

Massachusetts

Justice and Mental Health
Strategic Planning Conference
Report

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Justice and Mental Health Strategic Planning Conference Report

Introduction:

The Massachusetts Department of Mental Health, Department of Correction, and the Department of Youth Services obtained a Bureau of Justice Mental Health Collaboration Planning Grant to improve state planning and service provision for justice involved persons with co-occurring disorders. The goal of the grant is to create a statewide, interagency, interdisciplinary, collaborative forum to collect and disseminate information about current programs and best practices and develop strategic priorities for state expansion of programs for justice involved persons with co-occurring disorders and trauma.

Background:

Persons with mental illness are overrepresented across the criminal justice system. They have higher prevalence of co-occurring disorders, higher prevalence of trauma, and are more likely to be homeless. They spend more time incarcerated, have higher rates of disciplinary involvement while incarcerated and are more likely to fail under community supervision. Special populations include women, veterans and youth in transition.

Massachusetts, through local and state initiatives, has developed innovative and successful responses such as Police Crisis Intervention Teams, court based diversion programs, the Juvenile Detention Alternative Initiative and the Forensic Transition Team for persons with serious mental illness released from DOC custody. However, Massachusetts currently is exploring a statewide planning structure to strategically expand these initiatives, evaluate effectiveness of current programs, and inform government about priorities.

This initiative is timely as Massachusetts 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.

Conference Goals:

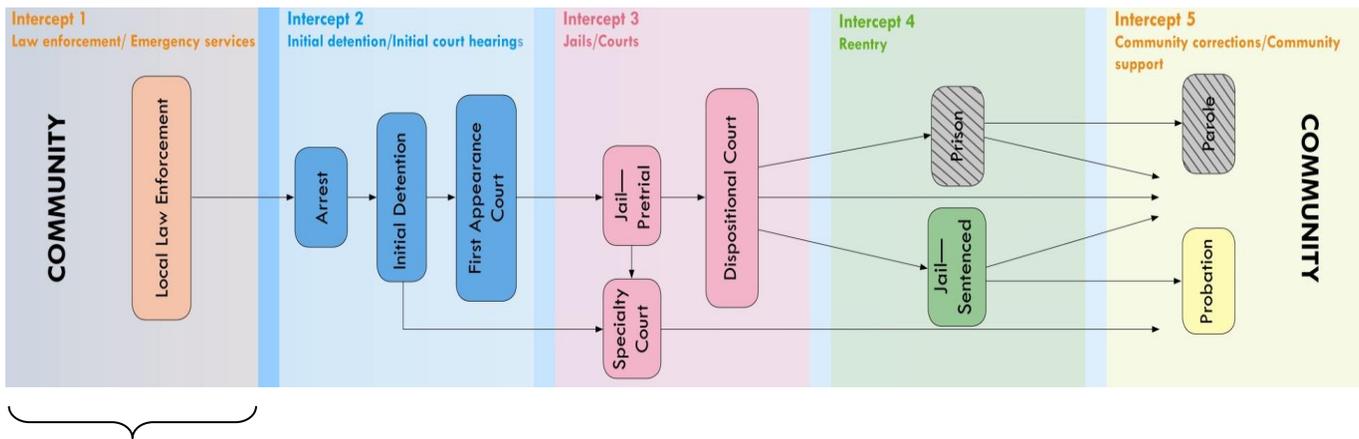
- to introduce the Sequential Intercept Model as a planning tool to strategically identify opportunities for coordination and collaboration, identify gaps and prioritize action steps
- to inform state and local stakeholders about best practices in the behavioral health and correctional field
- to consider the impact of health care reform on justice involved populations

- to build on successes by sharing information and best practices of existing Massachusetts programs for justice involved persons with mental illness
- to provide structured planning activities to focus on identifying opportunities for collaboration, identifying critical gaps, prioritizing need, and developing a planning structure to address them.

The following documents were reviewed and influenced this report:

- “Problem Solving Courts Cross-Agency Steering Group” PowerPoint presentation
- JD-CORP Planning Minutes
- “Decriminalization of Mental Illness: A Snapshot: Look at Diversion Models in the Commonwealth” (NAMI Massachusetts, 2011)
- Justice and Mental Health Collaboration - Strategic Planning Conference Exit Survey Data (Compiled by UMass Boston/Sociology)

Intercept 1: Pre-arrest Diversion



Resources

- Mental Health/Police co-response and Police CIT are available in the state
- Municipal Police Training Committee
- Police Mental Health First Aid Training
- NAMI Advisory Group

Gaps

- Insufficient MH training for Police
- Insufficient cross-sharing of information between police and service providers
- Lack of access to crisis services for Police and lack of uniform policies and procedures for police MH crisis response
- Lack of specialized crisis drop off, detox facilities, waits in emergency rooms
- Limited authority for treatment
- Training and resources on co-occurring disorders

Priorities

- Training for police
- Dual Diagnosis Resource
- Access to inpatient services and treatment

Recommendations

1. Continue with Mental Health First Aid Training and expansion of CIT training

Intercept 1 participants identify police training as a priority. The CSG Justice Center publication “Statewide Law Enforcement/Mental Health Efforts” describes statewide law enforcement initiatives and best practices (http://csgjusticecenter.org/wp-content/uploads/2013/01/1.8.12_Statewide-LE-MH_web.pdf).

2. Explore development of crisis stabilization centers

Nationally, lack of emergency services, inpatient and crisis stabilization beds is a common deficit. States and communities are improving response and resources for crisis intervention. The Texas one year evaluation of their Crisis Services Redesign Initiative can be found at:

<http://www.dshs.state.tx.us/mhsacsr/default.shtm>. A summary of the initiative is attached. (Appendix 1).

Washington and Virginia have recently funded and are developing crisis service enhancements.

(Appendices 2 and 3) and the National Association of Counties has published “Crisis Care Services for Counties” which provides community examples of Crisis Care programs. (Appendix 4).

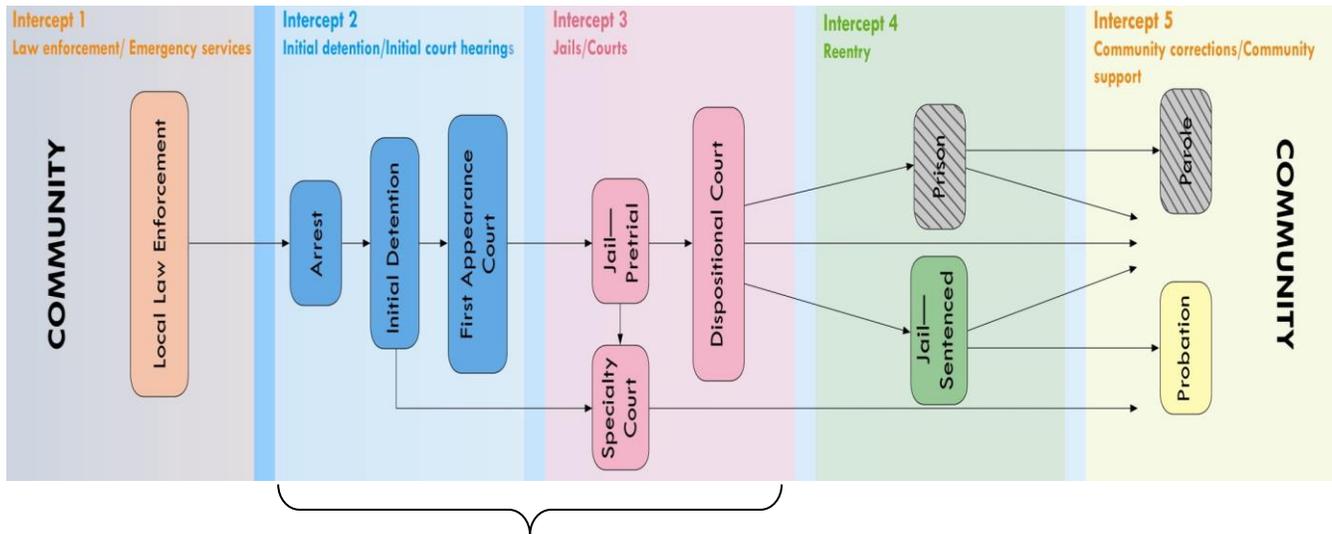
3. Develop Statewide Information Sharing Protocols

Participants identified information sharing between criminal justice and mental health agencies as a gap to service coordination and cooperation. Urban Institute published, “Opportunities for Information Sharing to Enhance Mental Health and Public Safety Outcomes”

<http://www.urban.org/publications/412788.html>.

The SAMHSA National GAINS Center Fact Sheet “Dispelling the Myths about Information Sharing Between the Mental Health and Criminal Justice Systems” (Appendix 5) also addresses information sharing strategies.

Intercepts 2 and 3:



Resources

- BSAS-BJA-DCE Grant for Data-Training-TA
- Women's Justice Network
- Hampden Co. Sheriff MH screening, Franklin Co. Kimball Reentry Facility
- Veterans: VJO, VSO's; MISSION Direct Vet: Worcester, Lawrence, Essex, Valor Act
- Court Clinic System
- Transformation Center
- JDAI Detention
- SAMHSA Trauma Grant Middlesex; IHR/BSAS
- MA Council on compulsive gambling
- New Bedford Court Alternative Program for Women
- Interagency Council
- 111E Drug Court Diversion
- MH and Justice/Veteran Coordinating Committee
- CJ Commission
- Criminal Offender Record Information (CORI) reform

- Parole & HOFC COMPASS Risk Assessment
- Peer Support

Gaps

- Communication among courts (consolidating cases)
- Trauma informed/gender specific services
- Early screening and intervention
- Jail-based treatment
- Resource awareness
- Co-occurring treatment services; Data to make informed decisions
- Data base integration/coordination
- Service gaps: housing; case management; co-occurring
- Recovery supports: employment; education
- Peer support

Priorities

- Special government committee on women
- Funding for Drug Court Coordinators
- Pre-plea diversion
- Increase case management in courts and pre-sentence
- Increase peer involvement in courts
- Co-occurring courts
- Examine Section 35 processes and facilities
- Cross training
- Review collateral sanctions

Recommendations

1. Review programs and services for justice involved women

Participants in the Intercept 2-3 workgroup identified gender specific programming and services as a priority. Nationally, gender specific programs and services tend to get overlooked in the criminal justice system. New Hampshire developed legislation which sought to equalize treatment of women in the justice system (Appendix 6).

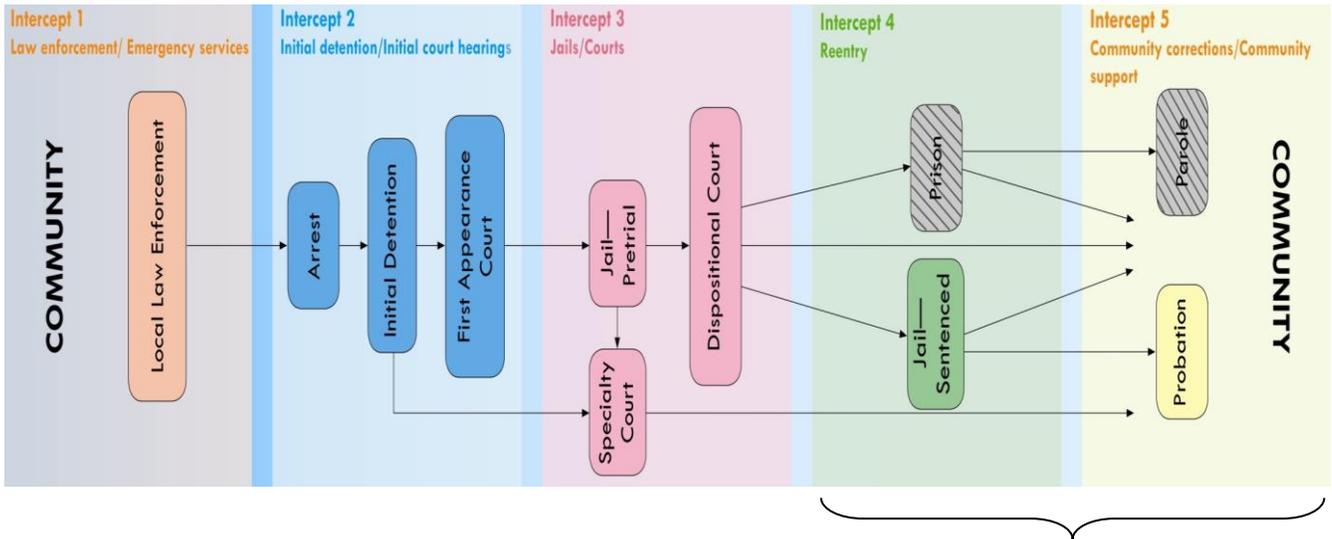
2. Expand pre-plea diversion options

Pre-Plea diversion minimizes collateral sanctions and allows for earlier intervention. Three programs, the NYC Legal Aid Manhattan Arraignment Program, the CASES NYC based NY County Court Transition Case Management Program, and the Tampa JDTR Diversion programs are examples of early diversion programs (Appendices 7, 8 and 9).

3. Review collateral sanctions

Minimizing collateral sanctions is essential to meaningful diversion strategies. Convictions result in barriers to employment and housing. In addition, court and program fines and fees accumulate and result in an overwhelming and unattainable financial obligation. Addressing collateral sanctions is essential to meaningful chances at recovery and rehabilitation. For an overview of state initiatives that address collateral sanctions see Appendix 10.

Intercepts 4 and 5:



Resources

Planning/Coordination

- Interagency Council on Substance Abuse and Prevention
- Hampden Co. Reentry Task Force
- Interagency Council on Housing and Homelessness
- DOC/Probation Collaboration
- Special Commission on CJ
- MOU's with Community Health Centers
- HIRE/MIDNET Data base sharing; Technology and information sharing
- Release planning meeting prior to release
- Interagency Collaboration and Funding
- Criminal Justice and DPH/DMH Interagency Conference Call planning

Services

- DOC and SPAN
- DOC Partnership with Mass Health
- Access to Recovery Programs
- Inmates released with medication and service plan
- Civil commitment upon release from DOC if needed
- Peer Models and Recovery Centers Statewide
- Conference on Community Health Centers
- BH/Primary Care Integration
- Whittier Street Health Center
- Boston Healthcare for Homeless Transition Clinic
- Health insurance access for MA residents

CJ specific

- DOC COMPASS Risk Assessment
- HOPE Probation Program
- Brook House Parole Program
- SPECTRUM Mentoring Program
- Education in prison

Gaps

- Funding-underpayment for MH services
- Housing
- Race and Perception: Need staff diversity
- Increase access to SA treatment
- Vocational Services
- Information Sharing (HIPPA)
- Family reunification
- Wait lists
- Staff competency in trauma, mental illness and SA
- TCs and Residential treatment
- Community Supervision

Priorities

- None identified

Recommendations

Conference notes do not address priorities in Intercepts IV and V and there are significant resources in these Intercepts.

However, analysis of the Gaps leads to the following recommendations:

1. Address housing for justice involved populations

Studies indicate that for high users of services, providing housing and supportive services may actually provide cost benefits (Appendices 11 and 12). The CSG Justice Center has also published, "Reentry Housing Options: The Policymaker's Guide" <http://csgjusticecenter.org/reentry/publications/reentry-housing-options-the-policymakers-guide-2/>.

2. Carefully consider whether TCs and Residential Treatment are appropriate for individuals with mental illness

Though listed as a gap, focus on TCs and Residential Treatment for persons with SMI may not be a fruitful strategy. Upon reentry, few are interested in long term residential treatment. However, some states have offered residential treatment as an alternative to long term incarceration. Department of Corrections Assessment and Sanction Units at Billings (BASC) and Missoula (MASC) are innovative programs that provide both prison diversion options for persons committed to DOC and a violation diversion option for persons who have violated conditions of probation or parole. Further, the centers provide transition programming for those nearing release from prison. The programs have capacity to provide mental health treatment to program participants. These programs serve as a step down from incarceration while still receiving credit toward reduction of incarceration and these programs can be effective. Justice involved persons with SMI in the community can benefit from Supportive Housing, including the Housing First model. (Appendices 11 and 12).

3. Incorporate Risk, Needs, Responsivity strategies into treatment settings working with the justice involved populations

States are implementing Risk, Needs, Responsivity (RNR) based Community Supervision strategies. The premise of these strategies is to focus supervision resources on those with the highest criminogenic needs

and target those needs for interventions. The CSG Justice Center published “The Ten Step Guide to Transforming Probation Departments to Reduce Recidivism” which describes implementation of RNR principles into probation supervision strategies <http://csgjusticecenter.org/corrections/publications/ten-step-guide-to-transforming-probation-departments-to-reduce-recidivism/>. Specialized Probation/Parole Caseloads have proven to reduce technical violations for persons with mental illness. The CSG Justice Center publication, “Improving Responses to People with Mental Illnesses: the Essential Elements of Specialized Probation Caseloads” <http://csgjusticecenter.org/cp/publications/improving-responses-to-people-with-mental-illnesses-the-essential-elements-of-specialized-probation-initiatives/> addresses benefits of specialized probation caseloads. In addition, the SAMHSA National GAINS Center Publication, “Targeting Criminal Recidivism in Justice Involved People with Mental Illness: Structured Clinical Approaches” <http://gainscenter.samhsa.gov/cms-assets/documents/69181-899513.rottercarr2010.pdf> addresses the importance of training clinicians to focus on criminogenic traits when working with justice involved persons.

Cross Intercept Recommendations

1. Develop capacity to provide Sequential Intercept Mapping across Massachusetts

Policy Research Associates has provided Sequential Intercept Mapping Train-the-Trainers events in Florida, New Jersey, Ohio, Pennsylvania and Texas. This approach has allowed states to systematically develop consistent and informed approaches to diversion and reentry. Review of the evaluations suggests conference participants would support such an initiative: “Take the show on the road to stakeholders in each community;” “Local (county) or regional meeting;” and, “Cross-agency/discipline training.”

