Bridging the Gaps between Criminal Justice and Mental Health Summit
February 5, 2015
Dublin, Ohio

Sequential Intercept Strategic Planning Report – Ohio

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March 13, 2015
# Table of Contents

**Executive Summary** ........................................................................................................................ 3

**Introduction** ................................................................................................................................... 4

**Summit Goals** ................................................................................................................................... 5

**Background** ..................................................................................................................................... 5

**Agenda** ........................................................................................................................................... 7

**Intercept 1  Strengths and Gaps** ................................................................................................. 9

**Intercepts 2 & 3  Strengths and Gaps** .......................................................................................... 11

**Intercepts 4 & 5  Strengths and Gaps** .......................................................................................... 13

**Recommendations** ....................................................................................................................... 16

**References** .................................................................................................................................... 22

**APPENDICES**

- Appendix A: Participant List
- Appendix B: CCOE Mapping Handout
- Appendix C: CCOE Mapping Priorities Handout
- Appendix D: Ohio SIM Projects Grid
- Appendix E: Final MAP Program Brief
- Appendix F: TCM Program Brief
- Appendix G: Jail Data Link
- Appendix H: Best Practices Exiting Criminal Justice Settings
- Appendix I: Peer Advocacy
Executive Summary

The National Alliance on Mental Illness of Ohio, with the support of funding from the Ohio Office of Attorney General, Mike DeWine, contracted with Policy Research Associates (PRA) to provide a strategic planning workshop to inform the work of Attorney General’s Task Force on Criminal Justice and Mental Illness. The *Bridging the Gaps between Criminal Justice and Mental Health Summit* was held February 5th, 2015 at the Embassy Suites in Dublin, Ohio.

There is a longstanding recognition that persons with behavioral health disorders are over-represented in the criminal justice system and once in the criminal justice system are subject to worse outcomes including being less likely to make bail, higher rates of disciplinary infractions and longer length of stay. In addition, incarcerated populations have higher prevalence rates of medical conditions and substance abuse.

This Summit was convened to address these disparities and to introduce the Sequential Intercept Model as a planning tool to strategically inform legislation, policy, planning, and funding. The workshop served to identify opportunities for coordination and collaboration among state and local stakeholders, inform state and local stakeholders about best practices in the behavioral health and correctional fields, and to consider the impact of health care reform, Ohio SB 43, “Outpatient Treatment Law” and state behavioral health and criminal justice initiatives on justice-involved populations.

The Sequential Intercept Strategic Planning workshop has three primary objectives:

1. Development of a comprehensive picture of how people with mental illness and co-occurring disorders flow through the criminal justice system along five distinct intercept points: Law Enforcement and Emergency Services, Initial Detention and Initial Court Hearings, Jails and Courts, Re-entry, and Community Corrections/Community Support.
2. Identification of gaps, resources, and opportunities at each intercept for individuals in the target population.
3. Development of priorities for activities designed to improve system and service level responses for individuals in the target population.

Recommendations:

1. Expand Crisis Care Continuum
2. Continue to expand CIT initiatives and CIT program development
3. Expand the Role of the Ohio Criminal Justice Coordination Center of Excellence (CJ CCOE)
4. Educate and train on use of court-ordered outpatient treatment, SB43
5. Expand Pre-trial Services and Early Diversion Opportunities
6. Continue to support the expansion of specialized dockets
7. Develop a Statewide Strategy to Assist Counties in Using Technology to Improve Jail Screening for Persons with Mental Illness
8. Insure Planning and Implementation of Medicaid Expansion, Health Home Implementation and Ohio SB 43 “Outpatient Treatment Law” Address the Specific Needs of Justice-Involved Persons with Behavioral Health Disorders
9. Expand and enhance successful Criminal Justice and Behavioral Health Programs
9a. Implement a prison based Social Security Access and Recovery (SOAR) initiative
9b. Utilize the CJ CCOE to facilitate replication and expansion of programs
10. Broaden and formalize county level criminal justice/behavioral health planning committees
Acknowledgement

PRA wishes to thank Betsy Johnson from the National Alliance on Mental Illness of Ohio for her assistance with the coordination of this event. In addition, we would like to thank the following individuals for sharing their expertise in the planning of the Summit: Fred Frese, Deb Herubin, Tereresa Jamison, Mark Munetz, Chris Nicastro, Michael Sheline, Ruth Simera, and Evelyn Stratton.

Introduction:

The National Alliance on Mental Illness of Ohio, with the support of funding from the Ohio Office of Attorney General, Mike DeWine, contracted with Policy Research Associates (PRA) to provide a strategic planning workshop to inform the work of Attorney General’s Task Force on Criminal Justice and Mental Illness. The Bridging the Gaps between Criminal Justice and Mental Health Summit was held February 5th, 2015 at the Embassy Suites in Dublin, Ohio.

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

Other characteristics of justice involved individuals with mental illness are:

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

Across the criminal justice system, persons with mental illness fare worse than those without.

In addition, incarcerated populations have higher prevalence rates of medical conditions and substance abuse:

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

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

Ohio has addressed the issues of mental illness in the criminal justice system head on. There are robust initiatives across the criminal justice system. Ohio is one of the national leaders in development of Police Crisis Intervention Teams, Mental Health Courts and Veterans Justice Initiatives. The Ohio Department

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of Rehabilitation and Corrections has substantially enhanced reentry planning initiative and the Ohio Department Mental Health and Addictions funds a broad range of diversion and reentry initiatives.

The Attorney General’s Task Force on Mental illness and Criminal Justice has provided for proactive state planning and this Summit provides an opportunity to identify critical areas to address.

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

**Summit Goals:**

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

The following documents were reviewed and influenced this report:

- The Ohio Office of the Attorney General’s Task Force on Criminal Justice and Mental Illness 2014 Annual Report
- The Ohio Crisis Intervention Team (CIT) 2015 Strategic Plan, prepared by the Ohio Criminal Justice Coordinating Center of Excellence (CJ CCoE)
- Ohio Mental Health and Addiction Services (OMHAS) 2014 Block Grant
- Ohio Association of County Behavioral Health Authorities (OACBHA) white paper, “Criminal Justice and Behavioral Health Care – Housing, Employment, Transportation and Treatment” (2015)
- Ohio Cross System’s Mapping Initiative handout prepared by the CJ CCoE (Appendix B)
- Sequential Intercept Mapping Priority Themes 2013-2014 prepared by the CJ CCoE (Appendix C)
- Ohio CJ/MH Initiatives Intercept Grid handout prepared by PRA (Appendix D)
- Supportive Housing for Returning Prisoners: Outcomes and Impacts of the Returning Home-Ohio Pilot Project, Urban Institute

**Background:**

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

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

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

3. Development of priorities for activities designed to improve system and service level responses for individuals in the target population.
The participants in the workshops represented multiple stakeholder systems including mental health, substance abuse treatment, health care, human services, local and state corrections, peers, advocates, law enforcement, and the courts. Patricia L. Griffin, Ph.D. Senior Consultant and Dan Abreu, M.S., C.R.C., L.M.H.C., Senior Project Associate for Policy Research Associates, Inc., facilitated the workshop session.

