Oregon Statewide Summit

January 20-21, 2016

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Acknowledgement:

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Introduction:

The Oregon Health Authority contracted with Policy Research Associates (PRA) to provide a strategic planning workshop to inform the work of Oregon Health Authority's Justice and Mental Health initiatives and targeted Legislative appropriations for crisis services and jail diversion. The *Criminal Justice and Behavioral Health Statewide Summit* was held January 20, 2016 at the Salem Convention Center, Salem, Oregon.

Persons with mental illness and co-occurring disorders are over represented in the criminal justice system. Steadman, et. al. (2009) found that the prevalence of people with serious mental illness is 3 times higher than the general population.[1] Teplin, et. al. (1991) found that 72% of jail inmates have a co-occurring disorder.[2]

Other characteristics of justice involved individuals with mental illness are:

- They are less likely to make bail.[3]
- They are more likely to have longer pre-trial incarceration. [3]
- They are more likely to have serious disciplinary issues in jail or prison.[4]
- They are more likely to face technical probation violations. [5]
- Trauma lifetime prevalence rates for persons with mental illness are over 90% (unpublished TAPA data).
- Trauma incurred within the year prior to arrest is over 70% (unpublished TAPA data).
- They have higher rates of homelessness, unemployment, and substance abuse. [4]

Across the criminal justice system, persons with mental illness fare worse than those without.
In addition, incarcerated populations have higher prevalence rates of medical conditions and substance abuse: [6]

- Tuberculosis 4 times higher
- Hepatitis C 9-10 times higher
- HIV 8-9 times higher

It is not surprising then, that a study of Washington state prison releases found that within 90 days of release the mortality rate for the cohort was 3 times higher than the general population and within 2 weeks of release, the mortality rate was 12 times higher than the general population. [7]

Oregon has been addressing the over representation of persons with mental illness in the criminal justice system as a result of legislative interest and grass roots advocacy. In 2011, the OHA received a legislative directive to convene a statewide workgroup to identify the needs of people with mental disorders involved in the criminal justice system. This workgroup made specific recommendations which were aligned with Sequential Intercept

Model Intercepts and resulted in additional appropriations for jail diversion initiatives, enhancements for Aid and Assist Programs and enhanced services to drug courts.

This initiative is timely as Oregon seeks to improve social services to the justice-involved population in a fiscally responsible and efficient way. In addition, health care reform presents new opportunities to expand the population served, expand partnerships, and design resources specific to the needs of the population.

Summit Goals:

- To introduce the Sequential Intercept Model as a planning tool to strategically inform legislation, policy, planning, and funding;
- To identify opportunities for coordination and collaboration among state and local stakeholders;
- To inform state and local stakeholders about best practices in the behavioral health and correctional fields; and
- To consider the impact of health care reform and state behavioral health and criminal justice initiatives on justice-involved populations.

The following documents were reviewed and influenced this report:

- Oregon's Community Mental Health Services and Substance Abuse Prevention & Treatment Block Grant Application (2014-2015)
- Behavioral Health System Mapping Fact Sheet 10/15
- Oregon Health Authority 2015-2018 Behavioral Health Strategic Plan
- Multnomah County Feasibility Assessment Mental Health Jail Diversion Project. 2/2015
- Senate Bill 832

Background:

The Sequential Intercept Mapping workshop has three primary objectives:

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

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

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

The participants in the workshops represented multiple stakeholder systems including mental health, substance abuse treatment, health care, human services, corrections, advocates, individuals, law enforcement, health care (emergency department and inpatient acute psychiatric care), and the courts. Dan Abreu, MS CRC LMHC, and Travis Parker, MS, LIMHP, CPC, Senior Project Associates at Policy Research Associates facilitated the workshop session.

Ninety-four (94) people were recorded present at the Oregon Summit.

References:

1. Steadman, H. J., Osher, F. C., Robbins, P. C., Case, B., & Samuels, S. (2009). Prevalence of serious mental illness among jail inmates. *Psychiatric Services*, 60, 761–765.

2. Abram, K.M. & Teplin, L.A. (1991). Co-Occurring disorders among mentally ill jail detainees. *American Psychologist*, 46 (10): 1036-1045 http://www.pacenterofexcellence.pitt.edu/documents/PsySJailMHStudy.pdf

3. Council of State Governments Justice Center. (2012). Improving Outcomes for People with Mental Illnesses Involved with New York City's Criminal Court and Correction Systems. https://csgjusticecenter.org/wp-content/uploads/2013/05/CTBNYC-Court-Jail_7-cc.pdf

4. James, D.J. & Glaze, L.E. (2006). Mental health problems of prison and jail inmates. Washington, DC: United States Department of Justice, Office of Justice Programs. http://www.bjs.gov/content/pub/pdf/mhppji.pdf

5. Porporino, F.J. & Motiuk, L.L. (1995). The prison careers of mentally disordered offenders. *International Journal of Law and Psychiatry,* 18:29–44.

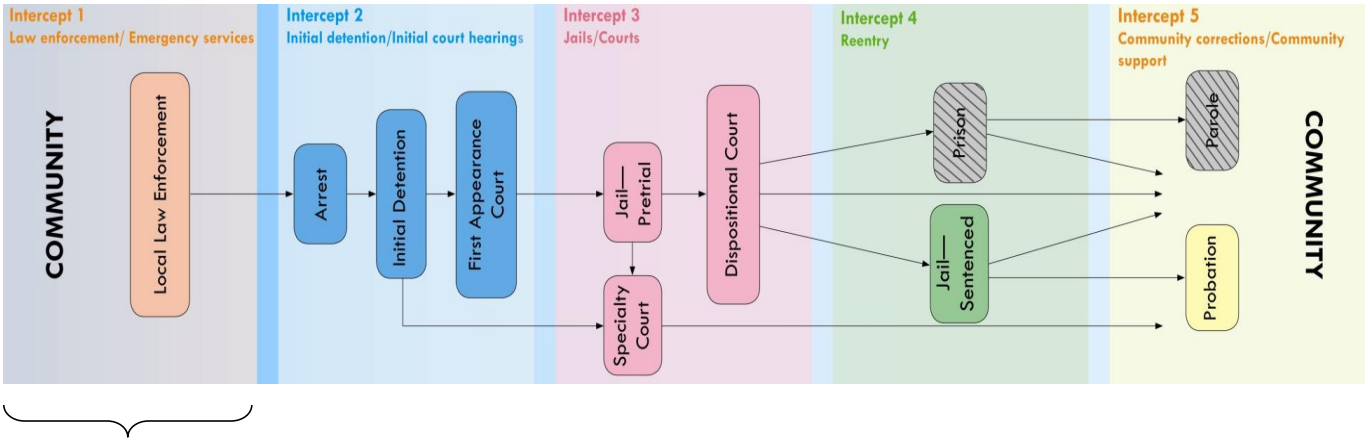
6.

Category	Condition	Prevalence Compared to U.S. Population
Infectious Diseases	Active tuberculosis	4 times greater
	Hepatitis C	9–10 times greater
	AIDS	5 times greater
	HIV infection	8–9 times greater
Chronic Diseases	Asthma	Higher
	Diabetes/hypertension	Lower
Mental Illness	Schizophrenia or other psychotic disorder	3–5 times greater
	Bipolar (depression) disorder	1.5–3 times greater
	Major depression	Roughly equivalent
Substance Abuse and Dependence	Alcohol dependence	25% fit CAGE profile
	Drug use	83% prior to offense; 33% at time of offense

SOURCES: NCCHC, "Prevalence of Communicable Disease, Chronic Disease, and Mental Illness Among the Inmate Population," *The Health Status of Soon-To-Be-Released Prisoners, A Report to Congress*, 2002; *BJS Special Report: Substance Abuse and Treatment, State and Federal Prisoners, 1997*, NCJ 172871, 1999.

7. Binswanger, I.A., Stern, M.F., Deyo, R.A., Heagerty, P.J., Cheadle, A., Elmore, J.G., & Koepsell, T.D. (2007). Release from Prison — A High Risk of Death for Former Inmates. *The New England Journal of Medicine,* 356:157-65. http://www.nejm.org/doi/pdf/10.1056/NEJMsa064115

Intercept 1



Resources

- Crisis Intervention Team (CIT) training/Steering Committee
- Crisis team
- Community outreach
- Crisis hotline
- Ride alongs
- Assertive Community Treatment (ACT) teams
- Alcohol and drug services
- Mental Health First Aid training
- Emergency Services (EMS) response
- Urgent psychiatric/crisis appointments
- Respite
- Detoxification center
- Stakeholder meetings
- Diversion case management
- Bi-lingual crisis worker/translation app available

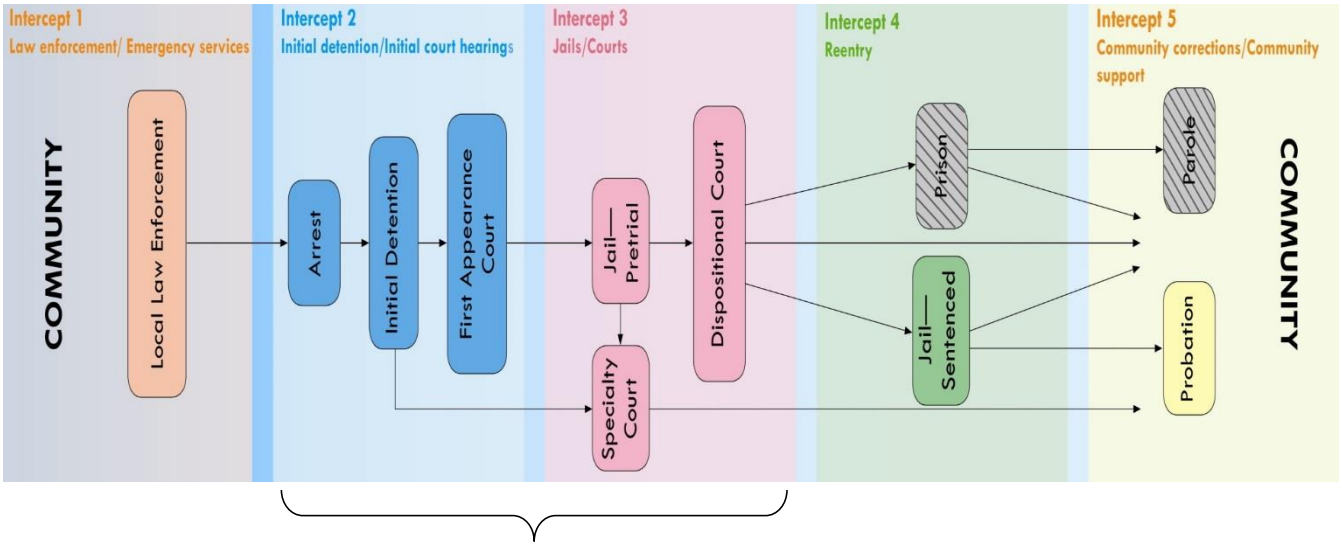
- Sub-acute
- Crisis walk-in
- Agency collaboration
- Peer-run organization
- Warm line
- Screening service
- Community Care Organizations partnership
- Veteran resource sharing
- Veteran Affairs Supportive Housing (VASH)

Gaps (with prioritization from the group)

- Housing/transitional (continuum of housing)- 14 votes
- Timely diversion- 8 votes
- Data tracking and outcomes- 8 votes
- CIT leadership support, direction, and guidance for law enforcement; crisis respite center- 8 votes
- Alternative payment methodology/reimbursement- 4 votes
- Inter-agency communication- 3 votes
- Training of court personnel- 2 votes
- Cross-discipline training- 2 votes
- Fidelity in training and policy- 2 votes
- Lack of detox centers- 2 votes
- Psychiatric prescribers- 2 votes
- Lack of mental health courts- 1 vote
- HIPAA- state interpretation expectations- 1 vote
- Behavioral health workforce- 1 vote

- Cultural competency stigma- 1
- Resource sharing
- Siloing of services
- Lack of diversion programs
- Non-profit support (i.e., NAMI)
- Disparity of resources
- SSDI/SSI Access
- Civil commitment process
- Trauma-informed care training
- Transportation

Intercepts 2 and 3



Resources

- Communication between resources
- Mental health summit (Lane County)
- Working relationship with jail (embedded staff)
- Coordination between mental health court, mental health, and community corrections
- Communication across counties
- Specialty courts (Clackamas)
- State role in mitigation
- Mental health and veteran screening at booking
- VA participation (Clackamas)
- Community standard
- Forensic diversion (multi)
- Peer involvement/participation at all levels
- Medication availability

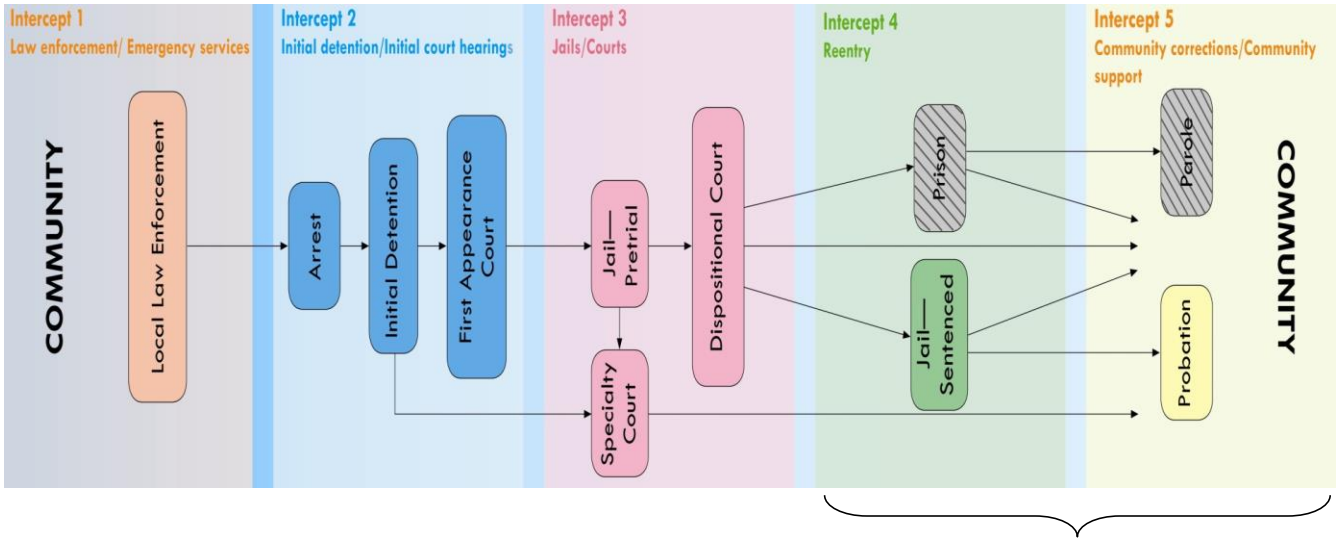
- Good assessment tools
- Dually credentialed staff
- Supporting people to attend community staff
- Peer-facilitated treatment
- Substance abuse treatment in jail and community corrections
- Flexibility/willingness of staff
- Jail staff are trained in CIT
- Medication Assisted Treatment (MAT)
- Telemedicine in local jail
- Assisted Outpatient Treatment (AOT)/Competency restoration
- In-home respite care

Gaps (with prioritization from the group)

- Housing- 18 votes
- Medicaid cancellation while incarcerated- 8 votes
- Lack of funding- 6 votes
- 370 treatment in community- 6 votes
- DA resistance- 5 votes
- Peer-run respite- 4 votes
- Access to dual diagnosis treatment- 3 votes
- Inpatient treatment facilities- 2 votes
- Lack of trained workforce- 2 votes
- Dismissed drugs for misdemeanors- 2 votes
- Lack of consistency in access to resources- 1 vote
- Cannot blend funding/no re-allocation of funding/insecure funding- 1 vote

- Different formularies- 1 vote
- Jail segregation- 1 vote
- Suicide watch practices/inconsistencies- 1 vote
- Trauma-informed care- 1 vote
- Lack of court-imposed sanctions for Assisted Outpatient Treatment (AOT)- 1 vote
- Lack of case management during legal process- 1 vote
- Improved communication with mental health services- 1 vote
- Inconsistent terminology between counties
- Inadequate mental health treatment in jail
- Public defenders are uninformed
- Lack of providers for court support
- Bench parole with no mandated treatment
- Lack of mandated substance abuse treatment
- Unfunded mandates (inpatient detox)
- Mandated sentences for misdemeanors- unable to aid and assist
- Lack of basic life skills training
- Not enough early intervention
- Lack of communication between police and the DA

Intercepts 4 and 5



Resources

- Collaboration between community mental health providers and corrections/community corrections/Governor's Re-entry Council
- OSH relationship with community mental health providers
- PSRB model
- Strong laws regarding employment, housing, and anti-discrimination
- Evidence-based re-entry practices/in-reach (needs based)
    - Assessments, treatment planning, case management, clinicians on staff, electronic medical records, peers
- Community Care Organizations/Medicaid access
- Assertive Community Treatment (ACT) teams/supported employment
- Continuum of care

Gaps (with prioritization from the group)

- Lack of affordable housing (still segregated, lack of integrated housing)- 10 votes

- Lack of alcohol/drug residential services focus to adequately treat individuals with serious mental illness; end up in mental health with no coordination - 8 votes
- Lack of psychiatric beds (and variation, results in jail placement)- 4 votes
- Silo of developmental disability/intellectual disability/gerontology/Anti-social Personality Disorder
- Access to medication treatment is lacking for judges (corrections does not always support the education/cost)- 2 votes
- Cut-off of Medicaid while in jail- 2 votes
- Inadequate transportation-2 votes
- Lack of comprehensive community-based and culturally appropriate services- 1 vote
- VA- lack of communication/cooperation with SSA- 1 vote
- Lack of technology- 1 vote
- Lack of doctor/psychiatric nurse practitioner
- Communication/funding gaps between jail/community/Community Care Organizations
- Lack of first responders
- Funding/billing for peer support is cumbersome
- Never ending growth/demand for services
- Physical/dental care access
- Lack of preventative/trauma-specific services
- Lack of understanding about HIPAA
- Lack of diversity in rural areas; unable to use best practices
- Lack of sex offender treatment/housing
- Lack of qualified staff; high turnover due to burnout
- Too many initiatives

Gaps in Current Legislation (with prioritization from the group)

- Prosecution and defense-led deferred prosecution initiative- 6 votes
- Need for better crisis services in the community- 2 votes
- Inadequate civil commitment statute- 1 vote
- Medication override
- Need for probation officer support for treatment of misdemeanors

Intercept-Specific Priorities

Intercept 1	Intercepts 2&3	Intercepts 4&5
Housing (14)	Housing (18)	Housing Expand Housing Models (10)
Enhanced Police and Crisis Response (8)	Medicaid cancellation while incarcerated (8)	Lack of Co-occurring Disorder Treatment Lack of Integration (8)
Timely Diversion (8)	Community 370 treatment (6)	Lack of Continuum of Psychiatric Beds (4)
Data and Tracking Outcomes (5)	Funding (6)	Silo of systems (special populations include TBI/Intellectual Disability/Aging Population (4)

Recommendations

The Summit demonstrated a convergence of state-led criminal justice and behavioral health initiatives and local, grassroots program development. Both the panel discussions and breakout groups highlighted opportunities to enhance the synergy between state and local efforts.

