Sequential Intercept Model Mapping Report for Minnehaha County, South Dakota

Prepared by: Policy Research, Inc.

Travis Parker, M.S., L.I.M.H.P., C.P.C.

Melissa Neal, DrPH, MPH

July, 2017

Delmar, NY

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Final Report

July 25, 2017

Travis Parker, MS, LIMHP, CPC

Melissa Neal, DrPH, MPH

Policy Research, Inc.

ACKNOWLEDGEMENTS

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RECOMMENDED CITATION

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CONTENTS

BACKGROUND

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

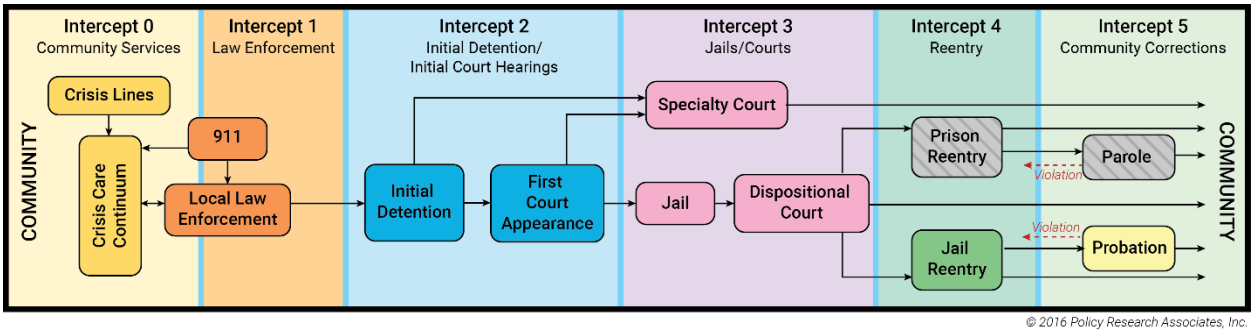
A Sequential Intercept Model mapping is a workshop to develop a map that illustrates how people with behavioral health needs come in contact with and flow through the criminal justice system. Through the workshop, facilitators and participants identify opportunities for linkage to services and for prevention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

The Sequential Intercept Mapping workshop has three primary objectives:

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

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

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



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

AGENDA

PRI
POLICY RESEARCH, INC.

SAFETY+JUSTICE CHALLENGE
Supported by the John D. and Catherine T. MacArthur Foundation

Sequential Intercept Mapping

AGENDA

Minnehaha County, SD

July 25, 2017

8:15 **Registration**

8:30 **Opening**
- Welcome and Introductions
- Overview of the Workshop
- Workshop Focus, Goals, and Tasks
- Collaboration: What's Happening Locally

What Works!
- Keys to Success

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

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

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

Wrap Up
- Review

4:30 **Adjourn**

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

There will be break for lunch at approximately noon.

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SAFETY+JUSTICE CHALLENGE
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Sequential Intercept Mapping

AGENDA

Minnehaha County, CA

July 26, 2017

8:30 **Registration and Networking**

9:00 **Opening**
- Remarks
- Preview of the Day

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

Action Planning

Finalizing the Action Plan

Next Steps

Summary and Closing

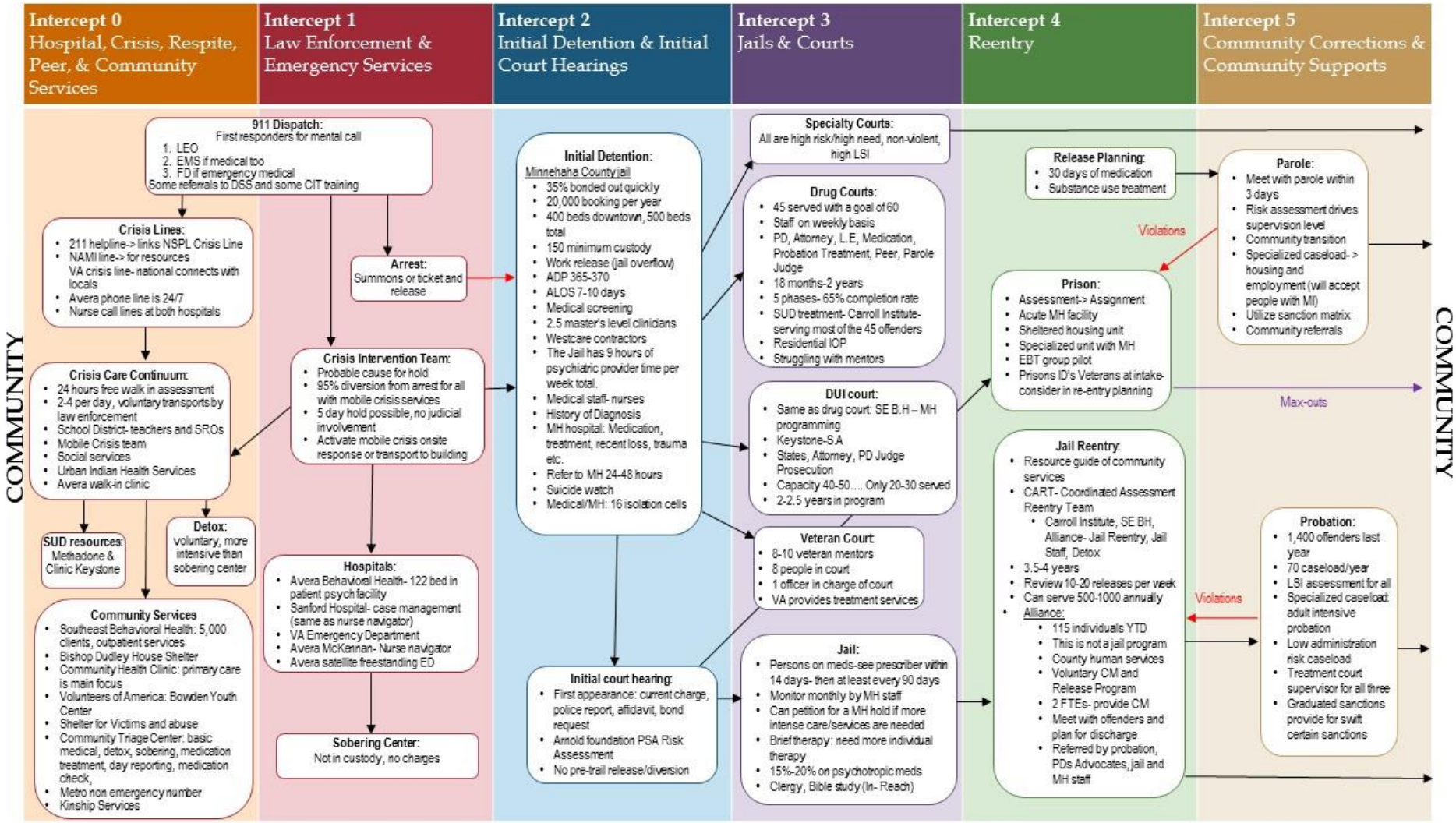
12:00 **SIM Conclusion**

1:00 **Afternoon Session with Judge Steve Leifman**

3:00 **Adjourn**

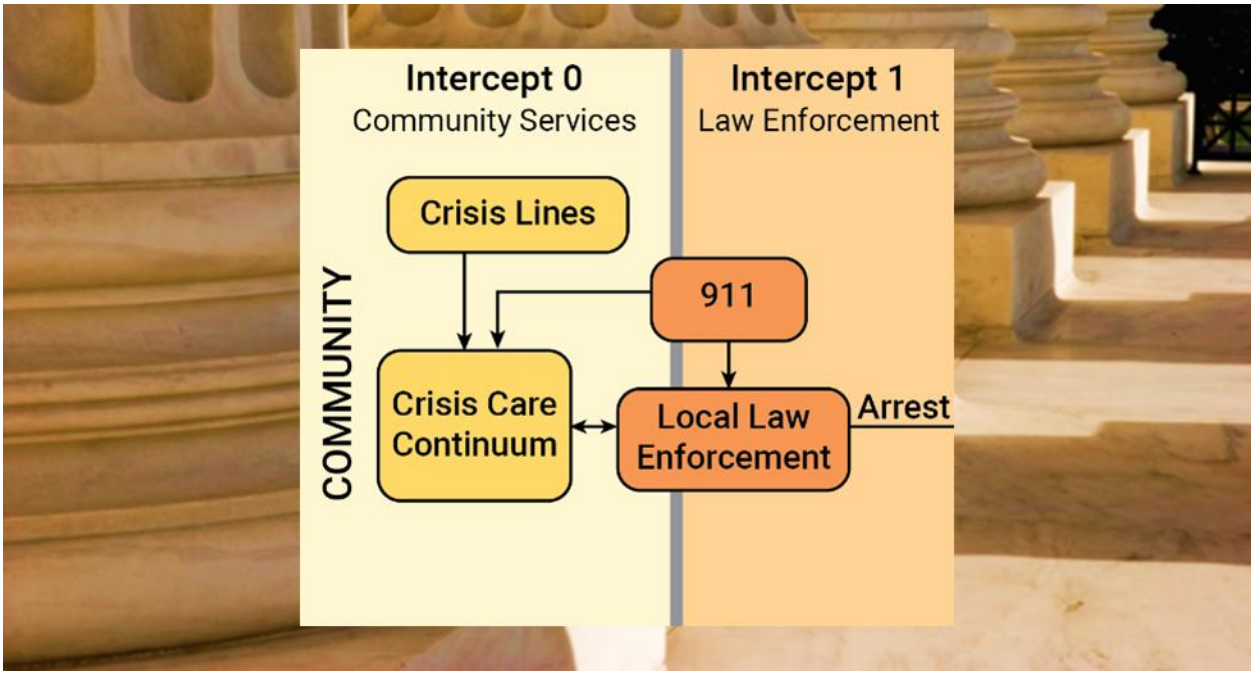
There will be a 15 minute break mid-morning.

SEQUENTIAL INTERCEPT MODEL MAP FOR MINNEHAHA, SD



RESOURCES AND GAPS AT EACH INTERCEPT

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



INTERCEPT 0 AND INTERCEPT 1

RESOURCES

- Avera Behavioral Health Center: psychiatric facility offering inpatient and outpatient services
    - 123 bed inpatient psychiatric facilities
    - 24-hour walk-in assessment for clients.
    - 24/7 call line for confidential assessments.
    - Walk-in clinic in downtown Sioux Falls.
    - Trauma assessments conducted.
    - There are 2-4 episodes per day of law enforcement bringing someone in for voluntary assessment.
- Sanford Hospital has a Nurse Navigator (case manager) that connects clients with services.
- Avera McKennan Hospital & University Health Center also have a nurse navigator and a satellite emergency department.
- The Veterans Affairs (VA) has their own emergency department and Crisis Line
- Indian Health Services
- Sobering Center (co-located at the jail; however, people who are not charged can be transported to here to sober and access services)
- Minnehaha County Detox –provides more intensive services than the Sobering Center
    - 5 day hold is possible
    - Capacity of 8 beds; average length of stay is 6 days.
- Lutheran Social Services

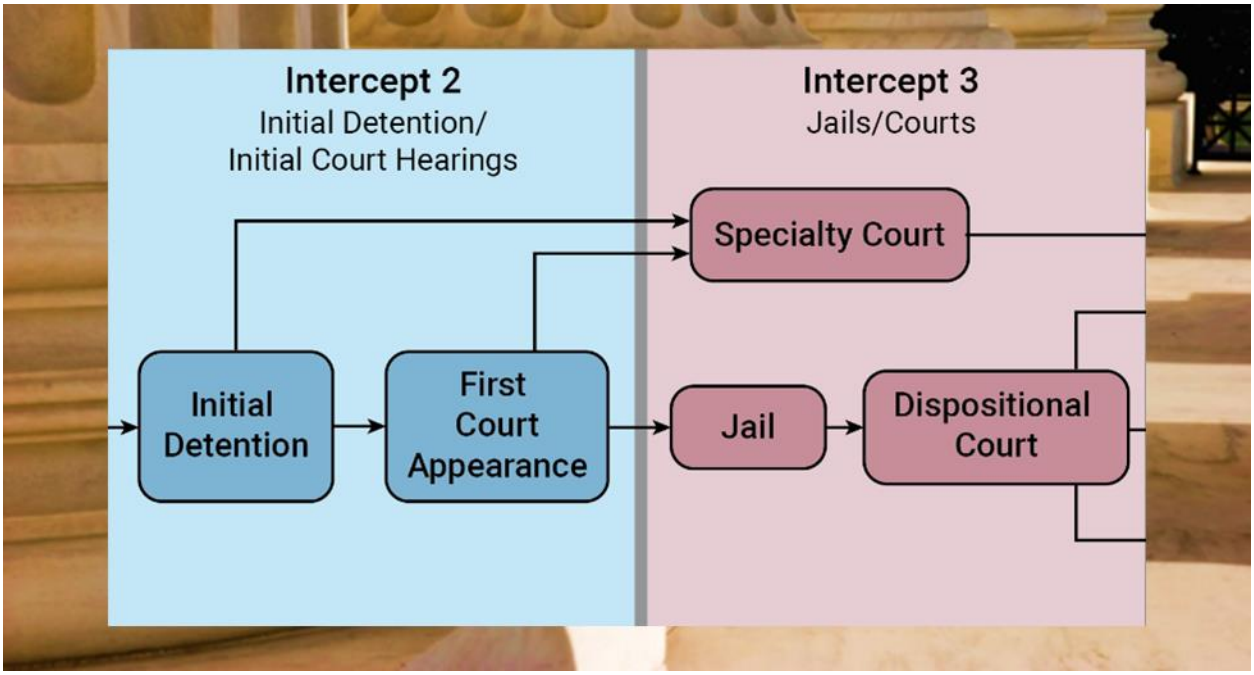
- Bishop Dudley Hospitality House (homeless shelter)
- Union Gospel Mission
- Volunteers of America
- Face It Together- Sioux Falls
    - Provides peer mentors model for individuals who suffer with addiction.
- Methadone Clinic (substance use disorder resources)
- Keystone (substance use disorder resources)
- Children's Inn (domestic violence shelter)
- Compass Center

Crisis lines and Crisis Services

- 24/7 211 Helpline Center- NAMI
    - 90,000 calls per year
    - Provides an annual Mental Health guide
- National Suicide Prevention Lifeline
- Veterans Affairs Crisis Line
- Southeastern Behavioral Health also has a crisis line for clients being served.
    - They serve 5,000 people within 4 counties.
- Crisis Intervention Team program
    - Some 911 operators have CIT (Crisis intervention Team) training.
    - CIT-officers can place offenders in an emergency mental health hold (a less intensive process than involuntary commitments; involves an Emergency Commitment up to 5 days without judicial involvement).
    - The Sioux Falls Police have 250 sworn officers with 20% trained in CIT.
        - They have 2 trainings a year with a maximum of 25 officers per class.
    - The Minnehaha County Sheriff's Office has 45 Patrol officers, with 18 of them trained in CIT.
- Law enforcement has access to and activates Mobile Crisis Teams.
- Mobile Crisis Teams (staffed by 12 clinicians) operate in Lincoln and Minnehaha Counties.
    - Operationalized by state law.
    - Services provided on a 24/7 basis.
    - Teams go to the location of the person in crisis rather than having the person transported to a treatment location.
    - Teams have space in the jail to do assessments and stabilization.
    - 95% of the clients served are diverted from incarceration through their team.
    - The number of law enforcement petitions for mental health holds have dropped by 20% during the first six months of the program implementation.

GAPS

- Mobile Crisis Teams must be activated by law enforcement rather than the general public.
- Peer services are needed in more Intercept 0 agencies and programs.
- Clients go directly from Emergency Medical Services Unit (EMT) to law enforcement when in crisis.
- Lack of publicizing and communicating to the public on how to access crisis services without calling 911 or involving law enforcement.
    - People over-utilize the emergency department because they don't know how to access crisis care services.
    - Clients have difficulty accessing services if English is not their primary language.
- Funding is an issue that may determine whether clients access services on their own or not.
    - Some people don't access services voluntarily because the involuntary commitment process will require the county to pay for services.
- Data is not being collected on CIT trained officers and responses to calls.
- There is a need for a location such as the planned Crisis Triage Center that will provide basic medical services, detox, mental health services, and sobering.