Fifty-two (52) people were recorded present at the Summit.
Bridging the Gaps Between Criminal Justice and Mental Health Summit
Embassy Suites Dublin
5100 Upper Metro Place, Dublin, Ohio 43017
February 5, 2015

Agenda

8:30 – 9:00 a.m. Registration/Light Refreshments

9:00 – 9:15 a.m. Welcome and Introductions
Lee Dunham, President, NAMI Ohio
Fred Frese, Ph.D., Psychologist

9:15 – 10:00 a.m. Why We Are Here
Facilitator: Evelyn Lundberg Stratton, Retired Justice, Supreme Court of Ohio
Panelists: Mike DeWine, Attorney General, State of Ohio
           Stuart Hudson, Chief of the Office of Prisons, Ohio Department of Rehabilitation and Correction
           Tracy Plouck, Director, Ohio Department of Mental Health and Addiction Services

10:00 – 10:45 a.m. The Sequential Intercept Model as a Tool for Planning
Dan Abreu, Facilitator, Policy Research Associates
Patricia Griffin, Facilitator, Policy Research Associates
Mark Munetz, Ohio Criminal Justice Coordinating Center of Excellence

10:45 – 11:00 a.m. Break

11:00 – 11:40 a.m. Panel: Sequential Intercept I
Facilitator: Evelyn Lundberg Stratton, Ret. Justice, Supreme Court of Ohio
Panelists: Jeff Futo, CIT Coordinator, Kent State University
           Ragan Leff, Crisis & Engagement Supervisor, Community Support Services, Inc.
           The Honorable Randy Rogers, Judge, Butler County Probate Court
           Amy Wickes, Consumer of Services

11:40 – 12:20 p.m. Panel: Sequential Intercept II and III
Facilitator: Evelyn Lundberg Stratton, Retired Justice, Supreme Court of Ohio
Panelists: 

Elizabeth Gump, VJO Specialist, Veteran’s Justice Outreach Program  
Dan Peterca, Retired, Cuyahoga County Probation Department  
The Honorable David Sunderman, Judge, Delaware County Municipal Mental Health Court  
Beth Ridenour, Family Member  

12:20 – 1:00 p.m. Lunch  

1:00 – 1:40 p.m. Panel: Sequential Intercept IV and V  
Facilitator: Evelyn Lundberg Stratton, Ret. Justice, Supreme Court of Ohio  
Panelists: Michael Fuller, Associate Director, Wood County Job and Family Services  
Jenny O’Donnell, Psy.D., St. Aloysius, Forensic Mental Health Services  
Ryan Kidwell, Administrator, Hancock County Jail  
Lisa Marie Griffin, Consumer of Services  

1:40 – 1:45 p.m. Break  

1:45 – 2:45 p.m. Breakout Session: Identifying the Priority Problems and Identifying the Best Ideas for Addressing Them  
Facilitators: Jeff Futo, CIT Coordinator, Kent State University  
Dan Peterca, Retired, Cuyahoga County Probation Department  
Ruth Simera, Director, Criminal Justice Coordinating Center of Excellence  

2:45 – 3:00 p.m. Break/Dessert  

3:00 – 3:30 p.m. Group Reports  

3:30 – 3:50 p.m. Next Steps  
Dan Abreu, Facilitator, Policy Research Associates  
Patricia Griffin, Facilitator, Policy Research Associates  

3:50 – 4:00 p.m. Closing Remarks  
Evelyn Lundberg Stratton, Ret. Justice, Supreme Court of Ohio
**Strengths**

- Law for emergency hospitalization (emergency cert., including police)
- Police collaboration and community resources (local and state)
- Police selection process promotes culture change
- On-scene stabilization d/t officer training
- Civil commitment statute (including outpatient- OP)
- More progressive thinking by law enforcement
- Awareness of crime as a symptom and not the primary problem
- Push for community policing
- CIT training
- Increased funding
- Improved policies/procedures
- Assisted Outpatient Treatment, SB 43

**Gaps**

- Lack of crisis stabilization beds
  - Funding/legislative constraints
- Lack of emergency services (inconsistent)
- Inconsistent Peace Officer mental health training
• Public knowledge of availability of specially trained officers
• Organizational infusion of CIT
• Certification/de-certification of police agencies
• Workforce: inadequate number of crisis mental health workers
• Emergency hospital- not universally understood/implemented
• Home Rule-improved coordination between local and state planning
Strengths

- Judicial Conference Supreme Court collaboration
- Office of Criminal Justice Services
- Attorney General (AG) Task Force
- Ohio Department of Rehabilitation and Coordination (ODRC) Coalition Think Tank
- Governor’s Office- Executive Branch
- Community Corrections funding
- Supreme Court Personnel Education and Training Committee
- Public defenders
- Specialty court dockets

Gaps

- Match jail intake list to MH agency/DD list
- Screening (Brief Jail Mental Health Screen- BJMHS)
  - Jail intake
  - Pretrial
- Educate judges on Veterans Justice Outreach (VJO)
- Training jail staff to contact Ohio Department of Job and Family Services (JFS) staff
- Training public defenders on veterans, juveniles and serious and persistent mental illness (SPMI) populations
• Jail suicide assessment
• Expansion of CIT training for corrections, dispatch, parks and recreation officers
• Internet infrastructure for ODRC
• Bed days/available in state beds/outpatient competency restoration
• Release from jail with adequate medication

Breakout Group Intercept 2-3 Quick Fixes

• Community Based Correctional Facility (CBCF) does not accept individuals with specific diagnoses
• Add veteran status to Indigency Affidavit
• Reactivate NAMI mental health jail training
• Move released inmates closer to home (reentry)
• Revive Forensic Competency Restoration Evaluation project
  o Bob Baker, J O’Donnell
• Law libraries have “Defending Veterans in the Criminal Justice System”
Strengths

- Faith-based initiatives
- Access to NAMI programs
- Continued cross-intercept training
- Transition out of prison and supports to stay out
- Mapping in some counties
- Reentry Coalitions
- Peer support
- Community linkage and OMHAS’ in-reach
- Wellness Management and Recovery (WMR) programs
- Medicaid expansion
- Chemical dependency specialist within American Psychiatric Association (APA) ranks
- 30 day medication supply and 2 prescriptions upon prison release
- Corrections Planning Boards
- Services are quicker when getting out of jails- linking better in some places
- Mental Health Courts availability- after supports
- Trauma-informed care movement and other evidence-based practices (Integrated Dual Disorder Treatment-IDDT, Assertive Community Treatment-ACT/ Forensic Assertive Community Treatment- FACT, peer support, Wellness Management and Recovery-WMR)
• CIT presence, but disproportionate
• Cross-collaboration between state and localities
• Pro-active state
• Home for Good Reentry Housing Program

Gaps

• Continued training in various arenas
  o Gap between release and access to services; still have long waiting lists and people fall through the cracks
• Housing/employment/transportation (wrap-around services)
• Medicaid reimbursement of peer support services and others, ACT
• Lack of services for youth/teens
• Dual diagnosis training
• Detox/Alcohol and other Drug (AoD) inpatient
• Discrimination/stigma concerning mental illness
  o Bar association/RN licensing other eligibility requirements
• Residency issues
• Adult residential facility- funding and awareness, and service eligibility requirements
• Capacity of AoD programming in Adult Parole Authority
• Need to be careful/evaluate promising best practices- implement with fidelity (CIT, Trauma-Informed Care-TIC)
• Prevention and early intervention services, including inpatient
• Disproportionate CIT coverage
• CIT should be inclusive of additional people/professionals, such as public defenders, court personnel, and inmates

Priorities for Change as Determined by Mapping Participants

Intercept 1
• Develop a continuum of crisis services (11 votes)
  o Resources including workforce
  o Training
  o Coordination
• Develop consistency in Peace Officer mental health training (11 votes)
• Organizational infusion of CIT (7 votes)
• Civil commitment- greater understanding and implementation consistency (3 votes)
• Required standards of certification for police agencies (2 votes)
• Public education (2 votes)

**Intercepts 2-3** (Priorities are rank ordered by consensus. No votes tabulated.)

• Assessments- expansion and training
  - Pre-trial services, suicide, jail (BJMHS), reentry (GAINS Reentry Checklist)
  - Match jail population to Mental Health Board and developmental disorder database and VJO for veterans
• Training
  - Expansion of CIT (to corrections, dispatch, and parks and recreation)
  - Judicial- VJOs
  - Public defenders and prosecutors
• Bed days/available in state beds/outpatient competency restoration

**Intercepts 4-5**

• Continued training in various arenas (9 votes)
  - Gap between release and access to services/timeliness
• Housing/employment/transportation (core/basic wrap-around services) (7 votes)
• Medicaid reimbursement of peer support services and others, ACT (7 votes)
• Lack of services for youth/teens (4 votes)
• Dual diagnosis training (3 votes)
• Detox/AoD inpatient (2 votes)
• Discrimination/stigma concerning mental illness (1 vote)
  - Bar association/RN licensing other eligibility requirements
• Residency issues (1 vote)
• Adult residential facility- funding and awareness, and service eligibility requirements (1 vote)
• Capacity of AoD programming in Adult Parole Authority (1 vote)
• Need to be careful/evaluate promising best practices- implement with fidelity (CIT, TIC)
• Prevention and early intervention services, including inpatient
• Disproportionate CIT coverage
• CIT should be inclusive of additional people/professionals, such as public defenders, court personnel, and inmates
The documents reviewed (see page 2 of this report) reflect a broad range of stakeholder involvement and planning. In many ways, the SIM Strategic Planning Workshop confirmed needs identified by other planning groups. The workshop also provided an opportunity to consider how various initiatives, funding streams and planning groups relate to one another.