1. **Formalize a Statewide Planning Body to address the needs of justice involved person with behavioral health disorders.**

   Oregon currently has an impressive list of behavioral health and justice initiatives:
   Oregon Health Authority (OHA) Jail Diversion Funding
   OHA Crisis Stabilization Funding
   Oregon Criminal Justice Commission Reinvestment Funding
   Sequential Intercept Model (SIM) Mapping Train the Trainers Initiative
   Police Crisis Intervention Training (CIT) expansion

   Oregon Behavioral Health initiatives such as SB 832 and the Excellence in Mental Health Certified Behavioral Health Clinic Demonstration Project, provide an opportunity to design services specifically to enhance care for justice involved persons with behavioral health disorders, providing that there is involvement of justice partners at the beginning of the planning process.

   The legislatively funded, Early Assessment and Support Alliance (Appendix 2), which provides for aggressive interventions for persons experiencing First Episode Psychosis, reports a decrease in criminal justice involvement of program participants. This an exemplary program in several Oregon communities. Further disseminating outcomes, replicating the program and enlisting police, judicial, probation and jail partnerships could improve case finding.

   In addition, Summit panels described exemplary local programs which could inform development of programs for justice involved persons in other communities. The Marion County Psychiatric Crisis Center (PCC) is another example of an exceptional program with good outcome data that can inform development and provide technical assistance to other communities.

   Judicial interest at the local level has fueled the development of Mental Health Courts.
   Summit panelists, Judge Wolke and Judge Fun both offered assistance to other communities developing mental health courts.

   The upcoming SIM Mapping Train the Trainer workshop will provide trained SIM mappers to assist in partnership building and implementation of jail diversion programs across the state.
   They will be collecting critical information about best practices and learning site opportunities, as well as about critical gaps that require technical assistance, funding or legislative or policy change to address.

   In addition, in his welcoming remarks, Ross Caldwell from the Criminal Justice Commission, noted there is $38.7 million in Justice Reinvestment money being distributed to counties.

Initiatives include improving jail mental health screening, embedding clinicians with Law Enforcement, funding in-reach services in the Northern counties of Oregon, and improving jail-based mental health services.

The Day 2 Summit Meeting of key stakeholders noted that there was a lack of knowledge about what communities across the state are doing with state grant funds and initiatives.

It will be important as these various state and local projects move forward to insure initiatives are coordinated, resources are used efficiently and are strategically employed, best practices are disseminated and outcomes are measured. Forming a statewide Criminal Justice/Behavioral Health workgroup can aid in addressing these issues.
See examples below:

- Ohio Attorney General's Task Force on Criminal Justice and Mental Illness
  http://www.ohioattorneygeneral.gov/Individuals-and-Families/Victims/Task-Force-on-Criminal-Justice-and-Mental-Illness

- Texas Correctional Office of Offenders with Medical and Mental Impairments
  http://www.hotrmhmr.org/mhTCOOMMI.html

- Virginia Commonwealth Consortium for Mental Health/Criminal Justice Transformation
  http://www.dbhds.virginia.gov/library/forensics/ofo%20-%20eo%20number%2062.pdf

- Pennsylvania Mental Health and Justice Center of Excellence and Transformation
  http://www.pacenterofexcellence.pitt.edu/

2. Continue expansion and enhancement of crisis care response.

The 2nd rated priority of the Intercept 1 Breakout Group was to enhance police and crisis response. It is noted that there is already a Crisis Stabilization funding appropriated and plans for Police Crisis Intervention Training (CIT) Expansion. The fact that police and crisis response enhancement is the 2nd rated priority further validates the priority of these initiatives.

3. Provide guidelines to communities regarding information sharing. If necessary, review current state legislation regarding confidentiality.

Information sharing and understanding HIPAA were identified gaps in two of the three work groups and while not identified as a priority, there was substantial discussion of how restrictions in information sharing inhibited collaboration and agency coordination. Also, in reviewing the Multnomah County Feasibility Assessment (2015), past SIM Mapping Reports from Clackamas (2010), Multnomah (2010) and Lane (2014) Counties, HIPAA is repeatedly mentioned as an area of confusion and an obstacle to developing criminal justice behavioral health partnerships.

Below are links to resources, which address information sharing between criminal justice and behavioral health professionals:

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

- The Council of State Governments Justice Center. Information Sharing in Criminal Justice-Mental Health Collaborations. http://csgjusticecenter.org/cp/publications/information-sharing-incriminal-justice-mental-health-collaborations/

- SAMHSA's GAINS Center. Dispelling the Myths about Information Sharing Between the Mental Health and Criminal Justice Systems. http://gainscenter.samhsa.gov/pdfs/integrating/Dispelling_Myths.pdf

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

Multiple priorities identified at the SIM workshop are related to expanding diversion. Policy Research Associates (PRA) recommends specifically focusing on Intercept 2 diversion strategies by improving screening for mental health and co-occurring disorders, service access and formalizing diversion activities at arraignment. Formalizing protocols and flow of information to the court and court partners can result in more timely diversion from jail and engagement into treatment.

Below are links to three publications describing Intercept 2 diversion essential elements and programs:

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

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

- Municipal Courts: An Effective Tool for Diverting People with Mental and Substance Use Disorders from the Criminal Justice System http://store.samhsa.gov/product/Municipal-Courts-An-Effective-Tool-for-Diverting-People-with-Mental-and-Substance-Use-Disorders-from-the-Criminal-Justice-System/All-New-Products/SMA15-4929

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

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

Below are data sharing and analysis guidelines and resources from various jurisdictions:

- "Mental Health Report Card" used by the King County, Washington Mental Health, Chemical Abuse and Dependency Services to document progress in meeting relevant client outcomes. For example, one outcome measure asks: Are we decreasing the number of times adults and older adults are incarcerated?
  http://www.kingcounty.gov/healthservices/MentalHealth/Reports.aspx

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

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

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

6. Support/Facilitate Judicial involvement in ongoing diversion efforts.

Judge Fun, from Washington County and Judge Wolke, from Josephine County participated in the Intercept II-III Panel. Both described how their courts were successful because of the collaboration with community partners to address the needs of justice involved persons with mental illness and co-occurring disorders. The presence of their courts helped advance other diversion strategies and improved access to care for court participants. Funding for both courts resulted from in-kind services from community partners. Both judges offered to provide guidance to other communities interested in establishing a Mental Health Court.

Judges Fun and Wolke report there are about 20 Mental Health Courts across the state and there is a recently formed Mental Health Court Association that meets regularly. Again, this is a grassroots initiative.

Judges can be central to the success of jail diversion initiatives at the local level and their involvement early on in the recently funded jail diversion initiatives is essential.

At the state level, the expertise of experienced mental health court judges is valuable to inform planning and funding of additional court based diversion initiatives and to provide training and mentoring for new mental health court judges.

7. Insure involvement of the Veterans Administration, specifically the Veterans Justice Outreach Coordinators (VJO's) in planned jail diversion implementation.

According to the Justice 4 Vets website, there are four Veterans Treatment Courts (VTCs) in Oregon. While important components of diversion strategies, VTCs are not required to divert veterans.

All jail diversion programs should routinely screen for veterans status and then depending upon charges and other circumstances, arrange for appropriate behavioral health services to address the needs of the veterans.

The Oregon VJOs are:
Belinda Maddy, Portland, VISN 20, Portland VA Medical Center,
belinda.maddy@VA.GOV

Susan Harrison, Roseburg, VISN 20, VA Roseburg Healthcare System,
susan.harrison@VA.GOV

Paul Skinner, White City, VISN 20, VA Southern Oregon Rehabilitation Center & Clinics,
paul.skinner@VA.GOV
The Defense bar, pretrial services and the jail are key veterans screening partners (Appendices 3 and 4).

8. **Develop a more formal approach at the local and state level to expanding housing options for justice-involved persons.**

Housing was the number 1 priority of all three Intercept breakout groups. The lack of housing was thought to result in longer jail stays and poorer criminal justice outcomes. It was also noted during the post-Summit Planning Meeting, that Housing 1st models are not widely used in Oregon. Communities around the country have begun to develop more formal approaches to housing development, including use of the Housing 1st model (Appendix 6). The 100,000 Home Initiative identifies key steps for communities to take to expand housing options for persons with mental illness (see http://100khomes.org/resources/housing-first-self-assessment).

Summit Panelist, Kim Travis, of the Oregon Housing Authority and Community Services noted that she is currently traveling across the state to assess regional housing needs. She noted her agency provides housing financing, rental assistance, "certificates of good standing" and advocacy to address NIMBY (Not in My Back Yard) issues.

Resources include:

- Moving Toward Evidence-based Housing Program for Person with Mental Illness in Contact with the Justice System
  http://gainscenter.samhsa.gov/pdfs/ebp/MovingTowardEvidence-BasedHousing.pdf

- Stefancic, A., Hul, L., Gillespie, C., Jost, J., Tsemberis, S., & 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., & Tsemberis, S. (2013). Implementing Housing First in Rural Areas: Pathways Vermont, *American Journal of Public Health*, *103*, 206–209.

9. Improve access to Medicaid and Social Security benefits to persons released from jail and prison.

Medicaid cancellation while incarcerated was the 2nd highest priority in the Intercept 2-3 workgroup and identified as a priority in the Intercept 4-5 workgroup. Review of SIM Mapping workshops indicated Medicaid and Social Security enrollment was a priority in the Clackamas SIM Mapping Workshop (2010) and in the Deschutes County SIM Mapping Workshop as recently as (2014). Oregon was one of the first states to allow for suspension of Medicaid for persons while incarcerated. Yet years later, the practice of terminating Medicaid continues. The Affordable Care Act has expanded access to Medicaid. Yet, communities across the country have lagged in enrolling justice involved individuals in Medicaid. Information obtained from the Summit and other documents cited, suggest a more aggressive and coordinated approach in Oregon is needed to insure Medicaid benefits essential to continuing prescribed medication and accessing critical behavioral health services.

Strategies include:

- Jail in-reach enrollment and health system navigators as described by Lt. Ted Larson of the Marion County Sheriff's Office.
- Survey of local Medicaid offices to determine how broadly Medicaid suspension is implemented, coupled with targeted technical assistance to insure counties implement Medicaid suspension.
- Providing jail-based or diversion health personnel with access to the local Medicaid database to promptly identify enrollees and insure continuation of coverage.
- Social Security Disability (SSD) and Social Security Supplemental Income (SSI) provide medical benefits and income which can improve access to housing and other services. Social Security Outreach Access and Recovery training (SOAR) can improve successful enrollments and reduce approval times from months to as soon as 60 days.
- Oregon has a SOAR initiative operated by the Central City Concern's Best Program in Portland. Expanding SOAR to jail and prison settings can greatly improve access to services, housing and reduce chances of recidivism (Appendix 7).

10. Continue to address broad strategies to combat the Opioid Abuse Epidemic and involve criminal justice partners.

John Mcilveen of OHA, detailed Oregon initiatives to address the Opioid Crisis which effects states across the nation. Strategies specific to the criminal justice partners include availability of Naloxone, expansion of Medication Assisted Treatment (MAT) to those involved in jail diversion programs and drug courts, and providing MAT upon release from jail and prison (Appendix 8).

APPENDIX INDEX

Appendix 1

Behavioral Health Criminal Justice Summit
Salem Convention Center
January 20, 2016

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Behavioral Health Criminal Justice Summit
Salem Convention Center
January 20, 2016

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19.	Christy, Chris	chris.r.christy@doc.state.or.us	2575 Center St. NE Salem, OR 97301	503-947-2357
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26.	Curtis, Rebecca	rebecca.l.curtis@dhsoha.state.or.us	Oregon State Hospital 2600 Center Street NE Salem, OR 97301	503-945-2860
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28.	Dentinger, Jean	jean.m.dentinger@multco.us	421 SW Oak St. #520 Portland, OR 97204	503-988-8259
29.	Dickison, Lance	ldickison@optionsonline.org	Options for Southern Oregon Grants Pass, OR 97526	541-476-2373
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31.	Dudley, Whitney	whitney.dudley@co.lane.or.us	2411 MLK JR BLVD Eugene, OR 97401	541-682-3267
32.	Dwiggins, Brian	briandwi@clackamas.us	11211 SE 82nd Ave. Ste O Happy Valley, OR 97086	503-722-6625
33.	Ernst, Jeremy	jernst@chaoregon.org	Community Health Alliance Roseburg, OR 97471	541-236-4084
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43.	Hlebechuk, Michael	Michael.hlebechuk@dhsoha.state.or.us	Human Services Building - 4th Floor 500 Summer Street NE Salem, OR 97301	503-945-6190
44.	Huston, John	hustonjd@jacksoncounty.org		
45.	Irmen, Timothy	tim.irmen@dhsoha.state.or.us	Oregon State Hospital 2600 Center Street NE Salem, OR 97301	503-945-7111

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47.	Knight, Allison	aknight@lanepds.org	Change Me Salem, OR 97301	503-555-1212
48.	Krolick, Jeffrey	jkrolick@optionsonline.org	Options for Southern Oregon Grants Pass, OR 97526	541-840-5614
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53.	Logan, Micky	micky.f.logan@dhsoha.state.or.us	Oregon State Hospital 2600 Center Street NE Salem, OR 97301	
54.	McChesney, Kevin	kmcchesney@telecarecorp.com	Telecare Mental Health Services of Oregon Gresham, OR 97030	503-319-6142
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62.	Nelson, Jeanne	jeanne.nelson@co.benton.or.us	530 NW 27th St Corvallis, OR 97330	541-766-6620
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70.	Reynolds, Emily	ereynolds@optionsonline.org	1215 SW G Street Grants Pass, OR 97526	541-314-5321
71.	Riutzel, Julia	julia.riutzel@co.lane.or.us	2411 Martin Luther King Blvd. Eugene, OR 97401	541-682-7508
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73.	Roberts, Stuart		Chief of Police, Pendleton Oregon	
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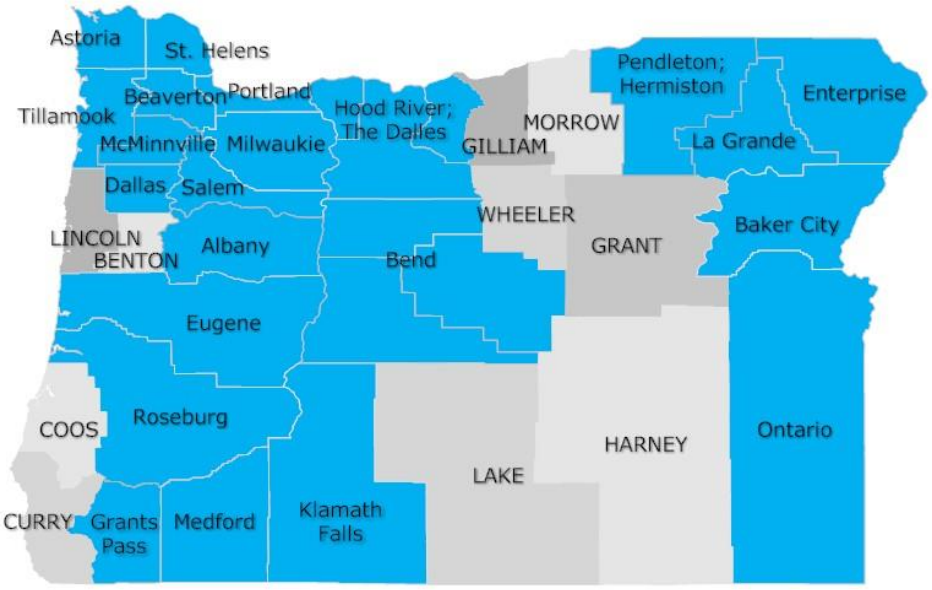
95.	Wood, Jeff	jwood@co.marion.or.us	4040 Aumsville Hwy. SE Salem, OR 97317	503-588-6824