2. Increase opportunities for trauma informed training and development of trauma-specific treatment

Conference evaluations reflected interest in more training on trauma and trauma informed care. Examples of comments: “The long term effects of witnessing trauma;” “trauma informed care/training and education for staff;” “press for trauma informed training for all staff;” and, “huge percentage of court involved in ‘trifecta’ of mental health, substance, trauma.” The SAMHSA National GAINS Center has the following publications which address trauma in the justice population:

- “Trauma Specific Interventions for Justice-Involved Individuals”
<http://gainscenter.samhsa.gov/pdfs/ebp/TraumaSpecificInterventions.pdf>
- “Creating a Trauma Informed Criminal Justice System for Women: Why and How”
<http://gainscenter.samhsa.gov/cms-assets/documents/73437-12763.ticjforwmn-2.pdf>

- “Essential Components of Trauma Informed Judicial Practice”

<http://gainscenter.samhsa.gov/cms-assets/documents/128389-391390.essentialtjudges.pdf>

3. Consider a Center of Excellence for justice involved persons with mental illness or a statewide task force/planning committee that addresses criminal justice/mental health programming across the Intercepts

It is apparent from review of resources across intercepts that Massachusetts has a number of fine programs and substantial resources. Many participants were not aware of many of the programs.

Establishing a central resource/planning body could perform the following functions:

- Cross system coordination and Planning
- Shared Funding Projects
- Provide Training and Technical Assistance with in-state resources
- Coordinate Budget priorities and proposals

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Appendix 1

Mental Health Substance Abuse Crisis Services Redesign Brief - May 2010

Crisis Services

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

The 80th Legislature

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

Crisis Funds

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

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

Competitive Funds Projects

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

- Provide from 8 hours up to 30 days of short-term, crisis care for individuals with low risk of harm to self or others
- Seven crisis respite units were funded
- **Crisis Step-Down Stabilization in Hospital Setting**
 - Provides from 3-10 days of psychiatric stabilization in a psychiatrically staffed local hospital setting
 - Six local step-down stabilization beds were funded
- **Outpatient Competency Restoration Services**
 - Provide community treatment to individuals with mental illness involved in the legal system
 - Reduces unnecessary burdens on jails and state psychiatric hospitals
 - Provides psychiatric stabilization and participant training in courtroom skills and behavior
 - Four Outpatient Competency Restoration projects were funded

The 81st Legislature

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

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

Appendix 2

Washington Senate Bill Report SB 5533

SENATE BILL REPORT

SB 5533

As Reported By Senate Committee On:
Human Services & Corrections, February 20, 2007
Ways & Means, March 5, 2007

Title: An act relating to procedures for individuals who are mentally ill and engaged in acts constituting criminal behavior.

Brief Description: Revising procedures for individuals who are mentally ill and engaged in acts constituting criminal behavior.

Sponsors: Senators Pflug, Hargrove, Kline, Swecker, Delvin, Stevens, Holmquist, Parlette and Hewitt.

Brief History:

Committee Activity: Human Services & Corrections: 2/02/07, 2/20/07 [DPS-WM].
Ways & Means: 2/28/07, 3/05/07 [DPS(HSC)].

SENATE COMMITTEE ON HUMAN SERVICES & CORRECTIONS

Majority Report: That Substitute Senate Bill No. 5533 be substituted therefor, and the substitute bill do pass and be referred to Committee on Ways & Means.

Signed by Senators Regala, Vice Chair; Brandland, Carrell, Marr and McAuliffe.

Staff: Indu Thomas (786-7459)

SENATE COMMITTEE ON WAYS & MEANS

Majority Report: That Substitute Senate Bill No. 5533 as recommended by Committee on Human Services & Corrections be substituted therefor, and the substitute bill do pass.

Signed by Senators Prentice, Chair; Fraser, Vice Chair, Capital Budget Chair; Pridemore, Vice Chair, Operating Budget; Zarelli, Ranking Minority Member; Brandland, Carrell, Fairley, Hatfield, Hewitt, Hobbs, Honeyford, Keiser, Kohl-Welles, Oemig, Parlette, Rasmussen, Regala, Roach, Rockefeller, Schoesler and Tom.

Staff: Tim Yowell (786-7435)

Background: Under current law, an individual can stand trial for a crime only when competent. A person who is competent is one who is capable of understanding his or her position as a criminal defendant and the nature of the criminal proceedings, and able to assist counsel in his or her defense. Competency evaluations and competency restoration treatments

This analysis was prepared by non-partisan legislative staff for the use of legislative members in their deliberations. This analysis is not a part of the legislation nor does it constitute a statement of legislative intent.

can be ordered by the court if mental illness is an issue. In general, individuals who commit acts constituting misdemeanor crimes which are not serious crimes generally spend a maximum of 30 days in jail facilities. However, jail officials report that individuals with mental disorders who commit the same type of crimes spend an average of 60 - 90 days in jail.

In September 2006, the Washington Association of Sheriffs and Police Chiefs (WASPC) and the Washington affiliate of the National Alliance on Mental Illness (NAMI) held a summit to address the increasing numbers, recidivism rates, and longer jail terms of offenders who suffer from mental illness.

Law enforcement-based crisis intervention teams and training to address increasing contacts with individuals with mental illness exist in some of the larger communities of Washington State. Some communities have crisis triage facilities or receiving centers for individuals with mental illness. Jail-based mental health services, including medications and stabilization, Mental Health Courts and Drug Courts that can accommodate co-occurring disorders have developed in communities across the state to address the issues presented by individuals with severe mental illness in the criminal justice system.

Summary of Bill: The legislative intent section of this bill states that the needs of individuals with mental illness and the public safety needs of society are better served when individuals with mental illness are provided with an opportunity to obtain treatment and support.

Prosecutors are permitted to refer individuals with mental illness who have been alleged to have committed misdemeanor crimes, which are not serious crimes, to mental health treatment. The general statutory provisions regarding competency evaluation and restoration of individuals with mental disorders are consolidated into one new section. Mental health professionals are permitted to return individuals to court at any time during the restoration period if they determine that the individual will not regain competency. Only individuals who have been alleged to have committed misdemeanor crimes that are serious in nature may be referred for competency evaluation or restoration.

A crisis stabilization unit is defined as a short-term facility for individuals who require only stabilization and intervention. The Department of Social and Health Services is required to certify and to establish for crisis stabilization units minimum standards, such as:

- 1) physical separation from the general offender population if in a jail;
- 2) administering treatment by mental health professionals; and
- 3) securing appropriately, given the nature of the crime involved.

The procedure for non-emergent detentions is modified and limited to cases involving allegations of grave disability only. If probable cause exists, the designated mental health professional may request that the court enter an order setting a hearing. The individual may stay at home until the hearing.

Emergent detentions are expanded to include a substantial likelihood of serious harm based on a recent overt act. If the individual is known to be mentally ill, police officers are permitted to detain individuals directly to a treatment facility when there is probable cause to believe that an individual has committed acts constituting a crime. Individuals may be held involuntarily

for up to 12 hours, only if they are seen by a mental health professional within three hours and a petition for involuntary treatment is filed within 12 hours.

The bill establishes a task force. The task force is mandated to review how to increase access to mental health services for individuals who are involved with the criminal justice system due to their mental illness.

EFFECT OF CHANGES MADE BY RECOMMENDED SUBSTITUTE AS PASSED COMMITTEE (Human Services & Corrections): Prosecutor diversion provisions are eliminated. Police diversion provisions are modified and clarified. A definition of imminent is added. The summons process and 24 hour reporting period in non-emergent Involuntary Treatment Act cases is eliminated and replaced with an "order to detain" process. The individual who poses a likelihood of serious harm or grave disability may be picked up if a judicial officer makes a probable cause finding based on the sworn statement of a mental health professional. It is expressly stated that no jail or correctional facility may be considered a less restrictive alternative. Two judicial officers are added to the task force. AAG is removed from the task force. One of two RSN representatives is eliminated and replaced with a representative of Washington Protection and Advocacy System. Technical corrections are made.

Appropriation: None.

Fiscal Note: Available.

Committee/Commission/Task Force Created: Yes.

Effective Date: Ninety days after adjournment of session in which bill is passed.

Staff Summary of Public Testimony (Human Services & Corrections): PRO: People with mental illness who are involved in the criminal justice system have similar needs to other individuals with mental illness. The Mental Health Summit organized by WASPC and NAMI and led by Sue Rohr educated legislators and community members about the need for adopting treatment alternatives for criminal offenders with mental illness. Individuals with mental illness spend as much as five times longer in jail than individuals without mental illness who commit the same crimes. These individuals are also much more likely to commit the same or similar crimes upon their release from custody.

This bill attempts to address that problem by creating a partnership between mental health service providers and the criminal justice system. There are many components to the bill, all of which are aimed at getting individuals into services that are appropriate for their needs. In the long run, this approach should save the counties and the state money. The bill does not mandate any one approach, but rather it develops options to enhance currently available resources. The three main options are: (1) the development of crisis stabilization units which are law enforcement and patient friendly; (2) authorization for police detentions directly to treatment; and (3) authorization for prosecutor initiated treatment alternatives.

This is a situation that we all know intuitively should be better; however, it must be balanced to assist individuals without violating their liberty interests. The purpose of the bill is to address the causes of the revolving door cycle and, hopefully, intervene in a manner that will prevent people from getting into the cycle.

This is a more humane way to deal with mentally ill offenders which will bring about positive outcomes for these individuals. This legislation tries to take a first step toward a more appropriate and effective place for these individuals. Mentally ill individuals struggle throughout their lives with the extensive though not necessarily serious criminal history which becomes an obstacle to education, employment, and housing, and, therefore, recovery. In addition to restoring dignity to the lives of these individuals, in the long run these measures will save taxpayers dollars. This bill will help lessen the cost for counties, lessen the financial burden on the jails, and alleviate prosecutor workload. The reporting requirements on the mental health system need refinement.

OTHER: It is important to add judicial officers and a member from the statewide council on mentally ill offenders housed in the Department of Corrections to the task force. The changes to the non-emergent and emergent processes that are addressed need further work. Some of these issues could be deferred and addressed through the System Transformation Initiative. Prosecutors would prefer to see a pre-arrest option for diversion and liability protections for the police officers. The provisions of the prosecutor diversion option are unnecessary and, at a minimum, they are worth reviewing. Narrowing the misdemeanants who are eligible for competency restoration without eliminating the qualifiers expands the gap in the misdemeanor competency statutes. The changes in the involuntary treatment act provisions need to be reviewed in light of the current case law in these areas. There are a number of issues in the process provisions.

Persons Testifying (Human Services & Corrections): PRO: Senator Pflug, prime sponsor; Peter Lukevich, Washington State Partners in Crisis; Seth Dawson, Gordon Bopp, Eleanor Owen, Jim Adams, John Fisher, National Alliance on Mental Illness; David Lord, Washington Protection and Advocacy System; Cecilia Saari, member and mental health social worker, King County Long-Term Care Ombudsman; Ken Irwin, Yakima County Sheriff; Joseph Maruca, Tacoma Area Coalition of Individuals with Disabilities.

OTHER: Sally Bagshaw, Ethan Rogers, King County Prosecutors Office; Tom McBride, Washington Association of Prosecuting Attorneys; Michael Finkle, Seattle City District Attorney; Rick Lichtenstadter, Washington Defenders Association and Washington Association of Criminal Defense Attorneys; Jean Wessman, Association of Counties; Dave Stewart, Pierce County Regional Support.

Staff Summary of Public Testimony (Ways & Means): PRO: Some people with mental illness commit minor, non-violent offenses and get caught in a cycle of arrest, jail, release, and re-arrest because they do not get the treatment they need. This is a terrible waste of state, local, and human resources. The bill will save significant money for local jails and courts over time.

OTHER: There is a severe lack of evaluation and treatment facilities, especially on the eastside of the state. There needs to be financial assistance to local governments from the operating and capital budgets to develop more such facilities if the promise of this legislation is to be fulfilled.

Persons Testifying (Ways & Means): PRO: Senator Pflug, prime sponsor; Senator Brandland; Seth Dawson, National Alliance for the Mentally Ill.

OTHER: Jean Wessman, Washington Association of Counties.

Appendix 3

CIT Programs - VA Request for FY14 Proposals

**Implementation of Crisis Intervention Team Assessment Sites:
Notice of Possible Funding and Information Regarding Anticipated DBHDS Request for Proposals**

The General Assembly passed an amendment to the FY14 budget includes \$900,000ⁱ to support the development of additional therapeutic law enforcement ‘drop-off centers’ (Assessment Sites)ⁱⁱ in areas with an established Crisis Intervention Team (CIT) program. The Department of Behavioral Health and Developmental Services (DBHDS) is issuing this Request for Proposals to implement 3 – 5 CIT Program Assessment Sites utilizing these funds. Although no change is anticipated, this funding is subject to the Governor’s final approval.

The anticipated timeline for the funding process is as follows:

- April 5, 2013: Request for Proposals is issued
- April 18, 2013: Technical assistance phone conferences for applicants (11:00 a.m. and 2:00 p.m.)
- May 17, 2013: Application deadline (5:00 p.m.)
- June 7, 2013: Notice of Awards is released
- July 1, 2013: Funds are made available
- Sept 1, 2013: All funded programs are fully operational

Applications will be accepted on behalf of an existing local Crisis Intervention Team (CIT) Program, and shall be submitted by the Virginia Community Services Board (CSB) participating in the CIT program and serving the program’s catchment area. Regional proposals submitted through a single lead CSB on behalf of multiple CITs and CSBs will also be considered. Programs submitting applications for new Assessment Sites will be preferred funding recipients. Existing CIT Assessment Sites currently operational, substantially funded utilizing DBHDS jail diversion funds, or which were awarded funds under the original FY13-14 assessment site allocation *may* apply however, any award of funds will be based on quality of application, comparative need, and availability of funds after new proposals have been considered.

The purpose of this solicitation is to allocate \$900,000 for the implementation and operation of 3 – 5 assessment sites for strong, existing CIT initiatives. Assessment Sites are intended to serve as a therapeutic, non-criminal justice site to which law enforcement officers can bring individuals in mental health crisis, as an alternative to incarceration. Sites should be designed to provide 24/7/365 accessibility for law enforcement custodial hand off, clinical assessment for possible civil commitment, referrals and linkage to services for acute and sub-acute mental health treatment needs, or as close to that goal as feasible given anticipated funding levels. The degree to which programs achieve around the clock operational capacity is a weighted factor in grant selection. Sites should be compatible with the statutory and policy goals of Virginia’s CIT programs. Applicants should utilize the Essential Elements for the Commonwealth of Virginia’s Crisis Intervention Team Programs (attached hereto) for guidance in the development of this application and their site plans and implementation strategies.

Individual awards will vary dependent upon actual amounts requested and total number of sites selected. Factors to be considered in making awards will include the following categories; listed here in the general order of their relative significance for meeting budget language parameters and for achieving effective and successful implementation, operation and integration of the site within the existing CIT program:

- Strength, progress and status of existing CIT program(s)
 - Adherence to the Virginia CIT Essential Elements
- Substantial completion of realistic strategic plan for site development and implementation
 - Clear statement of goals and projected outcomes

**Implementation of Crisis Intervention Team Assessment Sites:
Notice of Possible Funding and Information Regarding Anticipated DBHDS Request for Proposals**

- Evidence of strong leadership, diverse criminal justice, behavioral health and consumer partnership and stakeholder support
- Capacity to be fully operational within 60 days of receiving funds
- Capacity to provide around the clock access for law enforcement and provision of assessment
- Linkage to additional programs, resources and supports
- Persuasive, practicable and realistic budget and budget narrative
- Agreement to provide quarterly reporting, participate in established data collection process and meet other DBHDS requirements
 - Technical compliance with the matching funds (minimum 20% in year one and 30% every year thereafter – matching funds may be in-kind)
- Statement of agreement to comply with RFP submission requirements

It is anticipated the following detailed information will be included in the Request for Proposals, including submission forms:

I. Submission Date and Technical Requirements

- a. All proposals must be submitted electronically pursuant to the instructions below, and be received by DBHDS no later than **5:00 p.m. on Friday, May 17, 2013.**
- b. Proposals shall adhere to the page limitations set forth in each section.
 - i. The submission shall be in Word document, utilizing the application form attached hereto (completed application may also be submitted in its entirety as a PDF but must be reproduced at 100% of original document), except that
 1. Letters of support and other addenda, including inter and intra agency policy documents, Memoranda of Agreement (MOA), Memoranda of Understanding (MOU), etc. may be submitted as PDFs and need not comply with the technical requirements of the application form. However, all such attachments shall be reproduced at 100% of the original document size.
 - ii. All documents shall utilize one inch margins, shall be in 12 point Times New Roman font and may be single spaced (does not apply to letters of support)
 - iii. All pages shall be numbered sequentially, excluding letters of support and addenda, which may be separately identified and paginated
 - iv. Letters of support shall be signed and on agency or individual letterhead
- c. The fiscal agent for each project shall be the CIT program catchment area's CSB or lead CSB for regional submissions.
- d. All proposals shall be submitted, utilizing the forms provided, via e-mail to Victoria Cochran, Director – Office of Behavioral Health and Criminal Justice Services:
victoria.cochran@dbhds.virginia.gov
- e. **Documents submitted must be named and saved as follows: FY14 CIT Assessment Site Funding Application – (Name of CSB) (Segment – if applicable)** If submitted in multiple segments, please sequentially number each page of multiple word documents; when naming separate documents indicate the document name pursuant to the Elements of the Proposal

**Implementation of Crisis Intervention Team Assessment Sites:
Notice of Possible Funding and Information Regarding Anticipated DBHDS Request for Proposals**

listed below). If you are submitting a single PDF file please number each page sequentially, beginning with the cover page).