The recommendations below are primarily derived from the priorities identified in the breakout groups. However, document review, national initiatives and Policy Research Associates’ experience consulting to other states and localities also helped inform these recommendations.

1. **Expand Crisis Care Continuum**

Participants in the Intercept 1 workgroup cited *improvement in crisis response* as their top priority. Expansion of Crisis Services including Crisis Stabilization, Crisis Residential, Crisis Respite, Transitional Residential, Peer Respite, Urgent Care Centers and Mobile Crisis Teams is a critical and urgent need.

Ohio has a strong CIT presence throughout the state. However, like many states, behavioral health crisis response varies resulting in poor follow through and post crisis engagement. Beth Ridenour, family member and Summit Panelist, provided graphic testimony of the tragic consequences of a fragmented and insufficient crisis response.

This priority is consistent with recommendations identified in the Criminal Justice Coordinating Center of Excellence report on the Ohio Crisis Intervention Team Strategic Plan and with Focus Area 4 (Treatment and Crisis) of the OACBHA’s white paper. In addition, the Sequential Intercept Mapping initiative led by the CJ CCoE identified establishing a Crisis Stabilization Center as a priority in 5 of 7 counties.

Over the past few years, the Substance Abuse and Mental Health Services Administration (SAMHSA) and many states have begun to identify a “Continuum of Care for Crisis Services” ([http://store.samhsa.gov/shin/content/SMA14-4848/SMA14-4848.pdf](http://store.samhsa.gov/shin/content/SMA14-4848/SMA14-4848.pdf)). In addition, states including Texas, New York, Virginia, and California have state-funded initiatives to enhance crisis services in communities (State RFA’s available upon request). In Ohio, the Governor’s Office 2014 Mid Biennium Review indicates funding for crisis services and the Ohio MDAS Block grant provides funding for pilot Crisis Stabilization Centers in the South and Southeast regions.

2. **Continue to expand CIT initiatives and CIT program development**

Ohio’s commitment to CIT is impressive. According the Ohio Crisis Intervention Team (CIT) Strategic Plan, 86 counties have trained CIT officers and over 7500 trained CIT officers in 2013 and 2014.

However, CIT teams need partnerships with behavioral health providers to achieve the best outcomes for people in crisis. CIT program development is critical as the health care landscape is changing and new crisis response models are being funded and developed. Medicaid expansion can also foster new
opportunities to increase service engagement for persons encountered by CIT Teams. In addition, CIT for Youth (CIT-Y) is an important enhancement to CIT Training and according to the report, a revised youth curriculum was recently released providing an opportunity for expanding CIT-Y.

The recommendation listed in the Ohio Crisis Intervention Team (CIT) Strategic Plan are practical and timely and likely to promote service engagement and reduce involvement in the criminal justice system.

Note: Bureau of Justice Assistance is currently seeking applications for a Justice Mental Health Collaboration Program Grant. Specialized Law Enforcement responses to persons with mental illness is one of the priority areas identified in the grant, https://www.bja.gov/Funding/15JMHCPSol.pdf.

3. **Expand the Role of the Ohio Criminal Justice Coordinating Center of Excellence (CJ CCoE).**

Ohio is to be commended for its breadth of Behavioral Health and Criminal Justice collaboration throughout the state. The documents reviewed (see page 2 of this report) in preparation of this report reflect a broad range of stakeholder involvement as well as multiple points of advocacy, action and leadership. Expanding the role of the Ohio Criminal Justice Coordinating Center of Excellence (CJ CCoE) could enhance timely dissemination of initiatives, accelerate implementation of initiatives, and improve consistency in implementation of initiatives. The CJ CCoE will require additional support to maintain its efforts to continue the development of CIT statewide and county-level Sequential Intercept Mapping.

Expanded activities could include:

- Being the identified “go to” place in Ohio for key information
- Centralizing information on the array of state and local initiatives
- Providing diversion and reentry technical assistance to localities
- Collecting and tracking diversion activity and outcome data
- Centralizing and disseminating priorities elicited in the current SIM initiative
- Providing published research and resources

The Pennsylvania Mental Health and Justice Center of Excellence provides an example of how a broader focus can inform technical assistance and planning needs (http://www.pacenterofexcellence.pitt.edu/).

4. **Educate and train on use of court-ordered outpatient treatment, SB43.**

Ohio SB 43, “Outpatient Treatment Law” went into effect September 17, 2014. The law modifies and clarifies procedures for court ordered outpatient treatment. As Dr. Frese noted in his presentation, (See Agenda, p.9) findings from a study of Kendra’s Law in New York State indicated, while under court ordered treatment, there were reductions in hospitalization, arrests, and homelessness. There were also improvements in personal functioning, receipt of medication and receipt of case management.

It is important to insure that criminal justice partners are fully informed about the SB 43 to insure, when appropriate, justice involved persons with mental illness are considered for court ordered outpatient treatment and that the civil court system and criminal justice partners coordinate treatment and supervision approaches.

NAMI Ohio, the CJ CCoE, the Treatment Advocacy Center and the Margaret Clark Morgan Foundation are planning a major conference next year to educate both courts, providers and communities on how to use SB 43.
5. Expand Pre-trial Services and Early Diversion Opportunities.

The top priority in the Intercept 2-3 Workgroup was to expand pre-trial services. National data indicates that there is a high prevalence of persons with mental illness in jail and that persons with mental illness are less likely to make bail. Arraignment diversion is a challenge, generally due to the large volume of cases, lack of clinical background and ability to screen potential candidates, and hesitance to release someone with high bail risk indicators, e.g., lack of address, family support, employment, etc. While this is true, there are successful diversion models for arraignment diversion. In addition to assessing bail risk, pre-trial services can provide an important diversion screening function, as well as pre-trial supervision for justice-involved persons with mental illness. Other key components of an arraignment diversion program are court-based clinical staff who can provide assessment and immediate engagement and referral of participants.

The NYC Legal Aid Manhattan Arraignment Program (Appendix E) and the CASES Transition Case Management Program (Appendix F) are examples of arraignment diversion programs for persons with mental illness.

6. Continue to support the expansion of specialized dockets

Ohio has been a national leader in development of specialty dockets, with nearly 155 certified specialty dockets and more in development. Ohio has seen rapid growth of Veterans Courts and Dockets. These strategies promote improved collaboration and better use of resources. Partnering with the U.S. Department of Veterans Affairs (VA), VJO program, justice involved veterans can be linked to VA services, even in communities without a Veterans Court, accessing a whole range of federal resources and reducing the cost burden on local resources.

7. Develop a Statewide Strategy to Assist Counties in Using Technology to Improve Jail Screening for Persons with Mental Illness.

The Intercept 2-3 workgroup identified matching jail population data base to the Mental Health and Developmental Disability Board data base as a top priority.

The Illinois Jail Mental Health Data Link Project (Appendix G) is an internet-based application that performs cross-matching between the daily jail census and the Illinois Department of Human Services Department of Mental Health open case records, thereby immediately identifying detainees with mental illness eligible for, and at some point receiving, state-funded mental health services.


8. Insure Planning and Implementation of Medicaid Expansion and Health Home Implementation Address the Specific Needs of Justice-Involved Persons with Behavioral Health Disorders.
Intercept 4-5 participants identified *service gaps upon reentry* as a top priority. Many of these related issues can be improved through Medicaid expansion and healthcare reform initiatives such as Health Homes.

The Affordable Care Act and healthcare reform are currently reshaping how services are financed and provided. It is important to address the specific needs of justice-involved persons with behavioral health disorders in the planning and implementation of these initiatives.