INTERCEPT 2 AND INTERCEPT 3

RESOURCES

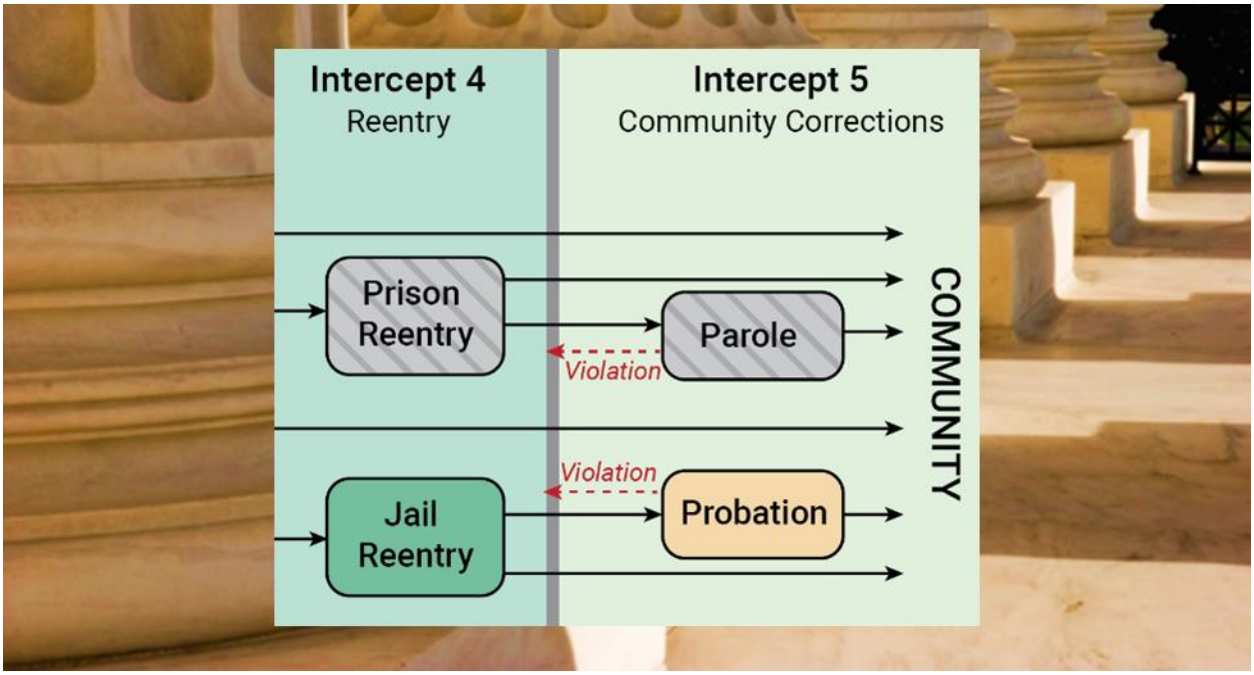
- Minnehaha County Jail
  - 400 beds at the downtown facility, with a total of 550 beds.
  - 150 beds for minimum custody offenders on work release at the jail overflow facility.
  - The average daily population is 365-370 offenders.
  - The average length of stay is 7-10 days.
  - The medical staff conducts screening and referrals to jail mental health staff within 48-72 hours.
    - Medical screening contains questions related to behavioral health.
    - Mental health services contracted through Westcare.
      - 2 FTE and 1 PTE Master's-level clinicians
      - 9 hours of psychiatric provider time per week total
- The Brief Jail Mental Health Screen (BJMHS) is being piloted.
- Sobering Center- co-located at the jail
- The Arnold Foundation's Public Safety Assessment (PSA) risk assessment is being used to assess clients for risk of flight and to public safety.
- Public defender present in the courtroom during bond hearings.
- There are limited group therapy or treatment programs; most of the jail programming is religious or provided by clergy.
- Drug Court serves clients with co-occurring disorders that are high risk/high need (HR/HN) since 2011.

  - 46 participants, with capacity up to 60 participants.
  - Average length of participation ranges from 3 months to 2 years.
  - 5 phase program, with Relapse Prevention phase at the end of the 6 months with supervision to support transition.
- DUI Court serves high risk/high need clients.
  - 20-30 participants, with capacity up to 45-50 offenders.
  - Average length of participants of 2-3 years in program; 5 years under probation (sentence).
- Veterans Court serves clients with co-occurring disorders that are high risk/high need (HR/HN).
  - Has 8 veteran mentors.
  - Partners with VA, which provides treatment services.
- New competency legislation:
  - Reduces time allowed for competency evaluations to 21 days.
  - Change of qualifications to conduct competency evaluations so they can be completed closer to home and hopefully in a more expedited fashion.
  - Counties have more control over who provides competency evaluations.

GAPS

- The Brief Jail Mental Health Screening (BJMHS) pilot will identify persons who are likely to be SMI, and it provides some information to the court to assist the judge in determining if a person needs to be assessed as a condition of bond if released.
  - The SMI diagnosis will come through that assessment.
  - The results of the BJMHS will be tracked through the court rather than the Jail.
- 35% of 20,000 offenders bond out prior to seeing medical or mental health contracted staff.
- All defendants should receive court notifications, not just Public Defender's clients.
- Significant lack of housing options.
- Limited community-based treatment capacity at intercepts 0, 1, and 2; people end up in jail when other places reach capacity.
- Need for more diversion options at intercept 2
- Need to create a way to identify people with mental health needs at this intercept.
- There is no peer support specialist certification program.
- There is no contract order issue when dealing with seriously mental illness clients.
- The jail is not an environment that is designed or conducive to treatment of a mental illness.
  - The Jail mental health clinicians are primarily tasked with stabilizing patients that are in a mental health crisis; once stabilized they work to maintain safety and appropriate behavior.
  - The counselors follow up with patients on a routine basis to maintain behavior.

- Group therapy and substance abuse treatment are very difficult to establish in the jail.
    - The Jail's population turns over frequently and most inmates are not willing participants in treatment programs or leave the program prior to completion.
    - Peer specialist for jails are also very difficult to come by due to security requirements of the facility.
- Drug Court is a post – plea court, requiring a guilty plea from program participants.
- Lack of/struggle with getting mentors for the drug court program
- Lack of/insufficient number of eligible candidates referred to treatment courts.
- Cost of a competency evaluations can range from $600.00 to over $1,000.00.
- Due to new legislation, the state no longer does 3 competency evaluations a month.
    - Counties are now responsible for competency evaluations.
    - New contracted competency evaluators are needed to meet the high level of need.



INTERCEPT 4 AND INTERCEPT 5

RESOURCES

- Alliance (re-entry program) – community-based, voluntary, case-management and an early planning program
    - 3 FTE staff members
    - Re-entry planning can start at any time (receive referrals of people already in the community too).
    - Facilitate warm hand-offs from jail to programming.
- Coordinated Assessment Re-entry Team (CART).
    - CART was created by the Alliance re-entry program.
    - Meets weekly to review inmates scheduled for release, and discuss planning.
- Safe Home is a housing-first program within the community.
- The mental health program in the jail works with Southeastern Behavioral Health (SEBH) to schedule follow-up visits.
- Veterans Justice Outreach (VJO) does outreach in the jail
- Medicaid will not cover any services provided while in custody.

Parole (Post-release from State Prison)

- Clients are assessed for substance use disorders (SUD) and mental health (MH) issues.

- Appointments are set up within communities for people with substance use and mental health disorders.
- Clients are given 30 days of medication and then provided with medication management.
- There are multiple housing options, depending on availability.
- Risk assessments conducted to determine appropriate supervision level.
    - Sioux Falls: They have 1,063 offenders on their caseload, including 32 persons that have a serious mental illness.
- Community Transition Program
    - 1 specialized caseload to assist with housing and employment (will accept people with MI)
    - Seeks to have clients employed within 60-90 days
- 67 caseload size
- Sanction matrix utilized.

Probation (Courts – Sentences, Revocations)

- 1,400 on probation in Minnehaha and Lincoln counties.
- Average caseload of 70 people per probation officer each year.
- Appointments are set up within communities for people with substance use and mental health disorders.
- Level of Service Inventory (LSI) risk/need assessment conducted on all clients.
- Specialized caseload: Adult Intensive Probation
- Provide supervision for the treatment courts: DUI, Drug Court, and Veterans Court.
- Response grid for technical violations inclusive of graduated sanctions, to ensure swift certain sanctions.

GAPS

- There is no behavioral health specialized caseload for Parole.
- Probation needs, at minimum, annual mental health and crisis training.
- Need housing and transitional housing
- Residential Treatment can take 3-4 months to access.

PRIORITIES FOR CHANGE

The priorities for change are determined through a voting process. Workshop participants are asked to identify a set of priorities followed by a vote where each participant has three votes. The voting took place on July 25, 2017. The top three priorities are highlighted in italicized text.

Rank	Priority	Votes
1	Create the Community Triage Center	22 votes
2	Create Peer Support and System Navigator positions	13 votes
2	Supportive housing that is affordable and long-term	13 votes
4.	Mobile Crisis Teams that can be activated by persons and agencies outside of law enforcement	6 votes
5.	Quicker/Easier access to psychotropic medications upon release	5 votes
5.	Collaborative data sharing and communication plans	5 votes
7.	Increased funding for mental health staffing at the Minnehaha County Jail	4 votes
7.	Expand the ability to initiate outpatient commitments	4 votes

Rank	Priority	Votes
9.	Create a co-responder model between mental health and law enforcement	3 votes
9.	Bolster Intercept 0; Empower community to utilize Intercept 0 resources	3 votes
9.	Data collection/analysis: CIT, BJMHS pilot, and Arnold PSA tool (3 votes-tie #9)	3 votes
9.	Increase prevention services at all levels (childhood through adult)	3 votes
13.	Step down, transitional housing	2 votes
13.	Increased support for refugee population	2 votes

ACTION PLANS

Priority Area # 1: Triage Center			
Objective	**Action Step**	**Who**	**When**
Funding Partnerships - Avera - Sanford - County - Providers/Services - City - State - Faith-Based - Business Community	- Further examine reports at Policy Committee meeting - Explore I.D who we may be missing - Consider philanthropists: Sanford (T. Denny)		
Location: vacated jail area - Need community mindset change -> system change	- Educate/ involve county community/ jail		
- Population: Who to serve and how to decide?	- Utilize data to explore sub-sets for triage center		

- Philosophy Change:
  o How officers are viewed
  o System/ approach change
	- Establish Communication Plan
	  o Public
	  o Stakeholders		

- Bring in Media - Be aware of verbiage: Diversion 'vs' Alternative - Find the right door	o City (consider homeless population count; use of meters as a fundraising tool) - Engage/Involve key stakeholders for buy-in/ be a part of creation. It is important to have conceivable plan to present - Public relations committee to work presentation to ALL (and particularly target the below) o Youth o Businesses		
- Services: ▪ Service-Crisis ▪ Mid-level ▪ Long-term link - Temporary check-in for medication - Link to mental health and substance use treatment - Connecting community to physical 211	- Immediate access- link to long-term provider ("Bridge"/"Conduit") - Utilize schooling/ college programs o Psychiatry residents o Social work programs o Nursing programs		
- Cost-Shifting/ Cost Sharing	- Gather data regarding cost, numbers, need - Research and compile data		
- Data Sharing o For measurable outcomes o For care execution	- Utilize HIPAA as a means to share vs. a hurdle - Start with internal data exchange, then grow into community education - Share with community for education		

Priority Area # 2: Peer Support/ System Navigator			
Objective	**Action Step**	**Who**	**When**
- Participate in webinar on 8/22	- "Using Peer Specialist in the Criminal Justice System"	- NAMI	- 8/22/17
- Define role of peer specialist	- Check into site visit at Lancaster County, Minneapolis	- Phyllis- Minnesota - Chad Clark, Jennifer	- 12/31/17
- Determine effectiveness of this role	- Data collection: look at SIM in geographic community, Lancaster County, Minnesota	- Sioux Falls Police Department	- 12/31/17
- Secure Funding	- Research other states in which the state manages Medicaid - Inquire with state staff as to possibilities: Department of Corrections, Department of Social Services etc. - Pilot 1-2 positions	- Gary, Chad Clark	- 4/30/18
- Training and Certification	- Research options	- Jennifer - Phyllis	- 12/31/14
- Identify target area in which to start (Criminal Justice ETC.)	- Probation, parole- obtain data re-current numbers (recidivism).	- Jim, Chad Clark	- 12/31/17

RECOMMENDATIONS

RECOMMENDATION 1:

Examine the feasibility and need for alternatives to detention and pre-adjudication diversion options for people with mental disorders at Intercept 2. Defendants with mental disorders who are remanded to pretrial detention often have worse public safety outcomes than defendants who are released to the community pending disposition of their criminal cases.

Consider proportional responses based on the severity of a defendant's criminal risk and behavioral health treatment needs.

1. Defendants with pending cases who are released to pre-trial services as an alternative to detention. These may be cases with moderate criminal risk, but where the individuals would benefit from community-based services that are not available while in pretrial detention and pretrial failure can be avoided through:
    a. A deferred prosecution approach where a low-risk defendant is directed to participate in a short-term community-based treatment program. Successful completion of the program results in dismissal of the charges while failure results in remand to custody and continuation of the criminal case.

    b. Consider a competency court docket, such as was established by the Seattle Municipal Court, to reduce time spent in jail during the competency process. Refer to the journal article by Finkle and colleagues (2009) and the 2013 report on the Seattle Municipal Court mental health court, which houses the competency court docket.

RECOMMENDATION 2:

Expand the utilization of Peer Support Specialists across the Intercepts:

Peer support is particularly helpful in easing the traumatization of the corrections process and encouraging consumers to engage in treatment services. Settings that have successfully integrated peers include crisis evaluation centers, emergency rooms, jails, treatment courts, and reentry services. GAINS staff recommends utilizing these services and also offers GAINS Center Senior Project Associate LaVerne Miller as a resource for more assistance. Her contact information is below. See below for more information and resources on Peer Support.

LaVerne D. Miller, Esq.

Policy Research Associates, Inc.

345 Delaware Avenue

Delmar, NY 12054

(518) 439-7415 x 5245 LMiller@prainc.com

RECOMMENDATION 3:

Increase trauma training for justice involved personnel:

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

RECOMMENDATION 4:

Improve data collections across intercepts

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

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

Towards this effort, it is also imperative to establish guidelines regarding information sharing and the utilization of HIPAA to aid, not hinder this information sharing. If necessary, review current state legislation regarding confidentiality (see resources for more information).

RESOURCES

Competency Evaluation and Restoration

- SAMHSA's GAINS Center. *Quick Fixes for Effectively Dealing with Persons Found Incompetent to Stand Trial*.
- Finkle, M., Kurth, R., Cadle, C., and Mullan, J. (2009) Competency Courts: A Creative Solution for Restoring Competency to the Competency Process. *Behavioral Science and the Law, 27,* 767-786.

Crisis Care, Crisis Response, and Law Enforcement

- Substance Abuse and Mental Health Services Administration. *Crisis Services: Effectiveness, Cost-Effectiveness, and Funding Strategies.*
- International Association of Chiefs of Police. *Building Safer Communities: Improving Police Responses to Persons with Mental Illness.*
- Suicide Prevention Resource Center. *The Role of Law Enforcement Officers in Preventing Suicide.*
- Saskatchewan Building Partnerships to Reduce Crime. *The Hub and COR Model*.
- Bureau of Justice Assistance. *Engaging Law Enforcement in Opioid Overdose Response: Frequently Asked Questions.*
- International Association of Chiefs of Police. Improving Police Response to Persons Affected by Mental Illness: Report from March 2016 IACP Symposium.
- International Association of Chiefs of Police. One Mind Campaign.

- Optum. In Salt Lake County, Optum Enhances Jail Diversion Initiatives with Effective Crisis Programs.
- The Case Assessment Management Program is a joint effort of the Los Angeles Department of Mental Health and the Los Angeles Police Department to provide effective follow-up and management of selected referrals involving high users of emergency services, abusers of the 911 system, and individuals at high risk of death or injury to themselves.
- National Association of Counties. Crisis Care Services for Counties: Preventing Individuals with Mental Illnesses from Entering Local Corrections Systems.
- CIT International.

Data Analysis and Matching

- Data-Driven Justice Initiative. Data-Driven Justice Playbook: How to Develop a System of Diversion.
- Urban Institute. *Justice Reinvestment at the Local Level Planning and Implementation Guide.*
- The Council of State Governments Justice Center. *Ten-Step Guide to Transforming Probation Departments to Reduce Recidivism*.
- New Orleans Health Department. *New Orleans Mental Health Dashboard.*
- Pennsylvania Commission on Crime and Delinquency. *Criminal Justice Advisory Board Data Dashboards*.
- Corporation for Supportive Housing. *Jail Data Link Frequent Users: A Data Matching Initiative in Illinois* (See Appendix 3)
- Vera Institute of Justice. *Closing the Gap: Using Criminal Justice and Public Health Data to Improve Identification of Mental Illness.*

Housing

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

Information Sharing

- American Probation and Parole Association. *Corrections and Reentry: Protected Health Information Privacy Framework for Information Sharing.*

Jail Inmate Information

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

Medication Assisted Treatment (MAT)

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

Mental Health First Aid

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

Peers

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

Pretrial Diversion

- CSG Justice Center. Improving Responses to People with Mental Illness at the Pretrial State: Essential Elements.
- National Resource Center on Justice Involved Women. Building Gender Informed Practices at the Pretrial Stage.
- Laura and John Arnold Foundation. The Hidden Costs of Pretrial Diversion.

