 | 4.88% 2 | 17.07% 7 | 41 | 3.06 |
| 3.07 Substance use assessments are conducted on a routine basis whenever a screening instrument indicates any such need for adults in contact with the criminal justice system. | 0.00% 0 | 26.19% 11 | 19.05% 8 | 23.81% 10 | 2.38% 1 | 28.57% 12 | 42 | 3.03 |
| 3.04 Beginning at the earliest points of contact with the criminal justice system, adults are universally screened for suicide risk by standardized instruments with demonstrated reliability and validity | 7.14% 3 | 21.43% 9 | 21.43% 9 | 21.43% 9 | 7.14% 3 | 21.43% 9 | 42 | 3.00 |
| 3.08 Risk assessments are performed in conjunction with screening and assessments to inform treatment and programming recommendations that balance public safety and behavioral health treatment needs. | 0.00% 0 | 26.83% 11 | 24.39% 10 | 17.07% 7 | 4.88% 2 | 26.83% 11 | 41 | 3.00 |
| 3.06 Mental health assessments are conducted on a routine basis whenever a screening instrument indicates any such need for adults in contact with the criminal justice system. | 4.76% 2 | 26.19% 11 | 19.05% 8 | 23.81% 10 | 2.38% 1 | 23.81% 10 | 42 | 2.91 |
| 3.10 Screens and assessments are administered on a routine basis as adults move from one point in the | 2.38% 1 | 35.71% 15 | 26.19% 11 | 7.14% 3 | 0.00% 0 | 28.57% 12 | 42 | 2.53 |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| criminal justice system to another. | | | | | | | | |
| 3.02 Beginning at the earliest points of contact with the criminal justice system, adults are universally screened for substance use disorders by standardized instruments with demonstrated reliability and validity. | 7.14% 3 | 42.86% 18 | 11.90% 5 | 11.90% 5 | 2.38% 1 | 23.81% 10 | 42 | 2.47 |
| 3.11 Data-matching between criminal justice agencies and behavioral health providers occurs on a routine basis to identify active and former consumers who have entered the criminal justice system. | 9.52% 4 | 30.95% 13 | 26.19% 11 | 7.14% 3 | 0.00% 0 | 26.19% 11 | 42 | 2.42 |
| 3.01 Beginning at the earliest points of contact with the criminal justice system, adults are universally screened for mental disorders by standardized instruments with demonstrated reliability and validity. | 7.14% 3 | 42.86% 18 | 16.67% 7 | 7.14% 3 | 0.00% 0 | 26.19% 11 | 42 | 2.32 |
| 3.03 Beginning at the earliest points of contact with the criminal justice system, adults are universally screened for violence and trauma-related symptoms by standardized instruments with demonstrated reliability and validity. | 11.90% 5 | 40.48% 17 | 16.67% 7 | 2.38% 1 | 0.00% 0 | 28.57% 12 | 42 | 2.13 |

# Q4 StrategiesA variety of interventions are necessary for a community to effectively respond to adults with mental disorders and substance use disorders involved with the criminal justice system.Please indicate your level of agreement with the statements below regarding a variety of approaches as they relate to your community.

Answered: 43 Skipped: 8

| | STRONGLY DISAGREE | DISAGREE | NEITHER AGREE OR DISAGREE | AGREE | STRONGLY AGREE | DON'T KNOW | TOTAL | WEIGHTED AVERAGE |
|---|---|---|---|---|---|---|---|---|
| 4.07 Treatment courts are aligned with best practice standards and oriented to serve high-risk/high-need individuals. | 4.65% 2 | 11.63% 5 | 18.60% 8 | 37.21% 16 | 6.98% 3 | 20.93% 9 | 43 | 3.38 |
| 4.03 Emergency communications call-takers and dispatchers are able to effectively identify and communicate details about crisis calls to law enforcement and other first responders. | 4.76% 2 | 16.67% 7 | 26.19% 11 | 28.57% 12 | 4.76% 2 | 19.05% 8 | 42 | 3.15 |
| 4.05 Pre-trial strategies are in place to reduce detention of low-risk defendants and to reduce failure to appear rates for people with mental and substance use disorders. | 4.76% 2 | 21.43% 9 | 16.67% 7 | 28.57% 12 | 7.14% 3 | 21.43% 9 | 42 | 3.15 |
| 4.04 Law enforcement and other first responders are trained to effectively respond to adults experiencing mental health crises. | 4.76% 2 | 21.43% 9 | 30.95% 13 | 33.33% 14 | 2.38% 1 | 7.14% 3 | 42 | 3.08 |
| 4.06 Pre-adjudication diversion strategies are as equally available as post-adjudication diversion strategies for individuals with mental disorders and substance use disorders. | 7.14% 3 | 16.67% 7 | 19.05% 8 | 21.43% 9 | 2.38% 1 | 33.33% 14 | 42 | 2.93 |
| 4.10 Psychotropic medication or prescriptions are provided to inmates with mental disorders to bridge the gaps from the day of jail release to their first appointment with a community-based prescriber. | 7.14% 3 | 23.81% 10 | 16.67% 7 | 30.95% 13 | 0.00% 0 | 21.43% 9 | 42 | 2.91 |
| 4.01 Justice-involved people with mental and substance use disorders have access to comprehensive community-based services. | 16.67% 7 | 30.95% 13 | 16.67% 7 | 26.19% 11 | 7.14% 3 | 2.38% 1 | 42 | 2.76 |
| 4.09 Jail transition planning is provided to | 9.52% 4 | 21.43% 9 | 23.81% 10 | 16.67% 7 | 2.38% 1 | 26.19% 11 | 42 | 2.74 |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| inmates with mental disorders to improve post-release recidivism and health care outcomes. | | | | | | | | |
| 4.13 Strategies to intervene with justice-involved adults with mental disorders and substance use disorders are evaluated on a regular basis to determine whether they are achieving the intended outcomes. | 0.00%<br>0 | 33.33%<br>14 | 14.29%<br>6 | 16.67%<br>7 | 0.00%<br>0 | 35.71%<br>15 | 42 | 2.74 |
| 4.08 Jail-based programming and health care meets the complex needs of individuals with mental disorders and substance use disorders, including behavioral health care and chronic health conditions (e.g., diabetes, HIV/AIDS). | 16.67%<br>7 | 14.29%<br>6 | 28.57%<br>12 | 14.29%<br>6 | 4.76%<br>2 | 21.43%<br>9 | 42 | 2.70 |
| 4.12 Community supervision agencies (probation and parole) field specialized caseloads for individuals with mental disorders to improve public safety outcomes, including reduced rates of technical violations. | 4.76%<br>2 | 23.81%<br>10 | 23.81%<br>10 | 11.90%<br>5 | 0.00%<br>0 | 35.71%<br>15 | 42 | 2.67 |
| 4.14 Evaluation results are reviewed by representatives from the behavioral health and criminal justice systems. | 7.14%<br>3 | 28.57%<br>12 | 21.43%<br>9 | 7.14%<br>3 | 0.00%<br>0 | 35.71%<br>15 | 42 | 2.44 |
| 4.11 Medication assisted treatment is provided to inmates with substance use disorders to reduce relapse episodes and risk for opioid overdoses following release from incarceration. | 11.90%<br>5 | 30.95%<br>13 | 21.43%<br>9 | 2.38%<br>1 | 2.38%<br>1 | 30.95%<br>13 | 42 | 2.31 |
| 4.02 There are adequate crisis services in place to meet the needs of people experiencing mental health crises. | 37.21%<br>16 | 27.91%<br>12 | 11.63%<br>5 | 13.95%<br>6 | 4.65%<br>2 | 4.65%<br>2 | 43 | 2.17 |

# Q5 ServicesAdults with mental disorders or substance use disorders in the criminal justice system should have access to effective treatment to meet their needs and with the goals of achieving greater community public health and public safety.Please indicate your level of agreement with the statements below as they related to your community.

Answered: 43 Skipped: 8

| | STRONGLY DISAGREE | DISAGREE | NEITHER AGREE OR DISAGREE | AGREE | STRONGLY AGREE | DON'T KNOW | TOTAL | WEIGHTED AVERAGE |
|---|---|---|---|---|---|---|---|---|
| 5.06 Justice-involved adults with mental disorders or substance use disorders receive assistance in obtaining legal forms of identification and benefits assistance (e.g., Medicaid/Medicare and Social Security disability benefits). | 4.76% 2 | 19.05% 8 | 16.67% 7 | 40.48% 17 | 9.52% 4 | 9.52% 4 | 42 | 3.34 |
| 5.08 There are gender-specific services and programs for women with mental disorders and substance use disorders involved with the criminal justice system. | 2.38% 1 | 16.67% 7 | 16.67% 7 | 21.43% 9 | 7.14% 3 | 35.71% 15 | 42 | 3.22 |
| 5.03 Behavioral health service providers understand how to put the risk-need-responsivity framework into practice with justice-involved adults with mental disorders or substance use disorders. | 2.38% 1 | 16.67% 7 | 21.43% 9 | 28.57% 12 | 2.38% 1 | 28.57% 12 | 42 | 3.17 |
| 5.05 Access to housing, peer, employment, transportation, family, and other recovery supports for justice-involved adults with mental and substance use disorders are significant priorities for behavioral health providers. | 7.14% 3 | 23.81% 10 | 23.81% 10 | 23.81% 10 | 7.14% 3 | 14.29% 6 | 42 | 3.00 |
| 5.02 Regardless of setting, all behavioral health services provided to justice-involved adults are evidence-based practices. Evidence-based practices are defined manual-based interventions with demonstrated positive outcomes based on repeated rigorous evaluation studies. | 7.14% 3 | 14.29% 6 | 23.81% 10 | 21.43% 9 | 2.38% 1 | 30.95% 13 | 42 | 2.97 |
| 5.09 Behavioral health providers, criminal justice agencies, and community providers share information on | 9.52% 4 | 30.95% 13 | 16.67% 7 | 30.95% 13 | 2.38% 1 | 9.52% 4 | 42 | 2.84 |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| individuals with mental disorders or substance use disorders, to the extent permitted by law, to assist effective delivery of services and programs. | | | | | | | | |
| 5.07 The services and programs provided to justice-involved adults by the behavioral health and criminal justice systems are culturally sensitive and designed to meet the needs of people of color. | 11.90% 5 | 16.67% 7 | 19.05% 8 | 14.29% 6 | 4.76% 2 | 33.33% 14 | 42 | 2.75 |
| 5.01 Adults with mental disorder and substance use disorders in contact with the criminal justice system have access to a continuum of comprehensive and effective community-based behavioral health care services. | 16.28% 7 | 34.88% 15 | 13.95% 6 | 30.23% 13 | 0.00% 0 | 4.65% 2 | 43 | 2.61 |
| 5.04 Justice-involved adults are fully engaged with behavioral health providers on the development of their treatment plans. | 4.76% 2 | 35.71% 15 | 21.43% 9 | 14.29% 6 | 0.00% 0 | 23.81% 10 | 42 | 2.59 |