A sample of issues to consider include:

- Development of enrollment sites in criminal justice settings
- Matching criminal justice data bases with provider data bases to:
  - Inform planning
  - Identify high users
  - Coordinate supervision with treatment
- Early notification of incarceration to providers to insure continuity of care and identify diversion candidates
- Information sharing agreements to promote coordination of response (particularly important with probation)
- Development of criminal justice metrics to identify the criminal justice outcomes for those enrolled in behavioral health programs
- Utilization of peers services in crisis, court, reentry and probation settings

The following publications are an excellent resource for guidance on including justice-involved populations in Healthcare Reform initiatives:

- The Affordable Care Act and Justice Populations

- Mapping the Criminal Justice System to Connect Offenders with Treatment and Health Care under the Affordable Care Act

- Questions and Answers: The Affordable Care Act and County Jails

- County Jails and the Affordable Care Act: Enrolling Eligible Individuals in Health Coverage

- The Patient Protection and Affordable Care Act and the Pretrial System: A “Front Door” to Health and Safety

The publication, “Guidelines for the Successful Transition of People with Behavioral Health Disorders from Jail and Prison” also addresses many of the issues raised in the Intercept 4-5 Breakout Group.
The “Criminal Justice and Behavioral Health Care Housing, Employment, Transportation and Treatment” White Paper recently issued by the OACBHA, contains a thorough review of current successful programs, analysis of current gaps and suggestions for Action.

The document touches on key areas identified by the Intercept 4-5 workgroup including housing, employment and transportation.

Nationally, Housing is key focus in Criminal Justice/Behavioral Health initiatives. Ohio is fortunate to have the Corporation for Supportive Housing as stakeholder in developing Criminal Justice/Behavioral Health housing initiatives. The evaluation of Ohio’s Returning Home – Ohio Initiative indicates that participants had lower criminal justice recidivism and higher utilization of behavioral health services than the comparison group. (“Supportive Housing for Returning Prisoners: Outcomes and Impacts of the Returning Home-Ohio Pilot Project”)

In addition to housing recommendations included in the OACBHA White Paper, the 100,000 Homes Initiative publication, “Developing a Unified Homeless System (A Primer)” provides guidance on development of a central housing data base and coordinated community strategy to improve access to housing.

The White Paper identified improving access to Medicaid and Social Security could improve access to housing for future participants. A SOAR initiative could improve access to housing. (Appendix H).

Transportation is frequently identified as a priority by communities across the country. Yet, nationally, few program models or planning strategies have been identified to address this critical component of service access.

The White Paper describes 3 transportation initiatives:

1. The NET – Plus initiative in Wood County, Ohio. NET Plus program coordinates transportation resources for Medicaid eligible populations and funds transportation for non-Medicaid eligible populations.
2. The Hardin County Volunteers in Police Service (VIPS) initiative operated by the Sheriff’s Department provides volunteer transportation to essential services for drug court clients.
3. The Franklin County Turn it Around Transportation & Re-development Services provides transportation for workers to various employers. The program is funded by self-contribution, payroll deduction and/or employers.

9b. Utilize the CJ CCOE to facilitate replication and expansion of these programs.
These three transportation initiatives are important programs to replicate. By expanding the role of CJ CCoE, as innovative and successful programs are identified, the CJ CCoE could develop program briefs, disseminate information about programs and organize technical assistance to counties.

Employment is a significant risk factor for recidivism. The White Paper’s focus on reducing collateral sanctions on employment is consistent with recommendations of the following groups:

- Legal Action Center publication, “Roadblocks to Reentry” (www.lac.org/roadblocks.html),

10. **Broaden and formalize county level criminal justice/behavioral health planning committees**

Ohio provides significant state funding to communities for diversion and reentry program and there is excellent state planning capacity through the Attorney General’s Criminal Justice and Mental Illness Task Force.

Experience shows that counties likely vary in their ability to successfully implement programs and strategically develop, expand and enhance criminal justice/behavioral health programs. CIT expansion, Affordable Care Act implementation, Health Home development, expansion of court based diversion programs, reentry initiatives and changes in community supervision policies require nimble local action. Having established CJ/MH planning committees at the local level insures that justice populations are not over looked as health care and funding evolves and that justice partners have adequate input in design and implementation. Similarly as criminal justice programs are expanded and policies change, it is important that justice agencies partner with behavioral health providers to insure service access and timely services. Planning Committees are also well positioned to apply for federal grants, respond to state RFP’s and blend criminal justice and mental health state funding to respond to local needs and priorities.

The Ohio Crisis Intervention Team (CIT) Strategic Plan report recommends each community have a CIT Steering Committee. Appendix G of that report is a summary of Ohio CIT Research. One of the findings is that “in many Ohio communities, CIT has helped develop a sustainable, cross system steering group for jail diversion.” In other words, the CIT Steering Committee has expanded its mission to address broader criminal justice/behavioral health initiative. CIT development can also spur broader criminal justice/behavioral health planning efforts. It is essential to include peers and family members on planning committees (Appendix I).

The CJ CCoE through its Sequential Intercept Mapping initiative is uniquely positioned to provide technical assistance to counties regarding the best local strategy to improve criminal justice/behavioral health planning.

Bexar County (Texas), Memphis (Tennessee), New Orleans Parish (Louisiana) and Pima County (Arizona) are examples of counties and municipalities that have developed Criminal Justice Mental Health Planning Committees.
References


Appendix A:
Participant List
Bridging the Gaps Between Criminal Justice and Mental Health Summit

February 5, 2015

List of Participants

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Appendix B:
Ohio Mapping Handout
Ohio Cross-Systems Mapping Initiative

Funded by a Bureau of Justice Assistance grant through the Wood County ADAMHS Board - pilot Ohio Sequential Intercept Mapping and Action Planning workshop

Wood County - September 2013

With Byrne Memorial Justice Assistance Grant funding from the Office of Criminal Justice Services, the Ohio Criminal justice Coordinating Center of Excellence completed mapping and planning exercises with the following counties:

Sandusky County – October 2013
Clermont County – November 2013
Lucas County – March 2014
Portage County – November 2014
Butler County – December 2014
Shelby County – December 2014

All seven counties documented action plans to address the top 5 local priorities for improving outcomes for justice-involved individuals with mental illness. While all continue to work toward completion of these action plans, a few examples of local accomplishments or concrete decisions toward meeting agreed upon goals include:

Low or No Cost changes or initiatives:
Common encounter form created for use across mental health and justice systems
County jail implemented use of Brief Jail Mental Health Screen
Common definitions/glossary of terms to increase understanding across systems
CIT Companion Training for Dispatchers

Innovative and Collaborative use of local funds:
ADAMHS Board matched transportation funds for non-Medicaid services and individuals
24-hour transportation phone line

Re-alignment of local funds:
Hospital outpatient services to redirect prescribing nurse hours to Medication Assisted Treatment
Shift focus of recent state grant to female recovery housing rather than treatment

This project funded by Edward Byrne Memorial Justice Assistance Grant Nos. 2012-JG-C01-6963 and 2013-JG-E01-6963 through the Ohio Office of Criminal Justice Services.
Appendix C:
Mapping Priority Themes
NUMBER OF TIMES APPEARED AS PRIORITY ACROSS 7 COUNTIES

Sequential Intercept Mapping Priority Themes 2013-2014

- Vocational, employment services
- Drug Court
- Pre-trial alternatives
- Female specific services
- Reentry and discharge services
- Medication Assisted Treatment
- Timeliness of Behavioral Health Services (assessment, outpatient & after hours)
- MH training and protocols (call takers and corrections)
- Involuntary civil commitment (LE role)
- Hospital services: ER and access to admissions
- Recovery Housing options; emergency housing & shelters
- Transportation
- Communication, information and data sharing
- Crisis Drop-off, Stabilization, Detox
Appendix D:
Ohio Intercept Grid
### Intercept 1
**Ohio CJ/MH Initiatives Intercept Grid**

**Governor’s Office Biennium Rev.**
- Housing and Crisis Services - $24.1 million
- CIT Training and Data
- CIT Expansion
- CIT Training at Veterans Homes
- TA with NAMI to CICC Counties
- 1st Responder and School Personnel Crisis Response

**AG’s CJ/MI Task Force**
- Survey benefits of pre-trial services
- Examine recycling of low level offenders

**MHAS Block Grant**
- Hot Spot Collaborative:
  - Crisis Stabilization in South and SE Regions
  - 1st Episode Psychosis Project

**Intercept 2**
**AG’s CJ/MI Task Force**
- CIT Training and Data
- CIT Expansion
- CIT Training at Veterans Homes
- TA with NAMI to CICC Counties
- 1st Responder and School Personnel Crisis Response

**Governor’s Office Biennium Rev.**
- Residential State Housing Supplement - $7.5 million
- Recovery Housing - $5 million
- Specialty Dockets - $4.4 million