Procedural Justice

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

- American Bar Association. Criminal Justice Standards on Mental Health.

Reentry

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

Screening and Assessment

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

Sequential Intercept Model

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

- SAMHSA's GAINS Center. *Developing a Comprehensive Plan for Behavioral Health and Criminal Justice Collaboration: The Sequential Intercept Model*.

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

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

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

Transition-Aged Youth

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

Trauma-Informed Care

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

Veterans

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

APPENDICES

Appendix 1	Sequential Intercept Mapping Workshop Participant List
Appendix 2	Texas Department of State Health Services. *Mental Health Substance Abuse Crisis Services Redesign Brief.*
Appendix 3	Corporation for Supportive Housing. *Jail Data Link Frequent Users: A Data Matching Initiative in Illinois.*
Appendix 4	Dennis, D., Ware, D., and Steadman, H.J. (2014). Best Practices for Increasing Access to SSI and SSDI on Exit from Criminal Justice Settings. *Psychiatric Services, 65,* 1081-1083.
Appendix 5	100,000 Homes/Center for Urban Community Services. *Housing First Self-Assessment: Assess and Align Your Program and Community with a Housing First Approach.*
Appendix 6	Remington, A.A. (2016). *Skyping During a Crisis? Telehealth is a 24/7 Crisis Connection.*
Appendix 7	SAMHSA. *Reentry Resources for Individuals, Providers, Communities, and States*.
Appendix 8	HB1183: An Act to provide and revise certain provisions regarding mental health procedures in criminal justice, to make an appropriation therefor, and to declare an emergency.
Appendix 9	HB 1183: An Act to provide and revise certain provisions regarding mental health procedures in criminal justice, to make an appropriation therefor, and to declare an emergency (Senate version).
Appendix 10	Sattizahn, G. 2017. Oversight Council for Improving Criminal Justice Reponses for Persons with Mental Illness

Appendix 11 Crime and Justice Institute at CRJ. 2017. HB 1183 Performance Measures: Oversite Council for Improving Criminal Justice Responses for Persons with Mental Illness.

Appendix 1

Minnehaha County SIM		
Last Name	**First Name**	**Organization**
Ahrends	Phyllis	NAMI
Albers	Kati	Parole
Benz	Kari	County Human Services
Boyd	Michelle	Sheriff's Office
Brown	Beth	Detox Administrator
Butler	Tiffany	Carroll Institute
Campbell	Chad	Bishop Dudley
Charbonneau	Julie	City Health
Clark	Chad	UJS- Probation
Collura	Alicia	City Health
Graham	Kris	Southeastern Behavioral Health
Gromer	Jeff	Minnehaha Co Sheriff's Office
Hansen	Kim	Southeastern Behavioral Health
Huether	Robin	Sanford Health
Johnson	Brett	County
Karsky	Dean	Minnehaha Co Commissioner
Miller	Mike	Public Defender
Miller	Skip	Sioux Falls Police Department
Moeller	Liz	Jail Mental Health
Montis	Lori	County Human Services
NAMI rep	NAMI rep	NAMI rep
Oldenkamp	Betty	Lutheran Social Services
Pekas	Judge John	UJS- Judge
Smith	Traci	Public Defender
Smith	Suzy	Augustana Research Institute
Snedecker	Jessica	Jail Mental Health
Srstka	Erin	Minnehaha Co Commission Office
Thorkelson	Chris	Lloyd Companies
Tuschen	Gary	Carrol Institute
Tvedt	Jon	UJS- Probation
Vermeulen	Alicia	Avera Health
Walton	Tarah	Sioux Falls Police Department

Appendix 2

TEXAS Department of State Health Services

Crisis Services

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

The 80th Legislature

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

Crisis Funds

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

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

Competitive Funds Projects

- **Crisis Stabilization Units (CSU)**
  - Provide immediate access to emergency psychiatric care and short-term residential treatment for acute symptoms
  - Two CSUs were funded
- **Extended Observation Units**
  - Provide 23-48 hours of observation and treatment for psychiatric stabilization
  - Three extended observation units were funded
- **Crisis Residential Services**
  - Provide from 1-14 days crisis services in a clinically staffed, safe residential setting for individuals with some risk of harm to self or others
  - Four crisis residential units were funded
- **Crisis Respite Services**

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

- **Crisis Step-Down Stabilization in Hospital Setting**
  - Provides from 3-10 days of psychiatric stabilization in a psychiatrically staffed local hospital setting
  - Six local step-down stabilization beds were funded
- **Outpatient Competency Restoration Services**
  - Provide community treatment to individuals with mental illness involved in the legal system
  - Reduces unnecessary burdens on jails and state psychiatric hospitals
  - Provides psychiatric stabilization and participant training in courtroom skills and behavior
  - Four Outpatient Competency Restoration projects were funded

The 81st Legislature

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

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

Appendix 3

Jail Data Link Frequent Users
A Data Matching Initiative in Illinois

Overview of the Initiative

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

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

Target Population for Data Link Initiatives

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

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

Legal Basis for the Data Matching Initiative

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

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

Sample Data at a Demo Web Site

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

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

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

Program Partners and Funding Sources

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

Partnership Between Criminal Justice and Other Public Systems

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

Managing the Partnership

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

About CSH and the Returning Home Initiative

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

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

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

Appendix 4

Substance Abuse and Mental Health Services Administration
SAMHSA
www.samhsa.gov • 1-877-SAMHSA-7 (1-877-726-4727)

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 5

Housing First Self-Assessment

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

100,000 HOMES

CUCS center for urban community services

HIGH PERFORMANCE SERIES

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

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

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

Housing First Self-Assessment

Assess and Align Your Program with a Housing First Approach

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

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

What is Housing First?

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

Why is this Toolkit Needed?

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

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

How Should My Community Use This Tool?

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

Who Does This Well?

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

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

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

Related Tools and Resources

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

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

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

Housing First Self-Assessment for Outreach Programs

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

Number of Points Scored:

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

Number of Points Scored:

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

Number of Points Scored:

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

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

    Checked Five = 5 points

    Checked Four = 4 points

    Checked Three = 3 points

    Checked Two = 2 points

    Checked One = 1 point

    Checked Zero = 0 points

Total Points Scored:

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

Total Housing First Score:

If you scored: 13 points or more

- ✓ Housing First principles are likely being implemented ideally

If you scored between: 10 – 12 points

- ✓ Housing First principles are likely being well-implemented

If you scored between: 7 – 9 points

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

If you scored between: 4 - 6 points

- ✓ Housing First principles are likely being poorly implemented

If you scored between: 0 – 3 points

- ✓ Housing First principles are likely not being implemented

Housing First Self-Assessment
For Emergency Shelter Programs

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

Number of Points Scored:

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

Number of Points Scored:

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

    Checked Five = 5 points

    Checked Four = 4 points

Checked Three = 3 points

Checked Two = 2 points

Checked One = 1 point

Checked Zero = 0 points

Total Points Scored:

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

Total Housing First Score:

If you scored: 10 points or more

- ✓ Housing First principles are likely being implemented ideally

If you scored between: 6 – 9 points

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

If you scored between: 3 - 5 points

- ✓ Housing First principles are likely being poorly implemented

If you scored between: 0 – 2 points

- ✓ Housing First principles are likely not being implemented

Housing First Self-Assessment for Permanent Housing Programs

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

a) Active Substance Use

- Yes = 1 point
- No = 0 points

b) Chronic Substance Use Issues

- Yes = 1 point
- No = 0 points

c) Untreated Mental Illness

- Yes = 1 point
- No = 0 points

d) Young Adults (18-24)

- Yes = 1 point
- No = 0 points

e) Criminal Background (any)

- Yes = 1 point
- No = 0 points

f) Felony Conviction

- Yes = 1 point
- No = 0 points

g) Sex Offender or Arson Conviction

- Yes = 1 point
- No = 0 points

h) Poor Credit

- Yes = 1 point
- No = 0 points

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

- Yes = 1 point
- No = 0 points

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

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

Total Points Scored:

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

    Checked Five = 5 points

Checked Four = 4 points

Checked Three = 3 points

Checked Two = 2 points

Checked One = 1 point

Checked Zero = 0 points

Total Points Scored:

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

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

Checked Six = 0 points

Checked Five = 1 points

Checked Four = 2 points

Checked Three = 3 points

Checked Two = 4 points

Checked One = 5 point

Checked Zero = 6 points

Total Points Scored:

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

Total Housing First Score:

If you scored: 21 points or more

- ✓ Housing First principles are likely being implemented ideally

If you scored between: 15-20 points

- ✓ Housing First principles are likely being well-implemented

If you scored between: 10 – 14 points

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

If you scored between: 5 - 9 points

- ✓ Housing First principles are likely being poorly implemented

If you scored between: 0 – 4 points

- ✓ Housing First principles are likely not being implemented

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

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

Number of Points Scored:

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

Number of Points Scored:

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

Number of Points Scored:

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

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

Number of Points Scored:

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

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

Number of Points Scored:

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

   - Yes = 1 point
   - No = 0 points

Number of Points Scored:

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

Number of Points Scored:

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

Number of Points Scored:

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

Number of Points Scored:

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

Number of Points Scored:

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

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

Number of Points Scored:

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

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

Number of Points Scored:

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

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

Number of Points Scored:

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

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

Number of Points Scored:

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

a) Active Substance Use

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

b) Chronic Substance Use Issues

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

c) Untreated Mental Illness

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

d) Young Adults (18-24)

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

e) Criminal Background (any)

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

f) Felony Conviction

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

g) Sex Offender or Arson Conviction

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

h) Poor Credit

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

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

- Over 75% = 5 points

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

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

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

Total Housing First Score:

If you scored: 77 points or more

- ✓ Housing First principles are likely being implemented ideally

If you scored between: 57 – 76 points

- ✓ Housing First principles are likely being well-implemented

If you scored between: 37 – 56 points

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

If you scored between: 10 – 36 points

- ✓ Housing First principles are likely being poorly implemented

If you scored under 10 points

- ✓ Housing First principles are likely not being implemented

Appendix 6

SKYPING DURING A CRISIS?

Telehealth is a 24/7 Crisis Connection

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

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

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

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

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

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

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

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

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

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

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

Appendix 7

KEY ISSUE: REENTRY

REENTRY RESOURCES FOR INDIVIDUALS, PROVIDERS, COMMUNITIES, AND STATES

LEARN ABOUT SAMHSA REENTRY RESOURCES FOR:

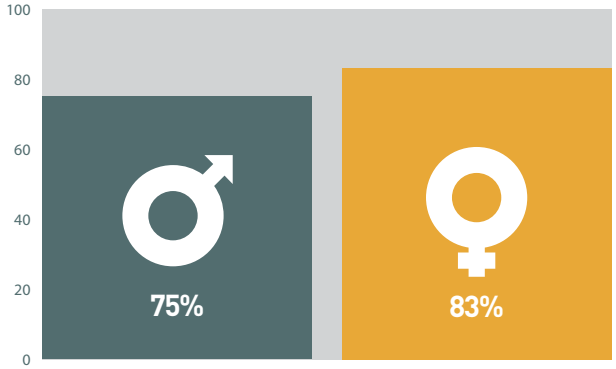
- Behavioral Health Providers & Criminal Justice Practitioners
- Individuals Returning From Jails & Prisons
- Communities & Local Jurisdictions
- State Policymakers

AT A GLANCE

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

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

More women returning to state prison report using illegal drugs compared to men.



ISSUE DATE 4.1.16

Behavioral health is essential to health.
Prevention works.
Treatment is effective.
PEOPLE RECOVER.

Substance Abuse and Mental Health Services Administration
SAMHSA
www.samhsa.gov
DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

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

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

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

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

SAMSHA RESOURCES

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

RESOURCES FOR BEHAVIORAL HEALTH PROVIDERS AND CRIMINAL JUSTICE PRACTITIONERS

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

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

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

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

Trauma Informed Response Training

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

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

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

SOAR TA Center

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

RESOURCES FOR INDIVIDUALS RETURNING FROM JAILS AND PRISONS

SAMHSA's Behavioral Health Treatment Locator

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

Self-Advocacy and Empowerment Toolkit

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

Obodo

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

SecondChanceResources Library

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

Right Path

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

RESOURCES FOR COMMUNITIES AND LOCAL JURISDICTIONS

Establishing and Maintaining Medicaid Eligibility upon Release from Public Institutions

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

Providing a Continuum of Care and Improving Collaboration among Services

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

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

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

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

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

SAMHSA's Offender Reentry Program

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

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

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

RESOURCES FOR STATE POLICYMAKERS

Behavioral Health Treatment Needs Assessment for States Toolkit

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

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

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

All publications are available free through SAMHSA's store

http://store.samhsa.gov/

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SAMHSA TOPICS

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Mental and Substance Use Disorders ■ Prescription Drug Misuse and Abuse ■ Prevention of Substance Abuse and Mental Illness
Recovery and Recovery Support ■ School and Campus Health ■ Specific Populations ■ State and Local Government Partnerships
Suicide Prevention ■ Trauma and Violence ■ Tribal Affairs ■ Underage Drinking ■ Veterans and Military Families ■ Wellness ■ Workforce

Appendix 8

AN ACT

ENTITLED, An Act to provide and revise certain provisions regarding mental health procedures in criminal justice, to make an appropriation therefor, and to declare an emergency.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF SOUTH DAKOTA:

Section 1. That the code be amended by adding a NEW SECTION to read:

Terms used in this Act mean:

(1) "Mental health response team," a support team tasked with finding viable community resources to help persons with severe mental illness involved in the court system;

(2) "Mental health screening tool," a brief, routine process using a standardized instrument that has been validated with offender populations to identify indicators of mental health issues that is used to determine a need for further mental health assessment or evaluation;

(3) "Oversight council," the council established by section 33 of this Act;

(4) "Performance measure," a metric that captures performance on critical variables central to accomplishing the mission and goals within this Act;

(5) "Psychiatric certification," a credential obtained by passing the psychiatric-mental health nursing board certification through the American Nurses Credentialing Center;

(6) "Telehealth," a mode of delivering healthcare services that utilizes information and communication technologies to enable the diagnosis, consultation, treatment, education, care management, and self-management of patients at a distance from health care providers.

Section 2. That the code be amended by adding a NEW SECTION to read:

The South Dakota Sheriffs' Association shall develop a jail mental health screening pilot program and convene at least four jail administrators and at least two mental health providers to select a mental health screening tool for the pilot program. The pilot program shall include at least four jails.

The jails in the pilot program shall utilize a mental health screening tool the during the jail intake process and shall collect and report data to the oversight council on the number of persons screened and the number of persons screening positive for signs and symptoms of acute psychiatric disturbance and disorder.

Section 3. That the code be amended by adding a NEW SECTION to read:

The South Dakota Sheriffs' Association shall coordinate training for jails to administer the jail mental health screening tool.

Section 4. That the code be amended by adding a NEW SECTION to read:

The South Dakota Sheriffs' Association shall coordinate with the jails in the jail mental health screening pilot program to develop a process to implement a mental health screening tool statewide.

Section 5. That chapter 24-11 be amended by adding a NEW SECTION to read:

Each jail shall report annually to the oversight council on the number and percentage of persons screened at intake using a mental health screening tool and the number and percentage of positive screenings.

Section 6. That chapter 24-11 be amended by adding a NEW SECTION to read:

Any jail using a mental health screening tool shall provide the screening results to the circuit committing magistrate or court.

Section 7. That the code be amended by adding a NEW SECTION to read:

The Department of Social Services shall create a crisis services grant program to any municipality, county, or groups of counties for the purposes of encouraging the establishment of new crisis response services or the expansion of existing crisis response services. The grant program shall be in existence until the grant program funding is exhausted. The department shall collect data on the number of applications for the grant program, the number and percentage of applications accepted, the amount awarded to each grantee, and the location, purpose, and population served by

the crisis response services. The department shall report this information semiannually to the oversight council until the program ends.

Section 8. That § 23-3-39.6 be amended to read:

23-3-39.6. Each state's attorney or deputy state's attorney shall receive training on evidence-based practices, as defined in subdivision 16-22-1(7); mental health and available mental health services; and the following issues pertaining to domestic abuse: enforcement of criminal laws in domestic abuse situations; availability of community resources; and protection of the victim. After initial training, each state's attorney or deputy state's attorney shall attend further training at least once every four years.