# Appendix 3

| ANSWER CHOICES | RESPONSES | |
|---|---|---|
| Expand co-responder efforts (one team for each bureau) to link “high utilizers” or “familiar faces” with treatment and other support services (e.g. individuals who frequently utilize 911, crisis services, hospital emergency department, and detention facility) and expansion of ICT-1 to offer 24/7 response (and multiple teams during peak periods) | 48.78% | 20 |
| No medical detox (would require medical director and nurse available 24/7) and expansion of social detox and sobering services. Limited access to detox services, primarily due to high costs and lack of funding for providers. | 36.59% | 15 |
| Create navigator roles to help connect people to all of the resources they need and foster cross-resource collaboration (If release date/time are determined too late, there is a gap in the services, medication, and resources provided upon release). | 29.27% | 12 |
| Long wait times for individuals who are uninsured seeking inpatient (and sometimes outpatient) substance use treatment. Longer for men vs. women. Also psychiatric beds. | 26.83% | 11 |
| High number of people are uninsured or underinsured (approximately 90% of COMCARE and SACK clients fall into this category). Additional SOAR-trained case managers | 24.39% | 10 |
| Shortage of behavioral health and substance use treatment professionals (including non-emergency physician prescribers) and quicker/low barrier access to medications including through education about workarounds that exist. | 24.39% | 10 |
| Access to “low barrier” shelter beds for individuals regardless of shelter access history, employment status, substance use, criminal history, etc. For both men and women (particularly single women who are not in a domestic violence situation). Immediate access during evenings/nights is very challenging. | 21.95% | 9 |
| Expansion of peer support services across all intercepts. Peer support workforce development (recruiting, training), peer support embedded in mobile responses, and peer support embedded in inpatient substance use treatment and detox services. | 9.76% | 4 |
| Ability to proactively analyze available data and develop a list of “high utilizers” or “familiar faces” of/in the behavioral health and criminal justice systems. | 9.76% | 4 |
| Additional training for 911 dispatchers on how to navigate conversations with individuals experiencing a behavioral health crisis, particularly individuals who are contemplating suicide and/or the availability of trained clinicians to assist with handling those types of calls. 911 dispatchers currently only transferring callers to crisis line/mobile crisis unit in response upon request and more dispatcher discretion could be beneficial. | 7.32% | 3 |
| Continued engagement through “warm handoffs” or case manager follow-up to ensure continuity of care and reimbursement for these types of services | 7.32% | 3 |
| Homeless and inmate populations do not have access to certain services due to health insurance barriers (inactive/unavailable). | 7.32% | 3 |
| Intercept 4/5 Staffing issues due to funding and hiring and retention issues (limited capacity to provide extensive services in-house due to funding as well as high supervision caseloads). | 7.32% | 3 |
| Limited EMS staff and compensation for staff (this is needed to expand co-responder efforts) | 4.88% | 2 |
| Limited transportation and sometimes long wait times to get people transported to crisis and detox service providers in the community (rely heavily on law enforcement for transportation). Consider utilizing cab/uber vouchers. | 4.88% | 2 |
| Housing case managers to provide assistance with accessing all levels of care | 4.88% | 2 |
| Judges could use a brief risk/needs assessment tool during pre-trial process. | 4.88% | 2 |
| Upon release from jail, it is difficult to get clients with mental health issues to the services they need in the community. | 4.88% | 2 |
| Limited homelessness services. Limited residential programs; designated residential post-release housing. | 4.88% | 2 |
| Establish a LSA-type meeting (Local Supervisory Authority) to foster connections and collaboration among correctional facilities, probation/parole services and community resources (including transportation, housing basic necessities and resources, and treatment resources). | 4.88% | 2 |
| Identifying and collecting data on individuals booked into the jail who are experiencing homelessness and/or Veterans. | 2.44% | 1 |

| | | |
|---|---|---|
| (How to ask questions to get more accurate responses). Also look at creating a veteran pod in the jail. Could use more staffing with specific duties related to the steps in intercepts 2/3. | 2.44% | 1 |
| Education for public and primary care physicians around triaging and accessing array of non-emergency services (alternatives to hospital emergency department) | 0.00% | 0 |
| Access to Sober Living Units (Oxford Houses) for individuals who can't afford the cost and fidelity to model | 0.00% | 0 |
| The Jail could use assessment tools/resources to assist people with drug possession charges due to short length of stay. | 0.00% | 0 |
| Total Respondents: 41 | | |

# Appendix 4

# Brief Jail Mental Health Screen

**Section 1**

| **Name:** _____ First MI Last | **Detainee #:** _____ | **Date:** __ __/__ __/__ __ __ __ | **Time:** _____ AM PM |
|---|---|---|---|

**Section 2**

| **Questions** | **No** | **Yes** | **General Comments** |
|---|---|---|---|
| 1. Do you *currently* believe that someone can control your mind by putting thoughts into your head or taking thoughts out of your head? | | | |
| 2. Do you *currently* feel that other people know your thoughts and can read your mind? | | | |
| 3. Have you *currently* lost or gained as much as two pounds a week for several weeks without even trying? | | | |
| 4. Have you or your family or friends noticed that you are *currently* much more active than you usually are? | | | |
| 5. Do you *currently* feel like you have to talk or move more slowly than you usually do? | | | |
| 6. Have there *currently* been a few weeks when you felt like you were useless or sinful? | | | |
| 7. Are you *currently* taking any medication prescribed for you by a physician for any emotional or mental health problems? | | | |
| 8. Have you <u>ever</u> been in a hospital for emotional or mental health problems? | | | |

**Section 3 (Optional)**

**Officer's Comments/Impressions (check *all* that apply):**

☐ Language barrier ☐ Under the influence of drugs/alcohol ☐ Non-cooperative

☐ Difficulty understanding questions ☐ Other, specify: _____

**Referral Instructions: This detainee should be referred for further mental health evaluation if he/she answered:**

- **YES to item 7; OR**
- **YES to item 8; OR**
- **YES to at least 2 of items 1 through 6; OR**
- **If you feel it is necessary for any other reason**

☐ Not Referred

☐ Referred on __ __/__ __/__ __ __ __ to _____

Person completing screen _____

INSTRUCTIONS ON REVERSE

# INSTRUCTIONS FOR COMPLETING THE BRIEF JAIL MENTAL HEALTH SCREEN

## GENERAL INFORMATION:

This Brief Jail Mental Health Screen (BJMHS) was developed by Policy Research Associates, Inc., with a grant from the National Institute of Justice. The BJMHS is an efficient mental health screen that will aid in the early identification of severe mental illnesses and other acute psychiatric problems during the intake process.

This screen should be administered by Correctional Officers during the jail's intake/booking process.

## INSTRUCTIONS FOR SECTION 1:

| | |
|---|---|
| NAME: | Enter detainees name — first, middle initial, and last |
| DETAINEE#: | Enter detainee number. |
| DATE: | Enter today's month, day, and year. |
| TIME: | Enter the current time and circle AM or PM. |

## INSTRUCTIONS FOR SECTION 2:

ITEMS 1-6:

Place a check mark in the appropriate column (for "NO" or "YES" response).

If the detainee REFUSES to answer the question or says that he/she DOES NOT KNOW the answer to the question, do not check "NO" or "YES." Instead, in the General Comments section, indicate REFUSED or DON'T KNOW and include information explaining why the detainee did not answer the question.

ITEMS 7-8:

ITEM 7: This refers to any *prescribed* medication for any emotional or mental health problems.

ITEM 8: Include any stay of one night or longer. Do NOT include contact with an Emergency Room if it did not lead to an admission to the hospital

If the detainee REFUSES to answer the question or says that he/she DOES NOT KNOW the answer to the question, do not check "NO" or "YES." Instead, in the General Comments section, indicate REFUSED or DON'T KNOW and include information explaining why the detainee did not answer the question.

General Comments Column:

As indicated above, if the detainee REFUSES to answer the question or says that he/she DOES NOT KNOW the answer to the question, do not check "NO" or "YES." Instead, in the General Comments section, indicate REFUSED or DON'T KNOW and include information explaining why the detainee did not answer the question.