II. Elements of the Proposal

- a. Transmittal Letter or memorandum on CSB letterhead
- b. Cover Page (Use form, attached)
 - i. Name, address, contact information and signature of CSB Executive Director
 - ii. Name, address, contact information of CSB fiscal representative
 - iii. Names, address, contact information for all project partners
 - iv. Statement of intent to abide by the conditions of the project contract if applicant is successful
- c. Narrative Summary (5 page limit – use form, attached) – The goal of this narrative section is to accurately describe the current status of your CIT program and readiness for developing/implementing a CIT assessment site component. This section should include, *at a minimum*:
 - i. Current CIT program description, including
 1. Current CIT program data – e.g., # of officers trained, # of CIT interventions annually, # of trainings held, # of ECO/TDO, # of incarcerated individuals with serious mental illness
 2. Narrative summary of current program, practices and policies
 - ii. Site development planning process utilized to create implementation plan
 - iii. Ongoing program oversight (including new assessment site and all aspects of current CIT program)
- d. Site Development, implementation and operational plan (5 page limit – use form, attached) – The goal of this section is to accurately describe the who, what, when, where, and how for the assessment site development/implementation/operational project and should include, *at a minimum*:
 - i. Location/service area/capacity
 - ii. Inter-and intra-agency protocols/policies/memoranda of agreement to be utilized in conjunction with the site (summarized in plan, attached to application as addenda; any MOA or MOU should contain signatures unless it is currently under proposal)
 - iii. Partners/stakeholders and their roles
 - iv. Access to and description of services, programs/evidence based and best practices to be utilized
 - v. Anticipated barriers and means for addressing
 - vi. Anticipated site modifications or renovations (if applicable)
- e. Process for Collecting Required Data (3 page limit – description of required data attached)
- f. Detailed Budget and Budget Narrative of anticipated expenditures and income (matching funds/third party payments, etc. – Use form, attached). At a minimum, budgets must contain categories for:
 - i. Personnel

**Implementation of Crisis Intervention Team Assessment Sites:
 Notice of Possible Funding and Information Regarding Anticipated DBHDS Request for Proposals**

- ii. One time expenditures of no more than 5% (equipment/site modifications/renovation, etc.)
No funds will be allocated for ground up construction.
 - iii. Ongoing expenditures other than personnel
 - iv. Matching funds
 - v. Anticipated income
 - vi. Budget narrative
 (Justification/explanation for each income or expense line item)
- g. Letters of Support are unlimited, however, each letter must include the following information:
- i. individual or agency letter head
 - ii. specific supporting resources of the agency or individual
 - iii. specific supporting activities if the agency or individual

For questions or technical assistance with this process, there will be two conference calls scheduled for all interested applicants. The first call will be at 2:00 p.m. on Thursday, April 18. The second call will be at 1:00 p.m. on Friday, April 28. To RSVP for the call and obtain call in information, please email Victoria Cochran at victoria.cochran@dbhds.virginia.gov. For further information about this process, please call or email:

Victoria Cochran, Director
 Office of Behavioral Health and Criminal Justice Services
victoria.cochran@dbhds.virginia.gov
 804 786 9084 (office)
 540 392 4101 (cell)

ⁱ Item 315#5c

Health And Human Resources	FY 12-13	FY 13-14	
Grants To Localities	\$0	\$900,000	GF

Language:

Page 285, line 35, strike "\$325,471,560" and insert "\$326,371,560".
 Page 289, line 12, strike the second "\$600,000" and insert "\$1,500,000".

Explanation:

(This amendment provides \$900,000 from the general fund the second year to expand capacity for therapeutic assessment drop-off centers to provide an alternative to incarceration for people with serious mental illness. Priority for new funding shall be given to programs that have implemented Crisis Intervention Teams pursuant to § 9.1-102 and § 9.1-187 et seq. of the Code of Virginia and have undergone planning to implement drop-off centers.)

ⁱⁱ While the vernacular term 'drop-off center' is utilized in the General Assembly budget language, this term is not preferred for utilization in the community. Assessment center, triage center, receiving facility, hand-off, and the like, are preferred, less stigmatizing, and more accurate descriptors. For purposes of this application you may identify and utilize the anticipated name or descriptor for your 'drop-off center' project. The term Assessment Site is used for purposes of this RFP.

Appendix 4

Crisis Care Services for Counties: Preventing Individuals with Mental Illnesses from Entering Local Corrections Systems

Crisis Care Services for Counties:

Preventing Individuals with Mental Illnesses from Entering Local Corrections Systems



Produced by the Community
Services Division of the County
Services Department

June 2010



Crisis Care Services for Counties: Preventing Individuals with Mental Illnesses from Entering Local Corrections Systems

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About NACO – The Voice of America’s Counties

The National Association of Counties (NACO) is the only national organization that represents county governments in the United States. Founded in 1935, NACO provides essential services to the nation’s 3,068 counties. NACO advances issues with a unified voice before the federal government, improves the public’s understanding of county government, assists counties in finding and sharing innovative solutions through education and research, and provides value-added services to save counties and taxpayers money. For more information about NACO, visit www.naco.org.

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- Those who contributed from King County, especially Amnon Shoenfeld, Director, Mental Health Chemical Abuse and Dependency Services Division.

Introduction

Almost fifteen percent of men and thirty- one percent of women recently booked in jail have a serious mental illness.¹ At present, there are three times more individuals with mental illness in jails and prisons than in hospitals.² Many jails are now de facto mental health hospitals, even though community services are more ideal for individuals with mental illness rather than jails or hospitals.

Individuals with mental illness tend to experience more frequent contact with the justice system. For example, in Los Angeles County Jail, ninety percent of inmates with mental illness are repeat offenders, with thirty- one percent incarcerated ten or more times. A multitude of issues arise when housing individuals with serious mental illnesses in jails. Individuals with mental illness in jails experience increased risk for abuse, suicide, and stay longer and have higher costs.³

The detrimental consequences of imprisoning individuals with mental illness are not exclusive to adults. Youth with mental health disorders are more likely to serve time in a facility and for an increased amount of time compared to youth without mental health disorders. This may be due to unnecessary detention; sixty- six percent of juvenile detention facilities reported holding youths who do not need to be in detention as they wait for mental health services in the community.⁴

Allowing youth and adults with mental illness to enter the justice system contributes to large corrections costs. Many individuals with mental illness commit minor public disturbances that lead to arrests. Focusing on alternative justice strategies can help save counties money. For each non-violent offender in jail moved to probation or parole, local government corrections systems could save almost \$25,000. Moving fifty percent of current non-violent inmates to probation or parole from jail could save local governments \$7.2 billion per year, even after factoring in additional probation and parole costs.⁵

Promising solutions for individuals with mental illness often involve counties offering mental health resources in the community prior to arrest. One study found that “the availability of alternative, less costly treatments may be critical in controlling the costs of pre-booking jail diversion.”⁶ For youth, the most effective programs at reducing recidivism exist in the community rather than in the criminal or juvenile justice systems.⁷

A productive way to facilitate reaching individuals with mental illness locally is through the implementation and effective use of crisis care services. Crisis care services aim to quickly address psychiatric emergencies in the community. Ideally this diverts people from being involved in the justice system or unnecessary emergency room visits. A psychiatric crisis can be defined as the following:

A psychiatric emergency (crisis) is a sudden serious psychological disturbance or change that affects behavior or functioning. If not responded to, it may result in life-threatening and unsafe consequences. Characteristics include a sense of urgency, sense of being overwhelmed, lack of coping abilities and the recognition of need for assistance from others to manage and alleviate distress. It often includes life threatening, life disrupting and life impairing behaviors.⁸

Crisis care services vary in form. Mobile crisis units are a great way of reaching people in their homes and allowing them to stay in the community. Crisis hotlines are avenues for directing people to the help they need. Crisis care centers offer a place for individuals to receive necessary services.

Regardless of the type of crisis care services, they ultimately have the same goal – to provide crisis assessment, intervention and linkages to community resources for stability. Counties need to assess their population, resources and geographic needs. Coordination and collaboration with many different organizations and agencies is essential for the development, success and sustainability of crisis care services. This best serves the individual by providing the help they need quickly. Counties benefit by ensuring needed services for residents. They also save money by preventing involvement in more costly systems such as jails and hospitals.

Law enforcement can play a vital role in linking individuals with mental illness to crisis care services. Often, people

1 Steadman, Osher, Robbins, Case & Samuels, “Prevalence of Serious Mental Illness Among Jail Inmates,” *Psychiatric Services* 60 (2009).

2 Treatment Advocacy Center & National Sheriff’s Association, *More Mentally Ill Persons Are in Jails and Prisons Than Hospitals: A Survey of the States* (2010).

3 Treatment Advocacy Center & National Sheriff’s Association, *More Mentally Ill Persons Are in Jails and Prisons Than Hospitals: A Survey of the States* (2010).

4 U.S. House of Representatives Committee on Government Reform – Minority Staff Special Investigations Division, *Incarceration of Youth who are Waiting for Community Mental Health Services in the United States* (2004)

5 Center for Economic and Policy Research, *The High Budgetary Cost of Incarceration* (2010).

6 Cowell, Broner & Dupont, “The Cost- Effectiveness of Criminal Justice Diversion Programs for People with Serious Mental Illness Co-Occurring with Substance Abuse,” *Journal of Contemporary Criminal Justice* 20 (2004).

7 Justice Policy Institute, *The Costs of Confinement: Why Good Juvenile Justice Policies Make Good Fiscal Sense* (2009).

8 Human Services and Public Health Department, Hennepin County, Minnesota. Community Outreach for Psychiatric Emergencies Power Point presentation, June 3, 2010.

are not aware of available crisis care services and will instead contact law enforcement. Without equipping law enforcement with the tools to recognize an opportunity for diversion, encounters with law enforcement may lead to unnecessary arrest or an over reliance on emergency departments. Crisis care services aim to work together with law enforcement to increase awareness of alternatives for individuals experiencing a mental health crisis. It takes a close partnership with law enforcement to divert individuals with mental illness from arrests, costly jail bookings, and unnecessary emergency room visits.

As managers of local corrections and social services budgets, county officials have a critical responsibility to understand available services for individuals with mental health issues. The indirect costs of mental illness, such as lost productivity in usual activities due to illness, can be as high as \$79 billion per year.⁹ Investing in these services provides residents with critical resources, allows counties to save money and offers options for law enforcement so they can focus on public safety.

The following county examples illustrate the various forms of crisis care services. Although each county differs in population size, demographic, location and resources, all commit to providing crisis care services to county residents. County commissioners in each site provide crucial leadership, support and input that lead to the success of crisis care services. Each county demonstrates collaboration and partnership with law enforcement to help divert individuals with mental illnesses from the justice system and into the services they most need, allowing counties to use resources more effectively.

9 United States Department of Health and Human Services, Surgeon General's Report on Mental Health (1999). Available online at: <http://www.surgeongeneral.gov/library/mentalhealth/toc.html>, accessed June 15, 2010.

Featured Counties

● Bexar County, Texas¹⁰

Population: 1,622,899¹¹

Highlight: Collaborating with law enforcement to reduce arrests and improper emergency department use for substantial cost- savings.

State, county and city funds contribute to the Center for Health Care Services (CHCS) to provide comprehensive crisis services for residents of Bexar County. One of the key services CHCS provides for crisis care is the Adult Crisis Care Center (ACCC). In September 2005, the adult crisis care unit developed and co-located with medical services. For individuals with mental illness at crisis care, the Center can offer minor medical clearance. This stabilizes the individual and allows for subsequent treatment of the behavioral health issue. Minor medical clearance can avoid costs as it takes place on site at the Center rather than in an emergency department (ED).

The Adult Crisis Care Center, open twenty- four hours per day, seven days per week, consists of an eight chair observation room and a twenty- three hour galley. Average length of stay is ten hours, although people may stay up to twenty- three hours. The Adult Crisis Care Center sees people eighteen and over, but the mobile crisis unit serves all ages. A separate child's crisis care center exists for those below eighteen years of age. The ACCC receives people via warrant, law enforcement drop-off and walk-in. The ACCC sees four- hundred to five- hundred people per month, with one- hundred to one- hundred and fifty from involuntary commitment. CHCS serves individuals regardless of access to insurance.

The Adult Crisis Care Center enjoys many options for stabilization and continued treatment of an individual who is in crisis, including partnerships and linkages to community services. Bexar County has a substance abuse treatment program, Seeking Safety, with a focus on trauma. A sobering unit with six to eight beds is available and solely used for law enforcement drop-off. A walk- in detox unit with twenty- seven beds is available for the homeless and indigent. A twenty- four hour crisis hotline assists residents.

10 Except where noted, all information is based on personal communication with Gilbert Gonzales and Jeanie Paradise, January 2010 through June 2010.

11 U.S. Census Bureau, Population Division (2008).

For additional stabilization there is a sixteen bed voluntary crisis residential unit. Bexar County also utilizes a mobile crisis outreach team that is able to go with law enforcement on a call and conduct clinical evaluations in the community.

Following treatment at the Adult Crisis Care Center, individuals with mental illness can receive an out-patient appointment, see a physician, receive medications or get hospitalization if necessary. Follow-up care and linkages to various community partners through a discharge plan prevents future incidents.

One of the most rewarding partnerships CHCS experiences is with law enforcement. The Bexar County Sheriff spearheaded the effort of collaboration between law enforcement and crisis care. Prior to the development of the Adult Crisis Care Center, there were limited resources for officers when they received a call for a person with mental health issues. Choices before the Center were to take people to the jail or the emergency department. This process reflected additional costs due to the improper use of the ED and unnecessary bookings in the jail. Most importantly, people did not receive the help they desperately needed. Law enforcement now has options for those who need help rather than jail time.

Results of this collaboration include a process which allows for greater utilization of the ACCC by law enforcement. When law enforcement arrives at the ACCC to drop off a person with a psychiatric emergency, the process takes five to fifteen minutes. The quick drop-off process allows the

officer to return to duty quickly to concentrate on public safety, rather than wait at an ED. Law enforcement officers are more likely to utilize the crisis care center when they are aware of the short drop-off time.

To date, nineteen percent of Bexar County's police force participated in Crisis Intervention Team training (CIT). Along with the usual CIT training involving role- playing, they now include training on police officer suicide and hold an eight hour refresher class every three years. Bexar County also provides a children's CIT class for school police and administrators once a year. All of the CIT trainings include education regarding alternatives to arrest, including the detox unit and Adult Crisis Care Center. In order to facilitate the continued collaboration with police, monthly CIT meetings occur between CIT officers, the hospital, ACCC, other law enforcement and the local chapter of the National Alliance on Mental Illness (NAMI).

Bexar County's comprehensive care developed due to a confluence of factors, including political will, funds dedicated to these services, and a forward- thinking sheriff. County Commissioners appointed five of the nine Adult Crisis Care Center Board members, which allows the County intricate involvement in the services available for residents. These factors led to the services Bexar County currently offers for crisis care and community linkages to stabilization and follow-up care. The co-location of services enables the coordination of services and negates patient anxiety over navigating multiple systems of care.

Electronic records and data are useful for assessing ef-

Results of Efforts to Address Mental Illness, Substance Abuse and Homelessness In San Antonio & Bexar County

Documented and Immediate Cost Avoidance

April 16, 2008 – March 31, 2009

Cost Category	City of San Antonio	Bexar County	Direct Cost Avoidance
Public Inebriates Diverted from Detention Facility	\$435,435	\$1,983,574	\$2,419,009
Injured Prisoner Diverted from UHS ER	\$528,000	\$1,267,200	\$1,795,200
Mentally Ill Diverted from UHS ER Cost	\$322,500	\$774,000	\$1,096,500
Mentally Ill Diverted from Magistration Facility	\$208,159	\$371,350	\$579,509
Reduction in Competency Restoration Wait Time in Jail for Hosp Admission 5/08-3/09	0	\$255,055	\$255,055
Reduction in Wait Time in Jail for Outpatient Competence/Wait Time for Restoration compared to Inpatient	0	\$137,898	\$137,898
Reduction in Jail Time for Competency Restoration on Bond and on Return	0	\$385,522	\$385,522
Total	\$1,494,094	\$5,174,599	\$6,668,693

Provide by the Center for Health Care Services

iciency. Through the Adult Crisis Care Center and comprehensive services, Bexar County diverts individuals with mental illness from the ED and continues to avoid building a new jail. According to data from Bexar County between April 16, 2008 and March 31, 2009, the direct cost-avoidance for diverting individuals who are mentally ill from the ED is almost \$800,000. Individuals with mental illness diverted from the Magistration Facility due to CHCS's services provided a cost-avoidance of over \$350,000. For injured prisoners treated for minor medical issues at CHCS rather than the ED, the cost-avoidance was about \$1.3 million dollars.^{12 13} The data allow decision-makers to see the value of investing in crisis services rather than a new jail facility.

Bexar County possesses comprehensive services and community partnerships. The demonstrated coordination of resources leads to the efficient functioning of all players involved. The services the ACCC provides result in significant cost-avoidance and allow people to receive the treatment they need rather than punishment. Close relationships with law enforcement allow the ACCC to successfully function as a viable alternative to arrests and jail.

12 Center for Health Care Services, *The Results of Efforts to Address Mental Illness, Substance Abuse and Homelessness in San Antonio & Bexar County, April 2008 through March 2009* (2009).

13 Center for Health Care Services, *The Results of Efforts to Address Mental Illness, Substance Abuse and Homelessness in San Antonio & Bexar County, Documented and Immediate Cost Avoidance, April 2008 through March 2009* (2009).

● Buncombe County, North Carolina

Population: 229,047¹⁴

Highlight: Innovative Crisis Intervention Team (CIT) and creating and sustaining crisis services with little grant money.

In 2003, North Carolina created a local management entity (LME) system to provide behavioral health services to counties on a regional basis. Western Highlands (WH) is the LME currently providing behavioral health services to eight counties, including Buncombe. Buncombe County provides \$600,000 per year to Western Highlands to assist with behavioral health services for its residents. The County also invests an additional \$600,000 annually from a mental health trust fund.¹⁵

Western Highlands has partnerships with numerous community entities to provide a continuum of care for Buncombe County residents. One of these partnerships is with Mission Hospital, which operates the Psychiatric Evaluation Area (PEA). PEA is part of the Emergency Department (ED) at Mission Hospital and is open twenty-four hours per day, seven days per week. Mission Hospital's ED sees around

14 U.S. Census Bureau, Population Division (2008).

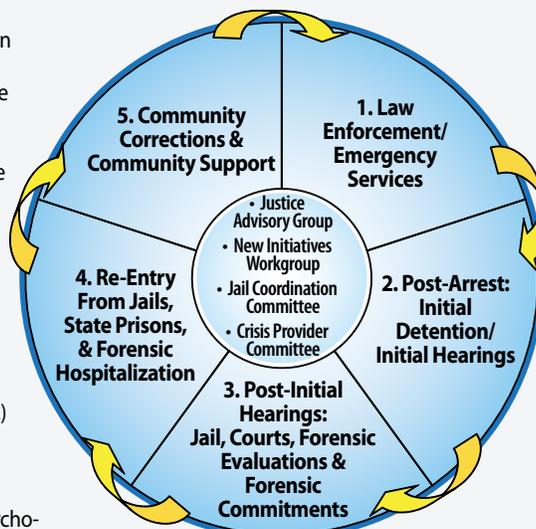
15 Buncombe County Public Safety Performance Program, *FY 2010 Buncombe County Behavioral Health Budget* (2009).

