Sequential Intercept Mapping Report – Franklin County, MA

Dan Abreu, M.S., C.R.C., L.M.H.C.
Brian Case, M.A.

Acknowledgement
SAMHSA’s GAINS Center wishes to thank the Hon. Paula M. Carey, Chief Justice of the Trial Court, and the Opioid Task Force of Franklin County and the North Quabbin Region including Director Marisa Hebble, Sheriff Chris Donelan, Register of Probate John Merrigan, and Northwestern District Attorney David Sullivan.
Introduction:
SAMHSA’s GAINS Center for Behavioral Health and Justice Transformation, operated by Policy Research Associates, Inc. (PRA), is known nationally for its work to improve outcomes for people with behavioral health needs in the justice system. On October 29, 2014, the GAINS Center released a solicitation requesting applications from communities interested in developing integrated strategies to better identify and respond to the needs of justice-involved adults with co-occurring mental and substance use disorders. The 2014 solicitation targeted communities that were focusing on Intercepts 1 and 2 as discussed below. The GAINS Center selected five of the 17 applicants to receive the Sequential Intercept Model for Early Diversion workshop, including Franklin County (MA).

Background:
The **Sequential Intercept Mapping workshop** has three primary objectives:

1. Development of a comprehensive picture of how people with mental illness and co-occurring disorders flow through the criminal justice system along five distinct intercept points: Law Enforcement and Emergency Services, Initial Detention and Initial Court Hearings, Jails and Courts, Reentry, and Community Corrections/Community Support.

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

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

The participants in the workshops represented multiple stakeholder systems including mental health, substance abuse treatment, health care, human services, corrections, advocates, individuals, law enforcement, health care (emergency department and inpatient acute psychiatric care), and the courts. Dan Abreu and Brian Case, Project Associates for SAMHSA’s GAINS Center for Behavioral Health and Justice Transformation and Policy Research Associates, Inc., facilitated the workshop session. The workshop opened with remarks from Hon. Paula M. Carey, Chief Justice of the Trial Court for the Commonwealth of Massachusetts.

Twenty-nine (29) people were recorded present at the Franklin County SIM.
Franklin County, MA SIM Agenda
Day 1: September 9

8:30  Registration and Networking

9:00  Openings
- Welcome and Introductions
  - Hon. Paula Carey, Chief Trial Court Judge
- Overview of the Workshop
- Workshop Focus, Goals, and Tasks
- Collaboration: What’s Happening Locally

What Works!
- Keys to Success

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

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

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

Wrap Up
- Review
- Setting the Stage for Day 2

4:30  Adjourn
Franklin County, MA SIM Agenda
Day 2: September 10

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
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<tbody>
<tr>
<td>8:30</td>
<td>Registration and Networking</td>
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<tr>
<td>9:00</td>
<td>Opening</td>
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<td>- Preview of the Day</td>
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<td>Review</td>
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<td>- Day 1 Accomplishments</td>
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<td>- Local County Priorities</td>
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<td>- Keys to Success in Community</td>
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<td>Action Planning</td>
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<td>- Identify Objectives and Action Steps for top priorities</td>
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<td>- Determine who or what committees will be responsible</td>
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<td>- Identify timelines</td>
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<td>Finalizing the Action Plan</td>
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<td>- Share Action Plan with the group</td>
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<td>12:30</td>
<td>Next Steps</td>
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<td>Summary and Closing</td>
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<td>Adjourn</td>
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</table>
Franklin County, MA Sequential Intercept Map

Community Resources

Behavioral Health
- BHN Detox (32 critical stabilizing unit; 32 open need area)
- Recovery Coaching
- DSAS Case Man, available
- Recovery Project (cran, sh, reach out)
- Montague Catholic Social Ministries Women's Center (Turner Falls, Moms w/SA group)
- Beacon/Orange (long-term recovery; Detox with beds (Holyoke, Springfield, Pittsfield, Waconia, Marlboro))
- NCI Framingham/Bridgewater (planned Sec. 35 expansion)
- Outpatient options: Partial Hospitalization at Baystate Recovery, clean/sobriety 5 days; Methadone Clinic 6-8 weeks; Suboxone (vitamin); 650 site; NH on call 233; CQEO (crisis services)
- NCI - CSO, CHO of Counseling; Planned SA expansion

Housing/Shelter
- RLS (7 day crisis response; 8HR); Drop-In City Shelters (Greenfield, Pittsfield, Springfield); SALT (40M/20F, Hampden); Recovery Home System (full)
- Rec. housing (10K program)
- Greenfield Housing Authority (CJ agreement)
- Franklin Regional Housing Authority (CJ agreement)
- Pathways (shelter); Famar House (SH, 40H), Wells ST; 24/7 (NA, Interfaith ER shelter)
- Recovery Home: Western Mass (Oak Park); Soldier On

Community Support
- Probation
- 6 P.O.S. (new program)
- MH screen
- GPR assessment (new 2R, 6R assessment)
- Inpatient recovery plan

Correction Reentry
- Medical services for sentenced (includes BH, MHSUD, assisted, pharmacy, record check, nunnery, MRT, release)
- Housing services
- Reentry planning (60 days, work w/confident to develop housing options)
- Medical discharge reentry meetings (biweekly, 35 days prior to release, court-mandated, in-reach, motivational interviewing, CBIS, severe head injury program)
- Motivational interviewing, Acceptance Therapy, DFT, thinking for a change

Violations
- 50-60% 1/15
- 75% technical/25% new charges: must re-reflect

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- 50-60% 1/15
- 75% technical/25% new charges: must re-reflect
The 911 manager has Crisis Intervention Team (CIT) training.