Section 9. That § 23A-43-3 be amended to read:

23A-43-3. If a determination is made that a release pursuant to § 23A-43-2 will not reasonably assure the appearance of the defendant as required, the committing magistrate or court shall, either in lieu of or in addition to the methods of release described in § 23A-43-2, impose the first of the following conditions of release which will reasonably assure the appearance of the defendant for trial or, if no single condition gives that assurance, any combination of the following conditions:

(1) Place the defendant in the custody of a designated person or organization agreeing to supervise him;

(2) Place restrictions on the travel, association, or place of abode of the defendant during the period of release;

(3) Require the defendant to complete a mental health assessment by a specified date and follow any treatment recommendations. The court shall consider available funding sources before imposing this condition of release;

(4) Require an appearance bond in a specified amount. The bond shall be executed by depositing with the clerk of the court, in cash or other security, as directed, a sum not to

exceed ten percent of the amount of the bond. The deposit shall be returned upon the performance of the conditions of release;

(5) Require the execution of a bail bond with sufficient solvent sureties, or the deposit of cash in lieu of a bail bond; or

(6) Impose any other condition reasonably necessary to assure the defendant's appearance as required, including a condition requiring that the defendant return to custody after specified hours.

Section 10. That chapter 23A-43 be amended by adding a NEW SECTION to read:

If a court has imposed conditions of release that require a defendant to follow any treatment recommendations pursuant to subdivision 23A-43-3(3), the provider of those treatment services shall report any noncompliance to the court that has imposed the condition of release.

Section 11. That the code be amended by adding a NEW SECTION to read:

The Supreme Court may establish rules, pursuant to § 16-3-1, regarding the definition of noncompliance in section 10 of this Act and how noncompliance may be reported to the court.

Section 12. That § 23A-43-4 be amended to read:

23A-43-4. In determining which conditions of release will reasonably assure appearance, a committing magistrate or court shall, on the basis of available information, take into account the nature and circumstances of the offense charged, the weight of the evidence against the defendant, the defendant's family ties, employment, financial resources, character and mental condition, the results of any mental health assessment, the length of the defendant's residence in the community, the defendant's record of convictions, the defendant's record of appearance at court proceedings or of flight to avoid prosecution or failure to appear at court proceedings, and the risk that the defendant will flee or pose a danger to any person or to the community.

Section 13. That the code be amended by adding a NEW SECTION to read:

The Unified Judicial System shall collect and report to the oversight council the number and percent of defendants for whom mental health assessment and mental health treatment is required as a condition of bond, and the number and percent of those with assessment and treatment as a condition of bond who comply with conditions.

Section 14. That the code be amended by adding a NEW SECTION to read:

The Unified Judicial System shall report semiannually to the oversight council the number of persons referred to any mental health court, the number and the percentage admitted to any mental health court, the number and the percentage of those admitted who complete mental health court requirements, and the number and the percentage of persons convicted of a new crime within one to three years of completing mental health court requirements.

Section 15. That the code be amended by adding a NEW SECTION to read:

The Association of County Commissioners, formed pursuant to § 7-7-28, may create and administer a fund for the purpose of assisting counties with the cost of competency evaluations for defendants for whom an evaluation has been ordered by the court. The Department of Social Services may contract with the association to reallocate funds used at the Human Services Center on contractual services for forensic evaluations to be administered through this fund. The fund may also receive and distribute money from any other source. The association board of directors shall provide procedures for the equitable distribution of money from this fund to the counties utilizing court-ordered competency evaluations and provide for the payment of an administrative fee and other reasonable expenses related to the administration of the fund. The association shall report to the oversight council the amount distributed annually in total and by county and the number of competency evaluations completed with funds from the program. The liability of the association related to the administration of this fund shall be limited to the money as is available for such purposes in the fund.

Section 16. That § 23A-10A-3 be amended to read:

23A-10A-3. At any time after the commencement of a prosecution for an offense and prior to the sentencing of the defendant, the defendant or the prosecuting attorney may file a motion for a hearing to determine the mental competency of the defendant. The court shall grant the motion, or shall order such a hearing on its own motion, if there is reasonable cause to believe that the defendant may presently be suffering from a mental disease or developmental disability, or other conditions set forth in § 23A-10A-1, rendering the defendant mentally incompetent to the extent that the defendant is unable to understand the nature and consequences of the proceeding against the defendant or to assist properly in the defendant's defense. Prior to the date of hearing, the court may order that a psychiatric or psychological examination of the defendant be conducted, and that a psychiatric or psychological report be filed with the court, pursuant to the provisions of §§ 23A-46-1 and 23A-46-2. The examination shall be completed within twenty-one days of the court order, unless for good cause the court grants a continuance. The hearing shall be conducted pursuant to the provisions of § 23A-46-3.

Section 17. That chapter 23A-10A be amended by adding a NEW SECTION to read:

The Unified Judicial System shall collect and report to the oversight council the average number of days from court order to the completion of competency examinations, and the number of competency examination continuances for good cause requested and granted.

Section 18. That § 23A-46-1 be amended to read:

23A-46-1. A psychiatric or psychological examination ordered pursuant to this chapter, §§ 23A-10A-3 to 23A-10A-4.2, inclusive, 23A-26-12 to 23A-26-12.6, inclusive, or 23A-27-42 to 23A-27-46, inclusive, shall be conducted by:

(1) A licensed or certified psychiatrist;

(2) A licensed clinical psychologist;

(3) A certified social worker licensed for private independent practice with two years of supervised clinical experience in a mental health setting and with training on how to conduct and score competency evaluations;

(4) A certified nurse practitioner or clinical nurse specialist with current psychiatric certification and with training on how to conduct and score competency evaluations;

(5) A licensed professional counselor-mental health with training on how to conduct and score competency evaluations; or

(6) If the court finds it appropriate, by more than one examiner.

Each examiner shall be designated by the court, except that if the examination is ordered under § 23A-27-43 or 23A-46-9, upon the request of the defendant an additional examiner may be selected by the defendant. For the purposes of an examination pursuant to an order under § 23A-10-4, 23A-10A-3, 23A-26-12.1, 23A-27-43, or 23A-46-9, the court may commit the person to be examined for a reasonable period to the custody of a suitable facility.

Section 19. That the code be amended by adding a NEW SECTION to read:

The licensing board of each professional listed in § 23A-46-1 shall maintain a list of each professional licensed under their authority qualified to conduct competency evaluations. The Department of Social Services shall maintain a list of those evaluators for use by the courts in coordination with Department of Health, as needed.

Section 20. That § 23A-46-2 be amended to read:

23A-46-2. A psychiatric or psychological report ordered pursuant to this chapter, §§ 23A-10A-3 to 23A-10A-4.2, inclusive; 23A-26-12 to 23A-26-12.6, inclusive; or 23A-27-42 to 23A-27-46, inclusive, shall be prepared by the examiner designated to conduct the psychiatric or psychological examination, shall be filed with the court with copies provided to the counsel for the person examined and to the prosecuting attorney and shall include:

(1) The person's history, if applicable, and present symptoms;

(2) A description of the psychiatric, psychological, and medical tests that were employed and their results;

(3) The examiner's findings; and

(4) The examiner's opinions as to diagnosis, prognosis and:

(a) If the examination is ordered under § 23A-10A-3, whether the person is suffering from a mental disease or defect rendering the person mentally incompetent to the extent that the person is unable to understand the nature and consequences of the proceedings against the person or to assist properly in the person's defense;

(b) If the examination is ordered under § 23A-10-4, whether the person was insane at the time of the offense charged;

(c) If the examination is ordered under § 23A-46-9, whether the person is suffering from a mental disease or defect as a result of which the person's release would create a substantial risk of bodily injury to another person or serious damage to property of another;

(d) If the examination is ordered under § 23A-26-12.1 or 23A-27-43, whether the person is suffering from a mental disease or defect as a result of which the person is in need of custody for care or treatment in a suitable facility; and

(e) If the examination is ordered as a part of a presentence investigation, any recommendation the examiner may have as to how the mental condition of the defendant should affect the sentence.

Section 21. That the code be amended by adding a NEW SECTION to read:

The presiding judge of each judicial circuit may appoint one or more mental health response teams. Each team appointed shall include a court services officer for the jurisdiction where the team

is to operate, a mental health provider, and a member of law enforcement and may also include a representative that works with jail administration and one or more representatives from the public. The Unified Judicial System shall maintain a record of the membership of each team and report nonidentifying data to the oversight council. The team may operate telephonically or through electronic communications.

The records prepared or maintained by the team are confidential. Notwithstanding, the records may be inspected by or disclosed to justices, judges, magistrates, and employees of the Unified Judicial System in the course of their duties or to any person specifically authorized by order of the court.

Section 22. That the code be amended by adding a NEW SECTION to read:

The mental health response team may establish a process for identifying eligible persons through assessment; a documented process for referral to treatment; a team approach to the development and modification of individualized treatment plans and ongoing coordination to ensure plan effectiveness; a process for information sharing among the team members; and planning and coordination, including referrals for nonmental health services and resources.

Section 23. That the code be amended by adding a NEW SECTION to read:

The Unified Judicial System shall collect and report to the oversight council the name of any circuits that establish mental health response teams, the number of persons meeting the mental health response team criteria, and the number and the percentage of persons meeting the criteria who are released from jail pretrial and referred for mental health assessment or treatment.

Section 24. That the code be amended by adding a NEW SECTION to read:

The Supreme Court may establish rules, pursuant to § 16-3-1, regarding formation of a mental health response team and the procedures to be followed by the team.

Section 25. That chapter 23A-40 be amended by adding a NEW SECTION to read:

Each court-appointed defense attorney shall receive training on mental illness, available mental health services, eligibility criteria and referral processes, and forensic evaluations.

Section 26. That the code be amended by adding a NEW SECTION to read:

The Supreme Court may establish rules, pursuant to § 16-3-1, regarding procedures for court-appointed defense attorney training on mental illness.

Section 27. That the code be amended by adding a NEW SECTION to read:

Officers within any state prison shall receive training on recognizing the signs and symptoms of mental health problems and defusing mental health crises. After initial training, each officer shall attend further training at least once every four years.

Section 28. That chapter 24-11 be amended by adding a NEW SECTION to read:

Officers within any jail, as defined in § 24-11-1, shall receive training developed by the Division of Criminal Investigation on recognizing the signs and symptoms of mental health problems and defusing mental health crises. After initial training, each officer shall attend further training at least once every four years.

Section 29. That § 16-22-15 be amended to read:

16-22-15. Any person who exercises supervision over a probationer pursuant to § 23A-27-12.1 or provides intervention services to any probationer shall receive sufficient training on evidence-based practices, how to target criminal risk factors to reduce recidivism, recognizing the signs and symptoms of mental health problems, and defusing mental health crises.

Section 30. That § 16-14-4 be amended to read:

16-14-4. The Chief Justice of the Supreme Court of South Dakota shall annually summon all the members of the Judicial Conference to attend a conference at such time and place in the state as the Chief Justice may designate and at which the Chief Justice, or such member as the Chief Justice may designate, shall preside. Special sessions of the conference may be called by the Chief Justice

at the times and places as the Chief Justice may designate. All persons so summoned shall attend the annual and special meetings.

Each magistrate and circuit judge shall complete training on evidence-based practices, including the use of validated risk and needs assessments and behavioral health assessments in decision making, mental illness, eligibility criteria for mental health services, and availability of mental health services. The form and length of this training requirement shall be determined by the Chief Justice. As used in this section, the term, behavioral health assessment, means an evaluation to determine the extent of an individual's substance abuse or mental health service needs.

Section 31. That the code be amended by adding a NEW SECTION to read:

The Department of Social Services shall annually compile a list of services available through the community mental health system and eligibility criteria for each service to distribute to judges, court services officers, and jails. The department shall coordinate with the Unified Judicial System and sheriffs to disseminate this information.

Section 32. That § 16-22-24 be amended to read:

16-22-24. Treatment and intervention programs, as used in this section, mean substance abuse, mental health, or cognitive based treatment received by probationers or parolees.

All treatment and intervention programs for parolees and probationers shall be intended to reduce recidivism as demonstrated by research or documented evidence.

Payment for substance abuse or mental health treatment services may be made only if the services are recommended through an assessment conducted by a provider accredited by the Department of Social Services. Payment for cognitive based treatment services may be made only if the services are recommended through a risk and needs assessment tool used by the Department of Corrections or the Unified Judicial System.

The Department of Social Services shall collect data related to the participation, completion and

treatment outcomes of all probationers and parolees receiving treatment services paid for by the Department of Social Services. The Department of Social Services shall report this information semiannually to the oversight council.

The Department of Corrections shall collect data on the recidivism outcomes of parolees receiving treatment and interventions. The Department of Corrections shall report this information semiannually to the oversight council.

The Unified Judicial System shall collect data on the recidivism outcomes of probationers receiving treatment and interventions, the number and the percentage of probationers referred for mental health assessment, the number and the percentage of probationers referred for mental health treatment, and the annual cost of probationer mental health assessments and treatment both in total and separated by funding source. The Unified Judicial System shall report this information semiannually to the oversight body established pursuant to § 16-22-21.

Section 33. That the code be amended by adding a NEW SECTION to read:

There is hereby established an oversight council responsible for monitoring and reporting performance and outcome measures related to the provisions set forth in this Act. The Unified Judicial System shall provide staff support for the council.

Section 34. That the code be amended by adding a NEW SECTION to read:

The oversight council shall be composed of fourteen members. The Governor shall appoint the following four members: a member from the Department of Social Services; a member from law enforcement; a member from a mental health provider; and one at-large member. The Chief Justice shall appoint the following four members: a member who is a criminal defense attorney; a member who is a judge; one member who is a county commissioner; and one at-large member. The majority leader of the Senate shall appoint two senators, one from each political party. The majority leader of the House of Representatives shall appoint two representatives, one from each political party. The

attorney general shall appoint two members, one of whom shall be a state's attorney.

Section 35. That the code be amended by adding a NEW SECTION to read:

The oversight council shall meet within ninety days after appointment and shall meet at least semiannually thereafter. The oversight council terminates five years after its first meeting, unless the Legislature, by Joint Resolution, continues the oversight council for a specified period of time.

The oversight council has the following powers and duties:

(1) Review the recommendations of the task force on community justice and mental illness early intervention from the final report dated November 2016 and track implementation and evaluate compliance with this Act;

(2) Review data and reporting required by this Act;

(3) Review compliance with the training required by this Act;

(4) Calculate costs averted by the provisions in this Act;

(5) Establish a statewide crisis intervention training review team. The review team shall analyze and make recommendations to the oversight council on the ongoing need for a crisis intervention training coordinator to provide training and technical assistance to cities, counties, or regions across the state; build local capacity for crisis intervention; and expand the number of crisis intervention trained law enforcement officers. The crisis intervention training review team shall collect and report semiannually to the oversight council data on the number of requests for assistance from the crisis intervention training coordinator, the names of the agencies submitting the requests for assistance, the number of requests granted, the number of law enforcement officers trained, and training adherence to the Memphis crisis intervention team model or other evidence-based model. The crisis intervention review team shall, upon completion of the first year of the crisis intervention training coordinator funding, make a recommendation to the oversight

council as to the continued funding of the crisis intervention training coordinator. The review team shall terminate upon the recommendation of the oversight council;

(6) Review the recommendations of the crisis intervention team training review team;

(7) Review the crisis response grants distributed pursuant to section 7 of this Act;

(8) Review the Division of Criminal Investigation's development of training on mental illness;

(9) Evaluate the need for and feasibility of a statewide crisis call center or regional call centers for persons in crisis;

(10) Track progress and make recommendations to improve the implementation of mental health screenings in jails pursuant to sections 2, 3, 4, and 5 of this Act;

(11) Establish a work group to make recommendations to the council to create a process for the completion of a mental health assessment following a jail mental health screening. The work group shall estimate the cost of assessments needed following screening at the time of jail intake, using data from the jail mental health screening pilot program; examine payment options including cost-sharing between state and counties; determine improvements to information sharing between jails and mental health providers; and consider whether an individual with a screening indicating the need for assessment has a pre-existing relationship with a mental health provider;

(12) Review the payments to counties for mental competency examinations and reports pursuant to section 15 of this Act;

(13) Evaluate the need for and feasibility of forensic assertive community treatment teams;

(14) Establish a work group that includes representatives from sheriffs, jail administrators, jail mental health staff providers, and community mental health providers to make recommendations to the council to improve information sharing among jails and mental

health providers and improve coordination among jails and mental health providers to refer persons released from jail to mental health services;

(15) Monitor the competency evaluation funding program;

(16) Study and make recommendations to improve the recruitment and retention of mental health professionals;

(17) Study and make recommendations to expand access to mental health services for criminal justice populations;

(18) Evaluate the need for and feasibility and cost effectiveness of telehealth options for jail mental health assessments, consultations for law enforcement officers who encounter persons in crisis, crisis response during law enforcement encounters with persons in crisis, mental health services for persons on probation, and mental health services for persons in jail;

(19) Make recommendations to the Governor and Legislature regarding pilot programs for needed and feasible telehealth options to provide mental health services to persons with mental illness in the criminal justice system; and

(20) Prepare and submit an annual summary report of the performance and outcome measures that are part of this Act to the Legislature, Governor, and Chief Justice. The report shall include recommendations for improvements and a summary of savings generated from this Act.