Sequential Intercept Model in Buncombe County

December 2009

- Probation/parole
- Day Reporting Center
- TASC case management for persons on probation
- Western Carolinians for Criminal Justice
- Federally Qualified Health Center—WNCCHS
- Access to mental health and substance abuse service—Western Highlands
- Pisgah Legal Services SOAR disability program

- Jail programs (chaplain, Alcoholics Anonymous, Narcotics Anonymous, etc.)
- Jail health services
- Mental health case management
- Substance abuse case management
- Mental health and substance abuse psycho-educational groups



- Family Treatment Court
- Drug Treatment Court
- Nuisance Court

- Crisis Intervention Team (CIT)
- Emergency Department (ED) at Mission Hospital
- Psychiatric Evaluation Area (PEA) at Mission Hospital
- Mobile Crisis Team
- WNCCHS Urgent Psychiatric Walk-in Clinic
- Neil Dobbins Detox/Crisis Stabilization Unit
- WCRM Wet Shelter
- Helpmate Domestic Violence Shelter
- Trinity Place Youth Shelter

- Jail Assessment Unit
- Pretrial Services
- JUST Jail Diversion Project*

* In the literature, this is referred to as a Non-Specialty First Appearance Court Model for Diverting Persons with Mental Illness

Munetz & Griffin, "Use of the Sequential Intercept Model as an Approach to Decriminalization of People with Serious Mental Illness," *Psychiatric Services* 57 (2006):544. Modifications and information added by Buncombe County.

100,000 visits per year and serves neighboring counties that lack hospitals.¹⁶ PEA can assess and then discharge with planning, recommend in-patient beds at facility, or recommend state hospital care. Law enforcement has the option of utilizing the PEA within the emergency department if they determine an individual may be in crisis.

Those in crisis can also benefit from the Mobile Crisis Unit (MCU). Mobile crisis services are available through a partnership between WH and a local provider named Families Together. Buncombe residents can access mobile crisis services twenty-four hours per day regardless of insurance. Calling mobile crisis instead of 911 is a viable option that allows law enforcement to remain focused on public safety calls and diverts individuals from the ED.

The MCU completes crisis treatment and follow-up care, including transport to other services if necessary. Mobile units are able to reach both children and adults to serve them in their own communities. MCU receives ninety calls per month; of these, ninety-three percent do not go to state hospitals. For follow-up services, mobile crisis can refer to detox, domestic violence shelters, the Crisis Stabilization Unit, a federally qualified health center, make appointments with providers and provide transport.

Western North Carolina Community Health Services (WNCCHS) is a designated Federally Qualified Health Center (FQHC).¹⁷ A Federally Qualified Health Center has many benefits, including enhanced Medicare and Medicaid reimbursement; medical malpractice coverage; eligibility to purchase prescription and non-prescription medications for outpatients at reduced cost and funding for new starts, among other benefits.¹⁸ The County Commissioners engaged in this partnership because of a historical commitment to respond to community needs. The FQHC increases capacity and addresses a gap in services to community residents while allowing the county to save money.¹⁹

The FQHC in Buncombe County opened in 1993 as an HIV clinic. Today it offers medical, urgent, chronic, and behavioral health care. Four hundred to five hundred mostly uninsured people per month appear through appointments and adult crisis walk-in. Western Highlands partners with the FQHC to provide urgent psychiatric walk-in care, and the County funds services for those released from jail. This

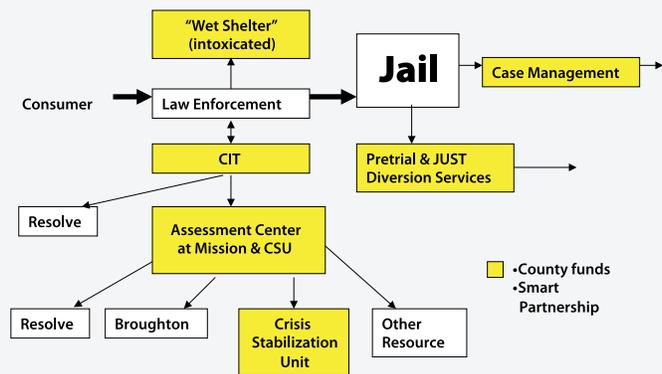
¹⁶ Personal communication with Dr. Ted Schiffman, Director of Behavioral Health Services, Mission Hospital, May 12, 2010.

¹⁷ Buncombe County Government letter from Assistant County Manager Amanda Stone. Available online at: https://www.bcmsonline.org/main/files/2009_mandy_stone_ltr.pdf. Accessed June 7, 2010.

¹⁸ Rural Action Center, FQHC Frequently Asked Questions. Available online at: http://www.raconline.org/info_guides/clinics/fqhc-faq.php#whatis. Accessed June 7, 2010.

¹⁹ Personal communication with Amanda Stone, Assistant County Manager, May 12, 2010.

Criminal Justice Diversion for Consumers of Mental Health & Substance Dependence Services



Crisis Intervention Team (CIT)

Provided by Buncombe County CIT Collaborative

system bridges care and allows those reentering from jail or other persons without a provider to remain stabilized until an appointment with a provider is available.

The Crisis Stabilization Unit (CSU) is another option for diverting individuals with mental illness from arrest. The CSU is a twenty-four hour per day seven day per week facility. It has sixteen beds, five for substance abuse detox, five for crisis stabilization and six beds which may be used for either detox or crisis stabilization. The CSU opened in April 2008 and carries out medical stabilization and assessment. Walk-ins, voluntary commitments, involuntary commitments, people from mobile crisis and drop-offs from law enforcement are all accepted.

Law enforcement can utilize the CSU as a drop-off center after consulting with Western Highlands via telephone. This diverts individuals with mental illness from arrest and over-using the ED and allows officers to return to public safety duties quickly. When law enforcement drops off a person in crisis, the CSU is able to treat, stabilize and connect to other community services for long term well-being.²⁰

Officers are aware of the drop-off options at the CSU and ED due to Buncombe County's commitment to Crisis Intervention Team (CIT) training. Since the first class in April 2008, the Buncombe County Sheriff's department has trained twenty percent of staff and the Asheville Police Department has trained ten percent. Many officers were not aware of community resources and alternatives to arrest prior to attending training.²¹

²⁰ Personal communication with Charlie Schoenheit and ARP-Phoenix staff, May 12, 2010.

²¹ Personal communication with Mona Cornwell, Asheville- Buncombe Technical Community College, May 12, 2010.

CIT training consists of a one- week forty- hour course that includes mental health information and role- playing exercises, among other sessions. The local community college provides training in partnership with Buncombe County Sheriffs' department, Asheville Police Department, the local chapter of the National Alliance on Mental Illness (NAMI), Western Highlands, Mission Hospital, Buncombe County and the City of Asheville.²²

Law enforcement officers learn skills for calls involving someone in crisis and discover community options for alternatives to arrest (Appendix A). Buncombe County Sheriffs' Office and Asheville Police Department allow officers full discretion regarding whether or not to arrest for a misdemeanor crime in which the officer suspects mental illness or substance abuse is a contributing factor.²³ The CIT

training and use of drop-off at the Mission Hospital ED and CSU is projected to create two- hundred sixty diversions from jail per year.²⁴ This represents significant cost avoidance by reducing arrests, jail booking costs, and potential unnecessary ED visits.

Many other entities have expressed interest in CIT training, including dispatchers, Fire-Rescue, EMS, jail staff, court officials, human services staff, school staff, probation, Mall Security and VA Hospital Security.²⁵ These groups often find it difficult to take time to attend a forty hour training class, and may find training more accessible if available in an adapted format. Therefore, Buncombe County plans to create an online CIT training module in partnership with the local community college. The online training module will include simulated role playing exercises. An online

22 Buncombe County Public Safety Performance Program, Buncombe County CIT Collaborative, *Memorandum of Agreement* (2007).

23 Buncombe County Public Safety Performance Program, Buncombe County CIT Collaborative, *Buncombe County Behavioral Health Crisis Continuum: A Guide for Law Enforcement* (2010).

24 Buncombe County Public Safety Performance Program, *Analysis of Major Diversion Programs* (2010).

25 Buncombe County Public Safety Performance Program, Buncombe County CIT Collaborative, *Crisis Intervention Training Online Module Overview* (2010).

Yellowstone County, Montana

In 2006, the Community Crisis Center (CCC) was formed with start-up funding through a federal grant. As a collaborative effort, four Yellowstone County agencies; Billings Clinic, St. Vincent Healthcare, South Central Mental Health Center and Riverstone Healthcare coordinated to become sponsoring agencies of this initiative. The two local hospitals, Billings Clinic and St. Vincent Healthcare, had been considering the concept for many years, as they were seeing an increase in the number of persons presenting to the local emergency rooms for mental health, substance abuse and social services care.

The CCC is a licensed Community Mental Health Stabilization Center and provides crisis services for individuals eighteen and over. With a staff of twenty- four, the center takes a team approach to decisions and has a no wrong door philosophy. Individuals are able remain with the CCC for twenty- three hours, fifty- nine minutes during which time the team sets up appropriate follow up and plans of care with the individual. The local mental health center provides case managers to assist individuals with their plan and the HUB, a part of the mental health center, provides a drop in day center offering a range of services and also works with individuals to find permanent housing. The Mental Health Center/HUB donates the case management and Riverstone Health provides the Board Chair and Medical Director.

After initial grant funding expired, the two local hospitals shared the total operational costs of the CCC. Additionally,

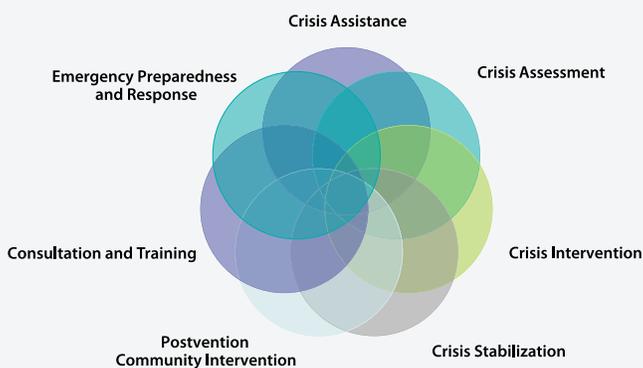
during FY 2009, the state of Montana, through a crisis services grant to eleven counties, provided \$294,000 towards the operation of the CCC. The remainder of the funding came from private donations, Medicaid reimbursements, mental health service plan funding and seventy- two hour presumptive eligibility reimbursements.

Since the inception of the CCC, the Yellowstone County Detention Facility and the local ERs have seen a significant decrease in numbers of persons admitted to their facilities due to mental illness/substance abuse. This is directly attributable to the efforts of law enforcement in diverting persons with mental illness to the CCC for more appropriate care.

CIT training is facilitated through this entity and has trained approximately one- hundred seventy- three officers, deputies and EMT in the region. Law enforcement has been supportive of these efforts and encouraged to utilize the center, when appropriate. Since the inception of the CCC, ED visits, jail populations and state hospital admissions have all been reduced.

On June 8th, 2010, the Yellowstone County Voters passed a mill levy which will contribute a significant base of sustainable funding for the CCC and the HUB. The levy was started through the support and hard work of County Commissioner Bill Kennedy. While the levy will be helpful with sustainability, the CCC and the HUB will still rely on the remainder of their total funding to be made from donations, the healthcare community, Medicaid-mental health service plan- and seventy- two hour presumptive eligibility funding from the state.

Child Crisis Services Available to Law Enforcement



Provided by Hennepin County Child Crisis

modified CIT training option may be the best way to reach programs that will not otherwise receive training, and can potentially increase diversions from jail and the ED. For example, EMS actually receives more calls than law enforcement requesting help with persons in a psychiatric crisis.

The County Commissioners have long supported these types of crisis services. Providing services to residents is a priority for the Commissioners, although cost remains an issue for a relatively small county. With privatization of some services and partnering with Western Highlands and the FQHC, Buncombe County residents are receiving high quality crisis services without further straining county budgets.

Self-sustainability is the ultimate goal as Buncombe County aims to avoid short-term grant money and opts to rely on data to guide smart long-term investments.²⁶ All of the investments thus far led to a system of care focused on alternatives to arrest and community care. The Commissioners planned to discuss the need for an addition to the county jail in 2010 but it has been postponed due to the efforts of crisis care and law enforcement to divert individuals with mental illness from less effective care and more costly systems.²⁷

²⁶ Personal Communication with Amanda Stone, Assistant County Manager, and Rich Munger, Planner/ Evaluator, May 12, 2010.

²⁷ Personal communication with Amanda Stone, Assistant County Manager, May 12, 2010.

● Hennepin County, MN²⁸

Population: 1,140,988²⁹

Highlight: Serving juveniles and adults in an increasingly diverse and growing population, and training 911 dispatch to call mobile crisis instead of law enforcement.

Since 2005 Hennepin County provides both juvenile and adult crisis services to residents through Child Crisis and Community Outreach for Psychiatric Emergencies (COPE). Both youth and adults in Hennepin County can access crisis assessment, intervention and stabilization services.

Child Crisis receives money from property tax revenue, 92% of which is county funding.³⁰ Services are available twenty-four hours per day, seven days per week and are provided in client homes, schools, hospitals and juvenile detention facilities. All of these services are in partnership with parents, schools, hospitals, community and faith based organizations and law enforcement.

Child Crisis partners with law enforcement and corrections in many ways, such as participating in Police Academy presentations, roll calls, developing statewide CIT and dispatch training. As standard CIT training does not include lessons specific to youth, Child Crisis and NAMI Minnesota are partnering to hold youth-specific CIT training for law enforcement.³¹ Child Crisis carries out interventions at school, assesses youth in detention and assists law enforcement on calls. All of these activities with law enforcement ultimately provide youth with additional alternatives to arrest or hospitalization.

Stabilization services are available to youth following a crisis intervention. Services include access within twenty-four hours to diagnostic assessment, therapy, and rapid access psychiatry appointments. As most community psychiatrist appointments are not available for twelve weeks, rapid access appointments allow children the opportunity for stabilization by connecting them quickly to follow-up appointments. Child Crisis provides transports to these appointments if necessary.

COPE manages the adult mobile crisis services. The County provides seventy-two percent of the property tax

²⁸ Unless otherwise noted, information is based on personal communication with Dr. Kay Pitkin, Manager of Child Crisis, and Carmen Castaneda, Human Services Program Manager for Community Outreach for Psychiatric Emergencies, January 2010- June 2010.

²⁹ U.S. Census Bureau, Population Division (2008).

³⁰ Human Services and Public Health Department, Hennepin County, Minnesota. Child Crisis Power Point presentation, June 3, 2010.

³¹ Personal communication with Suzette Scheele, Director of Children's Programs, National Alliance for Mental Illness, June 3, 2010.

revenue that COPE receives.³² The twenty-four hour seven days per week mobile unit allows individuals with mental illness to receive community interventions and treatment. These services facilitate diverting people from arrests, jail, and unnecessary emergency department (ED) visits.³³

Once COPE sees a consumer, there are many follow-up treatment services available if necessary. COPE offers counseling, medication, evaluation and treatment. While most appointments with a psychiatrist can take up to twelve weeks, rapid access appointments allow those in

immediate need to connect to assistance quickly. COPE can also connect with health insurance assistance, case management, community supports, medical services and crisis residential treatment for follow-up support. One residential treatment option is Nancy Page, which is a crisis stabilization short-term care residence for adults eighteen and over. Nancy Page aims to help those with serious and persistent mental illness and offers an option for avoiding psychiatric hospitalization.

The partnership between COPE and law enforcement is very important. Ninety percent of all adult mobile crisis calls result in the individual remaining in the community. Twelve percent of calls involve a law enforcement presence. In order to foster this partnership, COPE engages in training and outreach at CIT trainings, new recruit trainings at the police academy, roll call presentations, and training for dispatchers and probation officers. About one-half of all calls to COPE come from the consumer, but law enforcement is continuing to grow as a referral source in order to prevent arrests.

This partnership between COPE and law enforcement is significant for individuals with mental illness. COPE can assist law enforcement by identifying existing providers, referring to support services, and providing clinical assessments which can increase safety for all involved. Mobile crisis assists in diverting from the ED; allowing officers to return to duty quickly, rather than wait in an ED for a doctor to see the individual. Arrests are minimal as a result of involving adult mobile crisis, which is best for the individual and prevents additional costly jail bookings.

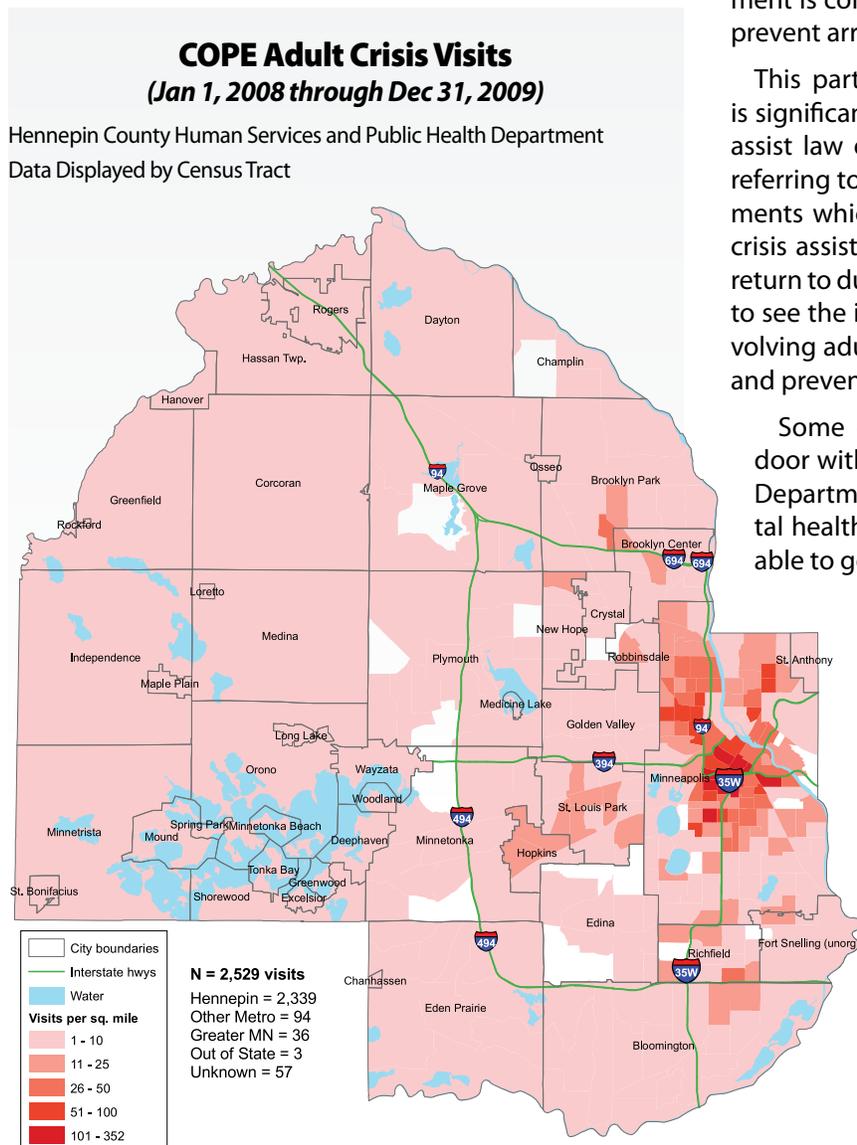
Some officers believe the jail would be a revolving door without COPE and Child Crisis. Minneapolis Police Department received 11,000 calls in 2009 involving mental health issues. They observe that of the calls COPE is able to go on, eighty percent do not call back again with another mental health crisis. COPE compliments the CIT training that a little over seventeen percent of Minneapolis PD has received.³⁴ Law enforcement officers can also take individuals experiencing a mental health crisis to Acute Psychiatric Services, part of Hennepin County Medical Center. The drop-off process for law-enforcement takes five to fifteen minutes.³⁵ This quick, secure exchange allows officers to return to the road quickly to focus on public safety.