Clinical and Support Options (CSO) staffing includes peer advocates.

Clinical and Support Options (CSO) focus on voluntary engagement and uses Section 12 as a last resort.

There is an informal response to frequent users of the emergency department/911/law enforcement. Baystate Franklin is launching a frequent user (5+ visits) of emergency room initiative.

CARES has a peer recovery specialist with a focus on substance use disorders to bridge between the emergency room and behavioral health services. The position is not based within the ER and responds only to self-referrals (informal mechanism for referrals).

There is a potential opportunity to co-locate CSO and the new Behavioral Health Network (BHN) location.

There is an ongoing conversation between advocates, emergency services, and law enforcement regarding the approach in Section 12 and Section 35 situations.

BSAS funding for recovery coaches exists (focus on continued support) and case management (focus on engagement).

In neighboring Hampshire County, Northampton has a peer crisis respite (open 7 days/week) and accepts voluntary self-referrals.

Western Mass Recovery Learning Center operates a drop-in center in Greenfield.

The law enforcement command structure supports officer discretion to divert to treatment.
There is EMT interest in implementing mobile integrated service, using the Canadian Hub and COR model.

The Northampton VA operates an urgent care and will find slots for veterans in crisis.

Baystate Franklin has hired 1 FTE mental health counselor.

Section 35 is an important resource for people who are seeking treatment both in and out of the criminal justice system.

### Gaps

- Additional training is needed for EMTs regarding mental health, substance use, and crisis de-escalation.
- Dispatchers do not identify mental health/substance abuse or veteran-related calls. There is a need for recommended best practices for training dispatchers to identify needs and determine whether a CIT officer should respond to a call.
- CSO has limited overnight response- it is limited to emergency room response.
- CSO does not co-respond with law enforcement. They only call law enforcement for transportation and Section 12 cases.
- The Northampton peer crisis respite is at capacity and needs funding to increase its capacity.
- Law enforcement faces an issue of “diversion to what?”
- The lack of community treatment has resulted in greater use of Section 35, which is at capacity.
- Detoxification slots are not centrally managed. Slots are located in Holyoke, Springfield, Pittsfield, Worcester, and Marlboro.
- In most instances, there is no support to transition people from the emergency department to behavioral health services.
- There is a lack of options for handling people who are intoxicated and/or experiencing substance withdrawal. There is a gap in treatment options to assist withdrawal from substances, including outpatient detoxification.
- A common experience for many families is that people with co-occurring disorders who go to the emergency room in substance crisis do not have mental health treatment needs identified and/or are not connected to services.
- There is a need for navigators in each hospital who can determine level of care and triage.
- All residential substance use providers can serve Section 35, but there is a problem with capacity.
- There is no assistance with transportation for Section 35 cases or detox across the state.
- Pre-crisis services, such as needle exchanges, are necessary.
• Ad hoc diversion takes place on informal basis through the bail commissioner.
• There is a suicide screen administered upon admission into custody.
• Pre-trial screening is administrated by probation.
• Valor Act pre-arrangement diversion (for veterans with no prior convictions)
  o 276 at 18-22 1st offense
• Pre-trial heroin (HOIST) program (capacity: 20).
• Probation has multiple resources including pre-trial release, day treatment, and referrals to community providers.
• The Court Clinic (BHN):
  o Focus on 15B/Not Guilty by Reason of Insanity
  o Section 12
  o CSO Mobile Crisis: forensic respite beds
• There is a two track Drug Court in Greenfield (20 each track)
• There is one Drug Court in Orange (13 months; 14-15 people)
• Three-county Veterans Treatment Court is in development to cover Western Massachusetts.
• Veterans Justice Partnership
  o Soldier On partners
  o Court/jail in reach
Gaps

- Explore Bail Commissioner at police department or House of Corrections
- Diversion at pre-arraignment in planning (Using Project Cope in Essex County as the model):
  - Full assessment
  - Treatment plan
  - DA/Court sign-off
  - 6-8 months
  - Case dismissed
  - Low level drug offenders
  - Looking at funding
  - May be expanded to post-arraignment
- There is no formal outpatient restoration.
- Bar advocate provides counsel when a Committee for Public Counsel Services attorney is not assigned.
- Limited transportation services.
- There is no diversion for people with serious mental illness, although there is some ad hoc pre-trial diversion for low level offenders.
- The jail is underutilizing the Veterans Reentry Search Service.
- Jail-based programming excludes the pretrial population.
- There is immediate withdrawal upon incarceration for substance using inmates.
Resources

- Franklin County House of Correction provides medication assisted treatment in jail and upon release.
- Reentry intake for sentence inmates includes LSI-R/Ohio Risk Assessment System (ORAS) and behavioral health screening.
- Reentry classification to determine needs and set planning targets.
- Soldier On jail in-reach for veterans.
- Those released leave with a prescription including a MAT appointment.
- Reentry group meets bimonthly.
- Second Chance Act funds support expanded transition planning services within the House of Correction.
- Service Net
- Reentry housing through agreements with the local housing authority.