All "YES" responses require a note in the General Comments section to document:

(1) Information about the detainee that the officer feels relevant and important
(2) Information specifically requested in question

If at any point during administration of the BJMHS the detainee experiences distress, he/she should follow the jails procedure for referral services.

## INSTRUCTIONS FOR SECTION 3:

OFFICER'S COMMENTS: Check any one or more of the four problems listed if applicable to this screening. If any other problem(s) occurred, please check OTHER, and note what it was.

## REFERRAL INSTRUCTIONS:

Any detainee answering YES to Item 7 or YES to Item 8 or YES to at least two of Items 1-6 should be referred for further mental health evaluation. If there is any other information or reason why the officer feels it is necessary for the detainee to have a mental health evaluation, the detainee should be referred. Please indicate whether or not the detainee was referred.

# Appendix 5

# Data Collection Across the Sequential Intercept Model: Essential Measures

## INTRODUCTION

The Sequential Intercept Model (SIM) was introduced in the early 2000s with the goal of helping communities understand and improve the interactions between criminal justice systems and people with mental and substance use disorders. The SIM is used to identify community resources and help plan for additional resources for people with mental and substance use disorders at each phase of interaction with the justice system, beginning with Intercept 0 (crisis response) and ending with Intercept 5 (community corrections). The SIM can help leaders and staff more effectively collaborate to divert people with mental and substance use disorders away from the justice system and into treatment. The SIM is used as the basis for a workshop, conducted by both Policy Research Associates, Inc., and the Substance Abuse and Mental Health Services Administration's (SAMHSA) GAINS Center, that produces an actual map of a community's resources across the intercepts. During the many SIM mapping workshops over the years, it has become clear that tracking and understanding data across the intercepts is a critical part of developing a robust continuum of behavioral health services and reducing justice system involvement of people with mental and substance use disorders. While stakeholders may agree that local system improvements are needed, challenges may exist in identifying, gathering, analyzing, and applying data to inform those changes.

### How to Use This Manual

This manual is a compilation of recommended data elements organized around each of the six intercepts represented in the SIM. Each section lists data points and measures that are essential to addressing how people with mental and substance use disorders flow through that intercept. The sections also cover common challenges with data collection and ways to overcome them, along with practical examples of how information is being used in the field. Efforts to share data often fail when stakeholders lack clarity on the most essential information to collect, integrate, and examine. This manual provides a starting place for jurisdictions in considering important data points and measures they should be gathering and analyzing at each intercept.

Information and resources to address concerns around data sharing are provided and should be considered before decisions are made against sharing or integrating data. While current regulations are intended to protect privacy, they were also developed with portability in mind. *Readers are encouraged to consider the guidance provided here, along with their state laws, as efforts are made to share information across intercepts.*

## Data Collection Approaches

The recommended data elements should be gathered and analyzed with the goal of understanding how people flow through the behavioral health and criminal justice systems. This can be accomplished through two approaches.

- Aggregate data may be gathered to understand the sheer volume of people with mental and substance use disorders across the intercepts and how the availability of or gaps in services at one intercept may impact other intercepts. In most cases, data in aggregate can provide substantial insight into how many people with mental and substance use disorders are encountered at each intercept and the capacity of community, behavioral health, and criminal justice systems to route people into appropriate services at each intercept. The data can illuminate where gaps or insufficiencies in the continuum of behavioral health services may be contributing to significant impacts on the criminal justice system.
- Alternatively, identifiers may be used to track individuals as they move through the intercepts, which requires that those identifiers be linked across systems and databases. This allows jurisdictions to understand more precisely how people with mental and substance use disorders flow from intercept to intercept and may provide a more accurate count of how many people need services and the frequency of their engagement with criminal justice and behavioral health systems.

## How to Use the Data

Once stakeholders have identified data to collect at each intercept, the following approaches to gathering, analyzing, and using data to support the development of services are recommended:

- **Capture baseline data.** Whenever possible, collect baseline data prior to implementing changes. These baseline data can help determine if program or policy changes influence the problems the community is trying to address. If changes have already begun, it may be possible to gather historical data—pulling data from before implementation—to analyze for emerging trends. Data can be analyzed to evaluate program impacts by comparing the baseline data with data captured at various intervals after systemic or programmatic changes have begun.
- **Analyze data in the aggregate and share findings across all agencies.** Stakeholders should work together to determine what types of data and measures are relevant at each intercept point and to identify the various sources of these data. If decision-makers aren't involved in the initial conversations, ensure that a clear request is presented to them, detailing exactly what data is needed and toward what purposes. Each data set may need to be extracted and analyzed by its own agency to maintain compliance with privacy laws. Aggregate, blinded data can then be shared about groups rather than individuals. Where identifiers are used to track individuals across systems, agreements will be essential to enabling the sharing and integration of data. The types of agreements will vary depending on the data sources, the intended use of the data, and the roles of the agencies using the data (see Information Sharing Guidance for more on this topic). Findings from these analyses should be shared in a collaborative manner, so that all agencies involved may benefit from the information shared and collectively strategize to make systemic improvements.
- **Collect data in an ongoing way.** Once stakeholders have determined which variables or measures are most valuable, develop a system for collecting these data in an ongoing, real-time way. These data may be exportable to encrypted Excel or other spreadsheet formats to allow for analysis; jurisdictions shouldn't wait until sophisticated databases or dashboards are developed to begin

sharing and integrating data as long as secure mechanisms of storing and analyzing the data are established. Memorandums of agreement should memorialize the decisions made around data collection, sharing, and integration in order to protect the integrity of the agreed-upon efforts as stakeholders and government leaders come and go.

- **Collect data for people with mental illness and people with substance use disorders.** Depending on how services are structured, jurisdictions should consider tracking data for people with mental illness, substance use disorders, and co-occurring disorders. As different treatment providers or systems may serve people with substance use disorders, it will be important to include these stakeholders in the data-collection planning process to ensure those data are gathered in addition to information regarding people with mental illness. Due to the terms established by 42 Code of Federal Regulations (CFR) 2, it may be necessary for substance use treatment agencies to analyze data internally and share only blinded, aggregate data with partners or to explore other creative data-sharing mechanisms that comply with federal regulations.

## Information Sharing Guidance

The Department of Health and Human Services has issued guidance on how to understand Health Insurance Portability and Accountability Act (HIPAA) privacy regulations as they relate to information sharing between criminal justice system entities and covered entities, such as medical and behavioral health service providers. This information is very helpful for agencies when negotiating agreements that clearly delineate what can be shared and under what circumstances.

- Information sharing guidance specific to law enforcement and corrections: https://www.hhs.gov/hipaa/for-professionals/faq/505/what-does-the-privacy-rule-allow-covered-entities-to-disclose-to-law-enforcement-officials/index.html
- Information sharing guidance specific to judicial and administrative proceedings: https://www.hhs.gov/hipaa/for-professionals/faq/judicial-and-administrative-proceedings/index.html.

The following scenarios demonstrate in practice how information may be shared in ways that are compliant with HIPAA regulations:

- A mental health center may share a client's information with a law enforcement officer if that information is needed "to prevent or lessen a serious and imminent threat to health or safety."
- Because they are a covered entity, mental health professionals acting as co-responders with law enforcement may also obtain information about a patient from other providers.
- Health providers may share information with jails about medication that a detained person has been prescribed if the information is shared to provide health care, ensure the health and safety of inmates and others, protect transporting officers, promote law enforcement on premises, or for the safety and security of the correctional facility.

State law considerations: Some state laws are more restrictive than HIPAA, so stakeholders should make efforts to distinguish what the state rules are and how they apply.

For additional information, please consider the following resource:

- *Information Sharing in Criminal Justice – Mental Health Collaborations; Working with HIPAA and Other Privacy Laws* https://www.bja.gov/Publications/CSG_CJMH_Info_Sharing.pdf

The Substance Abuse and Mental Health Services Administration has also issued guidance around the application of 42 CFR Part 2 regarding the provision of and information sharing related to substance use disorder treatment: https://www.samhsa.gov/about-us/who-we-are/laws-regulations/confidentiality-regulations-faqs. As this regulation differs from HIPAA, it is important that partners working on data collection efforts understand the regulation's requirements and develop workable pathways to gathering, analyzing, and sharing data about prevalent substance use disorders and resource gaps to inform systems change.

## INTERCEPT 0: Crisis Care and First Response Continuum

Intercept 0 involves interventions for people with mental and substance use disorders prior to formal involvement with the criminal justice system. The critical components of this intercept include the local continuum of crisis care services and resources that reduce reliance on emergency response, hospitalizations, and law enforcement to serve people in crisis or with low-acuity mental health needs. In jurisdictions where very few resources exist, law enforcement may be involved in Intercept 0 diversion efforts in a *parens patriae,* or "guardian," capacity, providing first responder services.