Section 36. There is hereby appropriated the sum of six hundred fifty-five thousand three hundred forty-three dollars ($655,343) in other fund expenditure authority, or so much thereof as may be necessary, to the Unified Judicial System for expenditures from the court automation fund for the purpose of mental health awareness and implementation.

Section 37. The Chief Justice of the Supreme Court shall approve vouchers and the state auditor

shall draw warrants to pay expenditures authorized by this Act.

Section 38. Any amounts appropriated in this Act not lawfully expended or obligated shall revert in accordance with the procedures prescribed in chapter 4-8.

Section 39. Sections 4, 5, 6, 14, 25, 26, and 28 of this Act are effective on July 1, 2018. The remaining sections of this Act, except sections 33 to 38, inclusive, are effective on July 1, 2017.

Section 40. Whereas, this Act is necessary for the support of the state government and its existing public institutions, an emergency is hereby declared to exist, and sections 33 to 38, inclusive, of this Act shall be in full force and effect from and after its passage and approval.

An Act to provide and revise certain provisions regarding mental health procedures in criminal justice, to make an appropriation therefor, and to declare an emergency.

==========

I certify that the attached Act originated in the

HOUSE as Bill No. 1183

_____
Chief Clerk

==========

_____
Speaker of the House

Attest:

_____
Chief Clerk

_____
President of the Senate

Attest:

_____
Secretary of the Senate

House Bill No. 1183
File No. ____
Chapter No. _____

==========

Received at this Executive Office this _____ day of _____ ,

20____ at _____ M.

By _____
for the Governor

==========

The attached Act is hereby approved this _____ day of _____ , A.D., 20___

_____
Governor

==========

STATE OF SOUTH DAKOTA,
ss.
Office of the Secretary of State

Filed _____ , 20___
at _____ o'clock __ M.

_____
Secretary of State

By _____
Asst. Secretary of State

Appendix 9

State of South Dakota

NINETY-SECOND SESSION
LEGISLATIVE ASSEMBLY, 2017

492Y0595

SENATE ENGROSSED NO. HB 1183 - 3/1/2017

Introduced by: Representatives Johns, Beal, Brunner, Chase, Glanzer, Haggar, Haugaard, Jensen (Kevin), Johnson, Lake, Lust, McPherson, Mickelson, Peterson (Kent), Qualm, Rhoden, Rounds, Rozum, Soli, Stevens, Tieszen, and Zikmund and Senators Solano and Rusch

FOR AN ACT ENTITLED, An Act to provide and revise certain provisions regarding mental health procedures in criminal justice, to make an appropriation therefor, and to declare an emergency.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF SOUTH DAKOTA:

Section 1. That the code be amended by adding a NEW SECTION to read:

Terms used in this Act mean:

(1) "Mental health response team," a support team tasked with finding viable community resources to help persons with severe mental illness involved in the court system;

(2) "Mental health screening tool," a brief, routine process using a standardized instrument that has been validated with offender populations to identify indicators of mental health issues that is used to determine a need for further mental health assessment or evaluation;

(3) "Oversight council," the council established by section 33 of this Act;

(4) "Performance measure," a metric that captures performance on critical variables

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central to accomplishing the mission and goals within this Act;

(5) "Psychiatric certification," a credential obtained by passing the psychiatric-mental health nursing board certification through the American Nurses Credentialing Center;

(6) "Telehealth," a mode of delivering healthcare services that utilizes information and communication technologies to enable the diagnosis, consultation, treatment, education, care management, and self-management of patients at a distance from health care providers.

Section 2. That the code be amended by adding a NEW SECTION to read:

The South Dakota Sheriffs' Association shall develop a jail mental health screening pilot program and convene at least four jail administrators and at least two mental health providers to select a mental health screening tool for the pilot program. The pilot program shall include at least four jails. The jails in the pilot program shall utilize a mental health screening tool the during the jail intake process and shall collect and report data to the oversight council on the number of persons screened and the number of persons screening positive for signs and symptoms of acute psychiatric disturbance and disorder.

Section 3. That the code be amended by adding a NEW SECTION to read:

The South Dakota Sheriffs' Association shall coordinate training for jails to administer the jail mental health screening tool.

Section 4. That the code be amended by adding a NEW SECTION to read:

The South Dakota Sheriffs' Association shall coordinate with the jails in the jail mental health screening pilot program to develop a process to implement a mental health screening tool statewide.

Section 5. That chapter 24-11 be amended by adding a NEW SECTION to read:

Each jail shall report annually to the oversight council on the number and percentage of

persons screened at intake using a mental health screening tool and the number and percentage of positive screenings.

Section 6. That chapter 24-11 be amended by adding a NEW SECTION to read:

Any jail using a mental health screening tool shall provide the screening results to the circuit committing magistrate or court.

Section 7. That the code be amended by adding a NEW SECTION to read:

The Department of Social Services shall create a crisis services grant program to any municipality, county, or groups of counties for the purposes of encouraging the establishment of new crisis response services or the expansion of existing crisis response services. The grant program shall be in existence until the grant program funding is exhausted. The department shall collect data on the number of applications for the grant program, the number and percentage of applications accepted, the amount awarded to each grantee, and the location, purpose, and population served by the crisis response services. The department shall report this information semiannually to the oversight council until the program ends.

Section 8. That § 23-3-39.6 be amended to read:

23-3-39.6. ~~Any~~ Each state's attorney or deputy state's attorney shall ~~attend~~ receive training on evidence-based practices, as defined in subdivision 16-22-1(7); mental health and available mental health services; and the following issues pertaining to domestic abuse: enforcement of criminal laws in domestic abuse situations; availability of community resources; and protection of the victim. After initial training, each state's attorney or deputy state's attorney shall attend further training at least once every four years.

Section 9. That § 23A-43-3 be amended to read:

23A-43-3. ~~When~~ If a determination is made that a release pursuant to § 23A-43-2 will not reasonably assure the appearance of the defendant as required, the committing magistrate or

court shall, either in lieu of or in addition to the methods of release described in § 23A-43-2, impose the first of the following conditions of release which will reasonably assure the appearance of the defendant for trial or, if no single condition gives that assurance, any combination of the following conditions:

(1) Place the defendant in the custody of a designated person or organization agreeing to supervise him;

(2) Place restrictions on the travel, association, or place of abode of the defendant during the period of release;

(3) Require the defendant to complete a mental health assessment by a specified date and follow any treatment recommendations. The court shall consider available funding sources before imposing this condition of release;

(4) Require an appearance bond in a specified amount. The bond shall be executed by depositing with the clerk of the court, in cash or other security, as directed, a sum not to exceed ten percent of the amount of the bond. The deposit shall be returned upon the performance of the conditions of release;

~~(4)~~(5) Require the execution of a bail bond with sufficient solvent sureties, or the deposit of cash in lieu of a bail bond; or

~~(5)~~(6) Impose any other condition reasonably necessary to assure the defendant's appearance as required, including a condition requiring that the defendant return to custody after specified hours.

Section 10. That chapter 23A-43 be amended by adding a NEW SECTION to read:

If a court has imposed conditions of release that require a defendant to follow any treatment recommendations pursuant to subdivision 23A-43-3(3), the provider of those treatment services shall report any noncompliance to the court that has imposed the condition of release.

Section 11. That the code be amended by adding a NEW SECTION to read:

The Supreme Court may establish rules, pursuant to § 16-3-1, regarding the definition of noncompliance in section 10 of this Act and how noncompliance may be reported to the court.

Section 12. That § 23A-43-4 be amended to read:

23A-43-4. In determining which conditions of release will reasonably assure appearance, a committing magistrate or court shall, on the basis of available information, take into account the nature and circumstances of the offense charged, the weight of the evidence against the defendant, the defendant's family ties, employment, financial resources, character and mental condition, the results of any mental health assessment, the length of ~~his~~ the defendant's residence in the community, ~~his~~ the defendant's record of convictions, ~~his~~ the defendant's record of appearance at court proceedings or of flight to avoid prosecution or failure to appear at court proceedings, and the risk that ~~he~~ the defendant will flee or pose a danger to any person or to the community.

Section 13. That the code be amended by adding a NEW SECTION to read:

The Unified Judicial System shall collect and report to the oversight council the number and percent of defendants for whom mental health assessment and mental health treatment is required as a condition of bond, and the number and percent of those with assessment and treatment as a condition of bond who comply with conditions.

Section 14. That the code be amended by adding a NEW SECTION to read:

The Unified Judicial System shall report semiannually to the oversight council the number of persons referred to any mental health court, the number and the percentage admitted to any mental health court, the number and the percentage of those admitted who complete mental health court requirements, and the number and the percentage of persons convicted of a new crime within one to three years of completing mental health court requirements.

Section 15. That the code be amended by adding a NEW SECTION to read:

The Association of County Commissioners, formed pursuant to § 7-7-28, may create and administer a fund for the purpose of assisting counties with the cost of competency evaluations for defendants for whom an evaluation has been ordered by the court. The Department of Social Services may contract with the association to reallocate funds used at the Human Services Center on contractual services for forensic evaluations to be administered through this fund. The fund may also receive and distribute money from any other source. The association board of directors shall provide procedures for the equitable distribution of money from this fund to the counties utilizing court-ordered competency evaluations and provide for the payment of an administrative fee and other reasonable expenses related to the administration of the fund. The association shall report to the oversight council the amount distributed annually in total and by county and the number of competency evaluations completed with funds from the program. The liability of the association related to the administration of this fund shall be limited to the money as is available for such purposes in the fund.

Section 16. That § 23A-10A-3 be amended to read:

23A-10A-3. At any time after the commencement of a prosecution for an offense and prior to the sentencing of the defendant, the defendant or the prosecuting attorney may file a motion for a hearing to determine the mental competency of the defendant. The court shall grant the motion, or shall order such a hearing on its own motion, if there is reasonable cause to believe that the defendant may presently be suffering from a mental disease or developmental disability, or other conditions set forth in § 23A-10A-1, rendering ~~him~~ the defendant mentally incompetent to the extent that ~~he~~ the defendant is unable to understand the nature and consequences of the proceeding against ~~him~~ the defendant or to assist properly in ~~his~~ the defendant's defense. Prior to the date of hearing, the court may order that a psychiatric or psychological examination of the

defendant be conducted, and that a psychiatric or psychological report be filed with the court, pursuant to the provisions of §§ 23A-46-1 and 23A-46-2. The examination shall be completed within twenty-one days of the court order, unless for good cause the court grants a continuance. The hearing shall be conducted pursuant to the provisions of § 23A-46-3.

Section 17. That chapter 23A-10A be amended by adding a NEW SECTION to read:

The Unified Judicial System shall collect and report to the oversight council the average number of days from court order to the completion of competency examinations, and the number of competency examination continuances for good cause requested and granted.

Section 18. That § 23A-46-1 be amended to read:

23A-46-1. A psychiatric or psychological examination ordered pursuant to this chapter, §§ 23A-10A-3 to 23A-10A-4.2, inclusive, 23A-26-12 to 23A-26-12.6, inclusive, or 23A-27-42 to 23A-27-46, inclusive, shall be conducted by ~~a~~:

(1) A licensed or certified psychiatrist ~~or~~;

(2) A licensed clinical psychologist~~, or, if~~;

(3) A certified social worker licensed for private independent practice with two years of supervised clinical experience in a mental health setting and with training on how to conduct and score competency evaluations;

(4) A certified nurse practitioner or clinical nurse specialist with current psychiatric certification and with training on how to conduct and score competency evaluations;

(5) A licensed professional counselor-mental health with training on how to conduct and score competency evaluations; or

(6) If the court finds it appropriate, by more than one ~~such~~ examiner.

Each examiner shall be designated by the court, except that if the examination is ordered under § 23A-27-43 or 23A-46-9, upon the request of the defendant an additional examiner may

be selected by the defendant. For the purposes of an examination pursuant to an order under § 23A-10-4, 23A-10A-3, 23A-26-12.1, 23A-27-43, or 23A-46-9, the court may commit the person to be examined for a reasonable period to the custody of a suitable facility.

Section 19. That the code be amended by adding a NEW SECTION to read:

The licensing board of each professional listed in § 23A-46-1 shall maintain a list of each professional licensed under their authority qualified to conduct competency evaluations. The Department of Social Services shall maintain a list of those evaluators for use by the courts in coordination with Department of Health, as needed.

Section 20. That § 23A-46-2 be amended to read:

23A-46-2. A psychiatric or psychological report ordered pursuant to this chapter, §§ 23A-10A-3 to 23A-10A-4.2, inclusive; 23A-26-12 to 23A-26-12.6, inclusive; or 23A-27-42 to 23A-27-46, inclusive, shall be prepared by the examiner designated to conduct the psychiatric or psychological examination, shall be filed with the court with copies provided to the counsel for the person examined and to the prosecuting attorney and shall include:

(1) The person's history, if applicable, and present symptoms;

(2) A description of the psychiatric, psychological, and medical tests that were employed and their results;

(3) The examiner's findings; and

(4) The examiner's opinions as to diagnosis, prognosis and:

(a) If the examination is ordered under § 23A-10A-3, whether the person is suffering from a mental disease or defect rendering ~~him~~ the person mentally incompetent to the extent that ~~he~~ the person is unable to understand the nature and consequences of the proceedings against ~~him~~ the person or to assist properly in ~~his~~ the person's defense;

(b) If the examination is ordered under § 23A-10-4, whether the person was insane at the time of the offense charged;

(c) If the examination is ordered under § 23A-46-9, whether the person is suffering from a mental disease or defect as a result of which ~~his~~ the person's release would create a substantial risk of bodily injury to another person or serious damage to property of another;

(d) If the examination is ordered under § 23A-26-12.1 or 23A-27-43, whether the person is suffering from a mental disease or defect as a result of which ~~he~~ the person is in need of custody for care or treatment in a suitable facility; and

(e) If the examination is ordered as a part of a presentence investigation, any recommendation the examiner may have as to how the mental condition of the defendant should affect the sentence.

Section 21. That the code be amended by adding a NEW SECTION to read:

The presiding judge of each judicial circuit may appoint one or more mental health response teams. Each team appointed shall include a court services officer for the jurisdiction where the team is to operate, a mental health provider, and a member of law enforcement and may also include a representative that works with jail administration and one or more representatives from the public. The Unified Judicial System shall maintain a record of the membership of each team and report nonidentifying data to the oversight council. The team may operate telephonically or through electronic communications.

The records prepared or maintained by the team are confidential. Notwithstanding, the records may be inspected by or disclosed to justices, judges, magistrates, and employees of the Unified Judicial System in the course of their duties or to any person specifically authorized by order of the court.

Section 22. That the code be amended by adding a NEW SECTION to read:

The mental health response team may establish a process for identifying eligible persons through assessment; a documented process for referral to treatment; a team approach to the development and modification of individualized treatment plans and ongoing coordination to ensure plan effectiveness; a process for information sharing among the team members; and planning and coordination, including referrals for nonmental health services and resources.

Section 23. That the code be amended by adding a NEW SECTION to read:

The Unified Judicial System shall collect and report to the oversight council the name of any circuits that establish mental health response teams, the number of persons meeting the mental health response team criteria, and the number and the percentage of persons meeting the criteria who are released from jail pretrial and referred for mental health assessment or treatment.

Section 24. That the code be amended by adding a NEW SECTION to read:

The Supreme Court may establish rules, pursuant to § 16-3-1, regarding formation of a mental health response team and the procedures to be followed by the team.

Section 25. That chapter 23A-40 be amended by adding a NEW SECTION to read:

Each court-appointed defense attorney shall receive training on mental illness, available mental health services, eligibility criteria and referral processes, and forensic evaluations.

Section 26. That the code be amended by adding a NEW SECTION to read:

The Supreme Court may establish rules, pursuant to § 16-3-1, regarding procedures for court-appointed defense attorney training on mental illness.

Section 27. That the code be amended by adding a NEW SECTION to read:

Officers within any state prison shall receive training on recognizing the signs and symptoms of mental health problems and defusing mental health crises. After initial training, each officer shall attend further training at least once every four years.

Section 28. That chapter 24-11 be amended by adding a NEW SECTION to read:

Officers within any jail, as defined in § 24-11-1, shall receive training developed by the Division of Criminal Investigation on recognizing the signs and symptoms of mental health problems and defusing mental health crises. After initial training, each officer shall attend further training at least once every four years.

Section 29. That § 16-22-15 be amended to read:

16-22-15. Any person who exercises supervision over a probationer pursuant to § 23A-27-12.1 or provides intervention services to any probationer shall receive sufficient training on evidence-based practices ~~and on~~, how to target criminal risk factors to reduce recidivism, recognizing the signs and symptoms of mental health problems, and defusing mental health crises.