Gaps

- Unplanned releases are a problem (40% of releases).
- A SOAR-trained person is needed within the House of Correction.
- Access to mental health services
- There is a need for Housing First options, as well as other safe housing options. There is an 8-year wait for Section 8 housing vouchers.
- Access to PATH funds in Franklin County.
Priorities for changes are determined through a voting process of workshop participants. The voting took place during strategic planning session on September 10, 2015.

1. Crisis drop-off center with community navigator (17 votes).

2. Pre/post-arraignment diversion implementation (9 votes).

3. Data collection and utilization (9 votes).

4. Recovery coach expansion; peer support expansion; and peer informed planning and programs (7 votes).

5. Funding strategies; funding map of proposals to the legislature (4 votes).

6. Housing (3 votes).

7. Expand services to jail pretrial population (3 votes).

8. Improve emergency room support (2 votes).


10. Access to detox services: expand use of outpatient detoxification and behavioral health alternatives and services (2 votes).

11. Crisis intervention team planning/implementation/expansion; include dispatch and insure substance abuse training module (1 vote)

12. Clarify role of family and friends (1 vote)
Parking Lot

- Advocate with the Commonwealth for technology management of detoxification beds.
- Transportation to courthouse.
- Review the “No show” ban for people who routinely miss appointments.
- Improved access to community service and waiver of fees at court.
- Obtain access to PATH funds in Franklin County.
**Recommendations**

1. **Expand the capacity of first responders to provide effective crisis response for people with mental and substance use disorders and improve the quality of the crisis care continuum in Franklin County.**
   
a. Identify county-wide frequent users of behavioral health emergency services and frequent callers to 911 for behavioral health reasons who would benefit from a coordinated response. Baystate Franklin is in the process of launching an initiative to address frequent users of the emergency department. Law enforcement and emergency medical services can coordinate this effort with Baystate Franklin to address frequent users of the 911 system, whether specifically for behavioral health reasons or as part of a broader initiative using the Hub and COR model (as discussed during the workshop). For example, consider the Case Assessment Management Program (http://qpc.co.la.ca.us/cms1_080719.pdf), 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.

b. Train 911 and law enforcement dispatchers to flag behavioral health calls and calls from veterans so that CIT-trained officers can respond directly to calls. When CIT officers are able to respond to calls, they are able to de-escalate situations and reduce the likelihood of injury to officers and people in crisis.

c. Establish an on-going dialogue of agencies responsible for behavioral health crisis response. This dialogue includes, but should not be limited to, law enforcement, emergency services, Baystate Franklin, CSO, BHN, the Court Clinic, NAMI, the Western Mass Recovery Learning Center, Massachusetts Department of Mental Health, and the Massachusetts Department of Public Health. The dialogue could be focused on the following questions:
   
i. How to improve coordination of crisis response services, considering so many agencies are involved in crisis response and crisis care? What would be role of a Community Navigator and what resources are necessary to make a navigator successful?

ii. How to improve access to outpatient detoxification services in Franklin County, considering the waiting list for detoxification beds in Massachusetts?

iii. How to make crisis response strategies recovery-oriented, person-centered, and responsive to individual and family needs? Are there local alternatives to Section 12 commitments that can be explored to reduce (not eliminate) the use of involuntary treatment services?

2. **At all stages of the Sequential Intercept Model, gather data to document the processing of people with mental and substance use disorders through the criminal justice system in Franklin County.**
With 9 votes, “data collection and utilization” was the third ranked priority. A data dashboard that can be reviewed by the Opioid Task Force and other criminal justice planning committees will assist people in understanding the scope of the problem and to identify programming needs.

a. Dashboard indicators can be developed on the prevalence, demographics, and case characteristics of adults with mental and substance use disorders who are being arrested, passing through the courts, booked into the Franklin County House of Correction, sentenced to the House of Correction or the Massachusetts Department of Correction, placed on probation, etc. See the Data Analysis/Matching publications in the Resources section.

b. A behavioral health crisis dashboard can also be developed for monitoring wait times in hospitals for people in crisis and transfer times from the emergency department to inpatient units or diversion to crisis services. Wait times for detoxification services, outpatient and residential treatment services, and placements from criminal justice agencies can also be tracked through the dashboard.

c. These dashboard indicators can be employed by the Opioid Task Force, the Reentry Committee, and others to better identify opportunities for programming and to determine where existing initiatives require an overhaul.

3. **Establish greater alternatives to detention and pre-adjudication diversion options at Intercept II.**

   Defendants who are remanded to pretrial detention often have worse outcomes than defendants who are released to the community pending the disposition of their criminal case.

   a. Pretrial release under supervision is an effective strategy for keeping defendants in the community who would otherwise be remanded to pretrial detention. These services could be expanded to have specialized caseloads for persons with serious mental illness or co-occurring mental and substance use disorders. Pretrial release could be a primary outlet for keeping defendants with serious mental illness out of the House of Correction.

   b. Consider prosecutor-led or defender-led diversion for defendants with serious mental illness, substance use disorders, or co-occurring disorder as a form of pre-adjudication diversion. Community-based providers could develop programs to manage and deliver services to persons diverted at arraignment:

      i. Defendants with pending cases who are released to the program as an alternative to detention. These may be cases where the charges are too serious to dismiss but where the individuals would benefit from community-based services that are not be available while in pretrial detention.

      ii. Persons whose cases are dismissed or where prosecution is declined on the condition that the person participate in community-based services. These may be cases involving minor charges, first-time offenders, or persons who are “well-known” to the justice system and where continued prosecution is not expected to reduce subsequent justice involvement.