**Intercept 3**
**AG’s CJ/MI Task Force**
- Veteran Court Peer Mentors
- Jail Standards
- Court ordered treatment
- Court gaps survey
- Increase housing assistance

**MHAS Block Grant**
- Veterans Treatment Court Project
- Drug Courts
- TASC at 14 sites
- Access to Recovery

**Intercept 4**
**AG’s CJ/MI Task Force**
- Medicaid enrollment of jail inmates
- Prison tele health reentry
- Post release medication
- HB 187 veteran sentencing mitigation
- Funded 2 reentry positions in Hancock and Mercer Counties
- Share treatment information at sentencing
- Expand and evaluate Home for Good

**MHAS Block Grant**
- Prison based TC’s
- Prison Community Linkage Social Workers

**Intercept 5**
**Governor’s Office Biennium Rev.**
- Residential State Housing Supplement - $7.5 million
- Recovery Housing - $5 million
- Specialty Dockets - $4.4 million

**AG’s CJ/MI Task Force**
- Veteran Court Peer Mentors
- Jail Standards
- Court ordered treatment
- Court gaps survey
- Increase housing assistance

**MHAS Block Grant**
- Access to Medication Assisted Treatment
- CCOE’s
- Medicaid Health Home Implementation
- Recovery Support for CJ Clients

### Cross Intercept Initiatives

**AG’s CJ/MI Task Force**
- Legislative Tracking Sheet
- Increase Medicaid Expansion
- Ohio Veterans Legal Assistance
- Prescriber Shortage

**MHAS Block Grant**
- Access to Medication Assisted Treatment
- CCOE’s
- Medicaid Health Home Implementation
- Recovery Support for CJ Clients
Appendix E:
The Manhattan Arraignment Diversion Project
Relatively few of the diversion programs developed in response to the overrepresentation of people with mental illness in the United States criminal justice system have targeted initial arraignment or first appearance courts. In 2010, the Legal Aid Society piloted the Misdemeanor Arraignment Project (MAP) in New York City Criminal Court through funding from the Langeloth Foundation. The Project aims to better identify, assess, and represent individuals with mental illness facing criminal charges at the earliest possible stages after arrest.

MAP is an early intervention model that seeks to decrease the frequency of arrest and short jail sentences for individuals with mental illness. MAP enhances the ability of a community to serve people with mental illness and provides them with continuous community-based mental health treatment, appropriate housing, and supports.

The interdisciplinary team includes the attorney and paralegal assigned to the case and a MAP licensed clinical social worker. The attorney is responsible for providing legal representation in arraignments. He/she works together with the other team members to distinguish how and when screening and assessment information should be used in legal advocacy to assist in the successful resolution of the case. The licensed clinical social worker is responsible for identifying and assessing detained clients awaiting arraignment, treatment planning, and court advocacy. The social worker is also responsible for organizing collateral contacts with family, significant others, and community providers. He/she also offers referrals to community treatment and accompanies clients in emergency/crisis situations when necessary.

Individuals who qualify for the target population for MAP:

- are 18 years of age or more
- have a mental illness and/or a substance use disorder
- are at risk of
  - being arraigned and released without supportive services
  - a jail sentence
  - being held in jail pending a court appearance
- consent to accept assessment, referral, and connection to treatment

Many MAP clients face challenges such as intellectual or developmental disabilities and homelessness or the risk of becoming homeless, in addition to behavioral health issues. MAP clients may be dealing with current crises (e.g., suicidal ideation) that require immediate attention in a psychiatric emergency room or may have a history of repeated use of inpatient treatment beds, crisis services, and/or correctional healthcare.
Current engagement in treatment does not preclude a potential client from use of MAP services.

Participants

MAP served 250 clients between July 2010 and April 2012. These clients varied in age: 20 years old and below (10%), 21-29 years old (20%), 30-39 years old (24%), 40-49 years old (25%), 50-59 years old (16%), and 60 years old and above (5%). A majority of the clients were male (72%). About half of the clients were African American (49%), followed by Hispanic (28%), Caucasian (15%), and other varied ethnicities.

Mood disorders (38%) and schizophrenia and other psychotic disorders (34%) were the most frequently seen diagnoses in clients. Overall, 57% of clients had co-occurring mental illness and substance abuse issues; 22% dealt only with mental illness; 7% dealt only with substance abuse issues; and 14% were missing diagnoses.

The crime that preceded enrollment in MAP was most frequently larceny (29.6%), followed by controlled substance offenses (12.4%), assault and related offenses (11.6%), other offenses relating to theft (10%), and burglary and related offences (9.2%).

Outcomes

Between July 2010 and April 2012, MAP completed 223 pre-arraignment assessments and 27 post-arraignment assessments. Of the 223 individuals assessed pre-arraignment, 149 were determined to be jail-divertible at arraignment. Table 1 shows the final determinations of all 149 cases.

<table>
<thead>
<tr>
<th>Status</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diverted</td>
<td>88</td>
<td>59.1</td>
</tr>
<tr>
<td>Judge Denied – DOC</td>
<td>32</td>
<td>21.5</td>
</tr>
<tr>
<td>Client Denied – DOC</td>
<td>17</td>
<td>11.4</td>
</tr>
<tr>
<td>MAP Unable to Place</td>
<td>4</td>
<td>2.7</td>
</tr>
<tr>
<td>LAS Relieved</td>
<td>2</td>
<td>1.3</td>
</tr>
<tr>
<td>Parole Hold</td>
<td>2</td>
<td>1.3</td>
</tr>
<tr>
<td>Transfer (MMTC)</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Open Warrants – DOC</td>
<td>1</td>
<td>0.7</td>
</tr>
<tr>
<td>Attorney Denied – DOC</td>
<td>1</td>
<td>0.7</td>
</tr>
<tr>
<td>Total</td>
<td>149</td>
<td>100</td>
</tr>
</tbody>
</table>

Eighty-eight individuals (59%) were diverted at arraignment. Table 2 shows the breakdown of legal outcomes for these 88 persons.

Of the 27 people assessed post-arraignment, 16 (59%) were diverted, for a total of 104 persons diverted. Of the 104 clients diverted between July 2010 and April 2012, 52% had no arrests within one year, 16% had one arrest, 13% had two arrests, 12% had three arrests, and 7% had four or more arrests.

<table>
<thead>
<tr>
<th>Status</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>ROR: Released on own Recognizance</td>
<td>44</td>
<td>50.0</td>
</tr>
<tr>
<td>PGSI: Conditional Discharge</td>
<td>24</td>
<td>27.3</td>
</tr>
<tr>
<td>PGSI – CASES</td>
<td>7</td>
<td>8.0</td>
</tr>
<tr>
<td>PGSI: Time Served</td>
<td>6</td>
<td>6.8</td>
</tr>
<tr>
<td>PGSI: Adj. Contemplation of Dismissal</td>
<td>5</td>
<td>5.7</td>
</tr>
<tr>
<td>9.43 – Dismissed</td>
<td>2</td>
<td>2.3</td>
</tr>
<tr>
<td>Total</td>
<td>88</td>
<td>100</td>
</tr>
</tbody>
</table>
The above data was compared to the number of arrests for 61 non-MAP-diverted clients. Twenty-three clients either refused MAP services, were unable to be placed, or their Legal Aid Society attorney was relieved, and 38 clients were either denied diversion by the judge, were on parole hold, were transferred, had an open warrant, or were remanded into custody for adjudicating or sentencing. Of these non-MAP diverted clients, 25% had no arrests within one year, 32% had one arrest, 11% had two arrests, 10% had three arrests, and 21% had four or more arrests. Figure 1 shows the difference in percentage of individuals arrested at 1 year between MAP-diverted clients and non-MAP-diverted clients.

Figure 1. Proportion Arrested 1 Year Post-MAP

Four Keys to Program Success

Education and Engagement of the Judiciary
Judicial buy-in and appreciation of the goals of MAP are essential to its success. Focus groups prior to the initiation of MAP and subsequent follow-up with judges as to their perception of the success and usefulness of MAP are key to evaluating potential and ongoing success of the program. Judicial feedback may indicate potential modifications to procedures in the courtroom. In addition, judicial endorsement of MAP is an incentive for prosecutorial cooperation and overall success.