Section 30. That § 16-14-4 be amended to read:

16-14-4. The Chief Justice of the Supreme Court of South Dakota shall annually summon all the members of the Judicial Conference to attend a conference at such time and place in the state as the Chief Justice may designate and at which the Chief Justice, or such member as the Chief Justice may designate, shall preside. Special sessions of the conference may be called by the Chief Justice at ~~such~~ the times and places as the Chief Justice may designate. All persons so summoned shall attend ~~such~~ the annual and special meetings.

Each magistrate and circuit judge shall complete training on evidence-based practices, including the use of validated risk and needs assessments and behavioral health assessments in decision making, mental illness, eligibility criteria for mental health services, and availability of mental health services. The form and length of this training requirement shall be determined by the Chief Justice. As used in this section, the term, behavioral health assessment, means an evaluation to determine the extent of an individual's substance abuse or mental health service

needs.

Section 31. That the code be amended by adding a NEW SECTION to read:

The Department of Social Services shall annually compile a list of services available through the community mental health system and eligibility criteria for each service to distribute to judges, court services officers, and jails. The department shall coordinate with the Unified Judicial System and sheriffs to disseminate this information.

Section 32. That § 16-22-24 be amended to read:

16-22-24. Treatment and intervention programs, as used in this section, mean substance abuse, mental health, or cognitive based treatment received by probationers or parolees.

All treatment and intervention programs for parolees and probationers shall be intended to reduce recidivism as demonstrated by research or documented evidence.

Payment for substance abuse or mental health treatment services may be made only if ~~such~~ the services are recommended through an assessment conducted by a provider accredited by the Department of Social Services. Payment for cognitive based treatment services may be made only if ~~such~~ the services are recommended through a risk and needs assessment tool used by the Department of Corrections or the Unified Judicial System.

The Department of Social Services shall collect data related to the participation, completion and treatment outcomes of all probationers and parolees receiving treatment services paid for by the Department of Social Services. The Department of Social Services shall report this information semiannually to the oversight council.

The Department of Corrections shall collect data on the recidivism outcomes of parolees receiving treatment and interventions. The Department of Corrections shall report this information semiannually to the oversight council.

The Unified Judicial System shall collect data on the recidivism outcomes of probationers

receiving treatment and interventions, the number and the percentage of probationers referred for mental health assessment, the number and the percentage of probationers referred for mental health treatment, and the annual cost of probationer mental health assessments and treatment both in total and separated by funding source. The Unified Judicial System shall report this information semiannually to the oversight body established pursuant to § 16-22-21.

Section 33. That the code be amended by adding a NEW SECTION to read:

There is hereby established an oversight council responsible for monitoring and reporting performance and outcome measures related to the provisions set forth in this Act. The Unified Judicial System shall provide staff support for the council.

Section 34. That the code be amended by adding a NEW SECTION to read:

The oversight council shall be composed of fourteen members. The Governor shall appoint the following four members: a member from the Department of Social Services; a member from law enforcement; a member from a mental health provider; and one at-large member. The Chief Justice shall appoint the following four members: a member who is a criminal defense attorney; a member who is a judge; one member who is a county commissioner; and one at-large member. The majority leader of the Senate shall appoint two senators, one from each political party. The majority leader of the House of Representatives shall appoint two representatives, one from each political party. The attorney general shall appoint two members, one of whom shall be a state's attorney.

Section 35. That the code be amended by adding a NEW SECTION to read:

The oversight council shall meet within ninety days after appointment and shall meet at least semiannually thereafter. The oversight council terminates five years after its first meeting, unless the Legislature, by Joint Resolution, continues the oversight council for a specified period of time.

The oversight council has the following powers and duties:

(1) Review the recommendations of the task force on community justice and mental illness early intervention from the final report dated November 2016 and track implementation and evaluate compliance with this Act;

(2) Review data and reporting required by this Act;

(3) Review compliance with the training required by this Act;

(4) Calculate costs averted by the provisions in this Act;

(5) Establish a statewide crisis intervention training review team. The review team shall analyze and make recommendations to the oversight council on the ongoing need for a crisis intervention training coordinator to provide training and technical assistance to cities, counties, or regions across the state; build local capacity for crisis intervention; and expand the number of crisis intervention trained law enforcement officers. The crisis intervention training review team shall collect and report semiannually to the oversight council data on the number of requests for assistance from the crisis intervention training coordinator, the names of the agencies submitting the requests for assistance, the number of requests granted, the number of law enforcement officers trained, and training adherence to the Memphis crisis intervention team model or other evidence-based model. The crisis intervention review team shall, upon completion of the first year of the crisis intervention training coordinator funding, make a recommendation to the oversight council as to the continued funding of the crisis intervention training coordinator. The review team shall terminate upon the recommendation of the oversight council;

(6) Review the recommendations of the crisis intervention team training review team;

(7) Review the crisis response grants distributed pursuant to section 7 of this Act;

(8) Review the Division of Criminal Investigation's development of training on mental illness;

(9) Evaluate the need for and feasibility of a statewide crisis call center or regional call centers for persons in crisis;

(10) Track progress and make recommendations to improve the implementation of mental health screenings in jails pursuant to sections 2, 3, 4, and 5 of this Act;

(11) Establish a work group to make recommendations to the council to create a process for the completion of a mental health assessment following a jail mental health screening. The work group shall estimate the cost of assessments needed following screening at the time of jail intake, using data from the jail mental health screening pilot program; examine payment options including cost-sharing between state and counties; determine improvements to information sharing between jails and mental health providers; and consider whether an individual with a screening indicating the need for assessment has a pre-existing relationship with a mental health provider;

(12) Review the payments to counties for mental competency examinations and reports pursuant to section 15 of this Act;

(13) Evaluate the need for and feasibility of forensic assertive community treatment teams;

(14) Establish a work group that includes representatives from sheriffs, jail administrators, jail mental health staff providers, and community mental health providers to make recommendations to the council to improve information sharing among jails and mental health providers and improve coordination among jails and mental health providers to refer persons released from jail to mental health services;

(15) Monitor the competency evaluation funding program;

(16) Study and make recommendations to improve the recruitment and retention of mental health professionals;

(17) Study and make recommendations to expand access to mental health services for criminal justice populations;

(18) Evaluate the need for and feasibility and cost effectiveness of telehealth options for jail mental health assessments, consultations for law enforcement officers who encounter persons in crisis, crisis response during law enforcement encounters with persons in crisis, mental health services for persons on probation, and mental health services for persons in jail;

(19) Make recommendations to the Governor and Legislature regarding pilot programs for needed and feasible telehealth options to provide mental health services to persons with mental illness in the criminal justice system; and

(20) Prepare and submit an annual summary report of the performance and outcome measures that are part of this Act to the Legislature, Governor, and Chief Justice. The report shall include recommendations for improvements and a summary of savings generated from this Act.

Section 36. There is hereby appropriated the sum of six hundred fifty-five thousand three hundred forty-three dollars ($655,343) in other fund expenditure authority, or so much thereof as may be necessary, to the Unified Judicial System for expenditures from the court automation fund for the purpose of mental health awareness and implementation.

Section 37. The Chief Justice of the Supreme Court shall approve vouchers and the state auditor shall draw warrants to pay expenditures authorized by this Act.

Section 38. Any amounts appropriated in this Act not lawfully expended or obligated shall revert in accordance with the procedures prescribed in chapter 4-8.

Section 39. Sections 4, 5, 6, 14, 25, 26, and 28 of this Act are effective on July 1, 2018. The remaining sections of this Act, except sections 33 to 38, inclusive, are effective on July 1, 2017.

Section 40. Whereas, this Act is necessary for the support of the state government and its existing public institutions, an emergency is hereby declared to exist, and sections 33 to 38, inclusive, of this Act shall be in full force and effect from and after its passage and approval.

Appendix 10

Oversight Council for Improving Criminal Justice Reponses for Persons with Mental Illness

Greg Sattizahn
State Court Administrator
July 18, 2017

Community Justice and Mental Illness Early Intervention: Task Force Primer

Task Force Goals

- To improve public safety and the treatment of people with mental illness, who come in contact with the criminal justice system.
- To more effectively identify mental illness in people coming into contact with the criminal justice system, while holding offenders and government more accountable.
- To better allocate limited local resources in order to improve early intervention services and preserve limited jail and prison resources for violent, chronic, and career criminals.

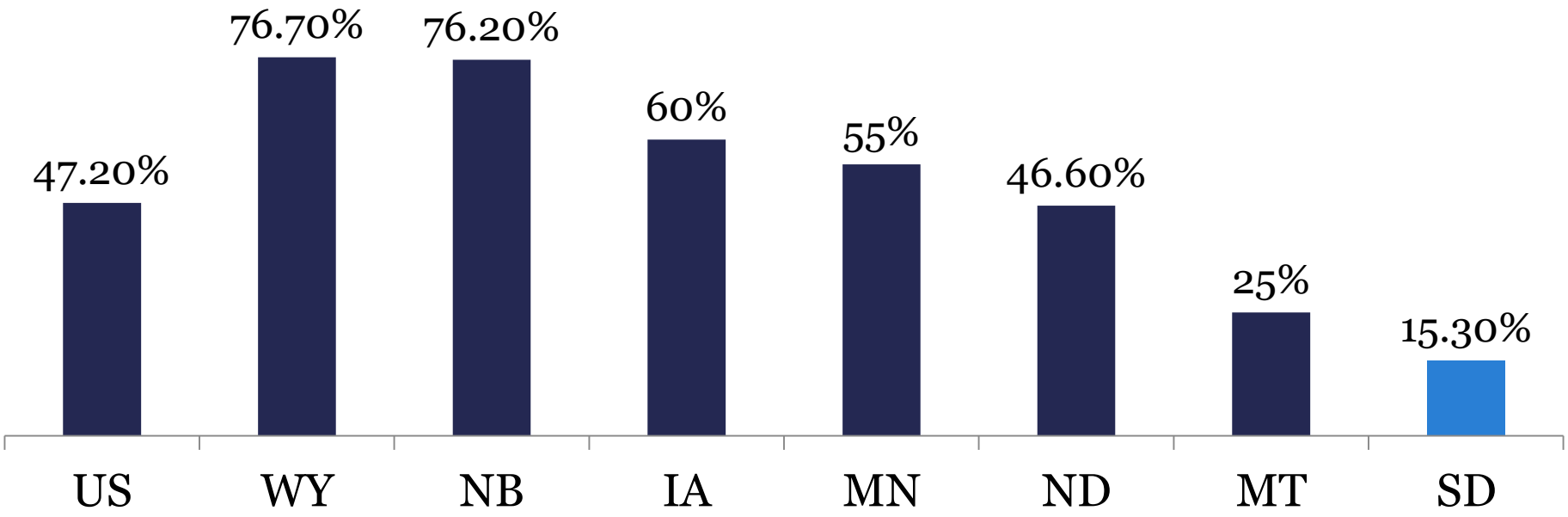
Task Force Membership

Chief Justice David Gilbertson (Chair)
South Dakota Supreme Court, Unified Judicial System
Jim Seward (Vice-chair)
General Counsel, Office of the Governor
Denny Kaemingk
Secretary, Department of Corrections
Lynne Valenti
Secretary, Department of Social Services
Dr. Clay Pavlis
Psychiatrist and Medical Director, Midwest Wellness Institute
Hon. Craig Pfeifle
Presiding Judge of the Seventh Judicial Circuit
Kevin Thom
Sheriff, Pennington County
Cindy Heiberger
County Commissioner, Minnehaha County
Hon. Larry Long
Presiding Judge of the Second Judicial Circuit
Aaron McGowan
State's Attorney, Minnehaha County
Michael Gibbs
CEO, Rapid City Regional Hospital
Mike Miller
Attorney, Minnehaha Public Defender's Office
Steve Emery
Secretary, Department of Tribal Relations
Wendy Giebink
Executive Director, NAMI South Dakota
Sen. Alan Solano
Senator, District 32
Rep. Timothy Johns
Representative, District 31
Greg Sattizahn
State Court Administrator, Unified Judicial System
Scott Peters
Attorney; Chair, Minnehaha-Lincoln Cnty Bd of Mental Illness
Tim Neyhart
Executive Director, South Dakota Advocacy Services
Sarah Petersen
Welfare Director, Codington County
Belinda Nelson
Director, Community Counseling Services (Huron)
Mike Milstead
Sheriff, Minnehaha

Data Discoveries

South Dakota only meets 15.3 percent of its need for psychiatrists.

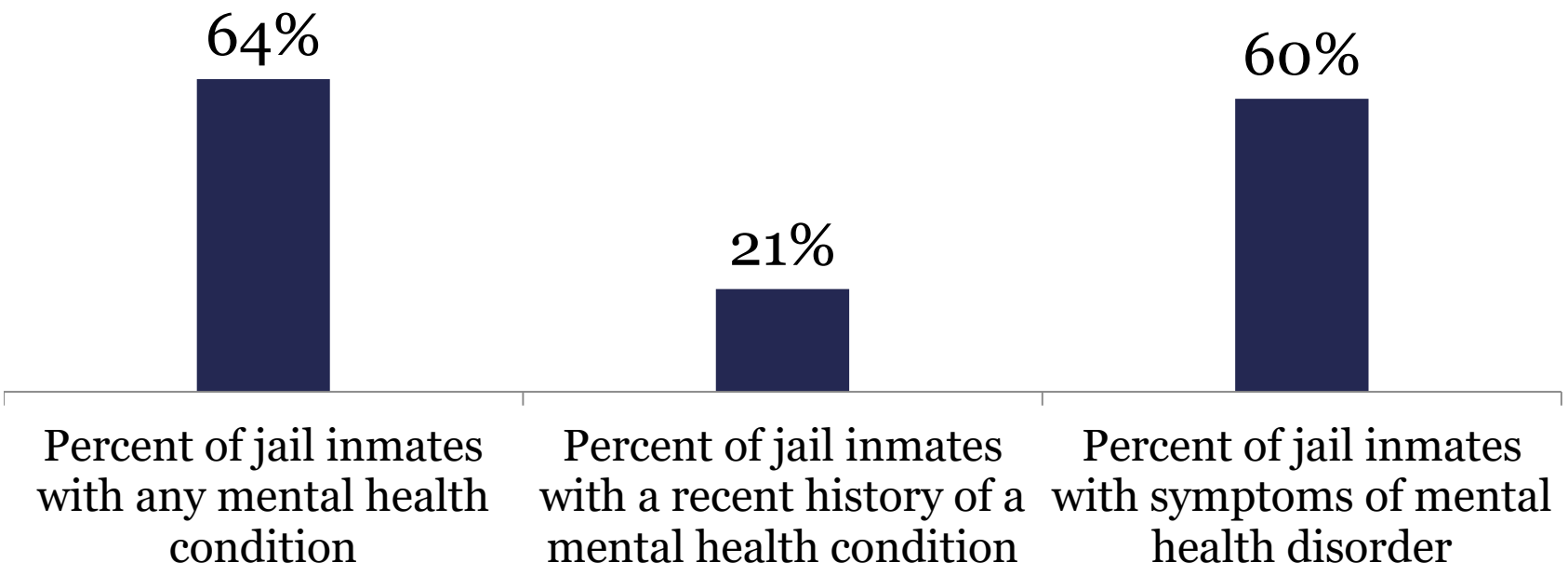
The shortage is based on a 2016 psychiatrist-to-population ratio of 1:30,000.