The CASES Transitional Case Management ([http://www.cases.org/articles/TCMProgramBrief.pdf](http://www.cases.org/articles/TCMProgramBrief.pdf))
and the Manhattan Arraignment Diversion Program (http://gainscenter.samhsa.gov/cms-assets/documents/96362-788132.map-program-brief.pdf) are two examples.

iii. A third option is a deferred prosecution approach where a person is directed to participate in a short-term community-based diversion program. Successful completion of the program results in dismissal of the charges while failure results in continued prosecution of the case.

c. Conduct a behavioral health needs assessment of the pretrial inmate population in the House of Correction to determine the level of need for behavioral health services and the proportion of the population that could be successfully managed in the community.

4. Expand forensic peer support and recovery coaching options to promote recovery for justice-involved people with mental and substance use disorder, from crisis-response strategies to reentry. Many communities have found that peer specialists and recovery coaches with a personal history of involvement in the behavioral health and justice systems are effective at engaging people who have previously resisted or had poor experiences with traditional behavioral health services.

5. Continue to include and build upon the work of the family members who have shown significant interest and effectiveness in collaborating to improve the continuum of criminal justice/behavioral health services. Many communities have found family members and consumers to be the most effective “voices” in helping to bring increased resources to the community.

6. Continue to coordinate with faith leaders and faith-based organizations to improve services and quality of life for justice-involved persons with mental and/or substance use disorders.

7. Improve the quality of medication assisted treatment (MAT) for substance use disorders in community-based settings. Medication assisted treatment is an evidence-based practice in the treatment of opioid and alcohol use disorders. The House of Correction is providing high quality MAT, but community-based MAT providers must be available to offer the same level of supports and monitoring provided within the jail.


8. Increase efforts to enroll justice-involved persons with mental and substance use disorders in the Supplement Security Income and the Social Security Disability Insurance programs through utilization of SSI/SSDI Outreach, Access, and Recovery (SOAR) trained staff. Given the lack of available services at key transition points (e.g., jail, prison, and probation) across the Intercepts, it is critical that justice-involved individuals be promptly enrolled in benefit programs. Enrollment in SSI/SSDI not only provides automatic Medicaid or Medicare in many states, but also provides monthly income sufficient to access housing programs.

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

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

   c. An article on SSI/SSDI best practices for justice-involved persons is included in the report as Appendix 4.

9. Conduct routine searches for House of Correction inmates who are veterans using the Veterans Reentry Search Service through the U.S. Department of Veterans Affairs and U.S. Department of Defense.
### Franklin County, MA Strategic Action Plan

#### Priority Area 1: Formalize Community Collaboration

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<tr>
<th>Objective</th>
<th>Action Step</th>
<th>Who</th>
<th>When</th>
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<tbody>
<tr>
<td>A</td>
<td>Establish MOU’s among key stakeholders</td>
<td>Committee Chairs</td>
<td>TBD</td>
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<tr>
<td></td>
<td>Existing Franklin County Criminal Justice/BH Committees (see Appendix 6) will review existing interagency partnerships and develop or update MOU&quot;s</td>
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<tr>
<td>B</td>
<td>Assign responsibility for SIM priorities</td>
<td>OTF</td>
<td>w/i 30 days</td>
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<tr>
<td></td>
<td>Determine which priorities to be referred to existing CJ/BH Committees. Opioid Task Force (OTF) Agenda Item</td>
<td>Marisa</td>
<td>w/i 30 days</td>
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<tr>
<td>C</td>
<td>SIM Workshop follow-up</td>
<td>OTF</td>
<td>w/i 30 days</td>
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<td>OTF will convene SIM follow-up. -review participant list -identify additional participants</td>
<td>Marisa</td>
<td>w/i 30 days</td>
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<td></td>
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<td>John and Marisa</td>
<td>w/i 30 days</td>
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<tr>
<td>D</td>
<td>Identify priorities which may be “low hanging fruit”</td>
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<td>Dispatch priorities to appropriate CJ/MH Committees.</td>
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### Priority Area 2: Data Collection and Utilization

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<tr>
<td>A</td>
<td>Collect Emergency Department Data</td>
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<td>January 2016</td>
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<td>Identify Data Points:</td>
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<tr>
<td></td>
<td>• Opioid visits</td>
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<td>• Section 12 visits</td>
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<td>• Section 35 visits</td>
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<td>• Police drop-offs by jurisdiction and type of patient</td>
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<td>• Frequent Users of Service</td>
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<td></td>
<td>• Return to ER &lt;30 days, &lt;90 days</td>
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<tr>
<td>B</td>
<td>Data Sharing</td>
<td>TBD</td>
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<td>Develop MOU for data sharing</td>
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<td>ID Data Collection Expertise</td>
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<tr>
<td>C</td>
<td>Identify Data Expert for next Opioid Task Force Meeting</td>
<td>Marisa</td>
<td>September, 2015</td>
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<tr>
<td></td>
<td>Invite Jeanette Vohs to next meeting</td>
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Resources

Competency Evaluation and Restoration

Crisis Response and Law Enforcement

Data Analysis/Matching
• Corporation for Supportive Housing. Jail Data Link Frequent Users: A Data Matching Initiative in Illinois (See Appendix 3)

• Vera Institute of Justice. Closing the Gap: Using Criminal Justice and Public Health Data to Improve Identification of Mental Illness.