34 Personal communication with Officers Gentz and Grobove, Minneapolis Police Department, June 3, 2010.

35 Personal communication with Karen Leaman, Director, Acute Psychiatric Services, Hennepin County Medical Center, June 3, 2010.

32 Human Services and Public Health Department, Hennepin County, Minnesota. Child Crisis Power Point presentation, June 3, 2010.

33 Human Services and Public Health Department, Hennepin County, Minnesota. Community Outreach for Psychiatric Emergencies Power Point presentation, June 3, 2010.



Source: Hennepin County HSPHD - Adult Behavioral Health, 1/26/2010
 Prepared by: Hennepin County HSPHD - GIS, 2/26/2010

One option Hennepin County is implementing to decrease arrests for individuals with mental illness is through 911 operators. There is a new Minnesota statute permitting dispatchers to transfer suitable calls directly to mental health crisis teams rather than law enforcement.³⁶ For Hennepin County, this means dispatchers can transfer 911 calls to Child Crisis and COPE if appropriate. This allows law enforcement officers to continue to focus on public safety issues and let mental health professionals treat mental health 911 calls instead. Executing the new statute is an on-going training and implementation process.

The County Board supports all of the youth and adult crisis services in Hennepin County. They believe the youth and adult mobile crisis units are essential for helping individuals with mental illness navigate a fragmented system and identify available community services. The Board aims to serve the community with robust crisis services to avoid involvement in more costly systems such as jail and the ED. Hennepin County built a new jail twelve years ago and has not considered expanding the jail since. The focus has shifted to increasing preventative services such as crisis care to offer treatment rather than punishment for mental health issues.³⁷

● Multi-County Partnership: Aitkin, Cass, Crow Wing, Morrison, Todd and Wadena Counties

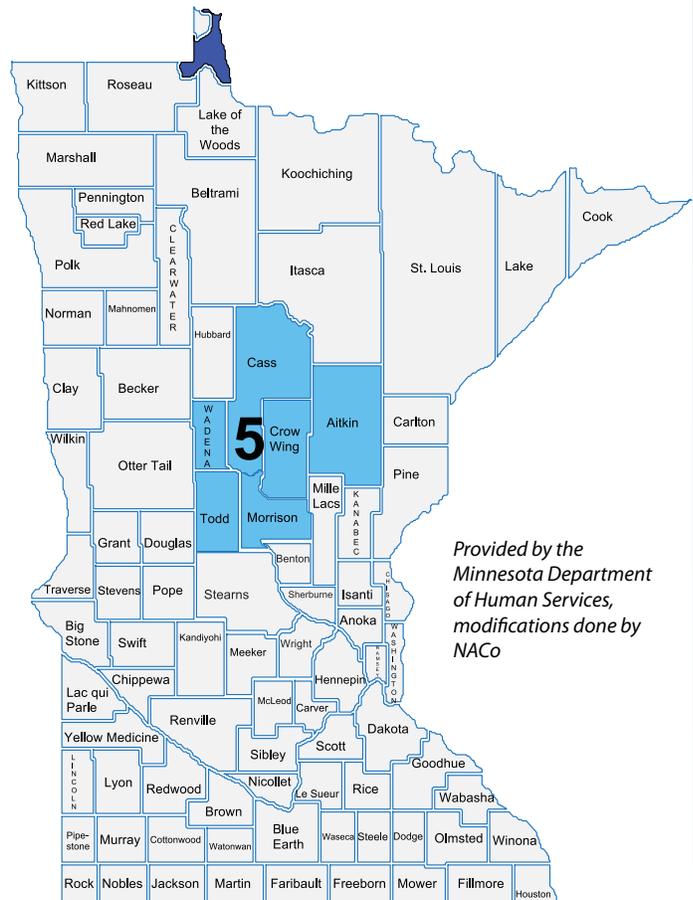
Population:³⁸ Aitkin County: 15,736
Cass County: 28,732
Crow Wing County: 62,172
Morrison County: 32,893
Todd County: 23,917
Wadena County: 13,311

Highlight: Coordinating a multi-county partnership to provide timely services that best accommodate the needs of a rural population in a vast geographic landscape.

In 1995, Minnesota began to downsize state mental health hospitals via the Minnesota Mental Health Initiative. Resources became available for localities to mitigate the impact of closing state hospitals. Counties received the chance to voluntarily form relationships with each other and apply for state grants to address crisis services.³⁹

38 U.S. Census Bureau, Population Division (2008).

39 Personal communication with Mark Bublitz, Mobile Crisis Outreach Services, Northern Pines Mental Health Center, June 4, 2010.



36 Minnesota bills HF0448 and SF707, passed on March 16, 2009 and April 27, 2009 respectively, amended Minnesota Statutes 2008, section 403.03.

37 Personal communication with Gail Dorfman, Hennepin County Commissioner, June 3, 2010.

The six central Minnesota counties of Aitkin, Cass, Crow Wing, Morrison, Todd and Wadena formed a regional partnership. In 2008, Northern Pines Mental Health Center accepted the contract to provide mobile behavioral health services throughout the six-county region. County Commissioners are intimately involved with Northern Pines; there are six county commissioners representing three counties on the Northern Pines Board. This allows for county input on comprehensive crisis services for its residents.

The crisis response begins when a person calls Crisis Line, a non-profit partnering with Northern Pines to provide a crisis hotline. Crisis Line takes calls twenty-four hours per day, seven days per week. Calls for both adults and children come through on this line, streamlining the process for residents. Trained volunteers receive calls and refer accordingly to many community resources. Volunteers often simply handle calls over the phone by suggesting community resources and follow-up. If it is determined that an in-person intervention may work best, Crisis Line will reach out to Mobile Crisis Outreach (MCO). Mobile Crisis Outreach is available twenty-four hours per day, seven days per week. The Crisis Line at year end in 2009 received 2942 calls; of these, MCO received a majority of the referrals to other services.⁴⁰

Mobile Crisis Outreach has an average response time of thirty-two minutes, while the average in-person intervention from start to finish lasts four hours.⁴¹ Once staff from MCO arrives, they can treat the crisis on site and suggest community stabilization services. As the wait time for a psychiatric appointment in the community can be up to six months, Northern Pines has developed a system for providing follow-up appointments in a timely manner called Rapid Access Psychiatry (RAP). This system allows Northern Pines to set up an appointment with a psychiatrist within twenty-four hours of the crisis. RAP appointments allow individuals with mental illness to connect with a mental health professional quickly in order to prevent future crises.

MCO serves all people in the county, regardless of access to insurance. Some counties in the six-county region provide funds to cover crisis services for uninsured individuals. Fortunately, there are few who do not. According to Health Care State Rankings of 2009, Minnesota ranked as the healthiest state in the United States, in part due to having the third highest population covered by health insurance.⁴²

40 Data provided by Mary Marana, Executive Director, Crisis Line, June 4, 2010.

41 Mobile Crisis Outreach Quarter to Quarter Comparison (2009). Provided by Mark Bublitz, June 4, 2010.

42 Morgan & Morgan, *Health Care State Rankings 2009* (CQ Press, 2009).

Northern Pines has reached out to police forces in all of the counties to provide education regarding Crisis Line and Mobile Crisis Outreach. Police use this training to recognize the need for MCO during a police contact. Most law enforcement have not received formal Crisis Intervention Team training (CIT) which develops skills for alternatives to arrest positive outcomes of a police contact involving a person in a mental health crisis. The police forces in the six-county region are too small to commit resources to a forty-hour training class. Although the training is free to attend, the participating officer's shift needs to be covered. With a police force of five to thirteen people, the

King County, Washington

In 2006 the King County Council asked the County Executive to develop a plan to reduce chronic homelessness and unnecessary involvement in the criminal and emergency systems through a continuum of community care. The plan that resulted after eighteen months of collaboration, research and site visits is the Mental Illness and Drug Dependency Action Plan (MIDD). To pay for the services developed in this plan, the County Council passed an ordinance authorizing a portion of sales tax to implement MIDD. This sales tax provides between \$40 and \$50 million dollars per year. One of the programs developed by the MIDD is a crisis diversion program.

The objective of the crisis diversion program is to provide community alternatives to adults who are in crisis. The intent is to avoid involvement in more costly systems such as jails and hospitals. The plan also includes a crisis diversion facility which police and other first responders can bring people to who are in crisis. In addition, there is a crisis interim facility which provides further stabilization and linkages to housing and community services for homeless individuals leaving the crisis diversion facility. Also included in the plan is a Mobile Crisis Team to reach those in crisis in the community.

The planning process for MIDD lasted eighteen months and included consultations with mental health diversion experts, community stakeholder meetings, workgroups, site visits to other crisis diversion facilities and research. Input from the King County Sheriff, city police and the county prosecuting attorney were essential for the development of MIDD. The crisis diversion program is set to open at the end of 2010. Look for more information on crisis diversion efforts from King County, Washington, in the future.

barriers to training a rural police force can be difficult to overcome. Northern Pines recognizes this and conducts outreach to police forces to educate them on the benefits of contacting MCO to assist, such as consumer safety and officer safety. In 2009, MCO received sixty referrals from police;⁴³ they expect this number to continue to rise as police become more familiar with MCO and its services.

Once MCO receives a call and arrives on scene, it takes care of the crisis at the home, or takes care of transport to the ED if necessary. At the ED, MCO will wait with the consumer until he or she sees a doctor; this frees the police to return to their shifts. The ED often calls MCO directly as individuals with mental illness and families walk in, not knowing who else to contact.⁴⁴ Northern Pines conducts outreach to individuals with mental illness and family members to educate regarding Crisis Line and Mobile Crisis Outreach. The goal is fewer 911 calls and emergency room visits.

One challenge Northern Pines faces in delivering crisis services is the small population and large geographic area of the six-county region. Taking this into consideration, a crisis center that takes walk-ins would not best suit the demographic. The small population spreads out among a large geographic area, making it difficult to place a crisis care center in a convenient location. Due to this and many additional reasons, Northern Pines decided that continuing and developing a mobile crisis unit would be the best way to serve this rural population. MCO treats people in their homes so they can remain in their communities with little disruption.

The most common outcome of a mobile crisis contact is the person is able stay in the community; seventy-five percent of calls to MCO are resolved this way.⁴⁵ Mobile Crisis Outreach serves individuals in a timely manner throughout the region and reduces the number of hospitalizations and treatments in the ED. For police, Mobile Crisis Outreach offers a resource for calls involving individuals with mental health issues, and allows them to concentrate on public safety issues. MCO is an alternative to police involvement, police arrest, jail population increase, and inappropriate use of the ED.

The region is so pleased with the crisis care services provided in the counties that Crow Wing County has not given any thought to expanding the jails. Commissioners can best offer their support to these services by developing, supporting and sustaining crisis services. Commissioner

Franzen of Crow Wing County notes “Counties need to make smart investments, and for us, mobile crisis is a great way to give the people the treatment they need. It also allows us to spend less money at the front end of the system rather than having someone move further into various other systems with more costly consequences.”⁴⁶

Conclusion

These county examples demonstrate a variety of crisis care services that serve as an essential tool for providing crisis mental health care. Crisis care services act as an alternative to arrest for law enforcement, allowing officers to link individuals with mental illnesses to much needed services and focus on more urgent public safety matters. Law enforcement partnerships are imperative for enhancing crisis services as alternatives to arrest. Their partnership can help reduce the revolving door effect of individuals with mental health issues in local corrections systems. This is not only good for individuals with mental illness and families, but potentially helps with jail population management issues. Crisis care services also facilitate diverting individuals with mental illness from unnecessary emergency department visits. Ensuring county residents have access to the crisis care services they need before moving into more costly systems is the right thing to do both for individuals with mental illness and counties.

County officials are a key piece to the success and sustainability of crisis care services. They can help facilitate collaboration, bring various stakeholders together, and provide leadership by placing a priority on these services for the county. County officials are in charge of local corrections and social services budgets and are responsible for investing scarce resources carefully. Crisis services represent an investment in individuals with mental health disorders to get them connected to community resources. “In the end, the cost of doing nothing is greater than the cost of crisis services. Devoting funds to crisis care to save money down the line is a big fiscal pay off for counties. It is economical and most importantly, it is the right thing to do.”⁴⁷

43 Mobile Crisis Outreach Law Enforcement Referrals (2009). Provided by Mark Bublitz, June 4, 2010.

44 Mobile Crisis Outreach Quarter to Quarter Comparison (2009). Provided by Mark Bublitz, June 4, 2010.

45 Personal communication with Mark Bublitz, Mobile Crisis Outreach Services, Northern Pines Mental Health Center, June 4, 2010.

46 Personal communication with Commissioner Franzen, Crow Wing County, June 4, 2010.

47 Personal communication with Dennis O. Johnson, Region V+ Adult Mental Health Initiative Coordinator, Minnesota, June 4, 2010.

● Appendix A

Buncombe County Behavioral Health Crisis Continuum: A Guide for Law Enforcement

What is departmental policy on arresting someone with mental illness or substance dependence who has committed a crime?

Both the Buncombe County Sheriff's Department and the Asheville Police Department give an officer/deputy full discretion whether to arrest a person who has committed a misdemeanor crime in which his or her mental illness or substance dependence is a contributing factor. The officer/deputy MAY choose to attempt to engage the person in treatment in lieu of arrest or press charges for the misdemeanor offense after treatment is sought. Crisis treatment resources are outlined below.

If the person has not committed a crime, the officer/deputy may try to engage the person in treatment as well.

Decision Question	Service	Provider	Contact & Location	Issues
Does the person already have a mental health provider?	Mental health first responders	Current mental health providers	Client may have the agency phone number or you may call Western Highlands to find out.	If you encounter a person in a psychiatric or substance dependence crisis, ask the person if he/she is receiving services already. If so, ask the person if he/she knows how to contact their case manager or agency. If he/she has a phone number, call and ask for the "mental health first responder." That person may consult with you on the phone or come to the scene to assist. If the client does not know his/her case manager's phone number, you may call Western Highlands at 225-2800 and they may be able to tell you how to contact the client's case manager.
Is the person homeless?	Homeless case outreach (PATH & A HOPE)	Homeward Bound	<u>PATH</u> Angela Denio 768-4655 Anthony Glenn 768-2458 <u>A Hope</u> Asia James 252-8883	Homeward Bound has fulltime case managers to provide outreach to homeless persons. If the person does not have a current mental health or substance dependence provider, the <u>PATH</u> case managers can come on-site and link the person to services. If the person has a current provider, the <u>A Hope</u> case manager can re-establish the linkage to services.
Not sure what to do?	Mobile Crisis Team	Families Together	Access Mobile Crisis Team by calling Western Highlands: 225-2800	Mobile Crisis Team will come <u>anywhere</u> on-site to evaluate someone with a mental health or substance dependence crisis. Typical response time is 30 minutes or less. They will consult with you on the phone and advise you when they can be on-site.
Is the person intoxicated and needs to dry out overnight?	Wet shelter (2 men & 1 women's bed)	Neil Dobbins Detox Center Western Carolina Rescue Ministries-WCRM	253-6306 277 Biltmore Ave. (Medical stability screening) 254-0471 225 Patton Ave (3 "wet" beds)	If you encounter someone who is intoxicated and has no place to go to "dry out," as an alternative to taking the person to the Detention Facility, you may transport the person to the Neil Dobbins Detox Center. The person will be examined (takes 10 minutes) and if medically cleared you may transport the person to the wet shelter at WCRM. Call the wet shelter before leaving Neil Dobbins to be sure a bed is available.

Decision Question	Service	Provider	Contact & Location	Issues
Is the person obviously in need of physical medical treatment?	Mission Hospital Emergency Department (ED)	Mission Hospital	Mission campus Biltmore Ave.	If someone appears to need physical medical treatment, you should transport to the Mission ED.
Is the person a veteran?	Veteran's Administration Hospital ED	VA	298-7911 1100 Tunnel Road	If you encounter someone in a psychiatric or substance dependence crisis, you may transport the person to the 24-hour VA Hospital ED if the person is veteran who is already enrolled in the VA Hospital system. Call ahead so security knows you are coming and you may drop off the person at the ED and leave.
Is the person under psychiatric commitment papers, or if the person needs a psychiatric evaluation—will he go voluntarily?	Mission Hospital Emergency Department Neill Dobbins Crisis Stabilization Unit	Mission Hospital ARP-Phoenix/RHA Health Services	Mission ED Biltmore Ave. 277 Biltmore Ave	If someone requires psychiatric evaluation, law enforcement may "drop off" at the Mission ED or Neil Dobbins Crisis Stabilization Unit. You will sign-over custody/supervision to the Buncombe County Sheriff's deputy onsite. You must call Western Highlands (225-2800) first, and ask them which facility to transport to. Western Highlands may have information about the client to help you judge safety risk. In rare instances, if the ED or CSU is very busy with psychiatric patients, the onsite deputy may ask you to remain until he/she feels comfortable with being able to supervise all patients or ask you to transport to the other facility (ED to CSU or CSU to ED).
Does the person need detoxification and will go voluntarily?	Neil Dobbins Detox & psychiatric crisis stabilization unit (CSU)	ARP-Phoenix/RHA Health Services	253-6306 277 Biltmore Ave	If someone requires detoxification, you may transport directly to the Neil Dobbins Center between the hours 8am and 6pm.
Has the person run out of medication?	Western North Carolina Community Health Services-WNCCHS urgent psychiatric "walk-in" clinic	WNCCHS	10 Ridgelawn Rd.	WNCCHS offers a walk-in clinic, during business hours, for persons who have an urgent need for a psychiatric medication evaluation. Typically, these clients do not have a mental health provider and have run out of medication. Clients or law enforcement must access this service through Western Highlands: 225-2800
Is a minor a runaway or needs immediate placement because of family a crisis?	Trinity Place shelter	Caring for Children	12 Ravenscroft 253-7233	Temporary residential placement for runaways or minors with family crises
Is a woman in crisis because of domestic violence?	Helpmate shelter	Helpmate	254-2968	Temporary residential placement for women in domestic violence situations

Provided by Buncombe County CIT Collaborative

Appendix 5

Dispelling the Myths about Information Sharing Between the Mental Health and
Criminal Justice Systems

Dispelling the Myths about Information Sharing Between the Mental Health and Criminal Justice Systems

John Petрила, JD, LLM¹

The CMHS National GAINS Center for Systemic Change for Justice-Involved People with Mental Illness

February, 2007

Recently, police arrested an individual with a long arrest record. During the arrest, he was injured and police took him to an area hospital for care. When the police came to check on him the next day, he had been released. The hospital spokesperson said that the Health Insurance Portability and Accountability Act (HIPAA) made it impossible for the hospital to communicate with the police regarding the individual's release.