Attorney Engagement and Endorsement
Attorneys have not generally referred matters to social workers during arraignments but have waited until subsequent appearances to have social workers assist. Continuous education of attorneys, both new and experienced, through presentations by the social worker will help foster understanding of the overall arraignment part defense strategies that can utilize social workers.

Assertive Assessment and Engagement of Clients Throughout Each Arraignment Shift
The social worker in this role must have a skill set suited to working with many different personalities (clients, attorneys, judges) in a fast-paced environment, which can often be highly charged for the client. Social workers must screen files prior to the attorneys and take the initiative to suggest to the attorneys that a client could be diverted to treatment or back to treatment. The social worker in the MAP project has to be on the lookout for appropriate clients in all ways – reviewing files, discussing with the attorneys, and assessing clients visually and through initial interaction. Some clients don’t want to speak to anyone other than their attorney or speak to anyone without their attorney. The skill of the social worker in making clients feel at ease in a difficult and potentially traumatizing situation is essential.
Ability to Establish Data Collection Systems Prior to Program Initiation and Conduct Accurate Follow Up

This is a labor-intensive part of the project. If it is possible to secure outside help to conduct extensive data analysis and program evaluation, either through partnership with a university or other outside source, this might be ideal.

References


Appendix F:
The CASES Transitional Case Management Program Brief
SUCCESSFULLY ENGAGING MISDEMEANOR DEFENDANTS WITH MENTAL ILLNESS IN JAIL DIVERSION: THE CASES TRANSITIONAL CASE MANAGEMENT PROGRAM

Goals of this document:

- Provide a description of the development and operation of an alternative-to-incarceration program for repetitive misdemeanants
- Outline the strategy used by the program to promote engagement with behavioral health services through case management
- Review the program’s effectiveness in reducing arrests, compliance with the court mandate, and linking participants to long-term treatment services
- Explain the role of positive court relations, standardized court screening, same-day engagement, and flexibility of service provision in the program’s success.

Individuals convicted of misdemeanor offenses receive relatively modest punishment within the criminal justice system. As a result, programs that divert misdemeanants with mental disorders into treatment services lack judicial leverage to counter noncompliance. Yet misdemeanor cases constitute a huge burden for criminal courts. For example, in 2007, misdemeanor cases accounted for three-quarters of all arraignments in the Manhattan Criminal Court. The behavioral, medical, and public safety implications of noncompliance present courts and service providers with a need for more effective engagement strategies.

The Center for Alternative Sentencing and Employment Services (CASES) launched the Transitional Case Management (TCM) alternative-to-incarceration program in 2007 for misdemeanor defendants in Manhattan Criminal Court. TCM has received funding from the New York City Department of Correction, New York Mayor’s Office of the Criminal Justice Coordinator, Bureau of Justice Assistance Justice and Mental Health Collaboration Program, Jacob and Valeria Langeloth Foundation, van Ameringen Foundation, Schnurmacher Foundation, and the Manhattan Borough President's Office. TCM provides screening, community case management, and coordinated support for individuals with mental disorders or co-occurring mental and substance use disorders at risk of jail sentences.

CASES clinical staff identify participants in arraignment, before sentencing, and also while completing a day custody program court mandate after sentencing. The participants are individuals with mental disorders or co-occurring mental and substance use disorders who have completed three days in the day...
custody program or are mandated by the court to participate in three or five community case management sessions as an alternative to incarceration.

Participants recruited from the day custody program voluntarily enter TCM after completing the court mandate. Defendants mandated to TCM directly from court can voluntarily continue in the program for up to three months after satisfying the court mandate. TCM is staffed by a psychologist responsible for court-based screening and project coordination, a licensed social work supervisor, a bachelor-level substance abuse case manager, and a part-time forensic peer specialist.

TCM enrolled 178 individuals from July 2007 through November 2010. Approximately three-quarters (78%) of participants were male. The mean age of participants was 40. About half (56%) were Black, 25% were Hispanic or Latino, 12% were White, 2% were Asian, and 5% were multi-ethnic.

The majority of participants had a psychiatric diagnosis of bipolar disorder (38%), depressive disorder (20%), or schizophrenia (19%). Most participants (85%) had a co-occurring substance use disorder. Ninety-five participants (53%) were homeless upon entry into TCM.

TCM participants had an extensive criminal history, with a mean of 27 lifetime arrests and a mean of 3.6 arrests in the past year. Every participant had at least one prior misdemeanor conviction and 53% had one or more prior felony convictions.

The conviction that preceded enrollment in TCM was for a property crime in about half of the cases (51%). One-quarter (25%) were convicted of possession of a controlled substance. Seventeen percent (17%) were convicted of a crime against a person.

### Outcomes

#### Rearrest

In the year after program entry, the participants experienced 2.5 mean arrests. This figure, compared with 3.6 mean arrests in the year prior to program entry, represents a 32% reduction between the two periods. This reduction is statistically significant at the p<.001 level. Seventy-two percent (72%) of participants were arrested at least once in the year after program entry.

<table>
<thead>
<tr>
<th>Lifetime Arrests</th>
<th>No.</th>
<th>%</th>
<th>1 Year Pre</th>
<th>1 Year Post</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-3</td>
<td>15</td>
<td>8.4</td>
<td>1.3</td>
<td>0.3</td>
</tr>
<tr>
<td>4-10</td>
<td>32</td>
<td>18.0</td>
<td>2.4</td>
<td>0.7</td>
</tr>
<tr>
<td>11-20</td>
<td>33</td>
<td>18.5</td>
<td>3.5</td>
<td>2.2</td>
</tr>
<tr>
<td>21-40</td>
<td>62</td>
<td>34.8</td>
<td>4.2</td>
<td>3.1</td>
</tr>
<tr>
<td>≥41</td>
<td>36</td>
<td>20.2</td>
<td>5.1</td>
<td>4.2</td>
</tr>
<tr>
<td>Total</td>
<td>178</td>
<td>100.0</td>
<td>3.6</td>
<td>2.5</td>
</tr>
</tbody>
</table>

Participants with more lifetime arrests experienced an attenuated reduction in arrests between the two periods. Participants with the most lifetime arrests (41 or more) experienced only an 18% reduction in mean arrests prior to and after program entry. Yet participants with three or fewer lifetime arrests experienced a 75% reduction in mean arrests. Mean arrests fell 70% for participants with 4 to 10 lifetime arrests, 37% for participants with 11 to 20
lifetime arrests, and 25% for participants with 21 to 40 lifetime arrests.

**Compliance and Service Linkage**

The majority (82%) of the mandated participants successfully completed the court mandate, and 85% of those participants chose to continue to receive case management services beyond the mandated period. On average, participants took part in 16 voluntary case management sessions over the course of 156 days. Thirty-nine percent (39%) of the TCM participants were linked to long-term services prior to TCM program enrollment, and the program linked and transferred 25% of participants to long-term treatment services.

**Positive Court Relations**

The TCM program benefits from having a professional clinician maintain a daily presence in the arraignment parts. This criminal justice–savvy individual is readily available to administer the screening protocol, engage with defense counsel, and provide pertinent information to judges to advocate for defendants who are eligible for the program. The clinician fine-tunes the program’s court operations in response to feedback from defense counsel and the judges.

**Standardized Court Screening**

The clinician administers the structured screening protocol in the courtroom interview pens to all referred defendants. The 75-minute protocol reviews mental health (Mental Health Screening Form III) and substance use (Texas Christian University Drug Screen II), psychosocial domains, risk factors, court mandate conditions, and program expectations and goals. As a result, the clinician is able to determine whether a defendant is eligible for TCM during the period before the individual appears before the judge. The majority of defendants referred by defense counsel and judges are eligible for TCM.

**Same Day Engagement**

The TCM case management protocol calls for immediate engagement of new participants in a standardized orientation protocol. The objective of the protocol is to increase the likelihood a new participant will engage in the case management services. Participant engagement begins with an orientation session that takes place immediately after release from court (participants referred from the day custody program are oriented on the day of admission). The project coordinator introduces the participant to project community staff. An evaluation of the participant is provided to staff, with a focus on immediate needs, risk factors, and details about the court mandate.