## Crisis Lines

- **The Issue:** Jurisdictions often have multiple disconnected access points to behavioral health services through "crisis lines," including, but not limited to, 211, crisis call centers, mobile crisis lines, and peer support lines. Stratifying calls for service by crisis, emergency, specialized (such as suicide prevention), or other categories can help clarify the demand for services, improve access to appropriate services, and reduce unnecessary utilization of public resources, resulting in a more streamlined, accessible service delivery system.
- **Sample Questions Data Can Answer:** What kinds of behavioral health services are most often requested by callers? During which days and times of the week are the most people seeking services or support? Are certain individuals calling multiple lines repeatedly within the same time frame?
- **Challenges:** Gathering data regarding calls to national call systems, such as the U.S. Department of Veterans Affairs' Veterans Crisis Line, may not be possible due to the size of the systems; however, efforts should be made to understand the call volume and nature of calls to local call systems. Many communities have several call lines that serve different purposes. It will require coordination and collaboration to bring data from these multiple sources together to create a comprehensive understanding of the services being requested by the community through call lines.
- **Recommended Variables and Measures:**
  - # of crisis and support lines in operation (phone and text)
  - # of calls within a set time frame (e.g., last 6 months), for each line

- Across all calls:
  - Type of caller (family member, law enforcement, self, etc.)
  - Type of call or service requested (need related to mental illness, suicidality, substance use, or detoxification)
  - # of times someone from this location has called the line
  - Day of the week and time of day of call
  - Type of outcome (e.g., referral to emergency service, community provider follow-up scheduled, stabilized with no further follow-up)

## Emergency Departments/Hospitals

- **The Issue:** Hospital emergency departments (EDs) are frequently used by individuals seeking care for a wide range of crisis and behavioral health needs. What is often not understood by stakeholders and the community is the impact of individuals presenting at EDs who do not meet the eligibility criteria for admission. Furthermore, many communities serve a population, often known as "high utilizers," with a strong and costly pattern of ED services use and little to no connection to community-based services and stabilization post-discharge. Identifying and tracking these individuals across systems can enable comprehensive planning to stabilize and appropriately support those frequently accessing the community's service systems.
- **Sample Questions Data Can Answer:** For individuals presenting at the ED for mental and substance use concerns, what proportions meet and do not meet criteria for hospital admission? What are the most common mental and substance use diagnoses among people presenting at the ED? What proportion of these individuals have health insurance coverage? How often does the hospital reach the full capacity of its psychiatric beds or unit?
- **Challenges:** While some of the recommended variables may be available in hospital electronic records systems, the data may be embedded in regional, statewide, or national databases, and its extraction may require a substantial time commitment from hospital information technology staff and data analysts. Obtaining the needed permissions to extract data for the local area can be a lengthy process, requiring multiple meetings to discuss exact data variables, understand how the data will be used, and gain buy-in from hospital administrators. Hospital electronic medical records (EMRs) may not have the capability to collect information about police involvement, such as officer wait time, or discharge planning, such as warm hand-offs to community-based services. These items may need to be tracked in supplemental reports and databases unless the hospital has the ability to add fields to its EMR system.
- **Recommended Variables and Measures:**
  - # and % of individuals presenting at ED with a primary or secondary diagnosis related to mental or substance use disorders or impairments (specific diagnosis codes may be needed)
    - Across this group:
      - # and % meeting criteria for inpatient admission

- – Average and median length of stay in ED and inpatient unit, if admitted
- – Insurance, by type (public, private, none, etc.)
- – Discharge outcome (including to home, warm hand-off to community provider, to shelter, release prior to being seen, etc.)
- – Mode of arrival (e.g., walked in alone, or brought in by car with family, by ambulance, by mobile crisis team, by co-responder team, or by police)
- – Wait time for law enforcement, if applicable
- – # of individuals who left prior to being evaluated or against medical advice

- # and % of days out of the year when EDs go on "diversion" (i.e., they no longer have capacity to receive patients in crisis or presenting with mental or substance use disorder symptoms)

## Crisis Response Centers

- **The Issue:** As an alternative to the ED for lower-acuity crisis or mental health needs, crisis response centers often serve as voluntary, "walk-ins accepted" facilities for people with mental and substance use disorders in need of care but who do not meet the criteria for hospital admission. Crisis response centers include crisis stabilization facilities, 23-hour mental health observation units, and respite centers, which may be peer led. Stakeholders should seek to understand how the center or centers are used, what services are most requested, and ways the center or centers may lessen the demand for services from hospitals, jails, and emergency response.
- **Sample Questions Data Can Answer:** How many people are diverted from jail into community-based crisis services each year? What are the types of services most often requested by individuals presenting at the center (medication management, crisis stabilization, detoxification, etc.)?
- **Challenges:** Capturing information from law enforcement entities during drop off may be challenging as officers likely need to return to street duties promptly. The process of gathering information about the presenting problem, transportation, or wait time should be brief. Further, many crisis centers are voluntary and patients may leave without notice; information on such departures should be tracked and appropriately shared with law enforcement partners to address any problems that arise with voluntary drop-offs.
- **Recommended Variables and Measures:**
  - # of crisis centers, by type (crisis stabilization facility, 23-hour mental health observation unit, respite center, etc.)
  - # of chairs, beds, or spaces per center
  - # of individuals presenting with mental or substance use disorders or impairments; % admitted
    - Across all patients:

– Mode of arrival (e.g., walked in alone, or brought in by car with family, by ambulance, by mobile crisis team, by co-responder team, or by police)

– Wait time for law enforcement

– Average and median length of stay

– Average cost or financial charges associated

– Insurance, by type (public, private, none, etc.)

– Type of presenting issue: % mental illness, % substance use-related, % co-occurring

– Primary service provided (e.g., medication management, crisis stabilization, observation, detoxification)

– Discharge outcome (e.g., release to home, warm hand-off to community provider, referral to case manager, release to shelter, release prior to being seen)

## Mobile Crisis Teams

- **The Issue:** Early, informed clinical decision-making by mobile crisis response teams or mental health professionals connected by telehealth can route people in crisis or with mental or substance use disorders to the most appropriate care setting, reduce the number of police transports, improve outcomes, and align services. Stakeholders should understand how mobile crisis or telehealth services are engaged, what primary services are provided, where services are needed, and how mobile crisis may lessen the burden of care shouldered by other community resources.
- **Sample Questions Data Can Answer:** How many people are diverted from a higher level of care or jail by mobile crisis or telehealth services? Where are people with mental and substance use disorders most often requesting services in the community?
- **Challenges:** Most of the recommended variables may be tracked in local mobile crisis team records, law enforcement records, or those of community-based service providers. Some items may need to be added to existing data collection efforts to ensure all relevant information is gathered.
- **Recommended Variables and Measures:**
  - # of individuals served annually
    - Across all individuals:

– Primary and secondary presenting problem

– Location of service delivery

– Primary service provided (e.g., medication management, stabilization)

– Type of outcome (e.g., stabilized in the community, transported to ED, diverted from jail, arrested and taken to jail)

– % with repeat service usages in past year

## Detox Services

- **The Issue:** Community-based detoxification and withdrawal management services provide a resource to people needing a safe place to sober or initiate services for a mental or substance use disorder. Gathering and integrating data regarding individuals who frequently use detoxification services may improve their stabilization, decrease returns for additional services, increase access to or facilitate warm hand-off to community-based treatment services, and decrease frequency and costs of services. This data can also provide insight into the community's more critical substance use issues.
- **Sample Questions Data Can Answer:** Do the community's detoxification services meet the current demand? How does providing detoxification services relieve the burden for services in other facilities, such as hospitals and the jail?
- **Challenges:** While all behavioral health agencies will need to ensure compliance with HIPAA in sharing information, detoxification centers will also need to consider 42 CFR Part 2 in planning and implementing data sharing plans.
- **Recommended Variables and Measures:**
    - # of beds and chairs available, by type of detoxification service (e.g., sobering center, social model, medical, transitional, residential, "wet beds")
    - # of individuals presenting for detoxification services
        - Across all individuals:
            - Discharge type (e.g., general discharge, admission to hospital)
            - # of times individual was previously seen in the past year

## Local Spotlight: Johnson County, Kansas

The My Resource Connection application, created in Johnson County, Kansas, combines data from multiple county-wide databases (from criminal justice and behavioral health) to identify overlapping clients of the different systems. Business associates agreements created the framework allowing partners to access combined de-identified data once staff take appropriate HIPAA training and sign confidentiality agreements. When a user queries the system regarding an individual, an alert informs the user if the individual is a "mutual client," that is, someone who is served by another agency that sends data to the system. Further information about that person and his or her case manager is also available to facilitate communication and collaboration. The platform has built-in automation to notify people involved in the person's treatment or case if emergency services or legal encounters occur.

For more information, see https://icma.org/articles/my-resource-connection-collaborating-client-success.

## INTERCEPT 1: Law Enforcement Calls and Responses

At Intercept 1, law enforcement and other emergency service providers respond to people with mental and substance use disorders who are in crisis in the community. In many jurisdictions, when a person in crisis exhibits illegal behavior, law enforcement officers have the discretion to place the person under arrest or to divert them to treatment or services. Effective diversion at Intercept 1 is supported by trainings, programming, and policies that integrate behavioral health care and law enforcement to enable and promote the diversion of people with mental illness away from arrest and a subsequent jail stay and into community-based services.