This 2006 newspaper story is notable for two reasons. First, it illustrates one of the many types of interactions between law enforcement officials and health care providers that occur every day across the United States. Second, it illustrates the many misunderstandings regarding HIPAA that continue to exist years after its enactment.

These misunderstandings are sometimes so deeply ingrained that they have assumed the status of myth. These myths have serious negative consequences for persons with mental illness who are justice-involved. They can bring efforts at cross-system collaboration to a halt and they can compromise appropriate clinical care and public safety. In fact, these myths are rarely rooted in the actual HIPAA regulation. HIPAA not only does not create a significant barrier to cross-system collaboration, it provides tools that communities should use in structuring information sharing arrangements.

What is HIPAA?

Congress enacted HIPAA in 1996 to improve the health care system by “encouraging the development of a health information system through the establishment of standards and

requirements for the electronic transmission of certain health information.”

The HIPAA “Privacy Rule” (which establishes standards for the privacy of information and took effect on April 14, 2003) has received most of the attention from those concerned about the

impact of HIPAA. However, as important, the Department of Health and Human Services adopted the Rule on Security Standards in 2003, to govern the security of individually identifiable health information in electronic form. An Enforcement Rule was also adopted, effective March 2006. Most of the myths about HIPAA concern the Privacy Rule, while too often ignoring the potentially more troublesome area of electronic security.

Contrary to myth, HIPAA covered entities do not include the courts, court personnel, accrediting agencies such as JCAHO, and law enforcement officials such as police or probation officers.

Who does the HIPAA Privacy Rule cover?

The Privacy Rule establishes standards for the protection and disclosure of health information. The Privacy Rule only applies to “covered entities,” which are health plans (such as a group health plan, or Medicaid); health care clearinghouses (entities that process health information into standard data elements); and health care providers. Other entities may be

¹ Department of Mental Health Law & Policy ♦ University of South Florida at Tampa

affected by HIPAA if they are “business associates” (discussed briefly, below).

Contrary to myth, HIPAA-covered entities do *not* include the courts, court personnel, accrediting agencies such as JCAHO, and law enforcement officials such as police or probation officers. There are special rules for correctional facilities, discussed briefly below.

What does the Privacy Rule require before disclosure of protected health information?

The Privacy Rule permits disclosure of health information in many circumstances *without requiring the individual’s consent to the disclosure*. These circumstances include the following:

- Disclosures or uses necessary to treatment, payment, or health care operations. This means, for example, that a care provider may release information to another treatment provider at discharge, because the disclosure is necessary for treatment. In addition, “health care operations” is defined broadly and includes quality improvement, case management, and care coordination among other things.
- HIPAA also permits other disclosures without the individual’s consent. Those relevant here include disclosures for public health activities; judicial and administrative proceedings; law enforcement purposes; disclosures necessary to avert a serious threat to health or safety; and disclosures mandated under state abuse and neglect laws.

In the example provided at the beginning of this fact sheet, the hospital properly could have notified law enforcement of the presence of the arrestee in the hospital

under the provision of HIPAA that permits a covered entity to disclose protected health information to a law enforcement official’s request for “information for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person” (164.512(f) (2)). While this section limits the type of information that may be disclosed for this purpose, it is clear that identifying information can be disclosed.

- In the case of correctional facilities, HIPAA permits health information to be shared with a correctional institution or law enforcement official with custody of the individual, if the information is necessary for the provision of health care to the individual; the health and safety of the inmate, other inmates, or correctional officials and staff; the health and safety of those providing transportation from one correctional setting to another; for law enforcement on the premises of the correctional facility; and for the administration and maintenance of the safety, security, and good order of the facility. This general provision does not apply when the person is released on parole or probation or otherwise released from custody.

HIPAA not only does not create a significant barrier to cross-system collaboration, it provides tools that communities should use in structuring information sharing arrangements.

Does this mean that consent is never required in these circumstances?

While HIPAA permits disclosure without consent in many situations, it does not mean that unlimited disclosure is permissible or that obtaining consent is unnecessary or inappropriate. First, confidentiality and privacy are important values in health care. Obtaining consent may be a way of demonstrating respect for the individual’s autonomy, whether or not it is legally required. Second, other laws may mandate that consent precede disclosure even if HIPAA does not. If a state law provides more stringent protection of privacy than HIPAA, then the state law must be followed. The same is true of the Federal rules

on the confidentiality of alcohol and drug abuse patient records (commonly referred to as Part 2). These rules, enacted more than 30 years ago, have strict requirements for the release of information that would identify a person as an abuser of alcohol or drugs. Another example illustrates this point: HIPAA permits disclosure of information in response to judicial and administrative subpoenas that many state laws limit. If state law has more procedural protection for the individual in that circumstance, then state law applies. Finally, HIPAA incorporates the principle that in general disclosures should be limited to the “minimal necessary” to accomplish the purpose for which disclosure is permitted.

Are there tools that can be used in cross-system information sharing?

There are several tools systems can adopt in creating an integrated approach to information sharing.

- *Uniform consent forms.* While HIPAA does not require prior consent to many disclosures, consent may still be necessary for legal (i.e., other state law) reasons, or because it serves important values. One barrier to collaboration is that most agencies use their own consent forms and consent is obtained transaction by transaction. In response, systems can adopt uniform consent forms that comply with Federal and state law requirements.

Such forms have several features. First, they permit consent to be obtained for disclosure throughout the system at whatever point the individual encounters the system. Second, the forms can be written to include all major entities in the collaborative system; the individual can be given the option to consent to disclosure to each entity in turn, by checking the box next to that entity, or consent can be presumed with the individual given the option of withholding information from a particular entity.

- *Standard judicial orders.* Courts and court officers (state attorneys, public defenders) are not covered entities under

HIPAA. However, in some jurisdictions care providers have been reluctant to share health information with the courts, or with probation officers, on the ground that HIPAA prohibits it. In response, some judges have created judicial orders with standard language mandating the sharing of information with certain entities, for example probation officers. Such orders do not concede that courts or court officers are covered by HIPAA; rather they are designed to eliminate mistaken assumptions that care providers may have regarding HIPAA.

- *Business associate agreements.* A “business associate” is a person or entity that is not a covered entity but that performs certain functions or activities that involve the use or disclosure of protected health information on behalf of, or provides services to, a covered entity. Examples include the provision of accounting, legal, or accreditation services; claims processing or management; quality assurance; and utilization review. Entities or persons providing these and other services described in the regulation must sign a business associate agreement with the covered entity for which the services are provided.

HIPAA does not discuss uniform consent forms or standard judicial orders, but it is evident that both will assist in easing sharing of information within and across systems. HIPAA does require the use of business associate agreements in some circumstances, and so knowledge of the requirements for such agreements is important. 42 CFR Part 2, on the confidentiality of alcohol and substance use information, has an analogous though not identical provision permitting the sharing of information with “qualified services organizations.”

Will HIPAA violations lead to severe penalties?

The fear of liability far outstrips the actual risk of liability in providing mental health care. This is true generally, and particularly true with confidentiality, where there have been few

lawsuits in the last three decades alleging a breach of confidentiality.

There is also great fear regarding the possibility of punishment for violating HIPAA.

Certainly, HIPAA provides for significant penalties, including civil and criminal fines and incarceration. However, there are two reasons that penalties for minor HIPAA violations, in particular, are unlikely.

First, if an individual's health information is disclosed inappropriately under HIPAA, that individual cannot bring a lawsuit for the violation. Rather, enforcement of HIPAA is done entirely through regulatory agencies, with primary enforcement the responsibility of the Office of Civil Rights of the Federal Department of Health and Human Services. Second, although, there had been 22,664 complaints received by OCR through September 30, 2006, not a single penalty has been imposed.

In fact, only 5,400 (or 23%) complaints required further investigation, and these were resolved either by informal action (for example, a letter) or no further action. Therefore, the actual, as opposed to perceived, risk for being severely punished for a HIPAA violation is remote.

A note on the Rule on Security Standards

As noted above, this rule was adopted in 2003 but has received comparatively little attention in discussions of cross-system collaboration. Yet while concerns regarding the Privacy Rule have been exaggerated in many jurisdictions, security issues may sometimes receive too little attention. For example, while protected health information may be shared in most circumstances, if it is done electronically steps must be taken to secure the information, for example by encrypting email exchanges. As systems get beyond the myths regarding sharing of information under HIPAA, it will be important to focus on the requirement of the Security Standards, particularly since the most egregious violations of individual privacy over the last few years have resulted from intrusions into electronic data.

Summary

HIPAA has become the reason many conversations regarding cross-system collaboration have come to a stop. Yet HIPAA provides no significant barrier to sharing information within and across systems. While confidentiality and privacy of health information are important and legally protected values, HIPAA has become subject to

myths that have no foundation in the text of the regulation. It is important that all parties involved in efforts to create integrated systems for people with mental illnesses in the criminal justice system put HIPAA aside as a reason these efforts cannot succeed. ■

... through September 30, 2006, not a single [HIPAA violation] penalty has been imposed.

Useful Resources

www.hhs.gov/ocr/hipaa

This is the home page for the Office of Civil Rights of the US Department of Health and Human Services. OCR has primary enforcement authority for HIPAA. This page has a wealth of information regarding HIPAA — it's the first place to go with questions.

www.hipaa.samhsa.gov/download2/SAMSAHIPAAComparisonClearedPDFVersion.pdf

This page links to a document prepared by SAMHSA that compares Part 2 (the Federal regulations on the confidentiality of substance use and alcohol information) with the HIPAA Privacy Rule.

www.hhs.gov/ocr/combinedregtext.pdf

This link provides the full text of the Privacy Rule and Security Standards for the Protection of Electronic Protected Health Information.

www.gainscenter.samhsa.gov/html/resources/presentations.asp

This page includes an audio replay and materials from a CMHS TAPA Center for Jail Diversion net/tele-conference: *HIPAA and Information Sharing*. A sample uniform consent form is included.

Appendix 6

From Needles and Thread to Legislative Mandates: New Hampshire Addresses the
Needs of Women in...

From Needles and Thread To Legislative Mandates: New Hampshire Addresses the Needs Of Women in...

By Moses, Marilyn C, Kirschbaum, Ellen

Authors' Note: This article does not necessarily represent the official position of the U.S. Department of Justice.

Although a number of state correctional agencies do have or have had an administrator of female offenders (see Table 1), last year the New Hampshire General Court (the legislative branch of the New Hampshire state government) legislatively mandated the creation of this position. It all began with the donation of sewing needles and thread to the state women's prison.

When this donation was made to the New Hampshire State Prison for Women in 2003, Ruth Griffin of the New Hampshire Executive Council¹ wondered aloud whether sewing was a skill in demand in the labor market. The question generated a discussion among members of the executive council as to what educational and training programs were available to incarcerated women. Thus, Gov. Craig Benson tasked the New Hampshire Commission on the Status of Women with providing the answer.

Findings from the Commission

New Hampshire's commission is not unlike many other such state commissions. It has a small budget, two paid staff members and 15 appointed commissioners who volunteer their time. The principal goal of these commissions is to identify and address inequities experienced by women and girls. The New Hampshire commission, similar to other state commissions for women, has also specifically addressed parity issues involving female offenders, through actions such as producing reports and influencing legislation.

Despite limited resources, the commission investigated and produced the report *Double Jeopardy: A Report on the Training and Educational Programs for New Hampshire's Female Offenders*.² The commission drew on a number of resources in developing its report, not the least of which was the professional expertise of three New Hampshire Department of Corrections commissioners and the staff and administrators from the State Prison for Women, located in Goffstown, N.H. Technical assistance from the National Institute of Corrections was deemed invaluable; however, "listening sessions" held with the incarcerated women were cited by all as the catalyst for the report. In these sessions, commission members and legislators met with female inmates to learn about their experiences, needs and what they thought was needed to increase their likelihood of success upon release. By learning about the problems women face, commission members discovered topic areas to focus on in their report - educational and vocational opportunities, reuniting with children, and finding jobs and housing. This process allowed

policy-makers to empathize with the inmates and inspired them to work to address the needs of female offenders.

After the conclusion of the listening sessions, consultations with correctional administrators and working with local academics to compile current research, the consensus was that the facility's administration and staff were talented and dedicated, but were under-resourced, as illustrated by the following conditions in 2003:

- * The DOC spent \$4,564 less annually per female inmate at the State Prison for Women than male offenders at the New Hampshire State Prison for Men and \$1,906 less than males incarcerated at the Northern Correctional Facility;
- * The women's prison was the only institution in the DOC system that did not offer a state-funded parenting program;
- * There was no on-site medical unit in the women's prison;
- * The women's prison was out of compliance with ADA regulations for its aging population;
- * There was no state-funded programming for female victims of abuse, but state-run and state-funded domestic violence programs were provided to male inmates; and
- * Female offenders were not afforded the opportunity to work in state-use industries, and there was a limited vocational program.

As the report revealed, it was not about what the men had but about what the women did not have. There was unanimity among members of the commission regarding the underlying reason for the lack of parity: Economies of scale through the years had led to a neglect of services for female offenders, who made up only a small fraction of the incarcerated population overall. Due to the size of the women's population (fewer than 200 in 2003), it was difficult for administrators to secure and retain resources to meet these offenders' needs. For example, if budgetary constraints required each institution to cut a single vocational program, the State Prison for Men would have seven remaining programs and the Northern Correctional Facility would have two. In contrast, the female institution's entire vocational program would be eliminated because the facility only had one program.

Beyond the findings, the report included three recommendations:

- * Implement a comprehensive data-collection effort on female offenders to establish a foundation for targeting resources and building gender-responsive policy and practice;
- * Establish a statewide planning initiative for the deliberate and gender-responsive management of female offenders, with membership drawn from all aspects of the criminal justice system and with the aim of effectively incorporating appropriate gender-responsive policies and procedures into the operational protocol of the DOC; and

* Develop strategies for gender-specific training for all DOC personnel, especially those working with female offenders.

Capitalizing on Wie Reports Results

After delivering the final report to the governor, the executive council, the DOC and the state Legislature, the commission used the report as a centerpiece of a public education campaign on the status of female offenders in the state. Among the efforts were a presentation at the attorney general's state-wide domestic violence conference; participating on a panel discussion at a New England seminar on incarcerated women's health, hosted by the U.S. Office of Women's Health; presenting the findings at an international conference in Washington, D.C, convened by the Institute for Women's Policy Research; hosting a policy briefing luncheon for female legislators; and hosting a breakfast meeting with high-level stakeholders from the DOC and national experts from the GAINS Center. The commission also established relationships with key community stakeholders such as the Citizen's Advisory Committee of the women's prison, the Task Force on Women and Addiction, and the Coalition Against Domestic and Sexual Violence.

These extensive outreach efforts resulted in building the political will within the state to act on the recommendations of the report. In November 2005, the DOC appointed a mental health program coordinator for female offenders at the women's prison and at Shea Farms, the women's halfway house in Concord, N.H. A grant from the Children's Trust Fund made an expansion of the Family Connections Center possible and allowed for implementation of an onsite parenting program for the halfway house. In addition, a four-day training program to address the needs of women in recovery from substance abuse, domestic or sexual violence, childhood trauma, and mental health disorders was implemented.

Seizing the opportunity to capitalize on the public support that had been generated by the commission, its report and outreach efforts, state Sen. Sylvia Larsen took the leadership role in moving the issue to the next level by sponsoring Senate Bill 262. This bill included the recommendations found in Double Jeopardy. It also mandated the creation of an administrator of women offenders and family services (see Figure 1 for responsibilities of the position) within the DOC and created an interagency coordinating council on women offenders (see Figure 2 for the council's composition). The legislation received bipartisan support, was passed by the Legislature and was signed into law on June 12, 2006, by Gov. John H. Lynch.

The rationale for legislatively mandating the creation of the administrator position was based on the economy of scale noted in Double Jeopardy. Supporters felt that the position had to be legislated in order to prevent it from being eliminated at a later time due to budgetary constraints or due to the changing priorities of future DOC commissioners.

The Council at Work

The primary goal of the interagency coordinating council is to identify opportunities for interagency cooperation in the management of female offenders. Specifically, standing councils in New Hampshire have the power to leverage expertise and resources from

different executive branch agencies working with the same population at different times in the client's life course - before, during and after release. "We are a small state with limited resources; we get a lot done by way of standing councils," said Councilor Debora Pignatelli.

Other responsibilities of the council include:

- * Identifying opportunities for interagency cooperation in the effective management of female offenders;
- * Developing memoranda of understanding outlining in-kind services, or cooperation to provide services, to incarcerated women and their children;
- * Developing gender-specific treatment for co-occurring conditions and a continuity of treatment from incarceration to community;
- * Coordinating interagency case management and reentry planning;
- * Assessing the impact of incarceration on family relations during and after incarceration; and
- * Applying for and administering federal and private sector grants for furthering the duties of the council and the development of gender-responsive, trauma-informed management of female offenders and their children.

Although the DOC is currently recruiting for the administrator position, members of the interagency council have been appointed and have begun work in that capacity. Hopefully, a selection will be made by the end of summer 2007.