Information Sharing


Medication Assisted Treatment


Mental Health First Aid


• Mental Health First Aid. http://www.mentalhealthfirstaid.org/cs/

• Pennsylvania Mental Health and Justice Center of Excellence. City of Philadelphia Mental Health First Aid Initiative.

http://www.pacenterofexcellence.pitt.edu/documents/Session10_Piloting_the_Public_Safety_Verison_of_MHFA.ppt

Peer Support

• Involving Peers in Criminal Justice and Problem-Solving Collaboratives.


• The Impact of Forensic Peer Support Specialists on Risk Reduction and Discharge Readiness in a Psychiatric Facility: A Five-Year Perspective.


• Peer Support within Criminal Justice Settings: The Role of Forensic Peer Specialists.

• Overcoming Legal Impediments to Hiring Forensic Peer Specialists.

Reentry
• The Council of State Government’s National Reentry Resource Center.
  http://csgjusticecenter.org/jc/category/reentry/nrrc/
• BJA’s Center for Program Evaluation and Performance Management.
  https://www.bja.gov/evaluation/program-corrections/reentry-index.htm
• The National Institute of Justice’s Offender Reentry page.

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

Screening and Assessment
  http://gainscenter.samhsa.gov/pdfs/jail_diversion/Psychiatric_Services_BJMHS.pdf

Sequential Intercept Model


**Trauma-Informed Care**

• SAMHSA, SAMHSA’s National Center on Trauma-Informed Care, and SAMHSA’s GAINS Center. *Essential Components of Trauma Informed Judicial Practice*. [http://www.nasmhpdp.org/docs/NCTIC/JudgesEssential_5%201%202013finaldraft.pdf](http://www.nasmhpdp.org/docs/NCTIC/JudgesEssential_5%201%202013finaldraft.pdf)

• SAMHSA’s GAINS Center. *Trauma Specific Interventions for Justice Involved Individuals*. [http://gainscenter.samhsa.gov/pdfs/ebp/TraumaSpecificInterventions.pdf](http://gainscenter.samhsa.gov/pdfs/ebp/TraumaSpecificInterventions.pdf)


**Veterans**


### APPENDIX INDEX

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<th>Appendix 1</th>
<th>Sequential Intercept Mapping Workshop Participant List (June 9-10, 2015)</th>
</tr>
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<tbody>
<tr>
<td>Appendix 2</td>
<td>Texas Department of State Health Services. <em>Crisis Services.</em></td>
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<tr>
<td>Appendix 3</td>
<td>Corporation for Supportive Housing. <em>Jail Data Link Frequent Users: A Data Matching Initiative in Illinois.</em></td>
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<tr>
<td>Appendix 5</td>
<td>100,000 Homes/Center for Urban Community Services. <em>Housing First Self-Assessment: Assess and Align Your Program and Community with a Housing First Approach.</em></td>
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<td>Appendix 6</td>
<td>Franklin County and Regional Criminal Justice/Behavioral Health Planning Groups</td>
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### GAINS Sequential Intercept Mapping Workshop
### Participant List

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Organization</th>
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<tbody>
<tr>
<td>Hon. John Merrigan</td>
<td>Register of Probate Task Force Co-Chair</td>
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<tr>
<td>Chris Donelan</td>
<td>Sheriff Task Force Co-Chair</td>
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<tr>
<td>Dave Sullivan</td>
<td>Northwestern District Attorney Task Force Co-Chair</td>
<td>Franklin County Sheriff’s Office</td>
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<tr>
<td>Hon. William Mazanec</td>
<td>First Justice</td>
<td></td>
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<tr>
<td>Bette Babinski</td>
<td>Chief Probation Officer Family Court</td>
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Crisis Services

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

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

Crisis Funds
- Crisis Hotline Services
  - Continuously available 24 hours per day, seven days per week
  - All 37 LMHAs and NorthSTAR have or contract with crisis hotlines that are accredited by the American Association of Suicidology (AAS)
- Mobile Crisis Outreach Teams (MCOT)
  - Operate in conjunction with crisis hotlines
  - Respond at the crisis site or a safe location in the community
  - All 37 LMHAs and NorthSTAR have MCOT teams
  - More limited coverage in some rural communities

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

Competitive Funds Projects
- Crisis Stabilization Units (CSU)
  - Provide immediate access to emergency psychiatric care and short-term residential treatment for acute symptoms
  - Two CSUs were funded
- Extended Observation Units
  - Provide 23-48 hours of observation and treatment for psychiatric stabilization
  - Three extended observation units were funded
- Crisis Residential Services
  - Provide from 1-14 days crisis services in a clinically staffed, safe residential setting for individuals with some risk of harm to self or others
  - Four crisis residential units were funded
- Crisis Respite Services
- Provide from 8 hours up to 30 days of short-term, crisis care for individuals with low risk of harm to self or others
  - Seven crisis respite units were funded
- **Crisis Step-Down Stabilization in Hospital Setting**
  - Provides from 3-10 days of psychiatric stabilization in a psychiatrically staffed local hospital setting
  - Six local step-down stabilization beds were funded
- **Outpatient Competency Restoration Services**
  - Provide community treatment to individuals with mental illness involved in the legal system
  - Reduces unnecessary burdens on jails and state psychiatric hospitals
  - Provides psychiatric stabilization and participant training in courtroom skills and behavior
  - Four Outpatient Competency Restoration projects were funded