### Dispatch

- **The Issue:** Dispatchers should be equipped with information and skills to respond efficiently and effectively to behavioral health-related calls. This includes having the capability to identify calls related to behavioral health needs and routing those calls to the appropriate services or responders. Data collection and analysis of calls to dispatch can help stakeholders understand, on a broad level, the types of mental and substance use disorder-related needs impacting the community. This information can also clarify how people are routed from their initial request for help into services or the justice system.
- **Sample Questions Data Can Answer:** What proportion of calls to 911 are related to mental or substance use disorder concerns? What locations generate the most calls for mental health and substance use concerns, and do these locations overlap with areas requesting services from Intercept 0 resources? How often are calls involving someone with a behavioral health need routed to specialized response units (e.g., mobile crisis teams, Crisis Intervention Team [CIT] officers, co-responders)?
- **Challenges:** These data are often contained in computer-aided-dispatch (CAD) systems managed by law enforcement agencies or other regional public safety authorities. These data are not private and may be shared. However, CAD systems may not have separate codes for noting how the call came into the agency (call type) and what happened at the end of the call (disposition codes). To address this challenge, some agencies request that officers or dispatchers update the call type when they "clear the call" and close the incident. Other jurisdictions add additional fields to their CAD or records management systems to capture both pieces of information. In some places, the final disposition of calls must be extracted from the narrative of police reports or emergency medical services (EMS) records after the incident is closed.
- **Recommended Variables and Measures:**
    - # of dispatchers that are CIT trained, by agency
    - # of calls with primary concern related to mental illness or substance use
        - Of those calls:
            - # forwarded to or triaged with a crisis line representative

- # dispatched to a specialized response (e.g., CIT-trained officer, co-responder team, mobile crisis)
- # dispatched to EMS
  - # and % with primary or secondary impression related to mental or substance use disorders or impairments
  - % of each disposition, by type
- # dispatched to law enforcement
  - % of each disposition, by type (e.g., stabilized in community, transported to hospital, referred to community-based services)
- # dispatched to fire department, where applicable
  - % of each disposition, by type (e.g., stabilized in community, transported to hospital, referred to community-based services)

○ Locations where calls for service originate

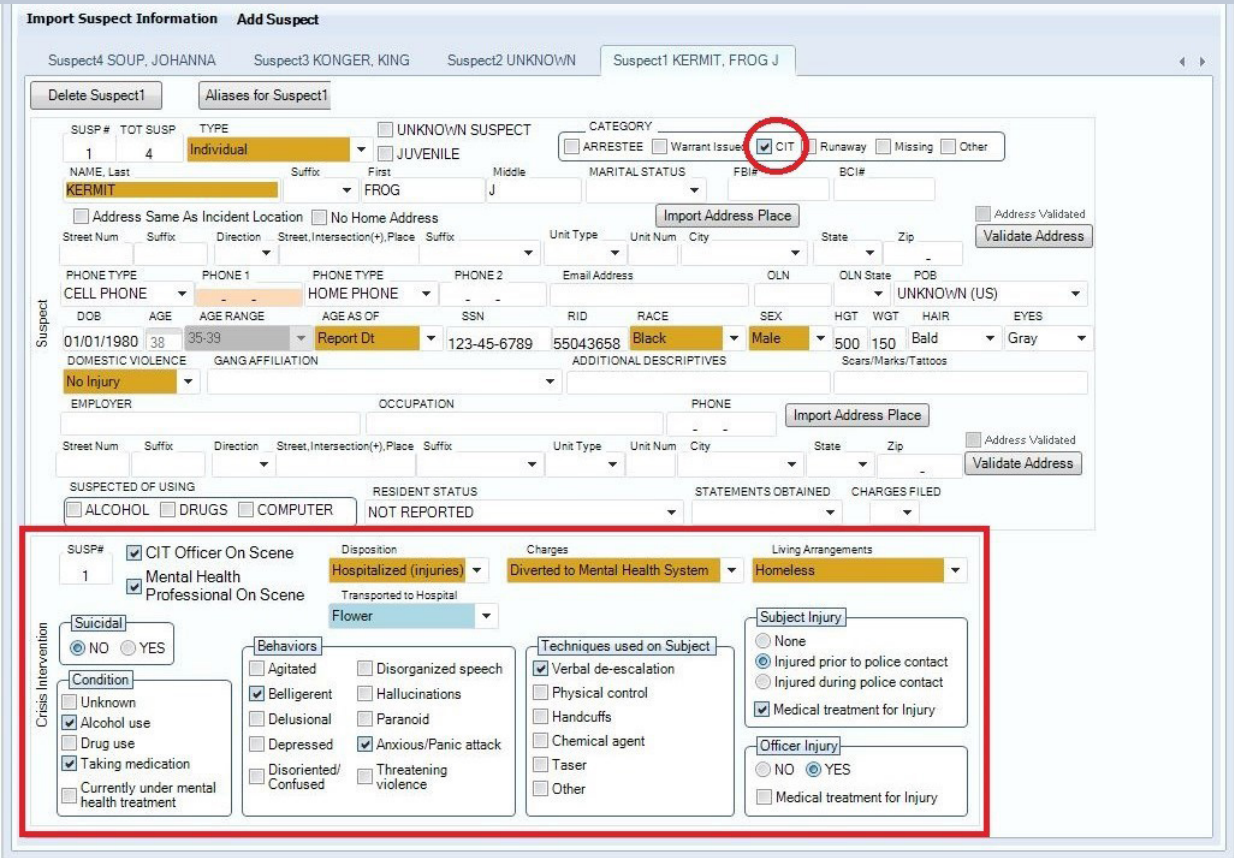
## Law Enforcement

- **The Issue:** Law enforcement officers are often the front line responders when community concerns are raised regarding a person who is experiencing a crisis or showing symptoms of a mental or substance use disorder. Specialized responses, such as CIT officers and co-responders, are promising or proven effective, but many jurisdictions lack data to demonstrate or evaluate the impact of those programs at the local level. Further, while calls involving mental health concerns may be tracked, many agencies are less consistent in recording and analyzing data around encounters during patrol that raise mental health or substance use concerns.
- **Sample Questions Data Can Answer:** How many calls or encounters in the field involve someone with a mental health or substance use-related need each year? How much time do officers spend transporting people in crisis to behavioral health services? What are the outcomes when specialized teams versus non-specialized teams respond?
- **Challenges:** Law enforcement agencies typically track all incidents where they take someone into custody, whether transporting to jail, to the ED, or to diversion locations, such as a crisis center. Those reports are contained in records management systems, which may not link to the CAD data. When officers do not take someone into custody, the only record of what happened at the scene may be what is contained in the CAD data. Some agencies require officers to complete separate data collection forms for CIT responses, but these reports are often inconsistently completed or may not link with other agencies' data.

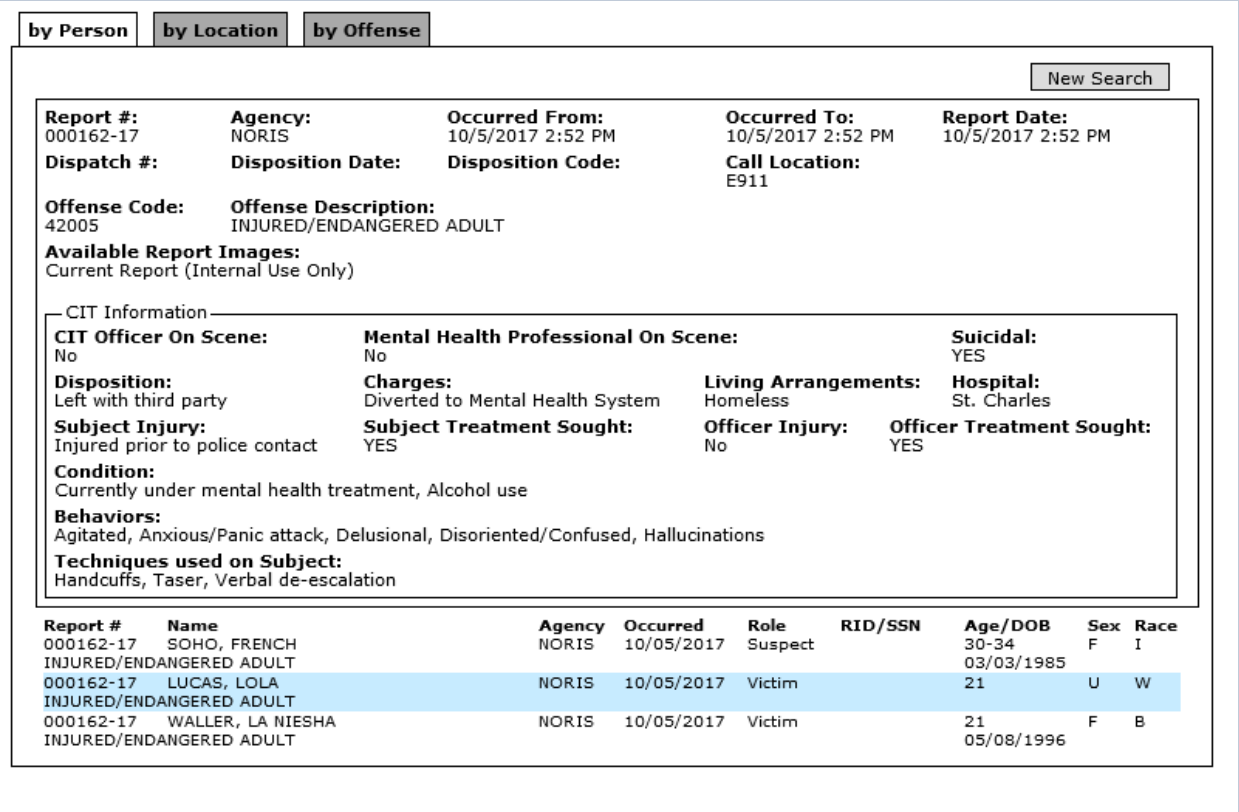
# **Local Spotlight:** Lucas County, Ohio

A web-based data entry portal enables law enforcement to enter and track information about CIT encounters, which may later be analyzed and shared with stakeholders. This tool allows the jurisdiction to better understand the dispositions of CIT calls for service, the general medical conditions of people apprehended, whether or not mental health professionals were on scene, and to where people with mental illness are diverted, such as a local hospital. In the aggregate, this information provides a wealth of insight about the level of need for community-based services, as well as the impact the CIT program is having on reducing bookings of people with mental illness. The jurisdiction also launched a CIT Person Query tool, where CIT officers can quickly search for previous interactions between law enforcement and a person with mental illness.