The council went to work within a month of the governor signing Senate

The council went to work within a month of the governor signing Senate Bill 262 into law. Council members spent the first few months educating themselves on the demographics and unique issues and concerns of female offenders in the state, such as the need for educational and vocational opportunities, medical and mental health services, and family reunification assistance. The council has solicited expert advice in these areas as well as conducted a tour of the women's prison and halfway house. Council members also were instrumental in creating the job description and requirements for the new administrator position. While recruitment for the administrator is under way, the council has focused on tracking proposed state legislation that will have an impact on the DOC and female offenders specifically. Proposed legislation currently under consideration involves bills related to alternative sentencing, community-based treatment and the DOC's operating budget.

Continuing Female Offender Awareness

Throughout the United States, the creation of female offender administrator positions and state councils or task forces on female offenders has been a trend in the past decade. The administrative positions have in some cases been in response to a Civil

Rights of Institutionalized Persons Act or other lawsuit. Frequently, these positions are administratively situated so that the person reports directly to the secretary or commissioner of corrections. This is thought to be necessary to ensure that the needs of women in custody do not get overlooked due to their overall small percentage of the correctional population.

Given this trend, the next obvious research questions will be: Are these administrative positions and task forces necessary? Are they effective? And how can effectiveness be measured? Although the long-term answers to these questions are unknown, it is certain that state and local women's commissions can be a valuable ally and play an important role in supporting a variety of criminal justice issues. According to Theresa de Langis, executive director of the State Prison for Women, "The New Hampshire Commission on the Status of Women is about equity and parity for women - all women - including the least among us. That includes incarcerated women."

ENDNOTES

1 The New Hampshire Executive Council has the authority and responsibility, together with the governor, to monitor the administration of the affairs of state as defined in the New Hampshire Constitution, the state statutes, and the advisory opinions of the state Supreme Court and attorney general. One duty of the executive council is that it must approve all receipts and expenditures for all state agencies, including donations to these agencies.

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Appendix 7

Creating an Indigent Defense Diversion Team: The Manhattan Arraignment
Diversion Project



CREATING AN INDIGENT DEFENSE DIVERSION TEAM: 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 1. 149 MAP Jail-Divertible Case Assessments in Arraignments

Status	N	%
Diverted	88	59.1
Judge Denied – DOC	32	21.5
Client Refused	17	11.4
MAP Unable to Place	4	2.7
LAS Relieved	2	1.3
Parole Hold	2	1.3
Transfer (MMTC)	2	1
Open Warrants – DOC	1	0.7
Attorney Denied – DOC	1	0.7
Total	149	100

Table 2. Legal Outcomes of MAP-Diverted Pre-Arraignment Defendants

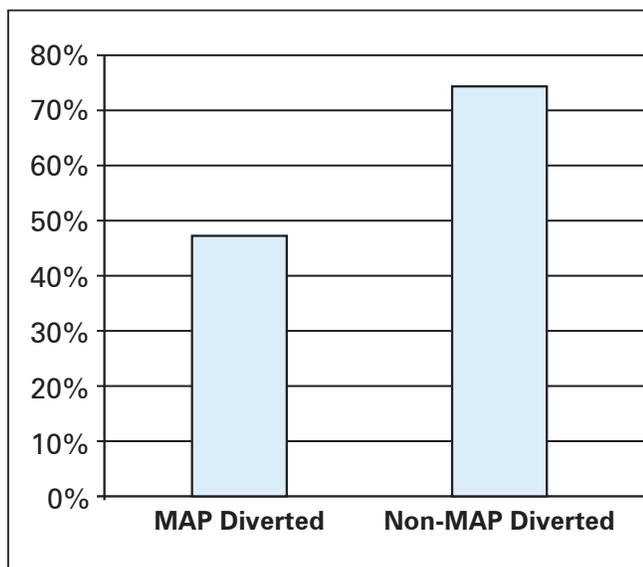
Status	N	%
ROR: Released on own Recognizance	44	50.0
PGSI: Conditional Discharge	24	27.3
PGSI – CASES	7	8.0
PGSI: Time Served	6	6.8
PGSI: Adj. Contemplation of Dismissal	5	5.7
9.43 – Dismissed	2	2.3
Total	88	100

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.

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.

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Appendix 8

**Successfully Engaging Misdemeanor Defendants with Mental Illness in Jail Diversion:
The CASES Transitional Case Management Program**



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.

Background

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.

Participants

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.

Pre-Entry and Post-Entry Mean Arrests for TCM Participants, by Lifetime Arrests (n=178)

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

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.

Keys to Program Success

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.

Conclusion

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.

For More Information...

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Appendix 9

Challenges of Diverting Veterans to Trauma Informed Care: The Heterogeneity of Intercept 2

Criminal Justice and Behavior

<http://cjb.sagepub.com/>

Challenges of Diverting Veterans to Trauma Informed Care : The Heterogeneity of Intercept 2

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CHALLENGES OF DIVERTING VETERANS TO TRAUMA INFORMED CARE

The Heterogeneity of Intercept 2

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The challenges of diverting veterans from the criminal justice system and into appropriate trauma informed mental health and substance abuse services at Intercept 2 of the Sequential Intercept Model (initial detention and initial first appearance court hearing) are discussed. Six challenges are considered, including identification of veterans and determining veteran status; navigating complex partnerships among stakeholders in the community and within the VA that are essential for a successful program, particularly in terms of a mutual understanding of the functions, resources, and philosophies of each in order to allow for cross-system collaboration; difficulties in defining and operationalizing jail diversion; the timing and logistics of diversion; and screening for trauma-related disorders in a sensitive and client-centered manner within the confines of the criminal justice system. A brief overview of the funding, policy, and program landscape related to diversion of veterans is related to the challenges of diversion generally, and specific to intercept 2, with examples from Florida's SAMHSA-funded Jail Diversion Trauma Recovery initiative.

Keywords: diversion; veterans; sequential intercept model; trauma

A focus on research, policy, and practice issues specific to health and social service issues for people who have served in the military is not a new phenomenon. These investigations include research and policy development related to trauma, traumatic brain injury (TBI), sexual trauma/violence, mental health, suicide, substance abuse, benefits, housing, relationships, and issues specific to women. Much of the research and policy focus has included a combination of two or more of these topical areas. Research on returning service members and veterans with TBI and post-traumatic stress disorder (PTSD) is but one recent example (e.g., Golding, Bass, Percy, & Goldberg, 2009; Hill, Mobo, & Cullen, 2009; Pietrzak, Johnson, Goldstein, Malley, & Southwick, 2009; Sayer et al., 2009).

Criminal justice involvement of returning service members and veterans is a topic that has not been examined to the same extent. Data from before the post-9/11 conflicts showed

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that “veterans account[ed] for nine of every hundred individuals in U.S. jails and prisons” (CMHS National Gains Center, 2008, p. 1; also see Greenberg & Rosenheck, 2009; Noonan & Mumola, 2007). This is proportional to the percentage of veterans in the overall population for the time frame of data analyzed. However, the percentage of returning service members and veterans that is included in the 2.3 million people incarcerated in American federal and state prisons and jails (Pew Center on the States, 2008) is currently not known because of a dearth of published analyses of more recent data.

There are an estimated 23 million veterans of the U.S. military (Holder, 2007; U.S. Census Bureau, 2011). The need for more current data and additional attention to factors related to justice involvement of returning service members and veterans is vital given the volume of those recently deployed and the continuation of military deployments. This includes over 2 million people who served in Operation Enduring Freedom (OEF) and/or Operation Iraqi Freedom (OIF), and those who are or will be serving in OEF and Operation New Dawn (OND). (OIF was renamed as OND as of February 2010 [Brannen, 2010; Operation New Dawn, n.d.] with OEF, OIF, and OND sometimes referred to as “post-9/11 conflicts”). As of January 3, 2012 there have been 6,322 deaths (with 4,993 killed in action and 1,329 classified as “non-hostile”) and 47,383 US military personnel wounded in action from OIF, OEF, and OND combined (see US Department of Defense [n.d.]; Fischer, 2010) for current statistics).

While there are commonalities in the experiences and outcomes of those from various eras of service, those serving in OEF/OIF and OND have had experiences that differ from those from other eras. For example, those serving in OEF/OIF/OND have seen higher survival rates due to improvements in battlefield medicine (Gawande, 2004), but that may come with lifelong challenges for veterans and their families posed by survival from severe injuries (Clark, Bair, Buckenmaier, & Gironda, 2007). The volume of those with brain injuries from these post-9/11 conflicts is higher than in other conflicts (Carlson et al., 2010; Hoge et al., 2008; Iverson, Langlois, McCrea, & Kelly, 2009; also see Department of Veterans Affairs, 2010, for *OEF/OIF Review* since 2003, and Taber & Hurley, 2010, for review and abstracts of this issue). Okie (2005) found an increase in head and neck injuries for those who served in OEF/OIF (30%), as compared to those who served in Vietnam (16%) and World War II (21%). Mild traumatic brain injury and PTSD are thought of as “signature injuries” for those deployed to OEF/OIF (Morrow, Bryan, & Isler, 2011, p. 224). The pattern of deployments for OEF/OIF and its relationship to a variety of issues such as readjustment and the relationship to future criminal justice system involvement also needs study. For example, the Army computes a BOG:Dwell ratio, which is the ratio between Boots on Ground (deployment time) and dwell (length of time at home station between deployments) (Johnson, 2009). While the Army had a BOG:Dwell ratio goal of 1:2 for its active component, it was “closer to 1:1” for OIF from the beginning of that conflict through December 2008 (Bonds, Baiocchi, & McDonald, 2010; also see U.S. Department of the Army, 2009).

POLICY DEVELOPMENTS RELEVANT TO JUSTICE-INVOLVED VETERANS

An April 2009 *Information Letter* from the VA’s *Under Secretary for Health* (U.S. Department of Veterans Affairs, Veteran Health Administration, 2009) “[provided] background on the needs of Veterans in the criminal justice system” and “[clarified] Veterans’

Health Administration (VHA) authority to provide services to these Veterans,” while “[outlining] pertinent VHA outreach” and “[making] recommendations regarding services to this group of Veterans.” As background, this letter discussed the need for access to services in the community (President’s New Freedom Commission on Mental Health, 2003), developments in jail diversion (CMHS National GAINS Center, 2007, 2009), the higher prevalence of trauma in correctional populations compared to the general population, and the Substance Abuse and Mental Health Services Administration (SAMHSA) National Center for Trauma-Informed Care (SAMHSA, n.d.) recommendation of addressing issues of trauma. The letter went on to encourage VA Medical Centers to create Veteran Justice Outreach (VJO) Specialist positions. As of June 2011, there was at least one VJO specialist at each of the VA’s 154 medical centers, with these VJO specialists serving as boundary spanners for identification of justice-involved veterans and linkages to services. Veterans’ Treatment Courts are yet another approach developed to address the needs of justice-involved veterans, with 78 Veterans Treatment Courts recognized as such by the National Association of Drug Court Professionals (2011) as of September 2011. The number of jurisdictions that take other approaches, such as consolidating hearings for veterans on certain days or coordinating linkages of returning service members and veterans to VA benefits and services that are not formally part of a “Veterans’ Treatment Court” is not known and is in need of study.

FUNDING

The past several years have seen funding for research and program evaluations with priority to veterans, a specific veteran focus, or inclusion of concepts such as coordination of VA benefits and services in requests for proposals. The U.S. Department of Veterans Affairs (VA) is putting resources into prison and jail re-entry, such as with the Health Care for Re-entry Veterans Initiative (United States Department of Veterans Affairs, n.d.-a) and to identify justice-involved veterans and link them to benefits and services with the Veteran Justice Outreach Initiative (United States Department of Veterans Affairs, n.d.-b). Other federal agencies are providing funding for a variety of initiatives that are specific to justice-involved veterans (see Bureau of Justice Assistance [BJA], 2010, 2011; Center for Substance Abuse Treatment [CSAT], 2010; National Institutes of Health [NIH], 2008, 2009, testimony from NIMH director that includes veterans issues; Insel, 2007a, 2007b, 2010a, 2010b, for budgets of institutes; see also Department of Health and Human Services [DHHS], 2008, 2009, 2010a, 2010b, and the U.S. Department of Labor, 2010a, 2010b). In addition, the VA National Center on Homelessness Among Veterans is dedicating some of its funding to justice-involved veterans (United States Department of Veterans Affairs, n.d.-c) as this group is seen as high risk for homelessness (McGuire, 2007).

Explicit to justice-involved veterans is SAMHSA’s Jail Diversion and Trauma Recovery initiative, or JDTR (Federal Register, 2009; also see CMHS National GAINS Center, 2011). This funding gave priority to veterans, with all 13 states in two cohorts focusing on this population. As is the case with many initiatives for justice-involved veterans, the SAMHSA JDTR projects are described using the Sequential Intercept Model, or SIM (Munetz & Griffin, 2006). The SIM is a way to conceptualize how people move through the criminal justice system (CMHS National GAINS Center, 2009; Munetz & Griffin, 2006). The SIM is “sequential” in that the way people move through the criminal justice

system as described in the SIM is predictable. The model includes five intercepts: (1) *law enforcement* (such as 911, local law enforcement), (2) *initial detention and initial court hearing* (including first appearance court), (3) *jails and courts* (including specialty court and dispositional court), (4) *reentry from prison or jail*, and (5) *community corrections* (parole and probation). It is an “intercept” model in that each of the five intercepts are seen as opportunities to identify needs, access services, and intervene to improve outcomes (Munetz & Griffin, 2006). The SIM includes several goals, among them use of the model as a way to approach and access appropriate services, with the goal of moving away from the criminal justice system to services and life in the community. The use of the SIM to approach access to services is especially important given the lack of services (National Alliance on Mental Illness [NAMI], 2009) and fragmentation of services (President’s New Freedom Commission on Mental Health, 2003) in many communities that must be put into the context of criminal justice system involvement.

The services accessed can include those in the criminal justice system, such as intervention at Intercept 1 by law enforcement agencies that follow the Crisis Intervention Training model (Ritter, Teller, Marcussen, Munetz, & Teasdale, 2011), at Intercept 3 by specialty courts (Hiller et al., 2010; Steadman, Redlich, Callahan, Robbins, & Vesselinov, 2011), or Intercept 5 with specialty probation (Louden, Skeem, Camp, & Christensen, 2008). The VA’s Veterans Justice Outreach specialists focus mainly on Intercepts 1, 2, and 3, while their Healthcare for Re-entry Veterans specialists focus on Intercepts 4 and 5.

The purpose of this article is to present challenges specific to one of these federally funded efforts, Florida’s SAMHSA-funded Jail Diversion Trauma Recovery Initiative with priority to veterans. The SAMHSA JDTR Request for Applications specified that participants should be “recruited from diversion points along the justice continuum including first contact with law enforcement, initial detention, court hearings and community corrections.” Florida was one of several states that participated in a SAMHSA-funded *Returning Veterans and Their Families Strategic Planning Conference and Policy Academy*, which led to the development of an Action Plan (Collins & Janes, 2009). Based on the information in this plan, the existence of diversion activities at Intercept 2 in the pilot county, and the goal of preventing further traumatic experiences from incarceration for already traumatized veterans, the JDTR Statewide Advisory Council decided to focus on Intercept 2. Six challenges to diverting veterans at Sequential Intercept 2 and examples from Florida’s SAMHSA JDTR pilot project are presented and discussed.

CHALLENGES OF IDENTIFYING AND DIVERTING VETERANS AT INTERCEPT 2

1. IDENTIFICATION OF RETURNING SERVICE MEMBERS AND VETERANS

Because Intercept 2 includes initial detention and first appearance (also called magistrate court in some jurisdictions), this means that identification of candidates for diversion often occurs at the county jail. The county for the pilot was chosen in part because of an already existing infrastructure for diversion and had the benefit of having one central jail at which bookings occur. The county jail did not have a question at booking to identify veterans and has not yet added one despite requests to do so from multiple stakeholders. This eliminated the most effective and efficient method of identifying those who had served in the U.S. military among the few hundred people booked each day. This necessitated alternative

methods to identify veterans, such as announcing prior to the start of the daily first appearance court information about the project and asking people to indicate if they had ever served in the U.S. armed forces. The lack of a veteran identifier at booking also means that people who bond out prior to first appearance court cannot be identified in booking data as having served in the military, eliminating another opportunity for diversion. There is a kiosk accessible to people held in the jail on which they can look up information, such as court docket dates, and on which contact information for the SAMHSA JDTR project was included. The idea was that veterans could call the toll free number provided and self-identify. However, this has not led to the identification of a meaningful number of veterans. Project staff may have discussions with public defender staff, who can identify people on their case loads who are veterans. This method often means that a case has progressed to Intercept 3 (dispositional court) by the time the public defender has time to have a discussion of any length with a defendant (given the space and time demands of first appearance court).

A full discussion of the definition of an eligible veteran, and the policy and practice implications of the definition, is beyond the scope of this article. However, any program that is designed to address the needs of veterans must understand these issues and have agreement from all stakeholders on how the definition will be applied. In the broadest sense, a veteran is anyone who served in the U.S. armed forces for any period of time. But what about someone who went through basic training but then was in the military for a short time? What about people who were in the reserves? And does it matter for people in the reserves if they had active duty? What about people who served in the military but who had bad conduct or dishonorable discharges? Does the reason for the bad conduct/discharge matter, such as aggressive behavior that may have been due to the effects of trauma? Will there be a focus only on people eligible for VA benefits? If so, which VA benefits: Pension, VA-funded health care? How important is eligibility for the VA's housing programs (such as Housing and Urban Development-Veterans Affairs Supported Housing [HUD-VASH] and Grants Per Diem programs), which have different eligibility rules from those for health care, which also vary from eligibility rule for pensions? How will this information be verified? Will people be given assistance to try to get a change in status, such as discharge status, change in percent service connected disability, which is then related to eligibility? For programs that involve veterans in program planning and service delivery, it is also important to consider their feelings as they often have strong opinions about who should be considered a veteran. These issues are complicated, require collaboration with VA and/or state veterans authority staff, and may be time consuming to resolve. The timing and logistics required to divert people at Intercept 2 mean that a clear definition needs to be established and understood, and there needs to be the resources to gather information to determine if people meet that definition. Can diversion take place while this is being explored, or must diversion wait for verification?

Asking the question "Have you ever served in the U.S. military?" at booking, jail classification (if the person stays long enough for classification), and by the public defender at first appearance court and throughout the process casts the widest net to identify veterans. Collecting this information early in the process (booking) allows veterans to be approached for diversion early. Asking throughout the process encourages those who were reticent to respond "yes" to do so when they feel comfortable doing that. Some veterans may be

hesitant to respond given that VA disability compensation and/or VA disability pensions may be reduced or discontinued while incarcerated, especially if the incarceration is for more than 60 days (Department of Veterans Affairs, Compensation and Pension Service, 2008). The extent to which justice-involved veterans and those working with them are aware of this issue and the impact this has had on decision making is in need of study.