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

- **Transitional Services**
  - Provides linkage between existing services and individuals with serious mental illness not linked with ongoing care
  - Provides temporary assistance and stability for up to 90 days
  - Adults may be homeless, in need of substance abuse treatment and primary health care, involved in the criminal justice system, or experiencing multiple psychiatric hospitalizations
- **Intensive Ongoing Services for Children and Adults**
  - Provides team-based Psychosocial Rehabilitation services and Assertive Community Treatment (ACT) services (Service Package 3 and Service Package 4) to engage high need adults in recovery-oriented services
  - Provides intensive, wraparound services that are recovery-oriented to address the child's mental health needs
  - Expands availability of ongoing services for persons entering mental health services as a result of a crisis encounter, hospitalization, or incarceration
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 Health.

- **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 publicly 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](http://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.
Best Practices for Increasing Access to SSI and SSDI on Exit From Criminal Justice Settings

Deborah Dennis, M.A.
Dazara Ware, M.P.C.
Henry J. Steadman, Ph.D.

Transitioning from jail or prison to community living frequently results in homelessness and recidivism. Access to benefits such as Supplemental Security Income (SSI) and Medicaid can increase access to housing and treatment and reduce recidivism. The authors review best practices for prerelease access to these benefits by using examples from five jails and four state prison systems. In these settings, approval rates for SSI applications averaged 70% or higher, with evidence of improved access to housing and reductions in recidivism. Success depends on the commitment of resources and leadership, ongoing communication, and monitoring of results. (Psychiatric Services 65:1081–1083, 2014; doi: 10.1176/appi.ps.201400120)

Seventeen percent of people currently in jails and prisons are estimated to have a serious mental illness (1). On release, the lack of treatment and income, inability to work, and few options for housing mean that many individuals quickly become homeless and recidivism is likely. A key to breaking this cycle may be linking offenders to the Social Security Administration’s (SSA’s) disability programs and to Medicaid.

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PSYCHIATRIC SERVICES • ps.psychiatryonline.org • September 2014 Vol. 65 No. 9 1081
the criminal justice system, making participants more attractive “paying customers.” An agreement between Miami-Dade County and SSA also reimburses the county (from participants’ retroactive benefit payment) for housing assistance provided between SSI/SSDI application and approval. The number of arrests two years before and two years after receipt of benefits and housing was reduced by 70% (57 versus 17 arrests).

Mercer and Bergen County Correctional Centers
In 2011, with SOAR training and technical assistance, two counties in New Jersey piloted the use of SOAR to increase access to SSI/SSDI for persons with disabilities soon to be released from jail. In each county, a collaborative working group with representatives from the correctional center, a community behavioral health agency, SSA, and the state Disability Determination Service met monthly to develop, implement, and monitor a process for screening and applying for SSI/SSDI for persons in jail or recently released. Applications were assisted by community behavioral health agency staff who were provided access to inmates as well as jail medical records. After one year, 89 inmates were screened in Mercer County, and 35 (39%) were deemed potentially eligible for SSI/SSDI. In Bergen County, 69 were screened, and 39 (57%) were potentially eligible. In Mercer County, 12 of 16 (75%) SSI/SSDI applications filed were approved on initial application; two of those initially denied were reversed at the reconsideration level without the need to go before a judge. In Bergen County, two of three former inmates assisted were approved for SSI/SSDI.

Fulton County, Georgia
In June 2009, the Georgia Department of Behavioral Health and Developmental Disabilities began a SOAR pilot project at the Fulton County Jail. Staff were issued jail identification cards that allowed access to potential applicants. Staff received referrals from social workers in the Office of the Public Defender, interviewed potential applicants at the jail, completed SSI/SSDI applications, and hand delivered them to SSA. Of 23 applications submitted, 16 (70%) were approved (average = 114 days). Using outcome data from the Fulton County Jail, the Georgia Department of Corrections provided SOAR training to 33 correctional officers, who were subsequently assigned by the department to work on SSI/SSDI applications in the state’s prisons.

SOAR collaborations with state prisons
“Sing Sing” Correctional Facility
The Center for Urban and Community Services was funded by the New York State Office of Mental Health with a PATH grant (Projects for Assistance in Transition from Homelessness) to assist with SSI/SSDI applications for participants in a 90-day reentry program for persons with mental illness released from New York State prisons. With SOAR training, the program at Sing Sing Correctional Facility achieved an 87% approval rate for 183 initial applications, two-thirds of which were approved before or within one month of release.

Oklahoma Department of Corrections
The Oklahoma Department of Corrections and the Oklahoma Department of Mental Health and Substance Abuse Services collaborated to initiate submission of SSI/SSDI applications using SOAR-trained staff. Approval rates for initial applications are about 90%. For those approved for SSI/SSDI, returns to prison within three years are 41% lower than for a comparison group.