## Dashboard Image 1



## Dashboard Image 2




- **Recommended Variables and Measures:**
  - # and % of officers that are CIT trained, by agency
  - # of cases (including calls to law enforcement and encounters in the field by law enforcement) where mental health or substance use is or becomes primary concern
    - Of those calls and encounters:
      - Length of time spent addressing the incident
      - # and % of incidents involving a specialized response (e.g., CIT)
      - # and % of dispositions, by type (arrest, by type of charge; transportation to services by law enforcement; referral to EMS; stabilized in community, etc.)
      - # of total custodial arrests, by type of charge
      - # of total citations and summonses, by type of charge
      - Rate of use of force

## INTERCEPT 2: Intake, Booking, and Bond Setting/Review

At Intercept 2, individuals who have been arrested will go through the intake and booking process and will have an initial hearing presided over by a judicial official. Important elements of this intercept include the identification of people with mental and substance use disorders being processed and booked in the jail, placement of people with mental and substance use disorders into community-based treatment after intake or booking at the jail, and availability of specialized mental health caseloads through pretrial service agencies.

## Initial Detention

- **The Issue:** Processing arrests and booking people into a jail provides an opportunity to screen them for mental and substance use disorders and assess their need for follow-up services. With the proper tools, processes, and systems in place, defendants may be screened in a timely manner, flagged for follow-up, and supported with necessary programs so that their mental or substance use conditions do not worsen as a result of being detained. Implementing a screening at the arrest processing stage can provide jurisdictions with an understanding of the extent to which people with mental and substance use disorders are interfacing with the local criminal justice system. When linked with booking data, these screening data help stakeholders understand what proportion of detainees in the jail have mental health or substance use needs, requiring evidence-based programming and a more intentional trauma-informed approach than may normally be implemented in jail settings. Finally, when shared with other systems of care, these data are instrumental in linking people with services, new treatments, and existing case managers.
- **Sample Questions Data Can Answer:** How many people in initial detention are screened (using a standardized tool) for mental and substance use disorder-related needs? What proportion of people at intake or booking are flagged as having a history of or currently experiencing mental or substance use disorders?
- **Challenges:** Processing intakes or bookings can take time, and adding screenings for mental or substance use disorders can result in long wait times, straining the capacity of the intake or booking staff and keeping arresting officers from returning to their duties. It is important that brief screenings be used to quickly capture information about an individual's mental and substance use disorder concerns; tools that may be administered by correctional staff as well as clinical staff can increase the expediency of this process. Many screening instruments exist, and it may be difficult to recognize which tools are most appropriate. SAMHSA's publication *Screening and Assessment of Co-occurring Disorders in the Justice System*, available from the SAMHSA store, can provide helpful guidance. Establishing infrastructure to share data gathered through screenings at intake or booking is critical to ensuring this information is used to increase the services or support provided. This level of data integration may require agreements, information technology capacity, and time from staff to ensure information is routed appropriately and acted upon accordingly.

- **Recommended Variables and Measures:**
  - Average # of intakes and bookings per day; average # of releases per day
  - Type of behavioral health screening conducted (if applicable, specify name of screening tool) and at what point in the intake or booking process
  - # of individuals screened for mental or substance use problems upon intake; % screening positive
  - # of individuals provided more in-depth assessment for mental or substance use disorders
  - # of individuals flagged for follow-up; % provided follow-up mental health- or substance use-related services
  - # of persons asked about Veteran status; % by response
  - % of Veterans booked into the jail with an identified mental or substance use disorder
  - # of persons at intake with no fixed address or address is a shelter

## Initial Court Hearing

- **The Issue:** The initial hearings, where probable cause is established and bond is set, are another opportunity to further engage individuals and assess their need for mental health or substance use services. Many court officials at this phase have the discretion to set bonds that allow warm hand-offs to community-based treatment providers, yet those diversions are often not tracked, analyzed for trends, or reported to partnering stakeholders. Thus, opportunities to divert are often not understood and are underutilized. Jurisdictions with pretrial services—conducted through regular or specialized mental health caseloads—often do not understand the impact of pretrial supervision on individuals with mental or substance use disorders.
- **Sample Questions Data Can Answer:** How many people with mental or substance use disorders are released on "time served" for low-level charges at the initial hearing? How many people with mental or substance use needs are diverted at the initial hearings to community-based services?
- **Challenges:** In many jurisdictions, court processes are funded by the state, rather than by local entities that are more familiar with local needs for mental and substance use services. It may be challenging to obtain or integrate data housed in state databases due to the permissions needed, as well as difficulties in extracting and exporting local-level information. Furthermore, not all state court systems collect the data that is needed, which may require local jurisdictions to create their own data collection processes and systems. Diversions may depend on a number of decisions, including choosing to refer the individual to services, to accept referred individuals onto pretrial services caseloads, or to accept referred individuals into community-based services. Stakeholders should gather and integrate data from magistrates or other initial hearing court officials, pretrial services, and community-based organizations to understand the need for and level of diversion at this intercept.

- **Recommended Variables and Measures:**
  - # of initial hearings annually for people identified as having a mental or substance use disorder
  - Rate of referrals to community-based services, including pretrial services, at initial hearings for this population, by agency initiating or requesting the referral (e.g., magistrate, public defenders' office, prosecutor's office, judge)
  - Rate of diversion to community-based services at initial hearings, as indicated by active engagement with service provider, by agency initiating or requesting the diversion (e.g., magistrate, public defenders' office, prosecutor's office, judge)
  - Type of pretrial services available and capacity of specialized mental health or substance use pretrial caseloads
    - # of clinicians with specialized caseloads
    - Average monthly caseload

## **Local Spotlight:** Johnson County, Kansas

In 2016, the Johnson County Jail integrated an electronic version of the Brief Jail Mental Health Screen (BJMHS) at the point of booking to identify people with mental illness. Using this data, the county is able to track and analyze the prevalence, length of stay, and recidivism of people with mental illness in the local jail. Additionally, individuals needing follow-up are flagged in a shared electronic database, and follow-up is provided by the county's mental health department either within the jail or in the community if the person is released. For more information, see https://www.prainc.com/bjmhs-johnson-co-ks/.

## INTERCEPT 3: Courts and Incarceration in Jail or Prison

At Intercept 3, individuals with mental or substance use disorders who have not yet been diverted at previous intercepts may be held in pretrial detention while awaiting disposition of their criminal cases. This intercept centers around diversion of individuals from the jail or prison into programs or services that allow criminal charges to be resolved while also addressing the defendant's mental and substance use disorder needs. The intercept also involves jail- and prison-based programming that supports defendants in a trauma-informed, evidence-based manner during their incarceration.

### Courts

- **The Issue:** Courts often have specific dockets or programs for moving individuals with mental or substance use disorders through the system to a final disposition. Often, issues of "competency" are raised during the court process for which specific evaluations and restoration services are required. However, persons found incompetent to stand trial may sometimes decompensate in jails when

evaluations are not conducted in a timely manner and information regarding the defendant's status is not reviewed regularly. Most jurisdictions have treatment courts to address populations with mental disorders, those facing driving while impaired charges, or people with other types of substance use disorders. Yet, many court systems do not fully understand the level of need for these programs, nor do they track outcomes.

- **Sample Questions Data Can Answer:** On average, how long does it take for people to be evaluated when issues of competency are raised? What is the average length of stay in jail for people found not competent before being transferred to treatment? Does the capacity of the treatment courts reflect the need for diversion and services at this intercept?
- **Challenges:** Data collection may not be prioritized when staff members have limited capacity to conduct client supervision, note taking, case management activities, court reporting, and court appearances. Leadership buy-in is critical to ensure that time, technology, and supports are in place to ensure adequate data entry and regular analysis of a treatment court's short- and long-term outcomes.
- **Recommended Variables and Measures:**
  - General:
    - Annual caseload of the court system
    - Caseload processing rate
    - # and % of persons sent for evaluation of competency to stand trial
  - Treatment courts:
    - # of referrals to each treatment court
    - % of referrals accepted into each court
    - Current capacity of each court
    - Rate of successful program completion ("graduation") of each court
    - Rates of recidivism after program completion (define in accordance with National Association of Drug Court Professionals recommendations)

## Jail/Prison

- **The Issue:** Jails are the largest de facto mental health facility in many counties, so it is critical that their environments, programs, and processes enable support for people with mental and substance use disorders. Prisons often hold people for more extended periods than jails; it is important that those institutions' programs and processes provide appropriate treatment during incarceration. Data regarding the daily population experiencing mental or substance use disorders, their treatment needs, medications, and services received should be gathered on an ongoing basis. Data from intake, booking, and previous incarcerations should be merged with this information to create a comprehensive understanding of the extent to which the jail or prison is providing behavioral health services for the community and to clarify the need for community-based treatment and follow-up.