Appendix 2

Oregon Early Assessment & Support Alliance (EASA) Programs



Counties with EASA Programs (City listed)

Appendix 3

Oregon Criminal Justice and Behavioral Health
Statewide Summit
January 20, 2016
Salem Convention Center

200 Commercial St SE
Salem, OR 97301

8:00 – 8:30 a.m.	**Registration & Coffee**
8:30 – 8:45 a.m.	**Welcome and Introductions**
8:45 – 9:20 a.m.	**Why We Are Here** Greg Roberts, Superintendent Oregon State Hospital Jason Myers, Marion County Sheriff Ross Caldwell, Justice Reinvestment Liaison, Oregon Criminal Justice Commission
9:20 – 10:20 a.m.	**The Sequential Intercept Model as a Tool for Planning** Dan Abreu, Senior Project Associate Travis Parker, Senior Project Associate
10:20 – 10:30 a.m.	**Break**
10:30 – 11:15 a.m.	Panel: Intercept I
11:15 – 12:00 noon	Panel: Intercept II/III
12:00 – 12:45 p.m.	Panel: Intercept IV/V
12:45 – 1:30 p.m.	**Lunch** (Main Room)
1:30 – 2:30 p.m.	**Setting Priorities Breakout Sessions:** Identifying Resources and Gaps • Intercept I • Intercept II/III • Intercept IV • Intercept V
2:30 – 3:00 p.m.	Priority Setting • Intercept I • Intercept II/III • Intercept IV • Intercept V
3:00 – 3:15 p.m.	**Break**
3:15 – 4:00 p.m.	**Group Reports and Integration**
4:00 – 4:15 p.m.	**Jail Diversion and Olmstead Decision** Rick Wilcox, Olmstead Policy Coordinator Health Policy and Analytics, Oregon Health Authority
4:15 – 4:30 p.m.	**Next Steps** Dan Abreu, Senior Project Associate Travis Parker, Senior Project Associate
4:30 – 4:45 p.m.	**Regional Coordination and Train-the-Trainer for Sequential Intercept Model Mapping**
4:45 – 5:00 p.m.	**Wrap-up**

Oregon Health Authority

Oregon Criminal Justice and Behavioral Health
Statewide Summit
January 21, 2016
Salem Convention Center

200 Commercial St SE
Salem, OR 97301

8:00 – 8:30 a.m.	**Registration & Coffee**
8:30 – 8:45 a.m.	**Welcome and Introductions**
8:45 – 9:00 a.m.	**Moving Forward** Karen Wheeler, MA, Business and Operational Policy Director Health Systems Division, Oregon Health Authority
9:00 – 10:30 a.m.	**Jail Diversion: Gaps and Opportunities - Facilitated Discussion** Dan Abreu, Senior Project Associate Travis Parker, Senior Project Associate
10:30 – 10:45 a.m.	**Break**
10:45 – 11:45 noon	**Local Mapping and Technical Assistance** Nomination of train-the-trainer attendees
11:45 – 12:00 noon	**Conference Close**

Oregon Health Authority

Appendix 4

Responding to the Needs of Justice-Involved Combat Veterans with Service-Related Trauma and Mental Health Conditions

A Consensus Report of the CMHS National GAINS Center's Forum on Combat Veterans, Trauma, and the Justice System

August 2008

> *… The 33-year-old veteran's readjustment to civilian life is tormented by sudden blackouts, nightmares and severe depression caused by his time in Iraq. Since moving to Albany last June … [he] accidentally smashed the family minivan, attempted suicide, separated from and reunited with his wife and lost his civilian driving job.*
>
> *In June … [he] erupted in a surprisingly loud verbal outbreak, drawing police and EMTs to his home.*
>
> War's Pain Comes Home
> Albany Times Union – November 12, 2006
>
> *… His internal terror got so bad that, in 2005, he shot up his El Paso, Texas, apartment and held police at bay for three hours with a 9-mm handgun, believing Iraqis were trying to get in …*
>
> *The El Paso shooting was only one of several incidents there, according to interviews. He had a number of driving accidents when, he later told his family, he swerved to avoid imagined roadside bombs; he once crashed over a curb after imagining that a stopped car contained Iraqi assassins. After a July 2007 motorcycle accident, his parents tried, unsuccessfully, to have him committed to a mental institution.*
>
> The Sad Saga of a Soldier from Long Island
> Long Island Newsday – July 5, 2008

On any given day, veterans account for nine of every hundred individuals in U.S. jails and prisons (Noonan & Mumola, 2007; Greenberg & Rosenheck, 2008). Although veterans are not overrepresented in the justice system as compared to their proportion in the United States general adult population, the unmet mental health service needs of justice-involved veterans are of growing concern as more veterans of Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) return home with combat stress exposure resulting in high rates of posttraumatic stress disorder (PTSD) and depression.

OEF/OIF veterans constitute a small proportion of all justice-involved veterans. The exact numbers are not known—the most recent data on incarcerated veterans is from 2004 for state and Federal prisoners (Noon & Mumola, 2007) and 2002 for local jail inmates (Greenberg & Rosenheck, 2008) before OEF/OIF veterans began returning in large numbers.

Some states have passed legislation expressing a preference for treatment over incarceration (California and Minnesota) and communities such as Buffalo (NY) and King County (WA) have implemented strategies for intercepting veterans with trauma and mental conditions as they encounter law enforcement or are processed through the courts. However, most communities do not know where to begin even if they recognize the problem.

This report is intended to bring these issues into clear focus and to provide local behavioral health and criminal justice systems with strategies for working with justice-involved combat veterans, especially those who served in OEF/OIF.

Combat Veterans, Trauma, and the Criminal Justice System Forum

The CMHS National GAINS Center convened a forum in May 2008 in Bethesda, MD, with the purpose of developing a community-based approach to meeting the mental health needs of combat veterans who come in contact with the criminal justice system. Approximately 30 people participated in the forum, representing community providers, law enforcement, corrections, the courts, community-based veterans health initiatives, peer support organizations, Federal agencies, and veteran advocacy organizations. See Appendix.

We begin with the recommendations that emerged from this meeting and then provide the data that support them.

Recommendations for Screening and Service Engagement Strategies

The following recommendations are intended to provide community-based mental health and criminal justice agencies with guidance for engaging justice-involved combat veterans in services, whether the services be community-based or through the U.S. Department of Veterans Affairs's healthcare system—the Veterans Health Administration (VHA).

➤ Recommendation 1: Screen for military service and traumatic experiences.

The first step in connecting people to services is identification. In addition to screening for symptoms of mental illness and substance use, it is important to ask questions about military service and traumatic experiences. This information is important for identifying and linking people to appropriate services.

The Bureau of Justice Statistics of the U.S. Department of Justice, Office of Justice Programs, has developed a set of essential questions for determining prior military service (Bureau of Justice Statistics, 2006). These questions relate to branch of service, combat experience, and length of service. See Figure 1 for the questions as they were asked in the 2002 Survey of Inmates in Local Jails. One question not asked in the BJS survey, but worth asking, is:

Did you ever serve in the National Guard or Reserves?

Yes
No

Did you ever serve in the U.S. Armed Forces?
- Yes
- No

In what branch(es) of the Armed Forces did you serve?
- Army (including Army National Guard or Reserve)
- Navy (including Reserve)
- Marine Corps (including Reserve)
- Air Force (including Air National Guard and Reserve)
- Coast Guard (including Reserve)
- Other – Specify

When did you first enter the Armed Forces?
- Month
- Year

During this time did you see combat in a combat line unit?
- Yes
- No

When were you last discharged?
- Month
- Year

Altogether, how much time did you serve in the Armed Forces?
- # of Years
- # of Months
- # of Days

What type of discharge did you receive?
- Honorable
- General (Honorable Conditions)
- General (Without Honorable Conditions)
- Other Than Honorable
- Bad Conduct
- Dishonorable
- Other – Specify
- Don't Know

Figure 1. Military Service Questions from the Bureau of Justice Statistics 2002 Survey of Inmates in Local Jails (Bureau of Justice Statistics, 2006)

A number of screens are available for mental illness and co-occurring substance use. Refer to the CMHS National GAINS Center's website (www.gainscenter.samhsa.gov) for the 2008 update of its monograph on behavioral health screening and assessment instruments. The National Center for PTSD of the U.S. Department of Veterans Affairs provides the most comprehensive information on screening instruments available for traumatic experiences, including combat exposure and PTSD. Many of the screens are available for download or by request from the Center's website (http://www.ncptsd.va.gov). Comparison charts of similar instruments are provided, rating the measures based on the number of items, time to administer, and more. Measures available from the Center include:

- PTSD Checklist (PCL): A self-report measure that contains 17 items and is available in three formats: civilian (PCL-C), specific (PCL-S), and military (PCL-M). The PCL requires up to 10 minutes to administer and follows DSM-IV criteria. The instrument may be scored in several ways.
- Deployment Risk and Resilience Inventory (DRRI): A set of 14 scales, the DRRI can be administered whole or in part. The scales assess risk and resilience factors at pre-deployment, deployment, and post-deployment.
- Clinician Administered PTSD Scale (CAPS): A 30-item interview that can assess PTSD symptoms over the past week, past month, or over a lifetime (National Center for PTSD, 2007).

➤ **Recommendation 2: Law enforcement, probation and parole, and corrections officers should receive training on identifying signs of combat-related trauma and the role of adaptive behaviors in justice system involvement.**

Knowing the signs of combat stress injury and adaptive behaviors will help inform law enforcement officers and other frontline criminal justice staff as they encounter veterans with combat-related trauma. Such information should be incorporated into Crisis Intervention Team (CIT) trainings. The Veterans Affairs Medical Center in Memphis (TN) has been involved in the development of the CIT model, training officers in veterans crisis issues, facilitating dialogue in non-crisis circumstances, and facilitating access to VA mental health services for veterans in crisis.

The Veterans Health Administration has committed to outreach, training, and boundary spanning with local law enforcement and other criminal justice agencies through the position of a Veterans' Justice Outreach Coordinator (Veterans Health Administration, 2008a). Each medical center is recommended to develop such a position. In addition to training, a coordinator's duties include facilitating mental health assessments for eligible veterans and participating in the development of plans for community care in lieu of incarceration where possible.

➤ **Recommendation 3: Help connect veterans to VHA healthcare services for which they are eligible, either through a community-based benefits specialist or transition planner, the VA's OEF/OIF Coordinators, or through a local Vet Center.**

Navigating the regulations around eligibility for VHA services is difficult, especially for those in need of services. To provide greater flexibility for combat veterans in need of health care services, enrollment eligibility has been extended to five years past the date of discharge (U.S. Department of Veterans Affairs, 2008) by the National Defense Authorization Act (Public Law 110-181). Linking a person to VHA health care services is dependent upon service eligibility and enrollment. Community providers can help navigate these regulations through a benefits specialist or by connecting combat veterans to a VA OEF/OIF Coordinator or local Vet Center.

Vet Centers, part of the U.S. Department of Veterans Affairs, provide no-cost readjustment counseling and outreach services for combat veterans and their families. Readjustment counseling services range from individual counseling to benefits assistance to substance use assessment. Counseling for military sexual trauma is also available. There are over 200 Vet Centers around the country. The national directory of Vet Centers is available through the national Vet Center website (http://www.vetcenter.va.gov/).

OEF/OIF Coordinators, or Points of Contact, are available through many facilities and at the network level (Veterans Integrated Service Network, or VISN). The coordinator's role is to provide OEF/OIF veterans in need of services with information regarding services and to connect them to facilities of their choice—even going so far as to arrange appointments.

In terms of access to VA services among justice-involved veterans, data are available on one criterion for determining eligibility: discharge status. Among jail inmates who are veterans, 80 percent received a discharge of honorable or general with honorable conditions (Bureau of Justice Statistics, 2006). Inmates in state (78.5%) or Federal (81.2%) prisons have similar rates (Noonan & Mumola, 2007). Apart

from discharge status, access to VA health care services is dependent upon service needs that are a direct result of combat deployment and enrollment within in a fixed time period after discharge. So despite this 80 percent figure, a significant proportion of justice-involved veterans who are ineligible for VA health care services based on eligibility criteria or who do not wish to receive services through the VA will depend on community-based services.

➤ **Recommendation 4: Expand community-based veteran-specific peer support services.**

Peer support in mental health is expanding as a service, and many mental health–criminal justice initiatives use forensic peer specialists as part of their service array. What matters most with peer support is the mutual experience—of combat, of mental illness, or of substance abuse (Davidson & Rowe, 2008). National peer support programs such as Vets4Vets and the US Department of Veteran Affairs's Vet to Vet programs have formed to meet the needs of OEF/OIF veterans. It is important that programs such as these continue to expand in communities around the country.

➤ **Recommendation 5: In addition to mental health needs, service providers should be ready to meet substance use, physical health, employment, and housing needs.**

Alcohol use among returning combat veterans is a growing issue, with between 12 and 15 percent of returning service members screening positive for alcohol misuse (Milliken et al, 2007). Based on a study of veterans in the Los Angeles County Jail in the late 1990s, nearly half were assessed with alcohol abuse or dependence and approximately 60 percent with other drug (McGuire et al, 2003). Moreover, the same study found that of incarcerated veterans assessed by counselors, approximately one-quarter had co-occurring disorders. One-third reported serious medical problems. Employment and housing were concerns for all the incarcerated veterans in the study.

Available information suggests that comprehensive services must be available to support justice-involved veterans in the community.

Background

Since the transition to an All Volunteer Force following withdrawal from Vietnam, the population serving in the U.S. Armed Forces has undergone dramatic demographic shifts. Compared with Vietnam theater veterans, a greater proportion of those who served in OEF/OIF are female, older, and constituted from the National Guard or Reserves. Fifteen percent of the individuals who have served in OEF/OIF are females, almost half are at least 30 years of age, and approximately 30 percent served in the National Guard or Reserves.

From the start of combat operations through November 2007, 1.6 million service members have been deployed to Iraq and Afghanistan, with nearly 500,000 from the National Guard and Reserves (Congressional Research Service, 2008). One-third have been deployed more than once. For OEF/OIF, the National Guard and Reserves have served an expanded role. Nearly 40 percent more reserve personnel were mobilized in the six years following September 11, 2001 than had been mobilized in the decade beginning with the Gulf War (Commission on the National Guard and Reserves, 2008). The National Guard, unlike the active branches of the U.S. Armed Forces and the Reserves, serves both state and Federal roles, and is often mobilized in response to emergencies and natural disasters.

Combat stress is a normal experience for those serving in theater. Many stress reactions are adaptive and do not persist. The development of combat-related mental health conditions is often a result of combat stress exposure that is too intense or too long (Nash, n.d.), such as multiple firefights (Hoge et al., 2004) or multiple deployments (Mental Health Advisory Team Five, 2008).