Source: US Department of Health and Human Services, Health Resources and Services Administration Data Warehouse, access 3/14/16

Data Discoveries

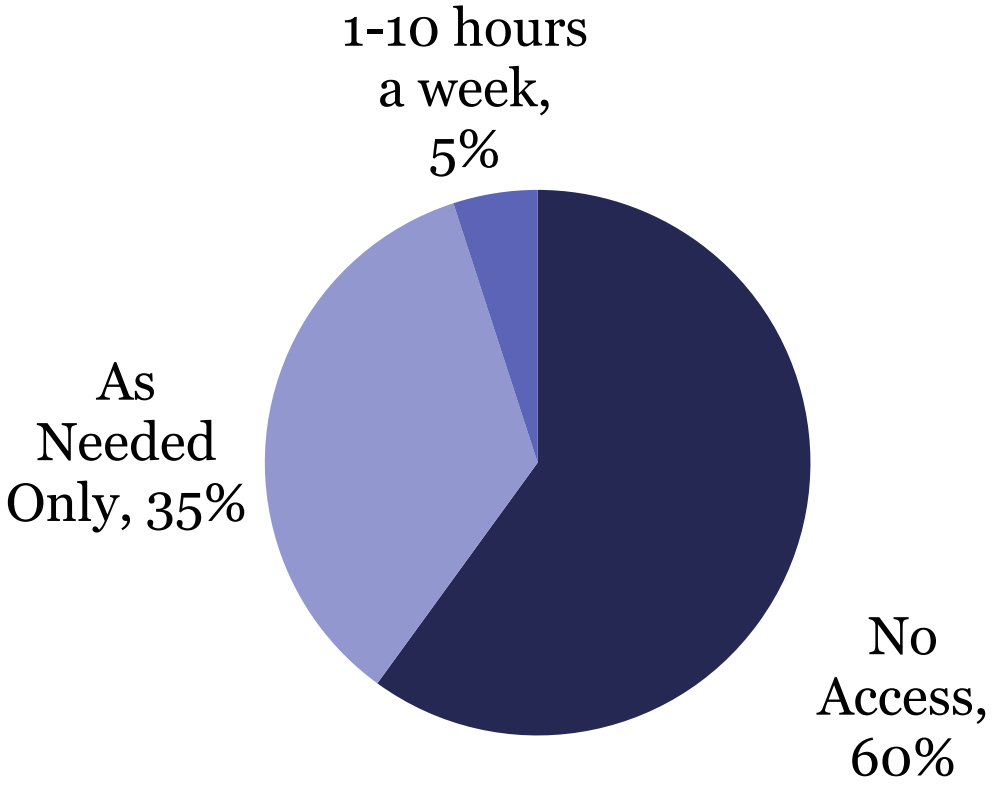
The prevalence of jail inmates with mental health conditions exceeds that of the general population.



Source: Bureau of Justice Statistics, 2006

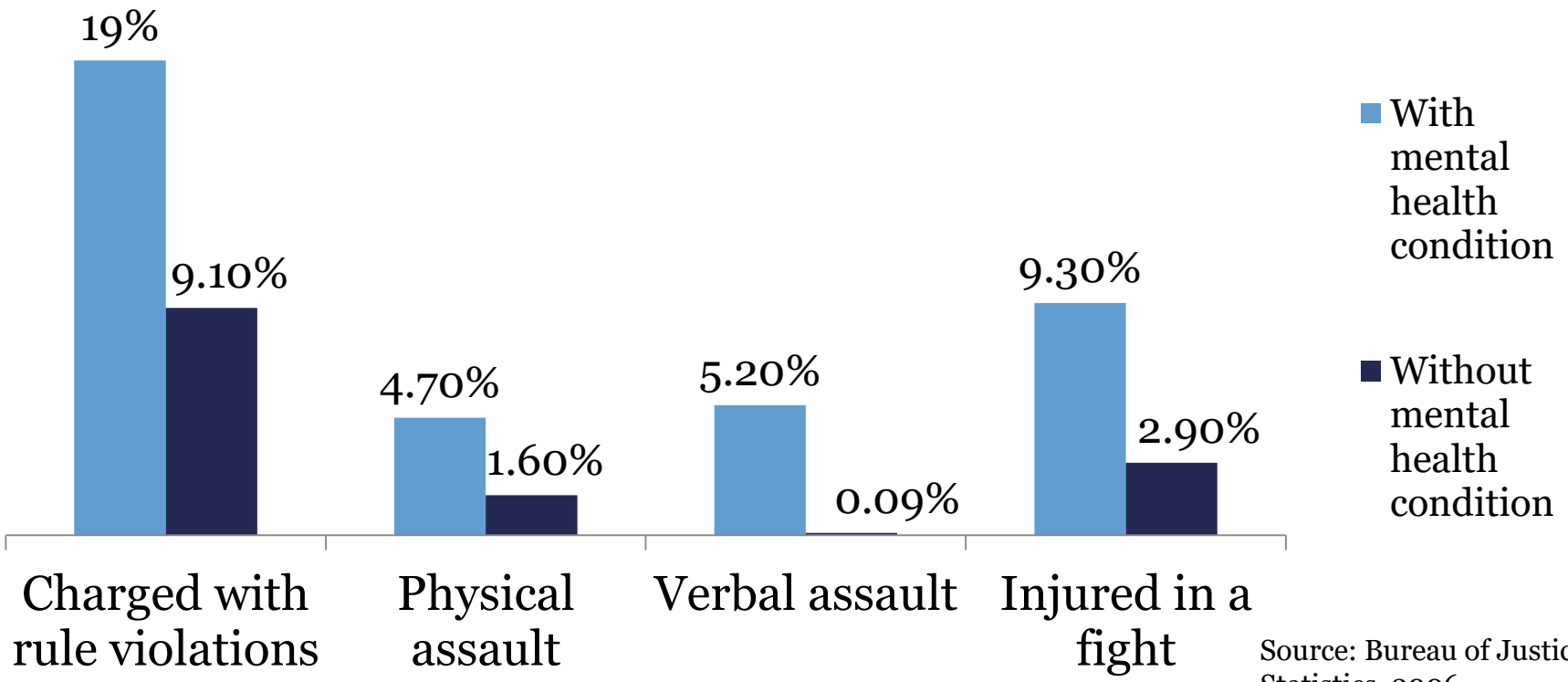
Data Discoveries

60 percent of South Dakota jails have no access to a staff or contracted psychiatrist.



Data Discoveries

Jail inmates with mental health conditions are far more likely to be charged with rule violations, involved in assaults, and injured in a fight.



Source: Bureau of Justice Statistics, 2006

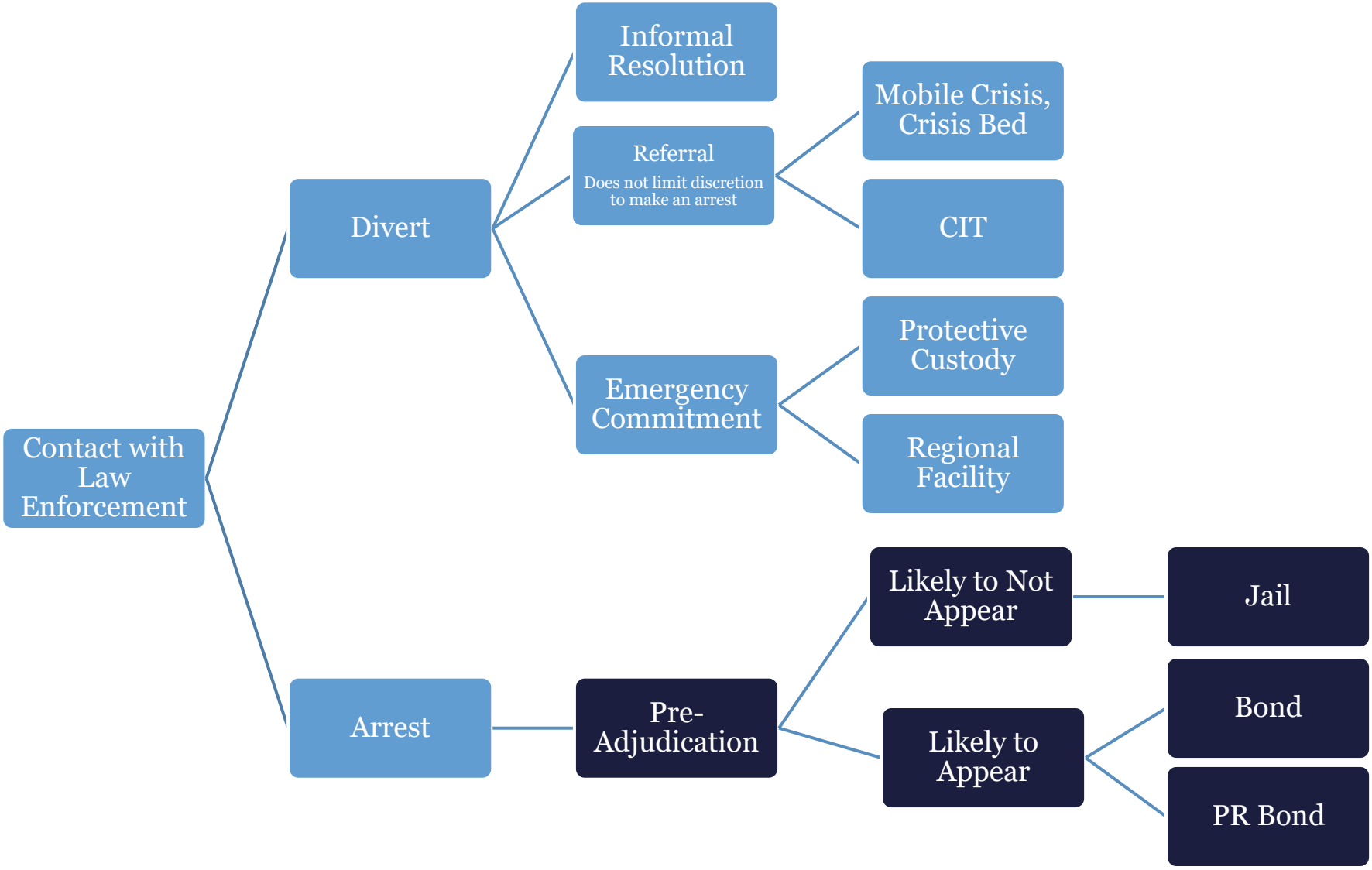
Key Findings

- Options to divert individuals from the criminal justice system are not available in all areas of the state.
- The criminal justice system lacks adequate procedures to identify mental illness early.
- People with indicators of mental illness are more likely to be jailed pretrial and to stay longer in jail.
- Court orders regarding competency evaluations tripled in a 3-year period, while multi-purpose evaluations and wait times for evaluations drove higher costs.

Progression through the Justice System

Pre-HB 1183

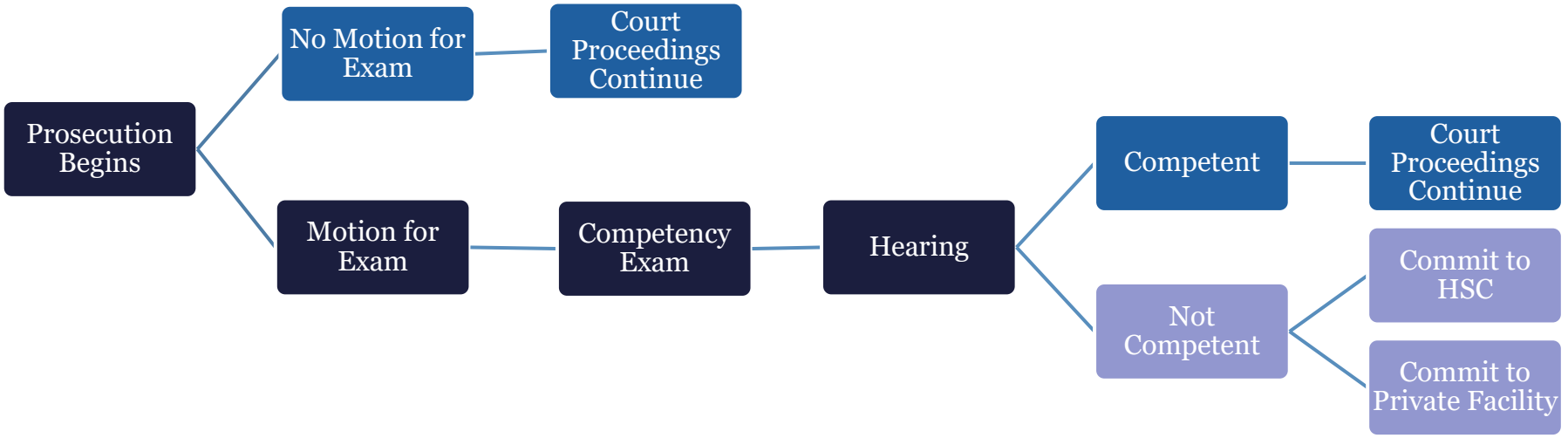
Contact with Law Enforcement



Options for Law Enforcement

- Law Enforcement can either:
  - Arrest an individual; or
  - Divert from the criminal justice system.
    - Informal Resolution;
    - Referral to mobile crisis team or crisis intervention team (if available);
    - Emergency mental illness commitment.

Contact with Judicial System



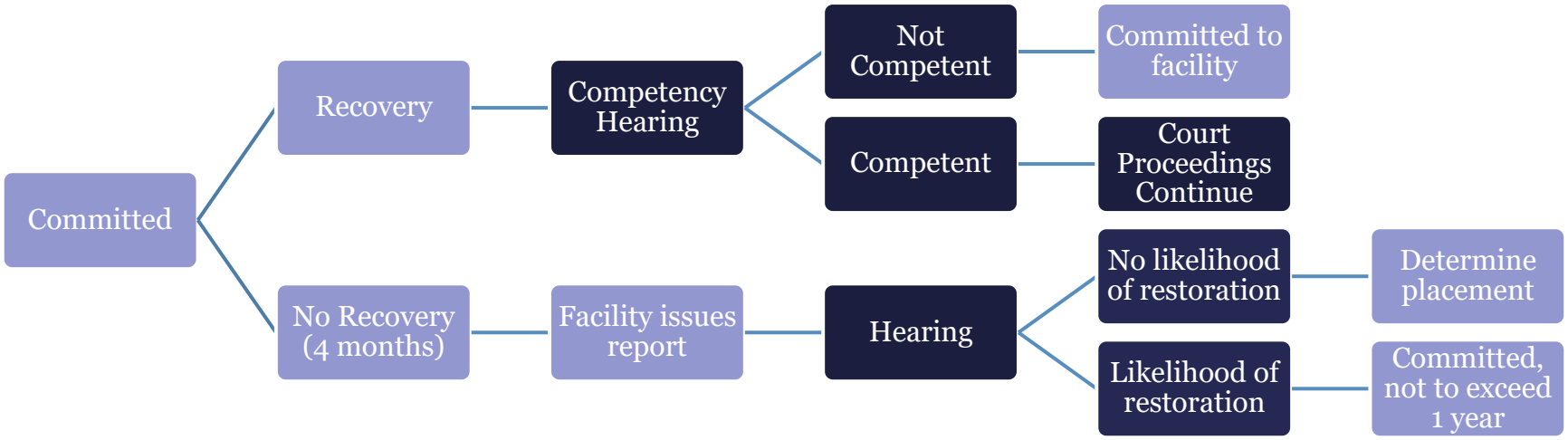
Options for the Court

- Court or magistrate may impose conditions of release on the individual in order to assure appearance.
- Among other factors, the court may consider the individual's mental condition.

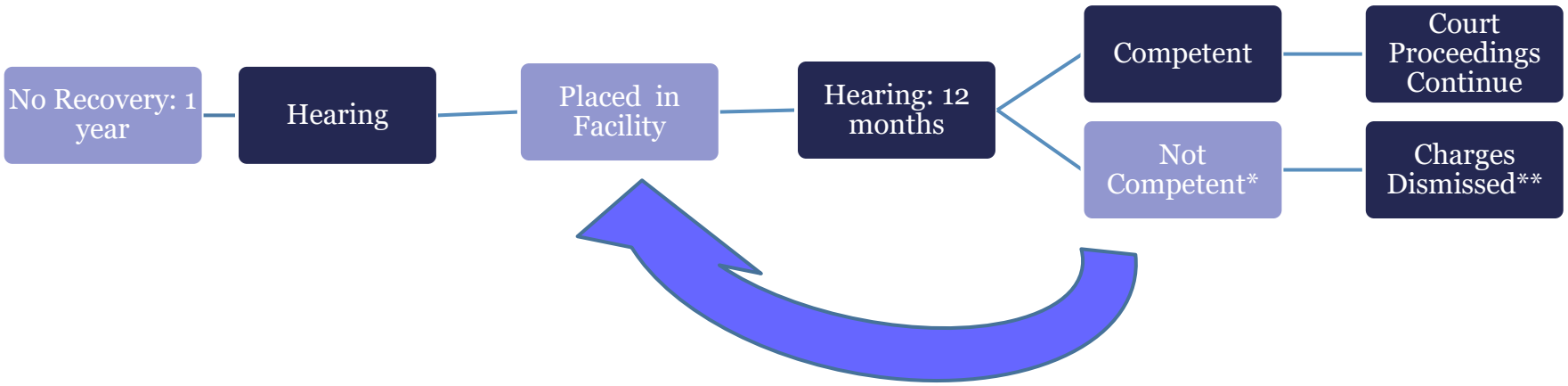
First Appearance Options

- Detain; or
- Release pending trial
  - Defendant must be ordered release pending trial on personal recognizance or bond unless:
    - Such a release will not reasonably assure appearance of defendant; or
    - Defendant may pose danger to any other person or community.

Individual Deemed Not Competent



Individual Deemed Not Competent, No Recovery



*The individual remains in custody until both the court order and the expiration of the longest time the defendant could have been served expires.

**Prosecutor may file a petition for involuntary commitment upon dismissal of charges if there is probable cause to believe defendant is a danger to himself or others.