Michigan Department of Corrections
In 2007, the Michigan Department of Corrections (MDOC) began planning a SOAR pilot in the region where most prisoners with mental illnesses are housed. A subcommittee of the SOAR State Planning Group was formed and continues to meet monthly. The subcommittee developed a process to address issues specific to MDOC, such as release before a decision is received from SSA, the amount of time before release that an application could be started, and collaboration with local SSA offices. Since 2007, MDOC has received 72 decisions on SSI/SSDI applications, in an average of 105 days and with a 60% approval rate. Seventeen percent of persons whose applications were denied were reincarcerated in the year after release, compared with only 2% of those with approved applications.

Park Center’s facility in-reach program
Park Center is a community mental health center in Nashville. In July 2010, staff began assisting with SSI/SSDI applications for people with mental illness in the Jefferson County Jail and several facilities administered by the Tennessee Department of Corrections. By November 2012, 100% of 44 applications were approved in an average of 41 days. In most cases, Park Center’s staff assisted with SSI/SSDI applications in the facilities before release. On release, a Park Center staff member accompanies the individual to the local SSA office where his or her release status is verified and SSI/SSDI benefits are initiated. [Additional details about these programs are available in an online data supplement to this column.]

Best practices for accessing SSI/SSDI
For five years, we have been providing SOAR technical assistance to eight of the nine jail or prison systems reviewed here. Below we describe several best practices. These are in addition to the critical components required by the SOAR model for assisting with SSI/SSDI applications (7).

Identify stakeholders with whom to collaborate. Jail-related stakeholders include specialized court or diversion judges, social workers in the public defenders’ office, chief jailers, jail mental health clinicians, county or city commissioners, local reentry advocacy leaders, and community SOAR providers. Prison-related stakeholders include the state department of corrections, commissioner, state director of reintegration and reentry services, director of medical or mental health services for the department of corrections, state mental health agency administrator, community reentry project directors, parole officers, and community SOAR providers. Including supported housing programs for persons with mental health needs to go before a judge. In Bergen County, two of three former inmates assisted were approved for SSI/SSDI.
illness is key to ensuring continuity of care and best overall outcomes after release. Fortunately, these are the same collaborations needed for successful postrelease transitions of offenders with mental illness. Thus access to SSI/SSDI can become a concrete foundation on which to build the overall reentry process. 

**Establish prerelease agreements with SSA.** Prerelease agreements can allow applications to be accepted up to 120 days before the expected release date. SSA can also establish a contact person to work with and accept paper applications and schedule phone interviews when necessary.

**Work with local SOAR providers to establish continuity of care.** Given the unpredictability of release dates, it is important to engage a community-based health provider either to begin the SSI/SSDI application process while the inmate is still in the facility or to assume responsibility for the individual’s transition and SSI/SSDI application on release.

**Collaborate within the jail or prison system.** Identifying persons in the jail or prison who may be eligible for SSI/SSDI will require the collaboration between the jail or prison corrections staff and medical staff. When a person is identified, assistance with SSI/SSDI can be done by staff in the jail or prison with a hand-off occurring on release, or the person can be assisted by community providers who come into the facility for this purpose. Frequently, correctional staff, medical or psychiatric staff, and medical records are administered separately, and collaborations must be established within the facility as well as with systems outside it.

**Commit leadership.** Starting an SSI/SSDI initiative as part of reentry requires a steering committee that meets regularly with a strong and effective coordinator. It is essential that the steering committee include someone who has authority in the jail or prison system and someone with a clinical background who can ensure that the clinical aspects of implementation are accomplished.

**Commit resources.** Successful initiatives commit resources for staffing to coordinate the overall effort and to assist with SSI/SSDI applications. In our experience, it is very difficult for current jail staff to assist with SSI/SSDI applications because of their competing demands, staffing levels, skill levels of the staff involved, and rapid turnover of the jail population. In the programs where we have worked, few or no applications would be completed for persons leaving jails without the assistance of community providers. Jail staff time may be best reserved for identifying individuals who may need assistance and referring them to community providers, facilitating community provider access to inmates before release, and assisting with access to jail medical records.

**Give it time.** Developing and implementing an initiative to access SSI/SSDI as part of reentry require a commitment of at least a year to see any results and at least two years to achieve a fully functioning program. During startup and early implementation, competing priorities can derail the best intentions. We have seen commitment wane as new administrations took office and the department of corrections commissioner changed. We have seen staff struggle without success to find the time to assist with applications. We have seen many facilities willing to conduct training but unwilling or unable to follow through on other key components.

**Train staff.** Training for staff in jails and prisons should include those who will identify and refer inmates to the program and who will assist with applications as well as medical records staff and physicians and psychologists. Specific training for each group is needed. However, without the elements described above in place, training is of limited value.

**Track outcomes.** The outcomes of SSI/SSDI application assistance are relatively few and easy to track (number of application decisions received, percentage approved, number of days to decision, and clinical outcomes, such as access to housing, rearrest, and reincarceration). A free Web-based application outcome tracking system is available at https://soartrack.prainc.com.

**Conclusions**

People with mental illness face extraordinary barriers to successful community reentry from jails and prisons. The SOAR approach has been implemented in 50 states, and there is programmatic evidence that it is transferable to correctional settings. The combination of access to SSI/SSDI and Medicaid and subsequent access to housing is commonly cited by the programs described here as responsible for the reduction in rearrests and reincarcerations. The positive outcomes related to reincarceration produced by SOAR pilot projects in jails and prisons should provide impetus for more correctional facilities to consider this approach as a foundation for building successful reentry programs.