A recent series of reports and published research has raised concerns over the mental health of OEF/OIF veterans and service members currently in theater. The Army's Fifth Mental Health Advisory Team report (2008) found long deployments, multiple deployments, and little time between deployments contributed to mental health conditions among those currently deployed for OEF/OIF. The survey found mental health problems peaked during the middle months of deployment and reports of

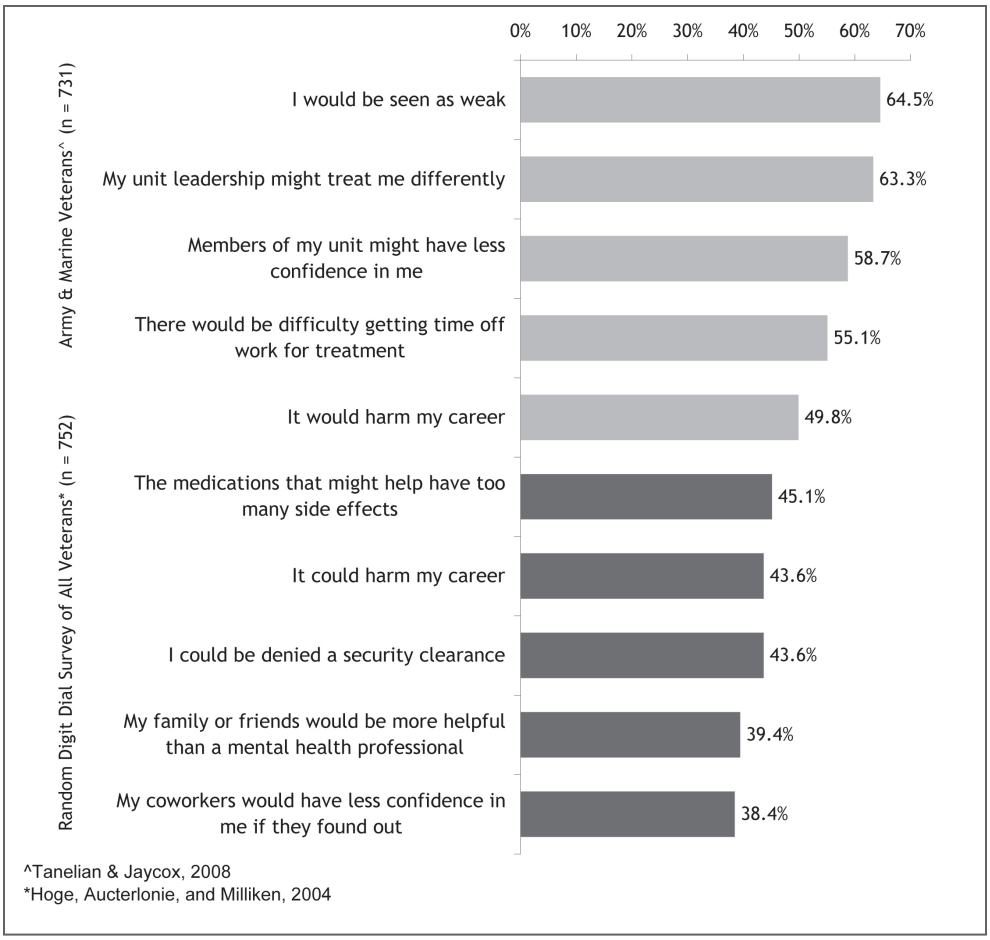


Figure 2. Most Reported Barriers to Care from Two Surveys of Individuals Who Served in OEF/OIF & Who Met Criteria for a Mental Health Condition

problems increased with successive deployments. In terms of returning service members, a random digit dial survey of 1,965 individuals who had served in OEF/OIF found approximately 18.5 percent had a current mental health condition and 19.5 percent had experienced a traumatic brain injury (TBI) during deployment. The prevalence of current PTSD was 14.0 percent, as was depression (Tanelian & Jaycox, 2008).

Reports of mental health conditions have increased as individuals have separated from service. By Department of Defense mandate, the Post-Deployment Health Assessment is administered to all service members at the end of deployment. Three to six months later, the Post-Deployment Health Reassessment is re-administered. From the time of the initial administration to the reassessment, positive screens for PTSD jumped 42 percent for those who served in the Army's active duty (from 12% to 17%) and 92 percent for Army National Guard and Army Reserve members (from 13% to 25%) (Milliken, Auchterlonie, & Hoge, 2007). Depression screens increased as well, with Army National Guard and Army Reserve members reporting higher rates than those who were active duty.

In addition to the increase in mental health conditions, the post-deployment transition is often complicated by barriers to care and the adaptive behaviors developed during combat to promote survival.

Behaviors that promote survival within the combat zone may cause difficulties during the transition back to civilian life. Hypervigilance, aggressive driving, carrying weapons at all times, and command and control interactions, all of which may be beneficial in theater, can result in negative and potentially criminal behavior back home. Battlemind, a set of training modules developed by the Walter Reed Army Institute of Research, has been designed to ease the transition for returning service members. Discussing aggressive driving, the Battlemind literature states, "In combat: Driving unpredictably, fast, using rapid lane changes and keeping other vehicles at a distance is designed to avoid improvised explosive devices and vehicle-born improvised explosive devices," but "At home: Aggressive driving and straddling the middle line leads to speeding tickets, accidents and fatalities." (Walter Reed Army Institute of Research, 2005).

Many veterans of OEF/OIF in need of health care services receive services through their local VHA facilities, whether the facilities be medical centers or outpatient clinics. Forty percent of separated active

duty service members who served in OEF/OIF use the health care services available from the VHA. For National Guard and Reserve members, the number is 38 percent (Veterans Health Administration, 2008b).

A number of barriers, however, reduce the likelihood that individuals will seek out or receive services. According to Tanelian and Jaycox (2008), of those veterans of OEF/OIF who screened positive for PTSD or depression, only half sought treatment in the past 12 months. To compound this treatment gap, the authors determined that of those who received treatment, half had received only minimally adequate services. In an earlier study of Army and Marine veterans of OEF/OIF with mental health conditions, Hoge and colleagues (2004) found only 30 percent had received professional help in the past 12 months despite approximately 80 percent acknowledging a problem. Even among OEF/OIF veterans who were receiving health care services from a U.S. Department of Veterans Affairs Medical Center (VAMC), only one-third of those who were referred to a VA mental health clinic following a post-deployment health screen actually attended an appointment (Seal et al., 2008). Based on surveys (Hoge, Auchterlonie, & Milliken, 2004; Tanelian & Jaycox, 2008) of perceived barriers to care among veterans of OEF/OIF who have mental health conditions, the most common reasons for not seeking treatment were related to beliefs about treatment and concerns about negative career outcomes.[1] See Figure 2 for a review of the two surveys' findings.

Justice System Involvement Among Veterans

At midyear 2007, approximately 1.6 million inmates were confined in state and Federal prisons, with another 780,000 inmates in local jails (Sabol & Couture, 2008; Sabol & Minton, 2008). Based on Bureau of Justice Statistics data (Noonan & Mumola, 2007; Greenberg & Rosenheck, 2008), on any given day approximately 9.4 percent, or 223,000, of the inmates in the country's prisons and jails are veterans. Comparable data for community corrections populations are not available.

The best predictor of justice system involvement comes from the National Vietnam Veterans Readjustment Study (NVVRS). Based on interviews conducted between 1986 and 1988, **the NVVRS found that among male combat veterans of Vietnam with current PTSD (approximately 15 percent of all male combat veterans of Vietnam), nearly half had been arrested one or more times (National Center for PTSD, n.d.).** At the time of the study, this represented approximately 223,000 people.

Veterans coming into contact with the criminal justice system have a number of unmet service needs. A study by McGuire and colleagues (2003) of veterans in the Los Angeles County Jail assessed for service needs by outreach workers found 39 percent reported current psychiatric symptoms. Based on counselor assessments, approximately one-quarter had co-occurring disorders. Housing and employment were also significant issues: one-fifth had experienced long term homelessness, while only 15 percent had maintained some form of employment in the three years prior to their current jail stay. Similar levels of homelessness have been reported in studies by Greenberg and Rosenheck (2008) and Saxon and colleagues (2001).

Conclusion

This report provides a series of recommendations and background to inform community-based responses to justice-involved combat veterans with mental health conditions. Many combat veterans of OEF/OIF are returning with PTSD and depression. Both for public health and public safety reasons, mental health and criminal justice agencies must take steps to identify such veterans and connect them to comprehensive and appropriate services when they come in contact with the criminal justice system.

1 In May 2008, Department of Defense Secretary Robert Gates, citing the Army's Fifth Mental Health Advisory Team report (2008) findings on barriers to care, announced that the question regarding mental health services on the security clearance form (Standard Form 88) would be adapted (Miles, 2008). The adapted question will instruct respondents to answer in the negative to the question if the delivered services were for a combat-related mental health condition. Those whose mental health condition is not combat related will continue to be required to provide information on services received, including providers' contact information and dates of service contact.

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Appendix

Participants of the CMHS National GAINS Center Forum on Combat Veterans, Trauma, and the Criminal Justice System

May 8, 2008, Bethesda, MD

A. Kathryn Power, MEd, Director of the Center for Mental Health Services at the Substance Abuse and Mental Health Services Administration, provided the opening comments at the forum.

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Appendix 5

Department of Veterans Affairs

Veterans Health Administration

Fact Sheet

January 2014

VA's Veterans Justice Outreach Program: Services for Veterans Involved in the Justice System

The Department of Veterans Affairs (VA) Veterans Justice Outreach (VJO) Program provides outreach to Veterans involved with the local criminal justice system (i.e., police, jails, and courts). The goal of the program is to provide timely access to VA services for eligible Veterans, preventing homelessness and avoiding unnecessary criminalization, while providing routes to mental health and other clinical treatment aimed toward a lasting rehabilitation and independence for the involved Veterans.

Approximately 50 percent of homeless Veterans have histories of encounters with the legal system. The most recent data from the U.S. Department of Justice Bureau of Justice Statistics (BJS) Survey of Inmates in Local Jails (2002) indicate that 9.3 percent of people incarcerated in jails are Veterans.[1] On average, these Veterans had five prior arrests, and 45 percent had served two or more state prison sentences. Three out of five had substance dependency problems, almost one in three had serious mental illness, and one in five was homeless, while 60 percent had a serious medical problem. From the beginning of the VJO program in fiscal year (FY) 2010 through the end of FY 2013, VJO Specialists served over 66,000 Veterans, gave over 4,800 presentations to 53,000 VA and community audience members, and participated in 289 trainings for over 6,000 police officers.

Each VA medical center has a VJO Specialist who serves as a liaison between VA and the local criminal justice system. Contact information for each Specialist is available at: http://www.va.gov/HOMELESS/VJO.asp. Structural and procedural differences among local justice systems dictate that not all VJO Specialists' roles are identical. VJO Specialists provide direct outreach, assessment, and, often, case management for justice-involved Veterans in local courts and jails. They may also provide or coordinate training for law enforcement personnel on Veteran-specific issues such as Posttraumatic Stress Disorder. Specialists may assist in eligibility determination and enrollment, function as members of court treatment teams, use evidence-based interventions appropriate for the justice-involved Veteran population[2] (e.g., Motivational Interviewing) and refer and link Veterans to appropriate VA and community services. Each Specialist's time may be spent differently in achieving this mission. One may work

[1] U.S. Department of Justice, Bureau of Justice Statistics. Survey of Inmates in Local Jails, 2002. Conducted by U.S. Department of Commerce, Bureau of the Census. Ann Arbor, MI: Inter-university Consortium for Political and Social Research, 2006.

[2] *See* Blodgett, J., Fuh, I., Maisel, N., & Midboe, A. (2013). A structured evidence review to identify treatment needs of justice-involved veterans and associated psychological interventions. Available at: http://csgjusticecenter.org/nrrc/publications/a-structured-evidence-review-to-identify-treatment-needs-of-justice-involved-veterans-and-associated-psychological-interventions/.

primarily with Veterans in court, while another conducts outreach mostly in jails.[3] Both can be equally valid models for achieving VJO's goal of linking justice-involved Veterans with VA services, because each will reflect a locally-informed decision, made in consultation with community partners, as to the most effective way to reach Veterans.[4]

VJO Specialists work with Veterans in a variety of justice system settings, but their work in the courts is the most visible. Increasingly, this work is done in Veterans Treatment Courts (VTC), a new but rapidly growing[5] model designed to connect justice-involved Veterans with needed treatment. VA was instrumental in creating the first VTC in Buffalo, New York, and efficient linkage to VA health care and benefits remains a defining aspect of the VTC model.[6]

VJO Specialists often contact Veterans in jail settings. The Specialists work closely with jail administrators and staff to identify Veterans as quickly as possible, conduct an initial clinical assessment, and facilitate linkage to needed treatment and other resources upon release.

Because a Veteran's contact with the justice system will often begin with a law enforcement encounter, VJO Specialists often provide training and consultation on Veteran-specific issues to community law enforcement agencies. As part of a joint national initiative to promote positive resolutions of crisis encounters with law enforcement, VJO Specialists and other VA mental health providers at each medical center serve on local training teams with VA Police officers. By the end of 2015, all VA Police officers will have received this two day skill-enhancement training.

VJO's newest initiative is the Veterans Reentry Search Service (VRSS), which launched in FY 2013. VRSS allows justice system users to identify all Veterans among their inmates or defendants via a comparison with VA's list of all Veterans who have served in the United States military. Since justice-involved Veterans tend to under-report their military service, many systems see more Veterans than they know of. For more information about VRSS, please go to: https://vrss.va.gov/ or call the contact number on this Fact Sheet.

Point of contact: Sean Clark, National Coordinator, Veterans Justice Outreach; Sean.Clark2@va.gov, (859) 233-4511 ext. 3188.

[3] *See* Clark, S., McGuire, J., & Blue-Howells, J. (2010). Development of veterans treatment courts: Local and legislative initiatives. *Drug Court Review, 7,* 171-208.
[4] *See* Blue-Howells, J.H., Clark, S.C., van den Berk-Clark, C., & McGuire, J.F. (2013). The US Department of Veterans Affairs Veterans Justice Programs and the sequential intercept model: Case examples in national dissemination of intervention for justice-involved veterans. *Psychological Services, 10,* 48-53.
[5] An informal VA survey identified 257 operational VTCs in November 2013.
[6] Justice for Vets, "The Ten Key Components of Veterans Treatment Courts." Available at: http://justiceforvets.org/sites/default/files/files/Ten%20Key%20Components%20of%20Veterans%20Treatment%20Courts%20.pdf.

Appendix 6

EUGENEWEEKLY.COM

Housing First?

A Salt Lake solution could work in Eugene

ARTICLE | AUGUST 20, 2015 - 12:00AM | BY CAMILLA MORTENSEN

Walk through downtown Eugene and you'll see shops, restaurants, bars, kids on bikes, artists, business people, random pedestrians ... and part of this quirky city scene is an assortment of panhandlers, travelers and unhoused residents not unlike those seen in downtowns across America.

Walk though downtown Salt Lake City and it feels a bit like Disneyland. Weirdly clean, it too has bars, restaurants and shops. The downtown mall, City Creek Center, has a manufactured creek running charmingly through its tidy, paved center.

And while it has its share of Mormons on mission (more accurately, members of the Church of Latter Day Saints) in the requisite white shirts and dark ties, it also has a typical scene of shoppers and strollers as well as people sleeping on benches and sitting on planters.

It's not just SLC's cleaner-than-clean downtown façade that made Utah's unhoused stand out to me. I was surprised because Salt Lake City, as I read in several articles before traveling there in July, has figured out the solution to homelessness.

But as I wandered from my hotel in search of coffee (which, like alcohol, is easily purchased in SLC despite rumors that the church forbids it) there were indeed homeless people, panhandling, riding mass transit and generally doing what the unhoused do in every city — surviving.

I met up with a local alternative news weekly reporter who quirked an eyebrow at me when I told him I had come to see Salt Lake City's solution to homelessness.

It didn't seem that odd a request. I'd read the story in ***Mother Jones*** and *The New Yorker*, seen the piece on NationSwell. *The Daily Show* even did a segment in January with correspondent Hasan Minhaj sitting down with Lloyd Pendleton, who had been the director of the Utah Homeless Task Force, to discuss (tongue in cheek on Minaj's part) how SLC had reduced its chronically homeless population by 72 percent.

We hopped on the TRAX, Salt Lake's light rail, which is free downtown and popular with the housed and unhoused alike in the area. We hopped off not far from downtown, near a sparsely populated mall. A short walk later, we were heading down the street toward The Road Home's Salt Lake Community Shelter and a cluster of other homeless services.

We walked through the throng of people waiting on the sidewalk for the day shelter to open. Not far from where drug dealers were blatantly peddling their wares stood families with small children in strollers, hoping for aid.

A young woman sitting on the sidewalk, looking exhausted, maybe a little spaced out, told us she comes to the shelter for food, a shower and a place to rest. A police officer going through the belongings of someone whose car was parked on the street was largely ignored by the rest of the 50 or so people scattered around the homeless services.

Given the scene outside, I wasn't too surprised when, arriving at the front desk and asking the receptionist if I could talk to someone about how Salt Lake City had solved the "homeless problem," she said: "How we did *what*?"

Her tone of shock and skeptical glare spoke volumes.

Yet, to a certain extent, Salt Lake City *has* solved a significant portion of the homeless issue in a way that other cities haven't. The solution is simple and relatively inexpensive: Housing First. Giving the homeless a place to live; not temporary shelters, giving them homes.

But as the staff of The Road Home, a shelter with around 800 beds, will tell you, SLC has not eradicated homelessness. Utah serves as both a model and a reminder for Eugene. The city has made a huge step in the right direction, and it's one that Lane County can emulate — if this area, like Salt Lake, can collaborate on large-scale solutions and, just as importantly, keep moving forward.