Competency

- While mentally incompetent, a person cannot be tried, sentenced, or punished for any public offense.
- The prosecution, defense, or court may raise a motion for a hearing to determine competency, and may be brought at any time after commencement of prosecution and prior to sentencing.

House Bill 1183: Legislation Primer

Strengthens opportunities to divert people from the criminal justice system into mental health treatment.

Opportunities to Divert

- Encourages state's attorneys to use deferred prosecution for defendants with mental illness by providing training on mental illness and available services.
- Revises conditions of bond to allow the court to add as a condition the requirement that a defendant complete a mental health assessment and follow treatment recommendations.
- Allows courts to establish multi-disciplinary teams to help plan and manage cases for people with mental illness.

Expedites the completion of competency exams ensuring speedier court processing and shorter jail stays.

Speedier Court Processing and Shorter Jail Stays

- Reallocate funds used at the Human Services Center for the costs associated with forensic evaluations to establish a contract with the SD Association of County Commissioners to create a fund for the purpose of assisting counties with the cost of court-ordered competency evaluations
- Sets a 21-day timeframe for completion of competency evaluations and expands the types of professionals who can perform these examinations.

Improves access to treatment of those with mental illness in criminal justice system through training and studying treatment options.

Access to Treatment

- Requires training on mental illness for court-appointed criminal defense attorneys, officers in jails and state prisons, judges, and court services officers to encourage appropriate response and available services.
- Establishes a group to recommend ways to improve communication between jails and mental health providers.

Provides tools to law enforcement and communities to address mental health crises early and prevent jail admissions.

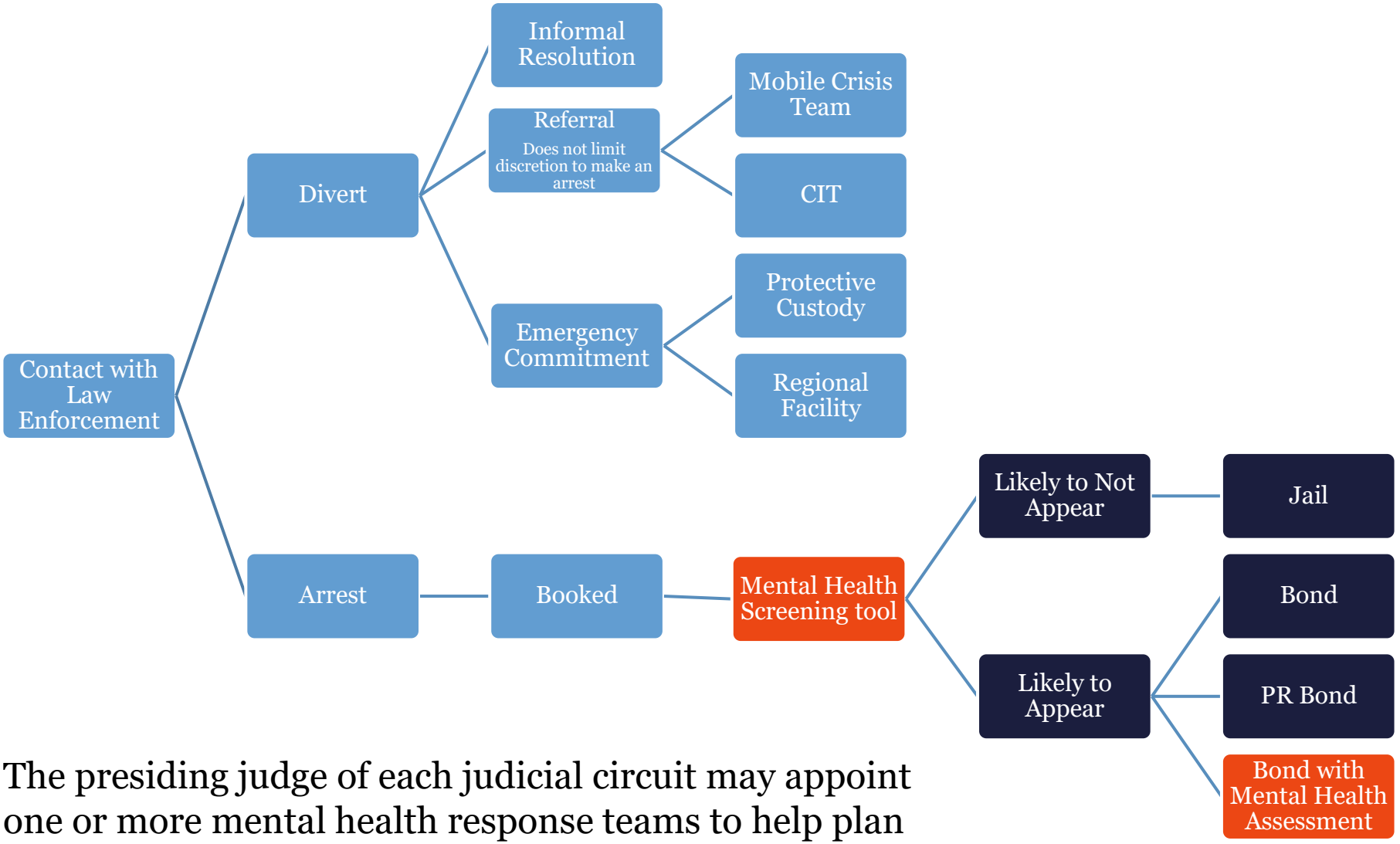
Tools for Law Enforcement

- Sets up a one-time grant program to encourage local governments to establish or expand crisis response services as a way to divert individuals with mental health concerns away from jail.
- Expands training resources for law enforcement and jails on mental illness and crisis intervention.

Progression through the Justice System

Post-HB 1183

Contact with Law Enforcement



The presiding judge of each judicial circuit may appoint one or more mental health response teams to help plan and mange cases for people with mental illness.

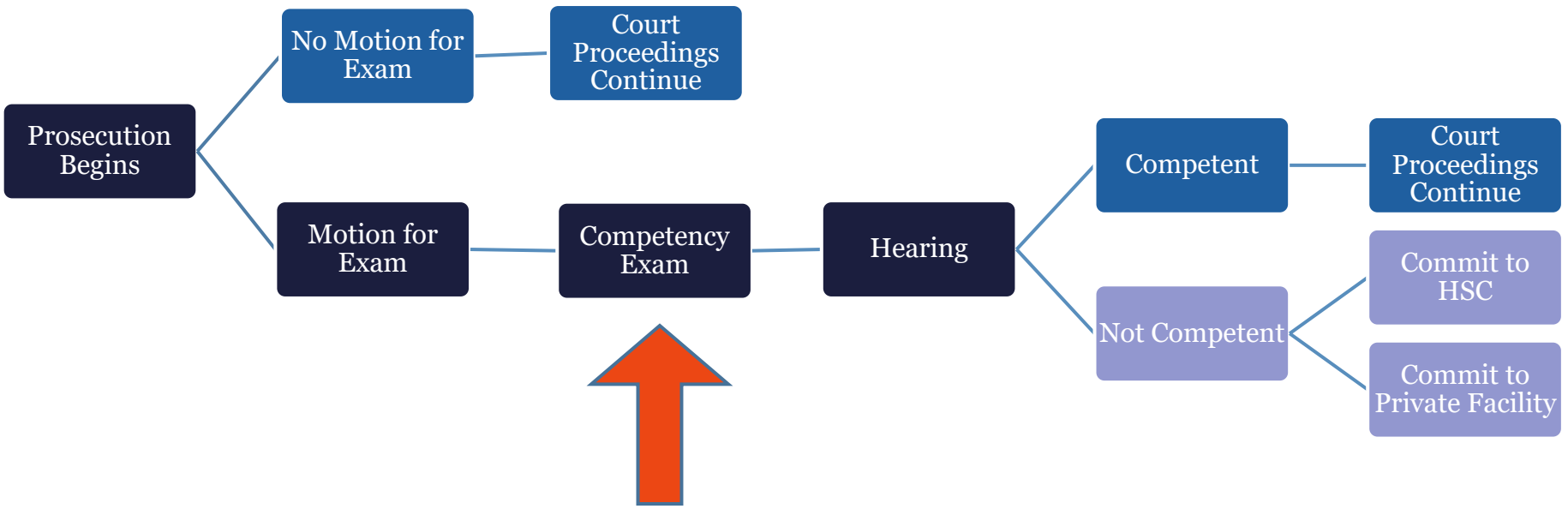
Mental Health Screening Tool

- HB 1183 calls for the South Dakota Sheriff's Association to develop a jail mental health screening pilot program.
- The tool is utilized during the jail intake process.
- The results of the screening tool will be provided to the circuit committing magistrate or court.

Mental Health Assessment

- The judge may require a defendant to complete a mental health assessment and follow any treatment recommendations as a condition of release.

Contact with Judicial System



Shall be completed within 21 days of the court order

Competency Evaluations

- Competency evaluation orders must be completed within twenty-one days of the court order. The court may grant a continuance for good cause.

Competency Evaluators

- The following professionals may conduct the evaluation:
  - A licensed or certified psychiatrist;
  - A licensed clinical psychologist;
  - *A certified social worker with competency evaluation training;
  - *Certified nurse practitioner or clinical nurse specialist with current psychiatric certification and competency evaluation training;
  - *Licensed professional counselor-mental health with training

*Added as a result of 1183

Oversight Council

Improving Criminal Justice Responses for Persons with Mental Illness

Duties of the Oversight Council

Study

- Study and make recommendations to improve the recruitment and retention of mental health professionals
- Study and make recommendations to expand access to mental health services for criminal justice populations

Duties of the Oversight Council

Review

- Review task force recommendations, track implementation and evaluate compliance
- Review data and reporting required by this Act
- Review compliance with the training required by this Act
- Review the recommendations of the crisis intervention team training review team
- Review the crisis response grants distributed
- Review DCI's development of training on mental illness
- Review the payments to counties for mental competency examinations and reports

Duties of the Oversight Council

Establish

- Establish a work group to make recommendations to improve information sharing among jails and mental health providers and improve coordination among jails and mental health providers to refer persons released from jail to mental health services
- Establish a statewide crisis intervention training review team to analyze and make recommendations on the ongoing need for a crisis intervention training coordinator
- Establish a work group to make recommendations to the council to create a process for the completion of a mental health assessment following a jail mental health screening

Duties of the Oversight Council

Evaluate

- Evaluate the need for and feasibility of forensic assertive community treatment teams
- Evaluate the need for and feasibility and cost effectiveness of telehealth options for jail mental health assessments, consultations for law enforcement officers who encounter persons in crisis, crisis response during law enforcement encounters with persons in crisis, mental health services for persons on probation, and mental health services for persons in jail
- Evaluate the need for and feasibility of a statewide crisis call center or regional call centers for persons in crisis

Duties of the Oversight Council

Actions

- Make recommendations regarding pilot programs for needed and feasible telehealth options to provide mental health services to persons with mental illness in the criminal justice system
- Prepare and submit an annual summary report of the performance and outcome measures that are part of this Act. The report shall include recommendations for improvements and a summary of savings
- Calculate costs averted by the provisions in this Act
- Monitor the competency evaluation funding program
- Track progress and make recommendations to improve the implementation of mental health screenings in jails

Questions?

Greg Sattizahn
State Court Administrator
Greg.Sattizahn@ujs.state.sd.us

Appendix 11

HB 1183 Performance Measures

OVERSIGHT COUNCIL FOR IMPROVING CRIMINAL JUSTICE REPONSES FOR PERSONS WITH MENTAL ILLNESS

JULY 18, 2017

Purpose of Performance Measures

Better understand the problem

Have data to inform decision making and future improvements

Monitor implementation

Track outcomes

Key Findings from the Task Force Process: Lack of National Data

Lack of comprehensive data on law enforcement contacts with individuals with mental illness

- No national data on law enforcement encounters with individuals with mental illness
- Studies estimate that 7% of law enforcement encounters involve people with mental illness (Borum (1998); Deane, Steadman, Borum, Veysey, & Morrissey (1999); Lodestar (2002))

No national data collected on prevalence of individuals with mental illness in the court system, pretrial experiences, court processing times, or sentencing

Outdated information about the prevalence of mental illness among jail populations (2006) and probationers (1999)

National Data: New Bureau of Justice Statistics Report Released in June 2017

Highlights

- More jail inmates (26%) met the threshold for serious psychological distress (SPD) in the past 30 days than the general population (5%)
  - SPD was determined using the Kessler 6 nonspecific psychological distress scale, a 6-question tool used to screen for serious mental illness in adults
  - The study also used "history of a mental health problem" as an indicator
- 30% of jail inmates who met the SPD threshold were receiving mental health treatment
- 10% of jail inmates who met the threshold for SPD were written up or charged with assault, as compared to 4% of inmates with no indicator of a mental health problem
- A larger percentage of females in jail (32%) than males in jail (26%) met the threshold for SPD in the past 30 days

Source: Indicators of Mental Health Problems Reported by Prisoners and Jail Inmates, 2011-12 (2017). US Department of Justice, Bureau of Justice Statistics.

Key Findings from the Task Force Process: Lack of Statewide Data

No statewide data on law enforcement encounters with people with mental illness or diversions from jail

- Reviewed data from Minnehaha County's Mobile Crisis Team
- Discussed diversions that resulted from the availability of Pennington County's Crisis Care Center
- Used key stakeholders to estimate how many agencies have personnel trained in CIT

No statewide data on mental illness among jail inmates

- Conducted a survey of South Dakota Jails
- Examined data from Minnehaha and Pennington County Jails using proxy measures for mental illness

Little statewide data on people with mental illness in the court system

- Reviewed data on orders for competency evaluations
- Analyzed data using a proxy measure for mental illness

A proxy is an indirect measure of the desired outcome which is itself strongly correlated to that outcome, commonly used when direct measures of the outcome are unobservable and/or unavailable.

Provide tools for law enforcement and communities to address mental health crises early and prevent jail admissions

HB 1183 Performance Measures: CIT Coordinator and Review Team

CIT review team assessment of statewide CIT coordinator

- Number of requests for assistance from CIT coordinator
- Names of agencies requesting assistance
- Number of requests granted
- Number of law enforcement officers trained
- Training adherence to Memphis or other evidence-based model

HB 1183 Performance Measures: Crisis Response Grants

Grant program for cities, counties, or groups of counties to establish or expand crisis response services

- Number of applications for grant program
- Number of applications accepted
- Amount awarded to each grantee
- Location, purpose, population served by grant

Expedite completion of competency exams ensuring speedier court processing and shorter jail stays

HB 1183 Performance Measures: Competency Evaluation Fund

Fund administered by the Association of County Officials to provide funding to counties for competency evaluations

- Amount distributed annually in total
- Amount distributed annually by county
- Number of competency evaluations completed with funds from the program

HB 1183 Performance Measures: Timely Competency Evaluations

21-day timeframe for completion of competency evaluations

- Average number of days from court order to completion of competency examinations
- Number of competency examination continuances requested
- Number of competency examination continuances granted

Strengthen opportunities to divert people from the criminal justice system into mental health treatment

HB 1183 Performance Measures: Assessment and Treatment as Bond Conditions

Allowable conditions of bond may include a requirement that a defendant complete a mental health assessment and follow treatment recommendations

- Number and percent of defendants for whom MH assessment is required as a condition of bond
- Number and percent of defendants for whom MH treatment is required as a condition of bond
- Number and percent of those with assessment and treatment as a condition of bond who comply with bond conditions

HB 1183 Performance Measures: Mental Health Response Teams

Mental health response teams to identify eligible individuals and utilize a multi-disciplinary approach to treatment planning, making treatment referrals and referrals to non-mental health services, and information sharing

- Name of any circuits that establish mental health response teams
- Number of persons meeting the response team criteria
- Number meeting criteria who are released pretrial and referred for MH assessment or treatment
- Percent meeting criteria who are released pretrial and referred for MH assessment or treatment

HB 1183 Performance Measures: Mental Health Court

Mental health court

- Number of persons referred to any MH court
- Number and percent admitted to MH court
- Number and percent admitted who complete MH court requirements
- Number and percent convicted of a new crime within one to three years of completing MH court

Continue to identify ways to improve criminal justice responses for those with mental illness

HB 1183 Performance Measures: Jail Mental Health Screening

Jail mental health screening pilot program to include at least 4 jails

- Number of persons screened
- Number screening positive

Development of a process for statewide rollout of a jail mental health screen

- Number and percent of persons screened at intake
- Number and percent of positive screens

HB 1183 Performance Measures: Probationer Mental Health Referrals

Data collection on probationers assessed and referred for mental health treatment

- Number and percent of probationers referred for MH assessment
- Number and percent of probationers referred for MH treatment
- Annual cost of probationer MH assessments and treatment, in total and by funding source

Questions?

Barbara Pierce

Managing Associate | Crime and Justice Institute at CRJ

bpierce@crj.org