**Acknowledgments and disclosures**

The authors report no competing interests.

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

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

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

The full series is available at: http://100khomes.org/resources/high-performance-series
Housing First Self-Assessment
Assess and Align Your Program with a Housing First Approach

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

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

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

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

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

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

Who Does This Well?

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

- Pathways to Housing — [www.pathwaystohousing.org](http://www.pathwaystohousing.org)
- DESC — [www.desc.org](http://www.desc.org)
- Center for Urban Community Services — [www.cucs.org](http://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](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](http://www.endhomelessness.org/pages/housingfirst)
- Pathways to Housing — [www.pathwaystohousing.org](http://www.pathwaystohousing.org)

For more information and support, please contact Erin Healy, Improvement Advisor • 100,000 Homes Campaign, at [ehealy@cmtysolutions.org](mailto: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 None = 0 points

   Number of Points Scored:
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
<table>
<thead>
<tr>
<th>Question Section</th>
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<tbody>
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<td><strong>Total Points Scored in Question #1:</strong></td>
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2. **Program participants are required to demonstrate housing readiness to gain access to units?**
   - No — Program participants have access to housing with no requirements to demonstrate readiness (other than provisions in a standard lease) = **3 points**
   - Minimal — Program participants have access to housing with minimal readiness requirements, such as engagement with case management = **2 points**
   - Yes — Program participant access to housing is determined by successfully completing a period of time in a program (e.g. transitional housing) = **1 point**
   - Yes — To qualify for housing, program participants must meet requirements such as sobriety, medication compliance, or willingness to comply with program rules = **0 points**

   **Total Points Scored:**

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

   **Checked Five = 5 points**
Checked Four = 4 points
Checked Three = 3 points
Checked Two = 2 points
Checked One = 1 point
Checked Zero = 0 points

Total Points Scored:

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

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

Checked Six = 0 points
Checked Five = 1 points
Checked Four = 2 points
Checked Three = 3 points
Checked Two = 4 points
Checked One = 5 point
Checked Zero = 6 points

Total Points Scored:

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

Total Housing First Score:

If you scored: 21 points or more
✓ Housing First principles are likely being implemented ideally

If you scored between: 15-20 points
✓ Housing First principles are likely being well-implemented

If you scored between: 10 – 14 points
✓ Housing First principles are likely being fairly well-implemented

If you scored between: 5 – 9 points
✓ Housing First principles are likely being poorly implemented

If you scored between: 0 – 4 points
✓ Housing First principles are likely not being implemented
Housing First Self-Assessment
For Systems & Community-Level Stakeholders

1. Does your community set outcome targets around permanent housing placement for your outreach programs?
   - Yes = 1 point
   - No = 0 points
   **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
11. Approximately what percentage of homeless people living on the streets go straight into permanent housing (without going through emergency shelter and transitional housing)?
   - More than 75% = 5 points
   - Between 51% and 75% = 4 points
   - Between 26% and 50% = 3 points
   - Between 11% and 25% = 2 points
   - 10% or less = 1 point
   - Unknown = 0 points

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

13. Within a given year, approximately what percentage of your community’s chronic and/or vulnerable homeless population who exit homelessness, exits into permanent supportive housing?
   - More than 85% = 5 points
   - Between 51% and 85% = 4 points
   - Between 26% and 50% = 3 points
   - Between 10% and 24% = 2 points
   - Less than 10% = 1 point
   - Unknown = 0 points
14. In a given year, approximately what percentage of your community’s chronic and/or vulnerable homeless population exiting homelessness, exits to Section 8 or other long-term subsidy (with limited or no follow-up services)?

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

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

a) Active Substance Use

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

b) Chronic Substance Use Issues

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

c) Untreated Mental Illness

- Over 75% = 5 points
- 75%-51% = 4 points
- 50%-26% = 3 points
- 25%-10% = 2 points
- Less than 10% = 1 point
- Unknown = 0 points
d) Young Adults (18-24)
- Over 75% = 5 points
- 75%-51% = 4 points
- 50%-26% = 3 points
- 25%-10% = 2 points
- Less than 10% = 1 points
- Unknown = 0 points

e) Criminal Background (any)
- Over 75% = 5 points
- 75%-51% = 4 points
- 50%-26% = 3 points
- 25%-10% = 2 points
- Less than 10% = 1 points
- Unknown = 0 points

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

g) Sex Offender or Arson Conviction
- Over 75% = 5 points
- 75%-51% = 4 points
- 50%-26% = 3 points
- 25%-10% = 2 points
- Less than 10% = 1 points
- Unknown = 0 points

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

i) No Current Source of Income (pending SSI/DI)
- Over 75% = 5 points
• 75%-51% = 4 points  
• 50%-26% = 3 points  
• 25%-10% = 2 points  
• Less than 10% = 1 point  
• Unknown = 0 points

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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
**Franklin County Criminal Justice/Behavioral Health Planning Groups**

1. Opioid Task Force of Franklin County and the North Quabbin Region  
   a. Executive Committee  
   b. Multiple Subcommittees  

2. Franklin County Law Enforcement and Mental Health Committee (DMH workgroup)  

3. Transition from Jail to Community Advisory Board  

4. North Quabbin Community Coalition  

5. Franklin County Resource Network