The Daily Show's Hasan Minhaj Questions how giving houses to 'Moochers' solves homelessness

The Salt Lake Solution

In that way the internet has of exaggerating things or getting details just wrong enough to make them better or worse than they really are, the news that began to float around social media last fall and into the winter was that Utah, the red state that has gifted the world with Mitt Romney and execution by firing squad, had somehow solved homelessness.

The Daily Show jumped on that news, as it does any news that sounds a bit odd or over the top, like two-headed fish or the BP oil spill. Hasan Minhaj interviewed Lloyd Pendleton, who has since retired from the state of Utah but still speaks and consults on homeless issues.

After pointing out the ridiculous things cities have done to discourage the unsheltered from being visible — from fining them for sleeping outdoors to arresting them for sitting down — the satirical segment says: "Salt Lake City has taken the next step, by removing homeless people from the streets altogether," then shows Minhaj fruitlessly and ironically hunting for people who might be living in cardboard boxes.

"Did you hide them underground?" he asks Pendleton. "Did you convert them from Mormon to gay?"

No. Nor from gay to Mormon either, Pendleton deadpans.

So how did they do it?

"We gave homes to the homeless. Yes, it's simple. You give them housing, and it ends homelessness," Pendleton says.

His response on *The Daily Show* is deadpan, but he's not at all kidding. Since 2005, Utah has reduced the numbers of the chronically homeless by 72 percent, according to the state's 2014 Comprehensive Report on Homelessness, and not gone broke doing it, by providing housing.

Providing housing to the homeless actually means cities spend less money.

Utah has a 10-year plan to end chronic and veteran homelessness by the end of 2015, and it's doing this by using a "Housing First" model. Housing First is, quite simply, the effort to focus on quickly providing permanent housing, not temporary shelter, to those experiencing homelessness, and then providing the needed services. It's the opposite of the typical model, which demands people who might be mentally ill or addicted first go through recovery, get dry or get treatment before "earning" shelter.

Eugene really doesn't have true Housing First, but we could, and many homeless advocates want it. In some ways, the temporary camps such as Whoville, which have been shuffled around the city, as well as the less temporary Opportunity Village Eugene (OVE), are a step in that direction. But while those solutions, as well as shelters such as the Eugene Mission, provide temporary or even longer-term shelter, they are not Housing First. Places such as OVE and Emerald Village Eugene (SquareOne Villages) require that residents not use alcohol or illegal drugs.

Pastor Dan Bryant

The federal government defines as chronically homeless any unaccompanied person who has been unhoused for 12 months or for four times in the previous three years and has some other existing condition such as mental illness or drug addiction, according to Dan Bryant. Bryant is pastor at Eugene's First Christian Church and is executive director of SquareOne Villages. Then there are the situationally homeless, Bryant says, individuals or a family that might be homeless for six months or nine months.

It's the situationally homeless that have been the focus of Bryant's work. "Frankly, I'm focused on the other end, higher functioning, not frequent flyers," he says. "Folks who just need a little bit of help."

Transitional housing programs such as SquareOne Villages' tiny houses are innovative, effective and have gotten their share of national attention, too. ShelterCare's The Inside Program has provided Housing First-type transitional homes and case management for the mentally ill since 2006. But as anyone who lives in Eugene knows, particularly those who live under bridges or in camps alongside rivers, the innovations have not "solved" homelessness.

Meanwhile in Utah, Pendleton is enthusiastic at the steps the large-scale implementation of the Housing First model has made to solve the problem — veteran homelessness is basically at a functional zero, he says. According to Pendleton, the key to the solution is collaboration as well as buy-in from groups and politicians. He says SLC was part of a 2003 federal plan to end chronic homelessness involving a pilot project in 11 cities. The Collaborative Initiative to Help End Chronic Homelessness was a $35-million program for housing and support services that combined Housing and Urban Development funds with other resources.

Utah learned about the Housing First program in New York City, but Pendleton says what works in NYC doesn't necessarily fly in Utah, so a pilot Housing First program was established in Salt Lake. He says the project, Sunrise Metro, took on 17 challenging chronically homeless people, and SLC learned "if we can house them, we can house anybody." He says that nationwide, Housing First projects show 85 percent of people are still housed after 12 months.

"We became believers," Pendleton says. It was a "huge paradigm shift, and we did it with our own people." Housing First soon had buy-in at all levels and across political lines in Utah, and that, Pendleton says, made it possible.

Why Housing First?

But what good does it do to put homeless people in homes if they still have the problems that led to them being unhoused in the first place? Financially it makes sense, Pendleton says. He estimates it costs $10,000 to $12,000 to house a chronically homeless person, but it costs the government $20,000 to deal with them on the street and up to $40,000 in other cities.

Transitional shelters, in the long run, are not cost effective if the homeless spend the whole time there, Pendleton says. If one chronically homeless person gets a bed, then 11 other situationally homeless people can use that bed the chronic person has been taking up. According to the state of Utah's statistics, 3.9 percent of Utah's homeless are considered chronically homeless or experience homelessness for long periods of time, but the chronically homeless take up a disproportionately large share of shelter beds and services.

Bryant says that much higher on-the-street cost has to do with the many contacts the unhoused have with public health and police — trips to the emergency room and to jail. But, he cautions, Housing First programs still need to be supplemented with services, and funding is always an issue.

Utah repurposed existing funding when it got under way with Housing First. Pendleton says, "I was not willing to go say, 'Give me $10 million to implement this new idea.'" But once the program showed success, it got champions at high levels and even outside donors, in addition to pulling from federal, state and local funding.

Back at The Road Home, the nonprofit's executive director Matt Minkevitch says while housing the chronically homeless has made a difference, the work is not done. "Candidly, I got concerned when I started sensing members of our coalition doing a victory dance," he says.

"We've made some measurable progress," Minkevitch tells *EW*. "Collaborations have been good. We had a collective focus," with groups from government officials to housing authorities "agreeing that we really wanted to make a significant impact on those who were living in the shelter as opposed to brief episodes of homelessness."

But, he says, there is still much to learn, and homeless advocates are only scratching the surface. While tremendous progress has been made, he says the 800-bed Road Home shelter "is putting out mats tonight" for people to sleep on. Right now, the homeless issue in SLC is stalled, Minkevitch says.

“The part that makes it all the more energizing, frustrating and encouraging is we’ve done this,” he says. “The most challenging people I’ve known for two decades, they are in housing, they heal, they do better. Do they go 12-step and become completely sober?” he asks. “No, but there’s a moderation in behavior.”

Housing First is “incredibly encouraging, but we haven’t scaled it up, and we need to step it up. Urban America needs to do this," Minkevitch says.

He’s looking at homeless families and at an economic situation and a housing situation that is leaving too many people on the edge. Minkevitch says that just down the street from the shelter, public funding is going to put in a high-end project that will have apartments for rent at $1,000 per month, the kind of places people at The Road Home might aspire to, but right now, or maybe forever, are out of their reach.

“We are creating the kind of environment where someone living in poverty is in constant peril of homelessness,” he says. For people at or below the federal poverty line for whom just getting their hours cut at work could mean losing their homes: “If they are not making $15 an hour, they can’t afford an apartment in Salt Lake City. Am I not describing a lot of cities across America?”

Our tax credits are not going to create housing for those people on the edge, Minkevitch says.

Where to go from here

Looking at Eugene, the city’s Multi-Unit Property Tax Exemption has given 10-year tax breaks to higher-end apartments and student housing. But a recent Eugene City Council decision means that developers are now required to give 10 percent of the MUPTE exemption to a city fund dedicated for affordable housing, or developers can designate a third of the units in the development at affordable rents.

But even with innovative projects such as SquareOne Villages and various Eugene Safe Spot rest stops, Eugene could be doing more, both for the chronically homeless as well as for the situationally homeless and those on the edge. Salt Lake is getting better, Minkevitch says, but also needs to do more. He tells me since I was there only last month a new police officer in the area has cracked down on the drug dealing outside the shelter.

Jacob Fox of the Housing and Community Services Agency of Lane County (HACSA) says the agency provides Section 8 (housing vouchers) and public housing for 5,000 households in Lane County. A significant number of those people are coming out of homelessness or transitional housing. Residents can use alcohol, but not illegal drugs, he says.

Fox is on Lane County’s Poverty and Homelessness Board that he says is “currently conducting due diligence to see if Housing First makes sense for our community.” He says the board is a committed group of individuals who are thinking out of the box, and that the group will know by the first quarter of 2016 if it will attempt to develop or aquire a 50-unit building that would serve the chronically homeless. Meetings of the board are open to the public.

On the state level, Bryant says that there was a Housing First bill in the Oregon Legislature this past session, House Bill 3420. The bill didn’t make it out of committee, but it would have established Housing First pilot programs in Eugene and Albany. Rep. Val Hoyle (D-West Eugene and Junction City) was one of the sponsors, and Bryant says the goal is to “restart and reshape and get something ready for short session in 2016.”

According to Pendleton, it’s that sort of thinking and collaboration, as well as buy-in from officials and funders at all levels, that makes Housing First work. Housing First needs a “champion,” he says. “The mayor or a county commissioner needs to say, ‘This is a priority, and I’m making this a commitment.’”

He adds: “It can be done. We know the solution; it’s housing. You just need to make the commitment.”

A recent filing by the federal Department of Justice in a Boise, Idaho case may also give hope to the impetus to provide homes for the unsheltered not criminalize those who live on the streets. The filing says:

“ ... when adequate shelter space does not exist, there is no meaningful distinction between the status of being homeless and the conduct of sleeping in public. Sleeping is a life-sustaining activity — i.e., it must occur at some time in some place. If a person literally has nowhere else to go, then enforcement of the anti-camping ordinance against that person criminalizes her for being homeless.”

And if Housing First works in Lane County, and we put forth a big, collaborative effort to free up shelter space and keep families at the edge of poverty out of homelessness while supporting those who are situationally homeless as well as those on the fringes through innovative programs, then, finally, we might be closer to "solving the homeless problem."

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About the Author »

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Camilla Mortensen is associate editor and reporter at *Eugene Weekly* . She is also a folklorist and a community college and university instructor. She has two horses, an assortment of dogs, and lives in a 1975 Airstream trailer. Sometimes all these details collide in unforeseen ways.

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Joel • 5 months ago

It sounds good in theory, but not quite fair to all the people struggling working one or two or three thankless, low-paying, grueling jobs to make rent every month, to turn around and give free housing to all the transients, some of whom have problems not of their own making, but many of whom are merely in the throes of addiction and unwilling to try to stay clean and sober. All the costs of those public service encounters will likely still exist as long as they are addicted, so it is disingenuous to claim that the 20 or 40K/year in public costs incurred per homeless will magically disappear if we spend ~$200,000 each constructing apartments for them all, on the taxpayers dime. Not to mention, Eugene is already a magnet for transients from other less friendly areas, free no strings attached housing will not help that situation.

What I think would be the best solution is a Federal Income Floor of say $1000 per month per adult, or whatever society can afford instead of the hodgepodge of programs with costly overhead. Far more efficient, and that way they have no one to blame if they spend it on drugs. Believe it or not, the threat of homelessness and the cruelty of a homeless existence can be a powerful incentive to getting and staying clean and sober.

△ | ▽ • Share ›

Christa Nichole Simotas • 5 months ago

"Places such as OVE and Emerald Village Eugene (SquareOne Villages) require that residents not use alcohol or illegal drugs."--- Camilla Mortensen

No, OVE requires that residents go at least 500 Feet from the property to indulge in activities such as drinking and using illegal drugs, and that residents that have indulged go directly to their housing unit. If they are being

Appendix 7

Substance Abuse and Mental Health Services Administration
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SSI/SSDI Outreach, Access and Recovery
for people who are homeless

January 2013

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

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

Introduction

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

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

SOAR training can help local corrections and community transition staff negotiate and integrate benefit options with community reentry strategies for people with mental illness and co-occurring disorders to assure successful outcomes. This best practices summary describes:

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

Mental Illness, Homelessness, and Incarceration

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

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

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

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

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

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

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

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

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

- In 2011 Sandra received SSI based on her mental illness. She was on probation, with three years remaining, when she violated the terms of probation by failing to report to her probation officer. As a result, Sandra was incarcerated in a state prison. Because she was incarcerated for more than 12 months, her benefits were terminated. Sandra received a tentative parole month of September 2012 contingent on her ability to establish a verifiable residential address. The parole board did not approve the family address she submitted because the location is considered a high crime area. Unfortunately, Sandra was unable to establish residency on her own as she had no income. Thus, she missed her opportunity for parole and must complete her maximum sentence. Sandra is scheduled for release in 2013.
- Sam was released from prison after serving four years. While incarcerated, he was diagnosed with a traumatic brain injury and depression. Sam had served his full sentence and was not required to report to probation or parole upon release. He was released with $25 and the phone number for a community mental health provider. Sam is 27 years old with a ninth grade education and no prior work history. He has no family support. Within two weeks of release, Sam was arrested for sleeping in an abandoned building. He was intoxicated and told the arresting officer that drinking helped the headaches he has suffered from since he was 14 years old. Sam was sent to jail.
- Manuel was arrested for stealing from a local grocery store. He was homeless at the time of arrest and had a diagnosis of schizophrenia. He was not receiving any community mental health services at the time. Manuel has no family. He was sent to a large county jail where he spent two years before being arraigned before a judge. His periodic acute symptoms resulted in his being taken to the state hospital until he was deemed stable enough to stand trial. However, the medications that helped Manuel's symptoms in the hospital weren't approved for use in the jail, and more acute episodes followed. Manuel cycled between the county jail and the state hospital four times over a two-year period before being able to stand before a judge.

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

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

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

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

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

Incarceration and SSA Disability Benefits

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

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

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

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

Role of Transition Services in Reentry for People with Mental Illness

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

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

Access to Benefits as an Essential Strategy for Reentry

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

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

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

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

The positive outcomes produced by SOAR pilot projects within jail and prison settings around the country that link people with mental illness to benefits upon their release should provide impetus for more correctional facilities to consider using this approach as a foundation for building successful transition or reentry programs.[10] Below are examples of SOAR collaborations in jails (Florida, Georgia, and New Jersey) and prison systems (New York, Oklahoma, and Michigan). In addition to those described below, new SOAR initiatives are underway in the jail system of Reno, Nevada and in the prison systems of Tennessee, Colorado, Connecticut, and the Federal Bureau of Prisons.

SOAR Collaborations with Jails

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

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

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

[9] Dennis et al., (2011). *op cit*.

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

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

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

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

Prior to this pilot project, neither behavioral health care provider involved had assisted with SSI/SSDI applications for persons re-entering the community from the county jail. After participating in the pilot project, both agencies remain committed to continuing such assistance despite the difficulty of budgeting staff time for these activities.

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

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

SOAR Collaborations with State and Federal Prisons

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

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

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

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

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

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

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

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

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

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

- Collaboration
- Leadership
- Resources
- Commitment
- Training

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

[11] See http://www.prainc.com/soar/criticalcomponents.

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

- **Identify stakeholders.** Potential stakeholders associated with jail/prisons include
  - ✓ Judges assigned to specialized courts and diversion programs
  - ✓ Social workers assigned to the public defenders' office
  - ✓ Chief jailers or chiefs of security
  - ✓ Jail mental health officer, psychologist, or psychiatrist
  - ✓ County or city commissioners
  - ✓ Local reentry advocacy project leaders
  - ✓ Commissioner of state department of corrections
  - ✓ State director of reintegration/reentry services
  - ✓ Director of medical or mental health services for state department of corrections
  - ✓ State mental health agency administrator
  - ✓ Community reentry project directors
  - ✓ Parole/probation managers

- **Collaborate with SSA to establish prerelease agreements.** SSA can establish prerelease agreements with correctional facilities to permit special procedures when people apply for benefits prior to their release and will often assign a contact person. For example, prerelease agreements can be negotiated to allow for applications to be submitted from 60 to 120 days before the applicant's expected release date. In addition, SSA can make arrangements to accept paper applications and schedule phone interviews when necessary.

- **Collaborate with local SOAR providers to establish continuity of care.** Given the unpredictability of release dates from jails and prisons, it is important to engage a community-based behavioral health provider to either begin the SSI/SSDI application process while the person is incarcerated or to assist with the individual's reentry and assume responsibility for completing his or her SSI/SSDI application following release. SOAR training can help local corrections and community transition staff assure continuity of care by determining and coordinating benefit options and reintegration strategies for people with mental illness. Collaboration among service providers, including supported housing programs that offer a variety of services, is key to assuring both continuity of care and best overall outcomes post-release.

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

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

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

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

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

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

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

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

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

Commitment. Developing and implementing an initiative to access SSI/SSDI as part of transition planning requires a commitment by the jail or prison's administration for a period of at least a year to see results and at least two years to see a fully functioning program. During the start up and early implementation period, competing priorities can often derail the best intentions. We have seen commitment wane as new administrations took office and the department of corrections commissioner changed. We have seen staff struggle without success to find time to assist with applications as part of the job they are already doing. We have seen many facilities, particularly state departments of corrections, willing to conduct training for staff, but unwilling or unable to follow through on the rest of what it takes to assist with SSI/SSDI applications.