**Flexibility in Service Provision**

The high engagement in services is attributed to TCM’s flexibility in delivering services to participants. TCM has the capacity to provide the frequency and duration of service contacts to participants based on their immediate and ongoing needs. Program participants are seen by program staff as often as needed in any community setting convenient for the participant. They are seen if they arrive late or miss an appointment. The participants are welcomed by the program whenever they arrive or make contact with the staff to obtain services.
The TCM program points to the value of case management services to support reductions in the criminal recidivism of people with mental disorders or co-occurring mental and substance use disorders arrested for misdemeanor crimes. The program is now working to enhance the nature of its case management services with the use of a validated risk and need instrument. This will provide the staff with specific information regarding the criminogenic needs of their clients that should be addressed with services to achieve greater reductions in recidivism.

Conclusion

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Reference

Appendix G:
Illinois Jail Data Link
Frequent Users
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.
Appendix H:
Best Practices for Increasing Access to SSI/SSDI upon Exiting Criminal Justice Settings
Introduction

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

The Social Security Administration (SSA), through its Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) programs, can provide income and other benefits to persons with mental illness who are reentering the community from jails and prisons. The SSI/SSDI Outreach, Access and Recovery program (SOAR), a project funded by the Substance Abuse and Mental Health Services Administration, is a national technical assistance program that helps people who are homeless or at risk for homelessness to access SSA disability benefits.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. Each year an estimated 725,000 persons are released from federal and state prisons, 125,000 with serious mental illness. More than 20 percent of people with mental illness were homeless in the months before their incarceration compared

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with 10 percent of the general prison population.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 offenses resulting from symptoms of untreated mental illness. In general, people with mental illnesses remain in jail eight times longer than other offenders at a cost that is seven times higher.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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Incarceration and SSA Disability Benefits

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

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

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

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

Role of Transition Services in Reentry for People with Mental Illness

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

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

Access to Benefits as an Essential Strategy for Reentry

The criminal justice and behavioral health communities consistently identify lack of timely access to income and other benefits, including health insurance, as among the most significant and persistent barriers to successful community reintegration and recovery for people with serious mental illnesses and co-occurring substance use disorders.
Many states and communities that have worked to ensure immediate access to benefits upon release have focused almost exclusively on Medicaid. Although access to Medicaid is critically important, focusing on this alone often means that needs for basic sustenance and housing are ignored. Only a few states (Oregon, Illinois, New York, Florida) provide for Medicaid to be suspended upon incarceration rather than terminated, and few states or communities have developed procedures to process new Medicaid applications prior to release.

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

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

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

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

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

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

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

**SOAR Collaborations with State and Federal Prisons**

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

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

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

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

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

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

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

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

Over the past several years, the following best practices have emerged with respect to implementing SOAR in correctional settings. These best practices are in addition to the critical components required by the SOAR model for assisting with SSI/SSDI applications.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

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

- **Identify stakeholders.** Potential stakeholders associated with jails/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 I: Involving Peers in Criminal Justice & Problem-Solving Collaboratives
Goals of this document:
• Define the titles and roles of peers in criminal justice and behavioral health collaboratives;
• Stress the value and importance of involving consumers with relevant lived experience in collaboratives;
• Provide guidance on how to involve consumers in collaboratives; and
• Outline state-specific peer specialist trainings, certifications, and Medicaid reimbursement policies.

Forensic peer support connects individuals with shared experiences, foremost with justice involvement, and often with mental illness, substance use problems, socio-economic, and/or further challenges that affect their ability to successfully reintegrate in their communities (Davidson & Rowe, 2008; Rowe et al., 2007). Support is provided to peers with the goal of overcoming challenges associated with criminal justice involvement and mental illness, and in promotion of desired social and personal change. Peer Support can be provided in many forms, such as linkage to community services (e.g., self-help groups, vocational services, and mental health/substance use services), mentoring and advice, social support, or simple encouragement (Davidson & Rowe, 2008; Rowe et al., 2007).

Involvement of Consumers or Peer Advocates on Advisory Boards
Many agencies and organizations recognize the value of a consumer perspective in their planning and decision-making processes. It is important, however, that the information and suggestions given by consumers are seriously considered and implemented when possible. The Council of State Governments (2002) reports on the frustration voiced by some consumers in advisory roles, such as feeling as though their “inclusion reflects tokenism rather than an openness to their experience or perceptions of the system” (CSG, 2002). It is critical that agencies and organizations support the engagement of an active role by consumer board members, and not simply hire them for the satisfaction of requirements.

What is a “Forensic Peer Specialist”?
The Forensic Peer Specialist encompasses a variety of roles and specific duties, and job requirements, training, and qualifications vary across settings (Harrington, 2011; Miller & Fuller, 2007). In 2001, Howie the Harp Peer Advocacy Center coined the term “Forensic Peer Specialist.” This training program laid the framework for many of forensic peer specialist training programs that exist today. The program’s core curriculum emphasizes: “Self-help and Recovery; Human Services Roles and Responsibilities; Work Readiness; Navigating the Criminal Justice System; and, Professional Ethics” (Miller & Fuller, 2007). Many forensic peer support programs engage trained forensic peer specialists who are qualified to address the individual needs of consumers seeking support, emanating from their own experiences with the justice system and barriers against recovery, and also from targeted training for providing support to this population.

One of the particular strengths of increasing the overall involvement of peers with histories in the behavioral health and criminal justice systems is that they have a better understanding of the culture of incarceration and the significant challenges that any involvement in the system has on such factors as eligibility for entitlements, housing, and employment. Forensic Peer Specialists have an enhanced ability to empathize while promoting recovery based personal reform because they have faced similar challenges and experiences (Davidson & Rowe, 2008).
Other Types of Peer Recovery & Support Services

There is a broad array of terms or titles for consumers who provide peer recovery and support services across the mental health and recovery services field. These terms are often used interchangeably, leading to some ambiguity and confusion about their specific meanings.

**Peer Mentoring and Peer Counseling** are mentoring and support services delivered to peers from peers, promoting wellness and recovery from the support of the provider’s lived experience. Peer staff can help to improve independence and self-sufficiency by providing linkage to available resources and services; showing empathy and sharing stories of past challenges and recovery; and assisting in development of crisis plans, interventions, and strategies. Peer mentors and peer counselors are not usually required to have specific licensing or certification.

A **Peer Wellness Coach** employs a holistic approach in assisting peers to engage in healthy decision-making and behaviors to enhance their overall wellness and quality of life. A Peer Wellness Coach can work with peer clients on reducing high risk behaviors such as smoking, poor nutrition, and lack of exercise. Empowerment is used as a strategy to support wellness goals and positive lifestyle change. A peer wellness coach does not apply counseling strategies or interventions.

**Peer Support Groups** are the joining together of peers with similar struggles and needs with the goal of mutual support. Group participants share personal experiences, challenges, and successes among the group to provide and receive support. A key principle of group support is that sharing experiences and strategies can help group participants to “cope with their condition” (USDHHS, 1999).

**Peer Advocates** raise awareness through education and training. They also give input for policy development, intervention strategies, and program development; provide information on linkages to support, treatments, and services; serve as a mediator; and promote the protection of rights (WHO, 2003).

A key peer advocacy role is raising awareness and educating the stakeholders such as service professionals, decision makers, and government officials about mental health matters. This includes informing stakeholders about issues and disparities that affect individuals with mental illness, substance use disorders, and co-occurring disorders. Having personal experience and direct insight into challenges that might be encountered by the population they are representing, peer advocates provide an invaluable voice to represent consumers. The power of awareness can have a significant impact on policy and implementation of procedures. Peer advocates can also contribute to training curricula for service providers or other professionals (McCormick, Crews, & Deaz, 2004 & WHO, 2003).

On the individual support level, peer advocates provide consumers with knowledge, skills, and resources to overcome barriers and sustain a healthy quality of life. Peer advocates can enhance skills and share strategies from personal experience as well as provide linkages with community services. They can also educate consumers on their rights and directly mediate and advocate for clients (WHO, 2003).

The **Forensic Peer Advocate** involves an additional component of legal and criminal justice representation. Forensic Peer Advocates can disseminate knowledge and insight to legal policy and procedures, offender programs, court decisions, and other areas that affect justice-involved individuals with mental illness, substance use disorder, and co-occurring disorders. In addition, a forensic peer advocate can mediate and represent individual offenders with linkage to services, case management, court hearings, and other legal matters.
Importance of Training

Training for a peer specialist or peer advocate position is important to ensure that job-tasks and duties are performed effectively and appropriately. An established training program is extremely valuable for ensuring the duties of the role are understood. Matching the training to the responsibilities and qualifications is crucial for all peer specialists.