- **Sample Questions Data Can Answer:** How many people with mental or substance use needs are in the jail or prison on any given day? What are the most common treatment needs? How often are these treatment needs being met by jail or prison services? How many suicide watches are conducted each year?
- **Challenges:** In many jails, medical services, including behavioral health services, are provided by private, contracted agencies. This can pose challenges in accessing the data, particularly if the agency neither is locally based nor has a vested interest in the local community. Partnerships will need to be forged both with the contracted medical provider agency and with the jail administrator overseeing its contract to ensure that the right data is collected and shared for analysis. Jail leadership should also be engaged to ensure that data is collected regarding other behavioral health programming that is provided apart from the contracted medical provider, such as therapy provided by community-based agencies, etc.
- **Recommended Variables and Measures:**
  - # and % of individuals with a history of or currently experiencing a mental or substance use disorder (either self-reported or confirmed through health records)
  - Average length of incarceration among people with mental illness versus the general population
  - # of individuals connected to supportive services and programming (faith-based groups, employment training, education, etc.)
  - # of suicide watches and # of days the facility is on suicide watch, annually
  - # and % of individuals receiving facility-based behavioral health treatment services
    - # of individuals seeing a psychiatrist
    - # of individuals receiving psychotropic medications
    - # of individuals receiving withdrawal protocol, by type of substance
    - # of individuals placed or continued on medication-assisted treatment
  - Capacity of mental health and substance use treatment staff to provide services

## **Local Spotlight:** Adams County, Colorado

Stakeholders in Adams County, Colorado, created a justice and behavioral health information sharing dashboard and analytics tool that allows for the sharing of information between the jail and the Community Resource Center. Legal agreements, including a project charter, business associate agreements, and management control agreements were put into place to enable this collaboration. As a result, jail custody and behavioral health diagnostic information can be merged and analyzed. To experience a demonstration of the dashboard and analytics tool, please follow the links below:

- http://demo.ojbc.org/saiku-ui/
- http://demo.ojbc.org/ocpu/library/DemoJailBookingDashboard/www/index.html

## INTERCEPT 4: Reentry

At Intercept 4, individuals transition from detention or incarceration in a jail or prison back to the community. This intercept requires transition planning with specific considerations to ensure people with mental and substance use disorders can access and utilize medication and psychosocial treatment, housing, healthcare coverage, and services from the moment of release and throughout their reentry back into the community.

### Reentry

- **The Issue:** Planning for reentry begins upon entry into jail or prison, with validated screening and assessment tools used to identify the risks and needs associated with people planning to reenter the community, to shape services delivered to them while in custody, and to inform their transition following release. Effective planning and transition back to the community may require data sharing at different points in the criminal justice process and from numerous partners, such as the release pod, mental and substance use treatment providers inside the jail or prison, reentry case managers, and community-based organizations.
- **Sample Questions Data Can Answer:** How many people with mental or substance use disorders are released with adequate medications or prescriptions to last until their first appointment with a medical provider? What proportion are released with a follow-up appointment already scheduled with a primary care, mental health, or substance use treatment provider?
- **Challenges:** Many jails do not have the processes or procedures in place to ensure data are gathered or integrated at the reentry phase. If data are gathered, they may be captured by different staff depending on their roles, including reentry case managers, psychiatrists, correctional officers in the release pod, court officials, pretrial services staff, or others, depending on the processes of the jail or prison. It will be important to ensure that a mechanism for gathering, combining, and analyzing the data is in place in order to develop a coordinated approach and produce a complete understanding of reentry service outcomes.
- **Recommended Variables and Measures:**
    - # and % of persons receiving assessment(s) to shape reentry plan
    - # and % of persons with mental or substance use disorders released annually
    - # and % of persons released with psychotropic medications
    - # of days of psychotropic medication or prescription coverage in possession upon release
    - Average # of days between release and contact with community-based prescribing treatment provider
    - # of persons discharged to homelessness, a shelter, or unknown address
    - # of persons released with health insurance coverage (reactivated Medicaid, private insurance, etc.)
    - Rate of linkage to reentry services
    - Rate of recidivism after release

## **Local Spotlight:** Camden Coalition of Healthcare Providers' Camden RESET, New Jersey

In collaboration with the Camden County Re-Entry Committee, the Camden Coalition of Healthcare Providers' Re-Entering Society with Effective Tools (RESET) program leverages data to serve people reentering the community. Potential participants are identified through a database—using integrated real-time data from jails and hospitals—that sorts local residents based on their history of admission to jail, the hospital, or the ED. Participants are enrolled into the program at the Camden County jail, where an interdisciplinary team of nurses, social workers, and community health workers creates patient-centered care plans to support the individuals in attaining medical and social wellness goals. The plans are continued as the person transitions from the jail to the community. Both the Camden Coalition Health Information Exchange and the Homeless Management Information System help to coordinate care, increase information sharing, and reduce duplication of efforts across the multiple systems involved in individuals' recovery.

## INTERCEPT 5: Community Corrections

At Intercept 5, community corrections agencies (also called probation and parole) provide essential community-based supervision, as an arm of the court, to individuals released to the community. People with mental and substance use disorders may be at risk for probation or parole violations and benefit from added supports at this intercept. Use of validated assessment tools, staff training on mental and substance use disorders, and responsive services, such as specialized caseloads, are vital to reducing unnecessary violations, decreasing criminal re-offense, and improving behavioral health outcomes, through enhanced connections to services and coordination of behavioral health treatment and criminal justice supervision goals.

## Community Corrections

- **The Issue:** By the time a person is placed under community corrections, it is possible they have already provided a wealth of information to and completed numerous assessments conducted by other justice system partners or behavioral health providers. It is essential to link this information, as appropriate, to ensure community corrections officers are equipped with the information needed to develop effective supervision plans. Other community-based programs with meaningful information could include medication-assisted treatment, assisted outpatient treatment, individualized employment programs, housing-first programs, and other recovery supports. On a systems level, stakeholders should understand the local level of need or demand for specialized responses, such as specialized mental health or substance use caseloads, to improve behavioral health outcomes and reduce further justice involvement of people with mental or substance use disorders under community supervision.
- **Sample Questions Data Can Answer:** How many people under community corrections' oversight have a mental or substance use disorder? What are the main reasons for revocations among people

with mental or substance use disorders? Are community corrections officers with specialized caseloads more effective at reducing rates of revocation?

- **Challenges:** Due to privacy constraints, it can be challenging for community corrections officers to track whether someone is accessing treatment offerings. As covered entities, behavioral health treatment providers may not share information with community corrections without authorization. To address this limitation, some courts have made this authorization a condition of release; other community corrections agencies seek to gain consent from people under supervision to access information from providers.
- **Recommended Variables and Measures:**
  - # and % of persons being served by community corrections with identified mental or substance use disorders
  - # of community corrections officers (both with and without specialized caseloads)
  - # of hours of mental health and substance use training of community corrections officers (both with and without specialized caseloads)
  - Average monthly caseload of community corrections officers (both with and without specialized caseloads)
  - Rate of revocations, by reason
  - Rate of revocations of individuals with mental illness, by reason

## **Local Spotlight:** Denver, Colorado

The Division of Community Corrections, through contracts with community-based organizations, gathers data on mental and substance use disorders among people under community corrections oversight. This information is used to match services to each individual's needs and, as necessary, to flag people requiring further evaluations. The data is entered into a state database; however, local stakeholders can pull information specific to their jurisdiction. The information is shared through an annual report to support the Community Corrections Board in placement decisions and to educate local providers on the importance of timely services that match each individual's needs.

## Across All Intercepts: Housing

- **The Issue:** Many people with mental or substance use disorders and experiencing homelessness are often channeled into the justice system. Having data systems that share information about a person's housing status may inform the decisions made by law enforcement officers in the streets, reentry coordinators in the jails or prisons, and community corrections officers. This requires coordination across housing providers, justice system agencies, and local housing coalitions.

- **Sample Questions Data Can Answer:** Do community housing resources meet the need for housing people with mental or substance use disorders and justice involvement?
- **Challenges:** A centralized database tracking housing information in the community may not be available; where it is available, the use of different identifiers may limit stakeholders' abilities to link individuals across systems. In many communities, housing partners are not yet included in strategic planning to improve the behavioral health service continuum.
- **Recommended Variables and Measures:**
  - # of units available, by housing type
  - Average wait time on housing program lists
  - # of persons experiencing homelessness with self-reported or confirmed mental or substance use disorders
  - # of persons under criminal justice supervision who are experiencing homelessness
  - # of persons housed, by payment type
  - Average tenure in public housing for persons with mental and substance use disorders versus those without

## Across All Intercepts: Diagnosis

- **The Issue:** Jurisdictions that are able to gather and share diagnosis data can more effectively create a comprehensive system of care across the healthcare and criminal justice sectors. Understanding the specific types of mental and substance use disorders that are impacting the community can increase the effective allocation of local and state funds to critical treatment and diversion programs.
- **Sample Questions Data Can Answer:** What are common diagnoses driving referrals to the mental health court or drug treatment court? What are the most common diagnoses of incarcerated individuals in the jail or prison? What are the diagnoses most frequently associated with probation or parole revocations?
- **Challenges:** Due to confidentiality and privacy laws, it may not always be possible or legal to share an individual's diagnosis with criminal justice partners. Some communities may need to create arrangements to ensure that diagnoses data can be shared in the aggregate without the risk of identifying individuals receiving treatment. These arrangements may require substantial commitments of staff time and clear data sharing agreements.
- **Recommended Variables and/or Measures:**
  - # and % of individuals presenting with a primary or secondary diagnosis related to mental or substance use disorders or impairments (specific diagnosis codes may be needed)

## **Local Spotlight:** Boone County, Missouri

Through a grant from the Corporation for Supportive Housing, this jurisdiction is creating a data integration tool that will integrate homelessness and criminal justice data and produce matched lists of frequent users of the homelessness and criminal justice systems. Since the individuals booked into the local jail are administered a mental health screen, information regarding mental disorders will be available to merge with data on homelessness, enabling the jurisdiction to have a more complete picture of what services and supports are needed for people utilizing system resources at high rates.