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

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

Conclusion

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

For More Information

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

Appendix 8

Notable Public Sector VIVITROL® Programs

As of February 11, 2015

1. **California** – Effective January 2014, VIVITROL (naltrexone for extended-release injectable suspension) is available to all alcohol or opioid dependent patients who are Medi-Cal beneficiaries with a felony or misdemeanor charge or conviction who are under supervision by the county or state, or are within the AB 109 population (e.g., offenders with post-release community supervision, straight sentence, mandatory supervision, and parolees under jurisdiction of California Department of Corrections and Rehabilitation (CDCR) and the court). Substance Abuse Prevention and Control, a division of the County of Los Angeles' Department of Public Health, continues to appropriate annual funds for VIVITROL and case management for the uninsured repeat detox population. Ten additional counties are involved in funding programs through various county departments for the use of VIVITROL with treatment for uninsured and/or Medicaid patients with opioid or alcohol dependence.

2. **Colorado –** The Colorado Department of Corrections, in collaboration with the Department of Human Services, has allocated $500K in FY'15 to provide comprehensive treatment with VIVITROL for parolees.

3. **Florida** – There was $5M appropriated in the 2014-2015 General Appropriations Act: $3M appropriated for the use of VIVITROL in Florida Drug Courts; $1.5M to the Florida Department of Children and Families to provide VIVITROL and treatment for indigent patients; and $500K to the Florida Department of Corrections to provide VIVITROL and treatment in its community corrections program.

4. **Maryland –** Through the Washington County Health Department, Division of Behavioral Health Services, VIVITROL and psychosocial therapy is provided to offenders with opioid or alcohol dependence prior to leaving the county detention center, and continued in the community post-release. Program funded through a Second Chance Act Grant and County Funds. Program recognized by the Substance Abuse and Mental Health Services Administration (SAMHSA) with a 2013 ***Science and Service Award***.
    a. Budget language includes $1M for VIVITROL pilot program in the treatment of opioid dependence in rural counties during FY'15.

5. **Massachusetts** – Ten of 13 Sheriffs are implementing comprehensive jail reentry programs with VIVITROL. Separately, the Massachusetts Department of Correction is implementing a statewide prison re-entry program with VIVITROL. $1M allocated through the Governor's Opioid Task Force is expanding this prison re-entry program to two additional facilities, totaling nine prisons across the state.

6. **Missouri** – There is $3.9M of recurring non-Medicaid funding allocated annually to programs including the use of VIVITROL: $3.4M by the Missouri Department of Mental Health and $500K by the Missouri Department of Corrections. Funding is for statewide implementation of VIVITROL for the uninsured and for those under probation and parole supervision.

7. **Ohio –** General Assembly appropriated $5M to the Ohio Department of Mental Health and Addiction Services to fund a six-county drug court pilot program for opioid and alcohol dependent offenders. The program funds comprehensive treatment including the use of FDA-approved medications to treat opioid dependence. Additionally, four counties were awarded Smart Ohio Plan grants by the Ohio Department of Rehabilitation and Corrections to provide treatment with VIVITROL in community corrections.

8. **Pennsylvania** – The Pennsylvania Department of Corrections is implementing a VIVITROL re-entry program at eight State Correctional Institutes for opioid and alcohol dependence in 2015. Residential Substance Abuse Treatment for State Prisoners (RSAT) Program funds will pay for 175 offenders for a total of 12 months.

9. **Wisconsin –** The Wisconsin General Assembly passed AB 701 legislation, appropriating $2M in new funding to create opioid treatment programs in two to three rural counties to address the heroin epidemic. The new treatment programs will deploy the latest FDA-approved medications, including the use of VIVITROL. Governor Scott Walker signed AB 701 in a ceremony on April 7, 2014.

10. **Illinois –** The Illinois General Assembly appropriated $500K per year in the FY'14 and FY'15 budget to the Illinois Department of Alcohol and Substance Abuse (DASA). The funding is to be equally divided between two initiatives: 1) a collaboration between DASA, Treatment Alternatives for Safe Communities (TASC), the 17th Judicial Circuit Court, Winnebago County and Rosecrance Health Network to treat drug court patients, and 2) a collaboration between DASA, Gateway Foundation, and Family Guidance Center to treat patients who have suffered multiple relapses to opioid dependence.

Appendix 9

CORRECTIONS AND REENTRY:

Protected Health Information Privacy Framework for Information Sharing

Corrections and Reentry:
Protected Health Information Privacy Framework for Information Sharing

Executive Summary

BARRIERS TO JUSTICE/HEALTH INFORMATION EXCHANGES

Nationwide polls show that Americans continue to be deeply concerned about the privacy and security of their protected health information (PHI), particularly when it is in electronic form, illustrating an ongoing challenge of balancing society's need to improve the quality, safety, and efficiency of health care with the protection of PHI.[1] The field of corrections, which includes incarceration, pretrial, probation, and parole, is no different. During the correctional process, an individual may receive medical, mental health, and/or substance abuse testing, assessment and/or treatment and, upon release, be referred for follow-up treatment in the community. Successful rehabilitation of these individuals and their ability to reintegrate into society upon release depends, to a large degree, upon the beneficial communication about their needs, treatment matching, and continuity of care.

Legal and technical barriers, both real and perceived, often prevent a smooth exchange of PHI among justice-to-health systems (and vice versa) and impede appropriate diagnosis, treatment, diversion, and transition of individuals while they are involved in the criminal justice system. For example, community treatment providers still cite confidentiality and the Health Insurance Portability and Accountability Act (HIPAA) as the primary reasons why they cannot or will not share PHI. However, HIPAA's restrictions on sharing PHI are often misunderstood, which has resulted in practitioners' misapplying the law to be far more restrictive than the actual regulatory language requires.[2] In many cases, the fear associated with these laws is inflated, and a careful examination, with corresponding changes in practice (e.g., obtaining consent forms), can alleviate most concerns. Other common concerns include an absence of rapport between agencies and limited knowledge of each other's capabilities.[3]

A gap exists in the public health and public safety paradigms. The two are interrelated, with drug abusers three to four times more likely to commit a crime and individuals with a mental illness two to three times more likely to be incarcerated. Yet limited communication exists between justice and health agencies.[4] Recidivism is high. It makes up a large proportion of the admittances to prisons or jails (in some jurisdictions, more than half of all incoming individuals). As many as 40 percent of adult prisoners are likely to recidivate (i.e., commit a new crime or get revoked on a technical violation) within three years of release.[5] Further, many individuals released to the community possess a history of substance abuse and/or mental illness as well as other medical disorders and ailments which, if left untreated, impede their ability to find employment and demonstrate prosocial behaviors.[6]

MAKING THE CASE FOR A PHI PRIVACY FRAMEWORK

For successful reentry, the exchange of PHI for diagnosis, treatment, and continuity of care is critical. Approximately 10 million people spend time in correctional facilities at some point each year. They are more likely than those in the general population to have behavioral health problems (i.e., mental health problems and addictions), communicable diseases (e.g., tuberculosis, Hepatitis C, and HIV infection), and chronic illnesses (e.g., diabetes, asthma, and hypertension).[7,8] This population is often at its sickest when detained, frequently experiencing a psychiatric crisis and/or active addiction.[9] In fact, 85 percent of jail detainees and 65 percent of prisoners (seven times the rate of the general population) are believed to be substance-involved.[10] Despite these stark findings, less than 20 percent of inmates will receive any formal treatment for their addictions while incarcerated.[11] According to the Bureau of Justice Statistics (BJS), in mid-year 2005 nearly half of all inmates (federal, state, and local) reported having some mental health problem.[12] These individuals are often the poorest, often homeless, and the most severely challenged in all aspects of community life.

While the Patient and Affordable Care Act (ACA), which was signed into law in March 2010,[13] may potentially aid individuals who are at risk for incarceration and those who have been incarcerated through new eligibility for Medicaid, it will also further illuminate the barriers between corrections and the health community to share PHI. This increased use of medical, behavioral, and substance abuse services is another reason why the exchange of PHI between corrections and providers is so crucial. Pretrial, probation, and parole agencies, as well as jails and prisons, are in a position to identify individuals who are newly eligible for Medicaid. Involving these entities in designing processes for enrolling individuals and for connecting them with community-based care upon release is important for improving the continuity of care between community- and corrections-based care and, in turn, maximizing the investment local and state governments make in correctional health care.[14]

Reentry into the community is a vulnerable time, marked by difficulties in adjusting, increased drug use, and a 12-fold increased risk of death in the first two weeks after release.[15] Effective transition planning and implementation can minimize the risk of these hazards; enhance public safety by increasing the possibility that individuals will participate in, and complete, supervision and treatment requirements; and improve individual outcomes. If effective PHI sharing occurs at—or ideally, prior to—an individual's release to the community, it may result in:

- Improved continuity of care.
- Improved individual physical and behavioral health.
- Improved public safety.
- Enhancement of criminal justice and other agencies' ability to implement evidence-based practices.
- Long-term reductions in costs associated with reductions in recidivism.
- The support of efforts to translate the research/literature on "what works" with individuals involved with the criminal justice system into more efficacious policies and practices (which may reduce the likelihood of recidivism and promote community safety).[16]

In order for corrections entities to effectively address the issues highlighted here and ensure compliance with HIPAA (for medical and mental health information), as well as with Title 42: Public Health, Part 2—Confidentiality of Substance Abuse Patient Records (42 CFR Part 2, for substance abuse information), a privacy framework must be established and implemented. A privacy framework involves not only the correctional entity and its commitment to adhere to laws and protect PHI, but also includes authorization to share PHI by the individual and—when appropriate—the courts. Also essential is the development of relationships and agreements between correctional entities and outside organizations that perform functions or services for the entity.

In sum, a privacy framework comprises three components:

1. A privacy policy to articulate the entity's position to protect medical, mental health, and substance abuse diagnosis and treatment information—or PHI; adhere to legal requirements; and specify the rules and procedures for such compliance. A well-developed and implemented PHI privacy policy protects the entity, the individual, and the public and contributes to reduced recidivism by establishing a mechanism for continuity of care and treatment.

2. Individual consent authorizations and/or court orders authorizing the sharing of PHI between corrections and community treatment providers. Obtaining permission from an individual to release his or her PHI is a straightforward way to facilitate information sharing.

3. Contractual agreements between correctional entities and outside organizations that perform a specified set of functions or provide services to or on behalf of the entity. Such agreements define the parameters of PHI disclosure and specifically articulate what the organization has been engaged to do. They require assurances that the organization will comply with PHI privacy and security regulations.

The PHI maintained by entities—if handled inappropriately—can cause problems for those affected. In worst cases, personal and public safety may be jeopardized. These issues affect the whole justice community, including law enforcement, prosecution, defense, courts, pretrial, parole, probation, corrections, and victim services, as well as members of the public. A well-developed and implemented PHI privacy framework protects the individual and the entity and enables the appropriate handling of this critical information.

RESOURCE OVERVIEW

The *Corrections and Reentry: Protected Health Information Privacy Framework for Information Sharing* PHI Framework Guide was developed by the Institute for Intergovernmental Research with funding support from the American Probation and Parole Association (APPA) and the Association of State Correctional Administrators (ASCA) under cooperative agreements by the Bureau of Justice Assistance (BJA), Office of Justice Programs (OJP), U.S. Department of Justice (DOJ). The purpose of the framework guide is to provide recommendations for addressing the issues described earlier in this brief: the protection, handling, and exchange of PHI between corrections and health providers in compliance with federal law.

This resource was designed to enable correctional entities to comply with HIPAA and 42 CFR Part 2 in the receipt or sharing of PHI, whether the correctional entity meets HIPAA's designation of a "covered entity,"[17] is determined by 42 CFR Part 2 to be a "federally assisted program,"[18] or does not meet either criteria. The tools within the resource may

be used by any correctional entity interested in articulating its commitment to protecting PHI and implementing the components of a privacy framework.

The PHI Framework Guide features an in-depth overview of HIPAA and 42 CFR Part 2 and describes how the regulations may apply to the entity. PHI policy provisions, contained in the policy development template chapter, are provided to assist entities in developing PHI privacy policies related to the medical, mental health, and, if applicable, substance abuse testing and treatment information the entities collect, receive, maintain, archive, access, and disclose to entity personnel; other correctional entities; participating criminal justice and public safety agencies; as well as to community medical, mental health, and substance abuse treatment providers. Each policy section comprises a fundamental component of a comprehensive PHI privacy policy that includes baseline provisions on information collection, information quality, collation and analysis, merging of records, information access and disclosure, redress, security safeguards, retention and destruction, accountability and enforcement, and training.

Template policy provisions are grouped according to related policy concepts and are presented in a user-friendly question-and-answer format to enable policy authors, prompted by key policy questions, to draft policy language that answers or addresses each question posed. Where applicable, HIPAA and 42 CFR Part 2 regulations are cited to illustrate how the provision ensures compliance. Sample language is also provided and follows each policy provision to help authors understand the meaning of the question asked and to illustrate how to write policy language that addresses the policy question (e.g., formulate privacy policies).

To further support a PHI privacy framework, this document includes useful tools, such as a sample consent authorization form and a sample contractual agreement, each of which meets both HIPAA and 42 CFR Part 2 requirements. Additionally, a PHI Policy Review Checklist is provided as a tool to enable entities to evaluate pre-established PHI policies to ensure that they are in compliance with the law or to use when performing an annual PHI policy review. Other resources include a sample court order, a confidentiality notice, a glossary of terms and definitions, a listing of applicable federal PHI privacy laws, and a resource list.

WHY USE THIS RESOURCE

Receipt and sharing of protected health information is critical for individuals entering or leaving the corrections environment. Establishing and implementing a PHI privacy framework among corrections entities and medical, behavioral, and substance abuse treatment providers using this resource will strengthen trust and public confidence by promoting effective and responsible sharing of PHI that supports fundamental privacy concepts. A comprehensive PHI privacy framework—composed of a well-developed privacy policy, documented and implemented individual consent authorizations, and compliant contractual agreements—is the fundamental linchpin to a system of trust that justice agencies are serving as responsible stewards of PHI. Implementing such a framework further supports the mission of corrections to protect public safety; enables the provision of proper care for offenders; and improves the transition of released individuals into society.

Endnotes

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[13] Affordable Care Act, U.S. Department of Health and Human Services, http://www.hhs.gov/opa/affordable-care-act/index.html.
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[15] *Release from prison—a high risk of death for former inmates,* Binswanger, I. A., Stern, M. F., Deyo, R. A., et al., New England Journal of Medicine, 2007; 356(3):157–65.
[16] *Justice-Health Collaboration: Improving Information Exchange Between Corrections and Health/Human Services Organizations*, Making the Case for Improved Reentry and Epidemiological Criminology, Matz, A. K., Wicklund, C., Douglas, J., and May, B., jointly developed by the American Probation and Parole Association, SEARCH, and the Association of State Correctional Administrators, September 2012; see also Matz, A. K. (2013).
[17] Covered entity—per 45 Code of Federal Regulations, Part 160, General Administrative Requirements, Subpart A, § 160.103 Definitions, is defined as a health plan; a health-care clearinghouse; a health-care provider who transmits any health information in electronic form in connection with a covered transaction [relating to a health claim report, status, payment, etc.].
[18] Federally assisted program—defined in 42 Code of Federal Regulations, Part 2, §§ 290dd-2, 42 CFR 2.11, is defined as a program which includes any individual or entity (other than a general medical care facility) that holds itself out as providing, in whole or in part, substance abuse diagnosis, treatment, referral for treatment or prevention; or an identified unit within a general medical facility which holds itself out as providing, and provides, substance abuse diagnosis, treatment, referral for treatment, or prevention; or medical personnel or other staff in a general medical facility whose primary function is the provision of substance abuse diagnosis, treatment, referral for treatment, or prevention, and who are identified as such providers. See 42 CFR Part 2 Subpart B § 2.12(e)(1) for examples.

Full guidance document available from the Bureau of Justice Assistance at https://www.bja.gov/Publications/APPA-Corr-Reentry-Health-Info.pdf

Appendix 10

Multnomah County

Department of County Human Services
Community Services Division

Benefit Acquisition Programs Annual Outcome Report FY 2013

Introduction

A reliable source of income is a key component to maintaining housing stability for homeless persons with disabilities. For persons with disabilities navigating the complex application process for federal disability and health benefits can be daunting. The level of medical documentation needed, denial rates, and required hearings causes many persons with disabilities to give up on the application process. Benefits acquisition programs are a proven strategy for helping vulnerable populations navigate the complex benefits application process more quickly and dramatically increase approval rates.

In Multnomah County there are two benefits acquisition programs serving vulnerable homeless populations: Homeless Benefits Recovery Program (HBR)[1], funded by Multnomah County Department of County Human Services ($411,297) and Benefit and Entitlement Specialty Team (BEST), funded by the City of Portland ($200,000). Both programs work with individuals who are homeless or at risk of homelessness to provide intensive coordinated assistance applying for Social Security Disability and Medicaid benefits.