Individuals who are involved in the criminal justice system and have mental illness, substance use, trauma, and co-occurring disorders can be vulnerable, and are often in a critical recovery and reintegration stage. Training is necessary to ensure consumers are counseled and responded to appropriately. Further, many training programs assist peer-providers in facing past challenges and ensuring recovery is sustained.

One example of forensic peer training is the renowned “Howie the Harp Forensic Peer Specialist Training” program. Their primary goal is to prepare peer specialists with legal and criminal justice history to provide services and support to currently recovering peers in reentry or community corrections.

The first step in the training program is to help trainees to accept and come to terms with their own mental health recovery and criminal justice and trauma histories. This is integral in their ability to provide support to other peers.

Next, the program teaches peer specialists necessary human services skills, work-readiness, and employment retention skills. These and additional skills taught by the program are transferable life skills.

Finally, peer specialists learn how to resolve any unresolved criminal justice or personal issues that might affect finding or sustaining employment (Miller & Fuller, 2007).

Statewide Certification and Medicaid Reimbursable Programs

Under the Social Security Act, Sections 1905 (a) 13 and 1915 (b) 3, peer services are considered a Medicaid reimbursable service in some states. In such cases, the peer specialist is required to undergo specific state delivered (or approved) training and credentialing programs, and must adhere to specific state provisions of supervision and coordination of care to qualify for reimbursement (Eiken & Campbell, 2008).

Most certification programs do not focus specifically on justice-involved. Strategies to integrate peer support with the criminal justice community include developing partnerships with state or local criminal justice stakeholders and cross-training of peer service providers on the criminal justice system. It is highly valuable to work with stakeholders to implement forensic peer service programs or trainings that consider the risks and needs of justice-involved individuals with mental illness, substance use, and co-occurring disorders.

How to Access Training or Peer Support Services

There may be available trainings or peer support services for referral in your area. Check with your state and local department of mental health, state-wide not-for-profit agencies, local mental health services, not-for-profit centers, and advocacy centers.

The National Association of State Mental Health Directors (NASMHPD) promotes peer-to-peer services. To learn more, visit www.nasmhpd.org.

The National Association of Peer Specialists provides peer services, training, and other resources. To learn more, visit www.naops.org.

“Pillars of Peer Support” provides background and recommendations on various aspects of peer support, including the expansion of Medicaid to allow states to consider peer services as Medicaid reimbursable. To learn more, visit www.pillarsofpeersupport.org.
The following list of states, certifications, trainings, and Medicaid criteria is from the OptumHealth State Handbook for Peer and Family Support Services (2010):

<table>
<thead>
<tr>
<th>State</th>
<th>Medicaid Reimbursable</th>
<th>State Certification</th>
<th>Certifying Agency</th>
<th>Title</th>
<th>Website</th>
</tr>
</thead>
<tbody>
<tr>
<td>California</td>
<td>N/S</td>
<td>N/S</td>
<td>N/S</td>
<td>N/S</td>
<td>N/A</td>
</tr>
<tr>
<td>Colorado</td>
<td>N/S</td>
<td>N/S</td>
<td>N/S</td>
<td>N/S</td>
<td>N/A</td>
</tr>
<tr>
<td>Georgia</td>
<td>Yes</td>
<td>Yes</td>
<td>Georgia Certified Peer Specialist Project</td>
<td>Certified Peer Specialist</td>
<td><a href="http://www.gacps.org">www.gacps.org</a></td>
</tr>
<tr>
<td>Illinois</td>
<td>N/S</td>
<td>Yes</td>
<td>DHS Division of Mental Health &amp; Illinois Certification Board</td>
<td>Certified Recovery Support Specialist</td>
<td><a href="http://www.iaodapca.org">www.iaodapca.org</a></td>
</tr>
<tr>
<td>New York</td>
<td>No</td>
<td>No</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Ohio</td>
<td>No</td>
<td>No; In Process</td>
<td>N/A</td>
<td>N/A</td>
<td><a href="http://www.mentalhealth.ohio.gov">www.mentalhealth.ohio.gov</a></td>
</tr>
<tr>
<td>Tennessee</td>
<td>N/S</td>
<td>Yes</td>
<td>Tennessee Certified Peer Specialist Program</td>
<td>Certified Peer Specialist</td>
<td><a href="http://www.tennessee.gov">www.tennessee.gov</a></td>
</tr>
<tr>
<td>Texas</td>
<td>No</td>
<td>Yes</td>
<td>viaHOPE Texas Mental Health Resource</td>
<td>Certified Peer Specialist; Recovery Focused Learning Community</td>
<td><a href="http://www.viahope.org">www.viahope.org</a></td>
</tr>
<tr>
<td>Wisconsin</td>
<td>Yes</td>
<td>In Process</td>
<td>Wisconsin Department of Health Services</td>
<td>N/S</td>
<td><a href="http://www.dhs.wisconsin.gov">www.dhs.wisconsin.gov</a></td>
</tr>
</tbody>
</table>

N/A: Not Available; N/S: Not Specified

While some certifications are state-sponsored, others are made available by local and community-based organizations. The following list of programs is from the OptumHealth State Handbook for Peer and Family Support Services (2010):

<table>
<thead>
<tr>
<th>State</th>
<th>Certifying Agency</th>
<th>Program Name</th>
<th>Website</th>
</tr>
</thead>
<tbody>
<tr>
<td>California</td>
<td>Recovery Innovations</td>
<td>Recovery Innovations, Peer Training and Employment</td>
<td><a href="http://www.recoveryinnovations.org">www.recoveryinnovations.org</a></td>
</tr>
<tr>
<td>California</td>
<td>Richmond Area Multi-Services (RAMS) and San Francisco State University (SFSU)</td>
<td>Peer Specialist Mental Health Certificate Program</td>
<td><a href="http://www.ramsinc.org">www.ramsinc.org</a></td>
</tr>
<tr>
<td>Colorado</td>
<td>Community Connections</td>
<td>The Peer Specialist Program, Peer Specialist Training the Trainer</td>
<td><a href="http://www.peertraining.com">www.peertraining.com</a></td>
</tr>
<tr>
<td>Colorado</td>
<td>Colorado West Regional Mental Health, Inc.</td>
<td>Colorado West Regional Mental Health Inc., Peer Specialist Training</td>
<td><a href="http://www.cwrmhc.org">www.cwrmhc.org</a></td>
</tr>
<tr>
<td>Illinois</td>
<td>Illinois Alcohol and Other Drug Abuse Professional Certification Association</td>
<td>Certified Criminal Justice Addictions Professional Program</td>
<td><a href="http://www.iaodapca.org">www.iaodapca.org</a></td>
</tr>
<tr>
<td>Illinois</td>
<td>Depression and Bipolar Support Alliance</td>
<td>Peer Specialist Training Program</td>
<td><a href="http://www.dbsalliance.org">www.dbsalliance.org</a></td>
</tr>
<tr>
<td>New York</td>
<td>Mental Health Empowerment Project</td>
<td>Peer Specialist Training Program</td>
<td><a href="http://www.mhepinc.org">www.mhepinc.org</a></td>
</tr>
<tr>
<td>New York</td>
<td>NYS Association of Psychiatric Rehabilitation Services</td>
<td>Peer Bridger Program; Peer Health Care Coaching</td>
<td><a href="http://www.nyaprs.org">www.nyaprs.org</a></td>
</tr>
<tr>
<td>New York</td>
<td>Community Access</td>
<td>Howie the Harp Peer Advocacy and Training Center</td>
<td><a href="http://www.communityaccess.org">www.communityaccess.org</a></td>
</tr>
<tr>
<td>Wisconsin</td>
<td>WI Department of Health, Services/Pathways to Independence, and the University of Wisconsin-Milwaukee</td>
<td>Wisconsin Certified Peer Specialist Program</td>
<td><a href="http://www.dhs.wisconsin.gov">www.dhs.wisconsin.gov</a></td>
</tr>
</tbody>
</table>

This document was developed by SAMHSA’s GAINS Center for technical assistance purposes for the Adult Treatment Court Collaborative.
References