# Appendix 6

# Housing First Self-Assessment

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

100,000 HOMES

CUCS center for urban community services

**HIGH PERFORMANCE SERIES**

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

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

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

# Housing First Self-Assessment

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

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

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

## What is Housing First?

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

## Why is this Toolkit Needed?

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

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

## How Should My Community Use This Tool?

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

# Who Does This Well?

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

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

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

# Related Tools and Resources

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

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

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

# Housing First Self-Assessment for Outreach Programs

1. **Does your program receive real-time information about vacancies in Permanent Supportive Housing?**
    - **Yes** = 1 point
    - **No** = 0 points

    | Number of Points Scored: |
    |---|

2. **The entire process from street outreach (with an engaged client) to move-in to permanent housing typically takes:**
    - More than 180 days = 0 points
    - Between 91 and 179 days = 1 point
    - Between 61 and 90 days = 2 points
    - Between 31 and 60 days = 3 points
    - 30 days or less = 4 points
    - Unknown = 0 points

    | Number of Points Scored: |
    |---|

3. **Approximately what percentage of chronic and vulnerable homeless people served by your outreach program goes straight into permanent housing (without going through emergency shelter and transitional housing)?**
    - More than 75% = 5 points
    - Between 51% and 75% = 4 points
    - Between 26% and 50% = 3 points
    - Between 11% and 25% = 2 points
    - 10% or less = 1 point
    - Unknown = 0 points

    | Number of Points Scored: |
    |---|

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

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

    **Checked Five = 5 points**

    **Checked Four = 4 points**

    **Checked Three = 3 points**

    **Checked Two = 2 points**

    **Checked One = 1 point**

    **Checked Zero = 0 points**

    | Total Points Scored: |
    |---|

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

| **Total Housing First Score:** |
|---|

If you scored: 13 points or more

- ✓ Housing First principles are likely being implemented ideally

If you scored between: 10 – 12 points

- ✓ Housing First principles are likely being well-implemented

If you scored between: 7 – 9 points

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

If you scored between: 4 - 6 points

- ✓ Housing First principles are likely being poorly implemented

If you scored between: 0 – 3 points

- ✓ Housing First principles are likely not being implemented

# Housing First Self-Assessment
# For Emergency Shelter Programs

1. **Does your program receive real-time information about vacancies in Permanent Supportive Housing?**
    - **Yes** = 1 point
    - **No** = 0 points

    | Number of Points Scored: |
    |---|

2. **Approximately what percentage of chronic and vulnerable homeless people staying in your emergency shelter go straight into permanent housing without first going through transitional housing?**
    - More than 75% = 5 points
    - Between 51% and 75% = 4 points
    - Between 26% and 50% = 3 points
    - Between 11% and 25% = 2 points
    - 10% or less = 1 point
    - Unknown = 0 points

    | Number of Points Scored: |
    |---|

3. **Indicate whether priority consideration for shelter at your program is given to potential program participants with following characteristics.** *Check all that apply*:
    - ☐ Participants who demonstrate a high level of housing instability/chronic homelessness
    - ☐ Participants who have criminal justice records, including currently on probation/parole/court mandate
    - ☐ Participants who are actively using substances, including alcohol and illicit drugs Participants who do not engage in any mental health or substance treatment services
    - ☐ Participants who demonstrate instability of mental health symptoms (NOT including those who present danger to self or others)

    **Checked Five = 5 points**

    **Checked Four = 4 points**

**Checked Three = 3 points**

**Checked Two = 2 points**

**Checked One = 1 point**

**Checked Zero = 0 points**

| Total Points Scored: |
|---|

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

| **Total Housing First Score:** |
|---|

If you scored: 10 points or more

- ✓ Housing First principles are likely being implemented ideally

If you scored between: 6 – 9 points

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

If you scored between: 3 - 5 points

- ✓ Housing First principles are likely being poorly implemented

If you scored between: 0 – 2 points

- ✓ Housing First principles are likely not being implemented

# Housing First Self-Assessment for Permanent Housing Programs

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

**a) Active Substance Use**

- Yes = 1 point
- No = 0 points

**b) Chronic Substance Use Issues**

- Yes = 1 point
- No = 0 points

**c) Untreated Mental Illness**

- Yes = 1 point
- No = 0 points

**d) Young Adults (18-24)**

- Yes = 1 point
- No = 0 points

**e) Criminal Background (any)**

- Yes = 1 point
- No = 0 points

**f) Felony Conviction**

- Yes = 1 point
- No = 0 points

**g) Sex Offender or Arson Conviction**

- Yes = 1 point
- No = 0 points

**h) Poor Credit**

- Yes = 1 point
- No = 0 points

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

- Yes = 1 point
- No = 0 points

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

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

    | Total Points Scored: |
    |---|

3. **Indicate whether priority consideration for housing access is given to potential program participants with following characteristics.** *Check all that apply*:
    - ☐ Participants who demonstrate a high level of housing instability/chronic homelessness
    - ☐ Participants who have criminal justice records, including currently on probation/parole/court mandate
    - ☐ Participants who are actively using substances, including alcohol and illicit drugs (NOT including dependency or active addiction that compromises safety)
    - ☐ Participants who do not engage in any mental health or substance treatment services
    - ☐ Participants who demonstrate instability of mental health symptoms (NOT including those who present danger to self or others)

    **Checked Five = 5 points**

**Checked Four = 4 points**

**Checked Three = 3 points**

**Checked Two = 2 points**

**Checked One = 1 point**

**Checked Zero = 0 points**

| Total Points Scored: |
|---|

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

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

**Checked Six = 0 points**

**Checked Five = 1 points**

**Checked Four = 2 points**

**Checked Three = 3 points**

**Checked Two = 4 points**

**Checked One = 5 point**

**Checked Zero = 6 points**

| Total Points Scored: |
|---|

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

| **Total Housing First Score:** |
|---|

If you scored: 21 points or more

- ✓ Housing First principles are likely being implemented ideally

If you scored between: 15-20 points

- ✓ Housing First principles are likely being well-implemented

If you scored between: 10 – 14 points

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

If you scored between: 5 - 9 points

- ✓ Housing First principles are likely being poorly implemented

If you scored between: 0 – 4 points

- ✓ Housing First principles are likely not being implemented

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

1. **Does your community set outcome targets around permanent housing placement for your outreach programs?**
    - Yes = 1 point
    - No = 0 points

    | Number of Points Scored: |
    |---|

2. **For what percentage of your emergency shelters does your community set specific performance targets related to permanent housing placement?**
    - 90% or more = 4 points
    - Between 51% and 89% = 3 points
    - Between 26% and 50% = 2 points
    - 25% or less = 1 point
    - Unknown = 0 points

    | Number of Points Scored: |
    |---|

3. **Considering all of the funding sources for supportive housing, what percentage of your vacancies in existing permanent supportive housing units are dedicated for people who meet the definition of chronic and/or vulnerable homeless?**
    - 90% or more = 4 points
    - Between 51% and 89% = 3 points
    - Between 26% and 50% = 2 points
    - 25% or less = 1 point
    - Unknown = 0 points

    | Number of Points Scored: |
    |---|

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

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

   | Number of Points Scored: |
   |---|

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

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

   | Number of Points Scored: |
   |---|

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

   - Yes = 1 point
   - No = 0 points

   | Number of Points Scored: |
   |---|

7. **Does your community have a Coordinated Housing Placement System or Single Point of Access into permanent supportive housing?**
    - Yes = 1 point
    - Partial = ½ point
    - No = 0 points

    | Number of Points Scored: |
    |---|

8. **Does your community have a Coordinated Housing Placement System or Single Point of Access into permanent subsidized housing (e.g. Section 8 and other voucher programs)?**
    - Yes = 1 point
    - Partial = ½ point
    - No = 0 points

    | Number of Points Scored: |
    |---|

9. **Does your community have different application/housing placement processes for different populations and/or different funding sources? If so, how many separate processes does your community have?**
    - 5 or more processes = 0 points
    - 3-4 processes = 1 point
    - 2 processes = 2 points
    - 1 process for all populations = 3 points

    | Number of Points Scored: |
    |---|

10. **The entire process from street outreach (with an engaged client) to move-in to permanent housing typically takes:**
    - More than 180 days = 0 points
    - Between 91 and 179 days = 1 point
    - Between 61 and 90 days = 2 points
    - Between 31 and 60 days = 3 points
    - 30 days or less = 4 points
    - Unknown = 0 points

| Number of Points Scored: |
|---|

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

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

| Number of Points Scored: |
|---|

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

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

| Number of Points Scored: |
|---|

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

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

| Number of Points Scored: |
|---|

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

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

| Number of Points Scored: |
|---|

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

**a) Active Substance Use**

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

**b) Chronic Substance Use Issues**

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

**c) Untreated Mental Illness**

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

**d) Young Adults (18-24)**

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

**e) Criminal Background (any)**

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

**f) Felony Conviction**

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

**g) Sex Offender or Arson Conviction**

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

**h) Poor Credit**

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

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

- Over 75% = 5 points

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

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

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

| **Total Housing First Score:** |
|---|

If you scored: 77 points or more

- ✓ Housing First principles are likely being implemented ideally

If you scored between: 57 – 76 points

- ✓ Housing First principles are likely being well-implemented

If you scored between: 37 – 56 points

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

If you scored between: 10 – 36 points

- ✓ Housing First principles are likely being poorly implemented

If you scored under 10 points

- ✓ Housing First principles are likely not being implemented

# Appendix 7

# Jail Data Link Frequent Users
# A Data Matching Initiative in Illinois

## Overview of the Initiative

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

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

### Target Population for Data Link Initiatives

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

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

### Legal Basis for the Data Matching Initiative

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

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

### Sample Data at a Demo Web Site

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

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

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

## Program Partners and Funding Sources

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

## Partnership Between Criminal Justice and Other Public Systems

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

## Managing the Partnership

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

## About CSH and the Returning Home Initiative

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

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

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