HBR and BEST operate with the following key assumptions:

- The program would achieve better outcomes utilizing specialists who have been trained in the disability application process, than relying on training existing case managers to coordinate applications for disability benefits as in the SOAR model developed by SAMHSA[2].
- HBR/BEST would obtain benefits for individuals more quickly than the national average for disability applications
- Individuals served would increase their incomes, allowing them to pay for housing and food expenses.
- Individuals would obtain health insurance through Medicaid and/or Medicare, covering the cost of services otherwise paid for by County General Funds, thus saving dollars in other County-funded programs such as the Multnomah Treatment Fund.

People Served

This report covers the period of July 1, 2012 through June 30, 2013 (FY13). During FY13 the HBR/BEST programs provided services to 356 individuals, and 212 of these exited from the program. Outcomes focus on those who exited from the program during the report period.

Despite the challenge of working with a homeless and disabled population, the HBR/BEST program continued to have high rates of success in gaining federal disability benefits. Out of the 212 individuals who exited the program during FY13, 156 of them (74%) secured disability benefits.

While the program served a wide range of individuals, the typical HBR participant was a homeless white male in his mid-40s

[1] In 2013 HBR received an Achievement Award from the National Association of Counties.

[2] http://www.samhsa.gov/SAMHSA_news/VolumeXV_2/article1.htm

with a mental health disability. More detailed demographic information is included in the Appendix.

The incidence of mental health disabilities is very high among the homeless population. However they are also increasingly high among the disabled population as a whole. The Social Security Administration reported in 2011 that mental health disabilities were one of the fastest growing types of disability claims, accounting for 19.2% of all new claims.

Program Success: Disability Applications

The HBR/BEST programs continue to demonstrate that a small one-time investment can bring enormous returns.

On average, staff spent just 20 hours per client assisting them with securing benefits. Assistance included: completing application packets, obtaining medical and psychological records and evaluations, arranging transportation to related appointments and hearings, and representing clients at hearings. Typically it took just under 48 days for staff to work with clients to gather documentation and prepare and submit applications.

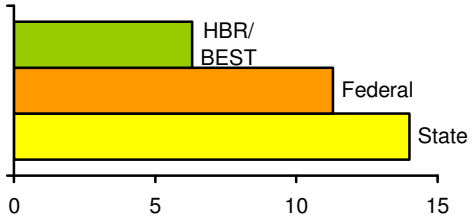
Clients utilizing the HBR/BEST program are more likely to be approved for benefits. With an investment of just 20 hours of specialized staffing assistance, 74% of HBR/BEST clients qualified for federal disability benefits. This approval rate is very high compared to the national rate of just 30%. Of the 156 in this cohort who qualified for federal benefits, 103 secured Social Security Income (SSI), 3 secured Social Security Disability Income (SSDI) and 50 secured both income sources.

Sixty-three percent of program applicants were approved based on their first application without any appeal. This is compared to the Oregon average of 32%.

A client who files for disability benefits with HBR/BEST is almost twice as likely to be approved on their first attempt than they would if they applied without using the program's services.

Clients enrolled in the HBR/BEST program are also approved much more quickly than the general population. If a client was approved on first application, it took an average of 94 days (just over 3 months).

Application Time Line



Months from Application to Approval

Overall, the program average from application to approval was 6.3 months (191.0 days). The rate from application to decision compares favorably to both state and national rates. In Oregon the average time from application to decision is 14.0 months.[3] Nationally the average length of time is 11.3 months. HBR/BEST's rate is also well below the goal of 8.9 months that the Social Security Administration set in 2011.[4]

The importance of securing benefits quickly is crucial in increasing financial stability for HBR/BEST clients. At the start of services HBR/BEST clients had an average income of just $107 per month. Disability awards secured by HBR/BEST ranged between $698 and $1,260 per month; most of the awards (99%) were between $698 and $730 per month. At exit incomes averaged $788 per month, an increase of 636% per month.

While $788 is still an extremely low income for a resident living in Multnomah

[3] http://www.ssa.gov/appeals/DataSets/01_NetStat_Report.pdf
[4] http://www.ssa.gov/asp/plan-2013-2016.pdf

County, this income coupled with health benefits and related services is often enough to stop the cycle of homelessness, help program clients get off the streets, and obtain services to stabilize medical and mental health conditions.

HBR/BEST was able to submit applications in only 48 days which demonstrated an improvement from 54 days in FY11 and 62 days in FY12. Despite this improvement, program success takes longer than it did in previous years due to increased time taken by Social Security to review the applications. Wait times for application review have gradually increased from 122 days in FY11 to 191 days in FY13. This is consistent with increased wait times nationwide as the Social Security Administration (SSA) has undergone 3 consecutive years of budget cuts, reducing staffing by an estimated 10%. Employee caseloads at SSA have increased 9.2% during that same time period causing wait times to rise. With additional cuts due to sequestration and the government shut-down, there will likely be further delays in reviewing applications in FY14.

Program Success: Savings to the Community

Although further study is needed, obtaining benefits for homeless individuals may have a positive benefit across many service systems, including:

- Reduced Emergency Department visits
- Reduced use of homeless services such as shelters
- Reduced use of police services
- Reduced use of County Health Department services
- Reduced use of County-paid mental health services

One area where the financial benefit of HBR/BEST is most striking is in the cost of mental health services. Only 41% of clients were on Medicaid at the start of services. At exit, 99% of the clients were Medicaid enrolled. Because of this the following costs that were paid using general fund dollars will be paid using Medicaid. In the twelve months prior to starting services at HBR and BEST, clients who did not have Medicaid coverage incurred $130,387 in costs to the General Fund that will now be covered by Medicaid including:

1. $50,072 in mental health service claims from Verity.
2. 139 days on emergency holds, the equivalent of $72,975.[5]
3. 20 incidents of mobile outreach with Project Respond; the equivalent of $7,340[6].

The 156 individuals who were awarded benefits in this fiscal year through HBR/BEST will bring $1,475,136 in federal resources[7] to support clients' needs for food, clothing, shelter, and transportation. These resources will be spent locally so also represent $1,475,136 in economic development benefit to the community. HBR/BEST produced a total annual community benefit of at least $1,605,523 when both client SSA incomes and mental health services cost offsets are included. This is a large return for a one time investment of $611,297.

In addition, HBR/BEST clients obtain benefits an average of 10.2 years earlier than the same population nationwide. If we calculate income and cost offsets for all 156 clients across 10.2 years, the total benefit is approximately $16,425,958, just from benefit income and mental health service offsets. The actual benefit would actually be much higher if we were able to better quantify the savings on systems these clients access, such as health and

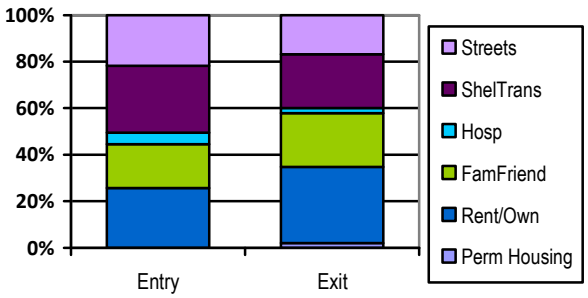
[5] at a projected cost of $525 day
[6] At a projected cost of $367per incident; calculated as annual budget/total number of responses in FY2011-12; $1,700,000/ 4,636
[7] This figure is computed by annualizing the average income of clients who received benefits ($788 * 12 = $9,456) and multiplying it by the number of clients (156).

housing. The benefit to clients in quality and length of life from obtaining benefits 10.2 years earlier is incalculable.

Program Success: Housing

Obtaining federal disability benefits was associated with a small positive trend toward more stable housing. At exit, 58% of clients were either in permanent subsidized housing, renting, living in their own home, or living with friends or family situations compared to 45% at program entry. Two fifths (40%) of clients, however were homeless[8] at program exit.

Housing at Entry and Exit



Since clients are exited from the program at the point where benefits are secured, follow-up data would be needed in order to adequately assess the full impact of benefits on housing.

Need for Additional Capacity

The success of the HBR/BEST programs is limited only by capacity. Although clients were served quickly once they were accepted into the program, on average the wait time to access the HBR/BEST program in FY13 was 100 days. This includes a period of 80 days during FY13 when the program closed to referrals due to the overwhelming numbers of individuals waiting for screening. Additional program capacity is needed to ensure that disabled individuals do not need to wait for benefit acquisition services.

In addition to overall capacity needs for HBR/BEST services, there are critical populations who generally cannot access the services at all. Populations in particular need include:

- Homeless families where either the head of household and/or children are experiencing disabilities
- Victims of domestic violence, with a particular focus on the high rates of undiagnosed traumatic brain injuries among survivors[9].
- Populations who are housed, with or without rent subsidy, but whose housing stability is jeopardized by the individual's lack of insurance and/or income
- Individuals with disabilities living in publicly subsidized housing who have no income. Not only do these individuals have to struggle mightily to meet their basic needs but their rents are fully publicly subsidized. When they gain income, they pay 30% of that income to Home Forward which are dollars that could be used to provide much needed additional housing subsidy in the community.

Conclusions

1. HBR/BEST is highly successful at obtaining federal disability benefits for clients. Clients in this program are obtaining benefits at nearly 2 ½ times the national rate. HBR/BEST had a 74% success rate compared to a national rate of 30%[10].
2. HBR/BEST clients are approved for benefits more than 10 years younger than the national average. Accessing benefits at an earlier age provides critical support and services over more of an individual's lifetime and has the potential to ameliorate many of the more damaging impacts of disability and homelessness while paying for

[8] Homeless includes those who are hospitalized, in jail, in temporary shelter or on the streets.

[9] http://www.biausa.org/tbims-abstracts/domestic-violence-related-mild-traumatic-brain-injuries-in-women

[10] http://www.ssa.gov/policy/docs/statcomps/ssi_asr/2011/ssi_asr11.pdf.

services with federal resources rather than local ones

3. Obtaining Medicaid allows mental and health care and medicine to be paid for by Medicaid instead of County General Fund. In the year prior to entering HBR, clients incurred $130,387 in mental health expenses.
4. There is a tremendous economic development benefit to the program. HBR/BEST produced a total annual community benefit of $1,605,523 when both client SSA incomes and mental health services cost offsets are combined. This is a 163% increase from the one time investment of $611,297.
5. HBR/BEST achieves these results extremely quickly. Applications are approved on average 9.5 months faster than the state average and are twice as likely to be approved on their first attempt as other applicants in Oregon.
6. HBR/BEST only required an average of 20.0 hours of service delivery per client to obtain benefits over a 2 month period. This offers evidence to support the practice of using specialized staff solely dedicated to benefits recovery work.
7. Client income increased by 636%.
8. There is insufficient data to evaluate the longer-term impact of the program on housing and utilization of other systems such as health, police, homeless shelters, etc. However initial evidence and feedback from provider agencies suggests that these savings may be substantial over the long term.
9. While the program has improved its efficiency at preparing applications, staffing cuts at the Social Security Administration will likely continue to negatively impact the length of time it takes for applications to be reviewed.
10. Communities of color are underrepresented in the HBR/BEST service group as compared to the general homeless population. Further analysis is needed to determine why these populations are not being served proportionately in these programs and to determine the best way to increase access to these important services for communities of color.

Next Steps

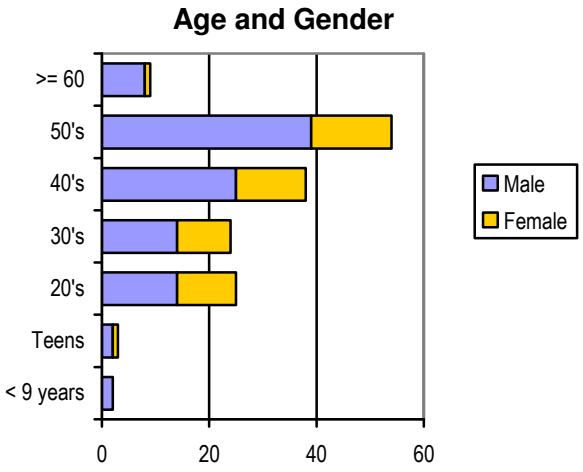
- The demand for the program continues to be much larger than available slots. As new funding allows the program can work with other vulnerable populations who struggle to obtain benefits including homeless families, victims of domestic violence and homeless disabled individuals who are not currently working directly with Multnomah Treatment Fund or other current County referral sources.
- Further study should be done to evaluate the disproportionate number of white clients in the program compared to the general homeless population. Program staff should work with culturally specific organizations to increase access to these populations as program slots become available.
- Program staff should add 3 and 6-month follow-ups to assess the longer-term benefits of the HBR/BEST programs on housing and other services.

Appendix

Demographic Information

Age and Gender

Two thirds (67%) of the clients approved for benefits were male and 33% were female. The ratio of males in the program are slightly higher than the homeless population in general. In the latest Point In Time Count 61% of the homeless population identified as male and 38% as female.[11]



The average age of clients approved for benefits in FY13 was 43.0 years. This is considerably younger than the national average age of disability determination of 53.2 years[12]. The impact of this cannot be overstated. The benefits to individuals are enormous: increased likelihood of housing stability, opportunities for regular medical and mental health treatment, less exposure to violence and trauma living on the street and the ability to reconnect with community. In addition, more than 10 years of federal funds are coming into the community in the form of disability payments and Medicare/Medicaid reimbursements.

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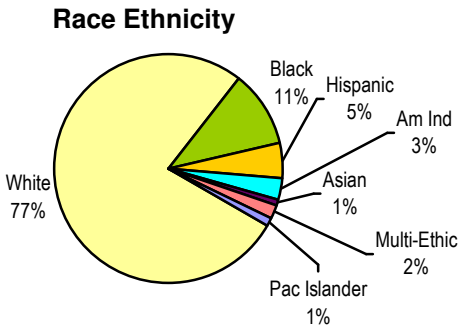
The chart below shows the demographic breakdowns of clients served in the HBR/BEST programs. One quarter (23%) of program participants were from communities of color and three quarters (77%) were White. In Multnomah County 29% of the population is from communities of color and 45% of the homeless population is from communities of color.



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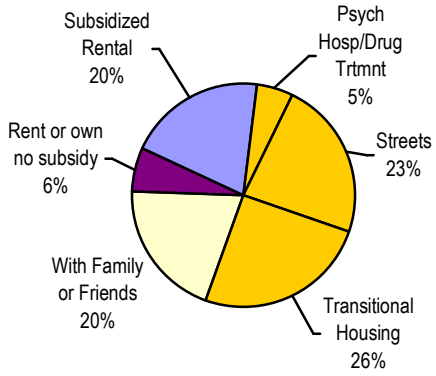

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Benefit Acquisition Programs Annual Outcome Report FY 2013

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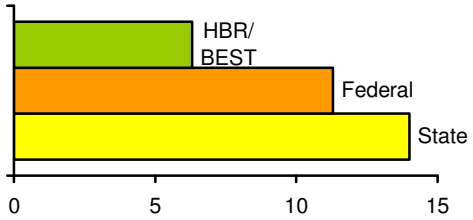

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The importance of securing benefits quickly is crucial in increasing financial stability for HBR/BEST clients. At the start of services HBR/BEST clients had an average income of just $107 per month. Disability awards secured by HBR/BEST ranged between $698 and $1,260 per month; most of the awards (99%) were between $698 and $730 per month. At exit incomes averaged $788 per month, an increase of 636% per month.

While $788 is still an extremely low income for a resident living in Multnomah

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County, this income coupled with health benefits and related services is often enough to stop the cycle of homelessness, help program clients get off the streets, and obtain services to stabilize medical and mental health conditions.

HBR/BEST was able to submit applications in only 48 days which demonstrated an improvement from 54 days in FY11 and 62 days in FY12. Despite this improvement, program success takes longer than it did in previous years due to increased time taken by Social Security to review the applications. Wait times for application review have gradually increased from 122 days in FY11 to 191 days in FY13. This is consistent with increased wait times nationwide as the Social Security Administration (SSA) has undergone 3 consecutive years of budget cuts, reducing staffing by an estimated 10%. Employee caseloads at SSA have increased 9.2% during that same time period causing wait times to rise. With additional cuts due to sequestration and the government shut-down, there will likely be further delays in reviewing applications in FY14.

Program Success: Savings to the Community

Although further study is needed, obtaining benefits for homeless individuals may have a positive benefit across many service systems, including:

- Reduced Emergency Department visits
- Reduced use of homeless services such as shelters
- Reduced use of police services
- Reduced use of County Health Department services
- Reduced use of County-paid mental health services

One area where the financial benefit of HBR/BEST is most striking is in the cost of mental health services. Only 41% of clients were on Medicaid at the start of services. At exit, 99% of the clients were Medicaid enrolled. Because of this the following costs that were paid using general fund dollars will be paid using Medicaid. In the twelve months prior to starting services at HBR and BEST, clients who did not have Medicaid coverage incurred $130,387 in costs to the General Fund that will now be covered by Medicaid including:

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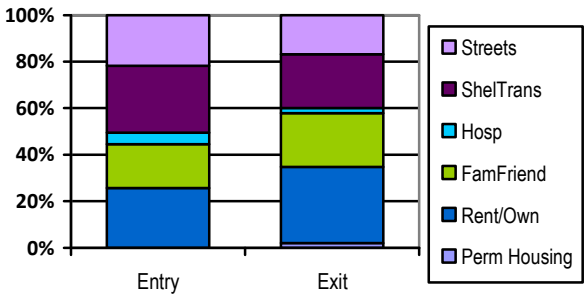
housing. The benefit to clients in quality and length of life from obtaining benefits 10.2 years earlier is incalculable.

Program Success: Housing

Obtaining federal disability benefits was associated with a small positive trend toward more stable housing. At exit, 58% of clients were either in permanent subsidized housing, renting, living in their own home, or living with friends or family situations compared to 45% at program entry. Two fifths (40%) of clients, however were homeless[8] at program exit.

Housing at Entry and Exit



Since clients are exited from the program at the point where benefits are secured, follow-up data would be needed in order to adequately assess the full impact of benefits on housing.

Need for Additional Capacity

The success of the HBR/BEST programs is limited only by capacity. Although clients were served quickly once they were accepted into the program, on average the wait time to access the HBR/BEST program in FY13 was 100 days. This includes a period of 80 days during FY13 when the program closed to referrals due to the overwhelming numbers of individuals waiting for screening. Additional program capacity is needed to ensure that disabled individuals do not need to wait for benefit acquisition services.

In addition to overall capacity needs for HBR/BEST services, there are critical populations who generally cannot access the services at all. Populations in particular need include:

- Homeless families where either the head of household and/or children are experiencing disabilities
- Victims of domestic violence, with a particular focus on the high rates of undiagnosed traumatic brain injuries among survivors[9].
- Populations who are housed, with or without rent subsidy, but whose housing stability is jeopardized by the individual's lack of insurance and/or income
- Individuals with disabilities living in publicly subsidized housing who have no income. Not only do these individuals have to struggle mightily to meet their basic needs but their rents are fully publicly subsidized. When they gain income, they pay 30% of that income to Home Forward which are dollars that could be used to provide much needed additional housing subsidy in the community.

Conclusions

1. HBR/BEST is highly successful at obtaining federal disability benefits for clients. Clients in this program are obtaining benefits at nearly 2 ½ times the national rate. HBR/BEST had a 74% success rate compared to a national rate of 30%[10].
2. HBR/BEST clients are approved for benefits more than 10 years younger than the national average. Accessing benefits at an earlier age provides critical support and services over more of an individual's lifetime and has the potential to ameliorate many of the more damaging impacts of disability and homelessness while paying for

[8] Homeless includes those who are hospitalized, in jail, in temporary shelter or on the streets.

[9] http://www.biausa.org/tbims-abstracts/domestic-violence-related-mild-traumatic-brain-injuries-in-women

[10] http://www.ssa.gov/policy/docs/statcomps/ssi_asr/2011/ssi_asr11.pdf.

services with federal resources rather than local ones

3. Obtaining Medicaid allows mental and health care and medicine to be paid for by Medicaid instead of County General Fund. In the year prior to entering HBR, clients incurred $130,387 in mental health expenses.
4. There is a tremendous economic development benefit to the program. HBR/BEST produced a total annual community benefit of $1,605,523 when both client SSA incomes and mental health services cost offsets are combined. This is a 163% increase from the one time investment of $611,297.
5. HBR/BEST achieves these results extremely quickly. Applications are approved on average 9.5 months faster than the state average and are twice as likely to be approved on their first attempt as other applicants in Oregon.
6. HBR/BEST only required an average of 20.0 hours of service delivery per client to obtain benefits over a 2 month period. This offers evidence to support the practice of using specialized staff solely dedicated to benefits recovery work.
7. Client income increased by 636%.
8. There is insufficient data to evaluate the longer-term impact of the program on housing and utilization of other systems such as health, police, homeless shelters, etc. However initial evidence and feedback from provider agencies suggests that these savings may be substantial over the long term.
9. While the program has improved its efficiency at preparing applications, staffing cuts at the Social Security Administration will likely continue to negatively impact the length of time it takes for applications to be reviewed.
10. Communities of color are underrepresented in the HBR/BEST service group as compared to the general homeless population. Further analysis is needed to determine why these populations are not being served proportionately in these programs and to determine the best way to increase access to these important services for communities of color.

Next Steps

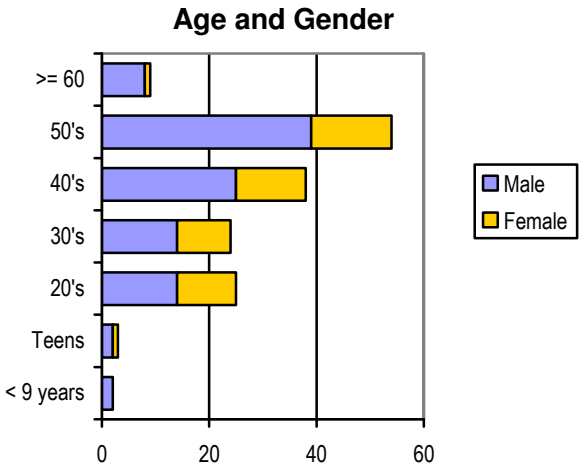
- The demand for the program continues to be much larger than available slots. As new funding allows the program can work with other vulnerable populations who struggle to obtain benefits including homeless families, victims of domestic violence and homeless disabled individuals who are not currently working directly with Multnomah Treatment Fund or other current County referral sources.
- Further study should be done to evaluate the disproportionate number of white clients in the program compared to the general homeless population. Program staff should work with culturally specific organizations to increase access to these populations as program slots become available.
- Program staff should add 3 and 6-month follow-ups to assess the longer-term benefits of the HBR/BEST programs on housing and other services.

Appendix

Demographic Information

Age and Gender

Two thirds (67%) of the clients approved for benefits were male and 33% were female. The ratio of males in the program are slightly higher than the homeless population in general. In the latest Point In Time Count 61% of the homeless population identified as male and 38% as female.[11]



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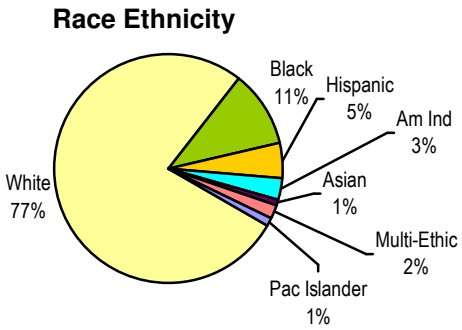

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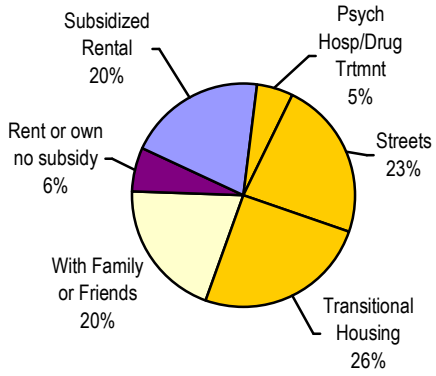

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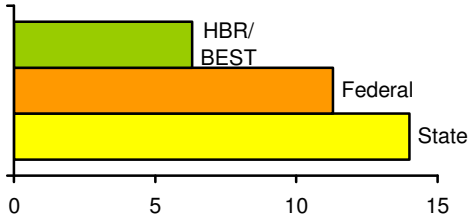

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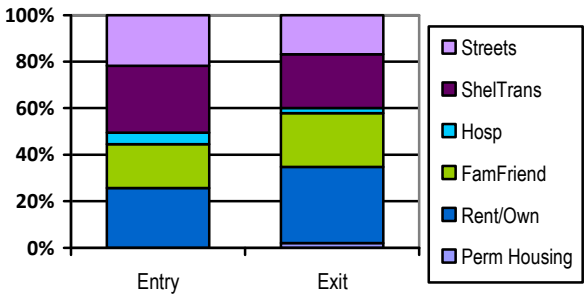
Obtaining federal disability benefits was associated with a small positive trend toward more stable housing. At exit, 58% of clients were either in permanent subsidized housing, renting, living in their own home, or living with friends or family situations compared to 45% at program entry. Two fifths (40%) of clients, however were homeless[8] at program exit.

Housing at Entry and Exit



Since clients are exited from the program at the point where benefits are secured, follow-up data would be needed in order to adequately assess the full impact of benefits on housing.

Need for Additional Capacity

The success of the HBR/BEST programs is limited only by capacity. Although clients were served quickly once they were accepted into the program, on average the wait time to access the HBR/BEST program in FY13 was 100 days. This includes a period of 80 days during FY13 when the program closed to referrals due to the overwhelming numbers of individuals waiting for screening. Additional program capacity is needed to ensure that disabled individuals do not need to wait for benefit acquisition services.

In addition to overall capacity needs for HBR/BEST services, there are critical populations who generally cannot access the services at all. Populations in particular need include:

- Homeless families where either the head of household and/or children are experiencing disabilities
- Victims of domestic violence, with a particular focus on the high rates of undiagnosed traumatic brain injuries among survivors[9].
- Populations who are housed, with or without rent subsidy, but whose housing stability is jeopardized by the individual's lack of insurance and/or income
- Individuals with disabilities living in publicly subsidized housing who have no income. Not only do these individuals have to struggle mightily to meet their basic needs but their rents are fully publicly subsidized. When they gain income, they pay 30% of that income to Home Forward which are dollars that could be used to provide much needed additional housing subsidy in the community.

Conclusions

1. HBR/BEST is highly successful at obtaining federal disability benefits for clients. Clients in this program are obtaining benefits at nearly 2 ½ times the national rate. HBR/BEST had a 74% success rate compared to a national rate of 30%[10].
2. HBR/BEST clients are approved for benefits more than 10 years younger than the national average. Accessing benefits at an earlier age provides critical support and services over more of an individual's lifetime and has the potential to ameliorate many of the more damaging impacts of disability and homelessness while paying for

[8] Homeless includes those who are hospitalized, in jail, in temporary shelter or on the streets.

[9] http://www.biausa.org/tbims-abstracts/domestic-violence-related-mild-traumatic-brain-injuries-in-women

[10] http://www.ssa.gov/policy/docs/statcomps/ssi_asr/2011/ssi_asr11.pdf.

services with federal resources rather than local ones

3. Obtaining Medicaid allows mental and health care and medicine to be paid for by Medicaid instead of County General Fund. In the year prior to entering HBR, clients incurred $130,387 in mental health expenses.
4. There is a tremendous economic development benefit to the program. HBR/BEST produced a total annual community benefit of $1,605,523 when both client SSA incomes and mental health services cost offsets are combined. This is a 163% increase from the one time investment of $611,297.
5. HBR/BEST achieves these results extremely quickly. Applications are approved on average 9.5 months faster than the state average and are twice as likely to be approved on their first attempt as other applicants in Oregon.
6. HBR/BEST only required an average of 20.0 hours of service delivery per client to obtain benefits over a 2 month period. This offers evidence to support the practice of using specialized staff solely dedicated to benefits recovery work.
7. Client income increased by 636%.
8. There is insufficient data to evaluate the longer-term impact of the program on housing and utilization of other systems such as health, police, homeless shelters, etc. However initial evidence and feedback from provider agencies suggests that these savings may be substantial over the long term.
9. While the program has improved its efficiency at preparing applications, staffing cuts at the Social Security Administration will likely continue to negatively impact the length of time it takes for applications to be reviewed.
10. Communities of color are underrepresented in the HBR/BEST service group as compared to the general homeless population. Further analysis is needed to determine why these populations are not being served proportionately in these programs and to determine the best way to increase access to these important services for communities of color.

Next Steps

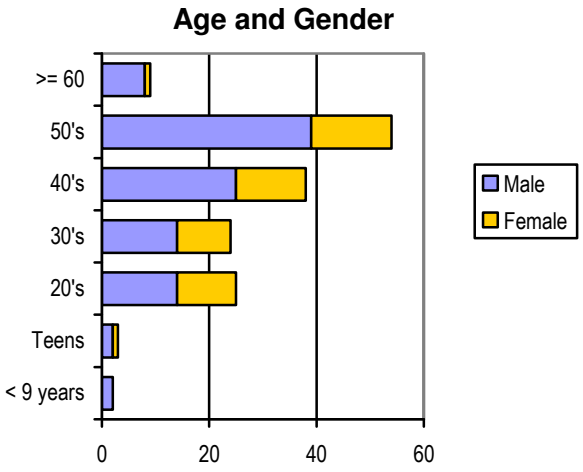
- The demand for the program continues to be much larger than available slots. As new funding allows the program can work with other vulnerable populations who struggle to obtain benefits including homeless families, victims of domestic violence and homeless disabled individuals who are not currently working directly with Multnomah Treatment Fund or other current County referral sources.
- Further study should be done to evaluate the disproportionate number of white clients in the program compared to the general homeless population. Program staff should work with culturally specific organizations to increase access to these populations as program slots become available.
- Program staff should add 3 and 6-month follow-ups to assess the longer-term benefits of the HBR/BEST programs on housing and other services.

Appendix

Demographic Information

Age and Gender

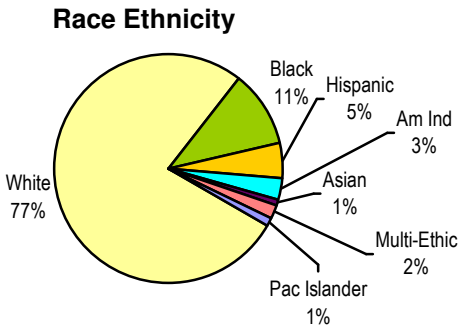
Two thirds (67%) of the clients approved for benefits were male and 33% were female. The ratio of males in the program are slightly higher than the homeless population in general. In the latest Point In Time Count 61% of the homeless population identified as male and 38% as female.[11]



The average age of clients approved for benefits in FY13 was 43.0 years. This is considerably younger than the national average age of disability determination of 53.2 years[12]. The impact of this cannot be overstated. The benefits to individuals are enormous: increased likelihood of housing stability, opportunities for regular medical and mental health treatment, less exposure to violence and trauma living on the street and the ability to reconnect with community. In addition, more than 10 years of federal funds are coming into the community in the form of disability payments and Medicare/Medicaid reimbursements.

Race/Ethnicity

The chart below shows the demographic breakdowns of clients served in the HBR/BEST programs. One quarter (23%) of program participants were from communities of color and three quarters (77%) were White. In Multnomah County 29% of the population is from communities of color and 45% of the homeless population is from communities of color.



Types of Disability

A significant number of clients served in the program (65%) have a mental health disability. These types of disabilities can be particularly challenging to prove in the application process. Most common diagnoses include:

- Major depressive or bi-polar (17%)
- Schizophrenia or schizoaffective (11%)
- Post-Traumatic Stress Disorder – PTSD (14%)
- Other Mental Health diagnosis (12%)
- Cognitive disorders (8%)
- Personality disorders (3%)

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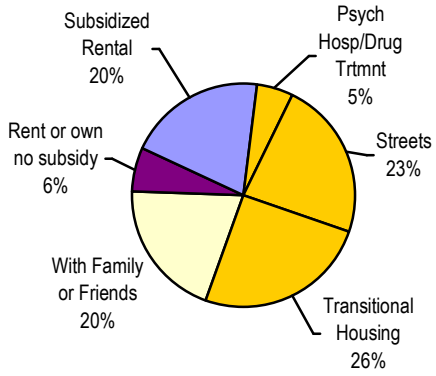
[11] 2013 Point-In-Time Count of Homelessness in Portland/Multnomah County, June 2013

[12] www.ssa.gov/policy/docs/chartbooks/fast_facts/2013/fast_facts13.pdf

Housing Status at Intake

The majority of clients utilizing the HBR/BEST programs (56%) were either homeless, transitionally housed or at risk of homelessness at the time of intake. The chart below shows the different types of living arrangements reported. A significant number were living in subsidized housing units, Single Room Occupancy units (SROs) or with family members or friends, which are often unstable situations.

Living Placement at Entry



Differences between HBR and BEST

HBR is funded by Multnomah County to serve referrals from County programs; BEST is funded by the City of Portland to serve referrals from City programs. Despite different names and funding sources the HBR and BEST programs operate essentially the same. From a client or staff perspective the programs are interchangeable.

Despite differing referral sources there were only two small differences between the populations funded in the two programs:

- HBR clients were more likely to have a mental health disability than BEST clients (72% vs. 52%). This is likely due to the County's focus on referring clients to HBR who are receiving mental health services paid by County General Fund dollars through the Multnomah Treatment Fund.

BEST clients were more likely to be living on the streets or in transitional housing (70% vs. 41%). Further research is needed however this is likely due to the County referring clients representing a broader range of the homelessness continuum, such as those doubled up or temporarily housed with other program funds.