2. KNOWLEDGE NEEDS OF STAKEHOLDERS INVOLVED IN THE DIVERSION PROCESS

2a. Need for community stakeholders, including mental health/substance abuse treatment providers, peer support specialists, and VA staff to have a basic understanding of the criminal justice system. There are concepts and terms about the operations of the criminal justice system that people working for mental health centers and those working for the VA need to understand in order to identify veterans for diversion and continue to engage them throughout the treatment process, while also managing issues related to their criminal justice involvement. A core feature of the Florida SAMHSA JDTR initiative is the engagement of peer support specialists with veterans diverted at Intercept 2, including Florida's development of a process to certify *Veteran Recovery Peer Support Specialists* (Florida Certification Board, 2011). While the specialists who will be certified may work with veterans in a variety of settings, it is important for those working with justice-involved veterans to have training on the steps in the criminal justice system, including the roles of key stakeholders. It would be ideal for veterans who serve as peer specialists for diversion programs to have also had some lived experience with mental health and the criminal justice system. However, just because a veteran peer has lived experiences with the criminal justice system does not mean he or she has the depth of knowledge about the criminal justice system necessary to help navigate the diversion process. Determining how to work out the logistics of diversion, deciding who to talk to about which issues, and even understanding what is and is not possible/feasible in certain circumstances relies on mental health center staff, VA staff, and peer specialist to have enough knowledge about the criminal justice system to make these decisions or pursue constructive guidance.

For example, knowledge about the role of the judge(s) for first appearance court, dispositional courts, as well as the special role of specialty court judges (such as drug court and mental health court) is needed to understand who to approach, when to approach them, and for what purpose. At the Florida SAMHSA JDTR first pilot site, the judges for first appearance court have the authority to divert some individuals, but not others. These judges may not divert people who are at first appearance court because of a violation of probation/parole (VOP). Other judges handle these cases, so they are the ones to approach for diversion of people on a VOP.

Knowledge about charge types and what they may mean for people considered for diversion is also important. Peers may have certain conceptions about what a felony-level arrest means and what a misdemeanor arrest means. For example, initially some peers were reticent to approach people for diversion who had minor charges, such as trespassing. This led to the need to educate the peers about how some people may have many arrests for charges that are relatively minor, that this pattern is problematic for the person and the system (in terms of use of resources and costs related to multiple arrests), and that this may also be a hint that individuals with such patterns of charges may be the very types of people in need of diversion and the services that go with the diversion. There has also at times been a

reticence to divert people because their charges were “too serious.” The arrangement for Florida’s SAMHSA JDTR project is that no charge is considered too severe, per se, but with the understanding that the public defender and state’s attorney must all be comfortable with diversion, and the provider must be comfortable serving the individual based on an assessment of risk, which includes the nature of the charge. Based on this arrangement, some charges would typically preclude diversion (such as rape or murder), but there are many charges that are in a gray area. Knowledge about what these different charges mean enhances the ability to make the decision for diversion. Because the offense upon which someone is booked is often changed, such as changing a felony-level arrest to a misdemeanor charge, those working to identify people for diversion need to be aware of this possibility and how that can open up possibilities to divert people. Knowledge about these issues is especially important for diversion at Intercept 2 because it is at this point in time when there are often changes from the initial offense level to the charge level, and that leads to decisions about which dispositional court (and which judge) the case is heard in Intercept 3.

There is a lingo to the criminal justice system that needs to be understood, such as the terms *VOP* (violation of probation), *ROR* (released on own recognizance), *PD* (public defender), *bonding out*, *magistrate court*, and *specialty court*. There is also community-specific lingo. Examples from Florida are terms for incompetence to proceed (916 cases) and civil commitment for mental health (Baker Act) and substance abuse (Marchman Act) diagnoses. Also, community stakeholders may use the term *intercept* colloquially to refer to the several places in Intercept 2 where diversion may occur. This causes confusion for a project that is focused on *one intercept* but that has a variety of places *within* that intercept where diversion occurs. This loose and, within the context of the SIM, incorrect use of the word *intercept* has created confusion about the difference between Intercepts 2 and 3.

2b. Need for community stakeholders involved in the diversion process to understand how the VA operates, as well as core concepts and lingo of the VA and veterans. “The soldier’s life is the soldier’s life . . . and civilian life is civilian life. The wariness of the veteran in dealing with those who have not shared his life and the half-grateful, half-apprehensive attitude of the civilian toward the veteran are as old as wars. These attitudes have pulled veterans together after each of our wars” (Haber, 1945, p. 167).

This sentiment still remains true today and highlights the importance of the multiple systems to be “veteran informed.” Just as there is a movement for “trauma informed” systems (SAMHSA, 2011), there is also a need for “veteran informed” systems. It is important to acknowledge the unique experience of returning service members and veterans and the challenges of those who have not been a part of or do not have experience with these populations to understand certain issues. This includes an understanding of the basic operations of the Department of Defense (DoD) and VA system, as well as complexities of the crossover from DoD to VA when a person becomes a veteran (U.S. GAO, 2008), but also identifying questions that are insensitive and should not be asked of veterans, such as asking if the veteran has killed anyone or making statements about support for or against various conflicts (Hannah, 2009).

The VA and military systems also have their own lingo. For example, the word *benefits* has a different meaning in the VA than it does to behavioral health providers and researchers, typically referring to benefits administered by the Veterans Benefits Administration (VBA) and not typically to health care benefits. This means that talking about “benefits”

can cause confusion when one stakeholder thinks he or she is talking about health care benefits (as in coverage/payment) and the other stakeholder thinks he or she is talking about a pension. Some of the lingo that those working in diversion program should know include DD-214 (the standard separation document from the U.S. Military, which includes discharge status), VBA (Veterans Benefit Administration), VHA (Veterans Health Administration), VJO (Veteran Justice Outreach Specialist), HCRV (Health Care for Re-entry Veterans), HCHV (VA Health Care for Homeless Veterans), HUD-VASH (Housing and Urban Development–Veterans Affairs Supportive Housing), and GPD (Grant and Per Diem Program, a supportive housing program of the VA). It is helpful for those implementing such diversions to understand concepts and lingo relevant to the Department of Defense, such as what it means to be in the reserves, how multiple deployments work for certain conflicts, and useful initiatives/constructs relevant to deployment (such as ARFORGEN and BOG:Dwell ratio; see U.S. Department of the Army, 2009). Understanding these concepts is also essential to grasp unique cultural aspects of those in the military, veterans, and their families (see Combat Stress Intervention Program, 2011).

2c. VA staff need to have knowledge of the various systems and the roles of stakeholders within them. In order for VA staff, such as VJO specialists and other VA social work staff, to collaborate on diversion programs with community providers, these VA staff must also have knowledge about the structure of behavioral health in their community. Each community has its own jargon to be learned. In Florida, this includes the terms CSU (crisis stabilization units where emergency commitments take place), SRTs (short-term residential treatment units), and mobile crisis.

3. SANCTIONS IN RELATION TO WHAT THE DIVERSION REQUIRES

Diversion at Intercept 2 means that people with every kind of case may be included. This includes people with minor charges that, at least in the jurisdiction of the first Florida SAMHSA JDTR pilot, can be disposed of at first appearance court. This means that people with certain types of charges (such as trespass and open container) often never make it to Intercept 3; therefore, figuring out how to approach people with these types of charges for diversions at Intercept 2 is especially important. As discussed previously, people with these types of charges may be the very types of people who could benefit from diversion and the services provided by initiatives such as the SAMHSA JDTR, such as persons who are homeless, with co-occurring disorders and trauma, and who may have multiple misdemeanor-level arrests. However, the sanctions in these situations may be quite minor (time served or a few days in jail) in relation to the length of engagement and activities required to be part of the diversion, such that people may not want to agree to the diversion. Plus, this scenario raises the question about whether someone was truly diverted, which leads us to the fourth challenge.

4. DEFINITION OF DIVERSION

“Jail diversion is not as simple a concept as it first appears, and as a result, it can be misinterpreted or misconstrued as crisis services or transitional planning” (CMHS National GAINS Center, 2007, p. 9). The GAINS Center review of lessons learned from 10 years of

diversion points out that “jail diversion is the avoidance or radical reduction in jail time achieved by linkage to community based services” (p. 9). For people with relatively minor charges, for which the sanctions may be a short jail sentence, it is unclear the extent to which identifying them for a diversion and engaging them in the program is really all that much of a diversion. If a person who normally would have spent 5 days in jail is released and does not serve those 5 days because of a diversion, then that is avoidance of jail time, and therefore could be considered a diversion. If the person would have been released in 5 days regardless of the “diversion” (but that release is construed by the stakeholders involved as being part of a diversion), then is this really a diversion? Stakeholders involved should be clear with the person being diverted about the pros and cons of diversion, including the criminal justice implications. In this respect, Challenge 2 (knowledge needs of stakeholders involved in the diversion process) is especially important. If people are agreeing to a diversion that will involve being engaged with a behavioral health intervention for 6 months to a year but without the diversion could have had their case disposed of with a 5-day jail sentence, they need to know that and have the guidance to make an informed decision. This issue of informed choice is important also because of its relationship to procedural justice and coercion and the impact of these constructs on various outcomes (see Poythress, Petrila, McGaha, & Boothroyd, 2002), as well as the need to address three core concepts of trauma informed care: “safety, voice, and choice” (National Association of State Mental Health Program Directors, 2011).

This leads to a larger policy question about whether individuals with these types of cases should be diverted, using SAMHSA project funds or BJA funds? Does it matter to policy makers and clinicians if the focus is on this type of scenario? Is this the best use of limited resources? Diversion of a person with minor charges may avoid future justice system involvement and thus benefit from diversion by avoiding longer jail or prison stays. Or is length of jail/prison time avoided to be considered when deciding how to approach diversion at Intercept 2? To whom does it matter and why?

Another scenario is someone whom the first appearance court judge releases on his or her own recognizance (no bond), but with the case to continue to dispositional court (and another judge’s docket, at Intercept 3). Should diversion programs engage the person, at least preliminarily, until the dispositional court hearing, where a decision about whether or not to divert from a jail/prison sentence can be made? Or should people only be approached for diversion once they reach dispositional court, that is, at Intercept 3 and not Intercept 2, when the extent to which diversion will be pursued and the nature of the diversion is clearer? It is possible that there are benefits to engaging someone early in the process, such as Intercept 2, but then is that ok to do in a diversion program if the dispositional court judge opts not to divert? Is the person then out of the diversion program? To a certain extent this challenge is related to timing and logistics issues, although timing and logistics are important to consider generally as they relate to other issues.

5. TIMING AND LOGISTICS

Events occur quickly at Intercept 2. People are booked into jail and have their first appearance court within about a day. First appearance court often involves having hundreds of people in a room, sometimes brought in waves because there is not space for everyone. In the jurisdiction for the Florida SAMHSA JDTR pilot, as with many others across the

country, court is held via video, with the judge at the courthouse and the defendants at the jail. There are one or two public defenders for many people, there is little to no room to talk to someone in a private setting, and the need to keep cases moving means that there is very little time to engage individuals. In a system where the jail identifies veterans at booking and allows researchers and clinicians involved in diversion projects to go into the jail housing units, people flagged on the docket as veterans could then be screened in a private room on the jail housing units. This approach was followed for a mental health court evaluation (Christy, Boothroyd, Petrila, & Poythress, 2003). But this is not possible if veterans are not identified on the docket or if the jail does not allow such access on the facility housing units. It is often not possible to verify veteran status quickly enough to formally enroll veterans for at least the few days until this can be verified. Unless the provider has another program that the person can be engaged in that does not require a person to be a veteran, judges and state attorneys may be reticent to agree to a diversion that is provisional on verifying veterans' status.

6. HOW TO SCREEN FOR TRAUMA IN A SENSITIVE WAY

Screening for trauma at Intercept 2 is a challenge. It needs to be done in a way that is sensitive to the "physical and psychological safety" of those screened (National Association of State Mental Health Program Directors, 2011, p. 3). This is especially true when talking to people close in time to first appearance court, but is also true at other court hearings. The location of the space where the screening can take place may not be private and the person may already be in a heightened emotional state after having recently been arrested (first appearance court, Intercept 2) or because of the nature of a dispositional hearing (Intercept 3). There may not be time to engage the person in a discussion about his or her trauma and needs that may arise if he or she becomes upset talking about trauma. Therefore, the screening to determine if someone meets requirements for diversion should be brief and not include pursuit of details about the trauma beyond what is absolutely necessary. Screening for trauma is usually a two-part process. First, it is determined whether the person has experienced any traumatic events. Then, the person is asked if he or she has had any problems related to those events. For the Florida JDTR project, it was decided to screen in the broadest sense for trauma-related disorders, and then a more in-depth clinical interview was used to determine diagnoses after diversion. The National Center on PTSD (www.ptsd.va.gov) is an invaluable resource for researchers and providers on screening instruments for veterans and civilians. Those screening for trauma should have a plan developed a priori for what to do if someone becomes upset during the screening process to address the person's mental health needs and in whatever setting that screening takes place (e.g., courthouse, jail).

DISCUSSION

Because returning service members and veterans are family, friends, and neighbors—living in our communities—the inclusion of multiple community stakeholders in research, policy development, and advocacy is essential (Institute of Medicine of the National Academies [IOM], 2010), a sentiment reflected by Dr. Thomas Insel (2010), Director of the National Institute of Mental Health.

The success of the Institute's mission depends on the effective collaboration of all stakeholders in the field of mental health. For example, NIMH, the Department of Veterans Affairs (VA), and the Department of Defense (DoD) are committed to research collaborations that will improve the mental health and well-being of military personnel and veterans. Not only is this important to the VA and military, but the knowledge we gain from research collaborations will be critical to the civilian sector: many veterans seek care within their home communities and the problems of soldiers are shared by the society they serve. Moreover, although research conducted on the mental health of military personnel is most immediately applicable in a military context, we expect that the knowledge gained will benefit civilians as well.

Keith Cicerone (Clay, 2011) also made this point about research on returning service members and veterans benefiting society when he said, "[t]raumatic brain injury is the signature injury of Iraq and Afghanistan, while it remains the silent epidemic in the civilian population" (p. 52). Research needs to be conducted with a broad perspective—one in which returning service members and veterans are studied within a community context that includes the DoD and VA, but also a wide variety of community stakeholders and agencies. This includes entities involved in *benefits* (such as the Social Security Administration, Medicaid, Medicare, and state funding programs), *health care* (such as general hospitals, emergency rooms, outpatient clinics, and hospice), *behavioral health* (such as privately and publicly funded inpatient psychiatric units, detox and other substance abuse service providers, outpatient clinics, and community mental health centers), *housing* (such as local housing coalitions), and *long-term care facilities* (such as assisted living facilities and nursing homes).

The developments in policy and funding as described earlier mean that justice-involved veterans are now also being studied, often within the context of this web of complicated issues affecting returning service members and veterans. However, there is still much empirical work and policy discussion that needs to occur about the challenges of diversion discussed specifically, and the multiple unanswered questions about justice-involved veterans presented in this article generally. Information about veterans from prior conflicts suggests "that peak demand for compensation has lagged behind the end of hostilities by 30 years or more, so the maximum stress on support systems for OEF and OIF veterans and their families might not be felt until 2040 or later" (IOM, 2010). This means that now is the time to keep building the momentum of this focus on veterans, including justice-involved veterans, to address what are sure to be significant future needs. This will benefit veterans, their families, and as Insel (2010) and Cicerone (Clay, 2011). point out, the communities in which they live.

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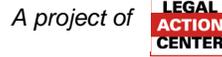
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Appendix 10

State Reforms Reducing Collateral Consequences for People with Criminal Records:
2011 - 2012 Legislative Round-Up



LEGISLATIVE UPDATE

September 2012

State Reforms Reducing Collateral Consequences for People with Criminal Records: 2011-2012 Legislative Round-Up¹

Over the past forty years the prison population in the United States has skyrocketed 600% and the number of Americans with felony convictions has grown to 19.8 million adults or 8.6% of the adult population.² According to the National Employment Law Project (NELP), an estimated 65 million Americans have a criminal record.³ Although it might be reasonable to assume that individuals who have completed their sentences are free from conviction-related constraints,⁴ according to Attorney General Eric Holder, the American Bar Association (ABA) has identified over 38,000 penalties, called collateral consequences that can impact people long after they complete their criminal sentence.⁵

Collateral consequences are the additional penalties tied to a conviction that greatly impact an individual's capacity to engage politically, economically and socially upon their reentry to society. These consequences include barriers to housing, education, and employment, felony disenfranchisement, and ineligibility for public benefits. Collateral consequences are distinct from direct consequences of convictions in that they are not factored into the calculation of punishment or sentencing, and are triggered outside the jurisdiction of the courts.

Nationwide there is a growing bipartisan awareness of the long-term negative impact of collateral consequences and states are taking steps to combat the ill effects of these sanctions.

¹ This paper is a collaboration of the ACLU, Crossroad Bible Institute, The Sentencing Project, the National Employment Law Project (NELP), and the National H.I.R.E. Network.

² Shannon S., Uggen C., Thompson M., Schnittker J., and Massoglia M. 2011. "Growth in the U.S. Ex-Felon And Ex-Prisoner Population, 1948 to 2010." Paper presented at the 2011 Annual Meetings of the Population Association of America.

³ Rodriguez M. and Emsellem M. 2011. "65 Million Need Not Apply: The Case for Reforming Criminal Background Checks for Employment." The National Employment Law Project. New York, NY.

⁴ Heumann M., Pinaire B. K., and Clark T. 2005. "Beyond the Sentence: Public Perceptions of Collateral Consequences for Felony Offenders." *Criminal Law Bulletin*, 41, pp. 24-46.

⁵ Written Testimony for Amy Soloman, Senior Advisor to the Asst. Attorney General, Office of Justice Programs, U.S. Dept. of Justice. "EEOC to Examine Arrest and Conviction Records as a Hiring Barrier," Meeting of July 26, 2011, available at <http://www1.eeoc.gov/eeoc/meetings/7-26-11/solomon.cfm?renderforprint=1>. A new interactive tool was released by the ABA, called the National Inventory of the Collateral Consequences of Conviction, available at <http://www.abacollateralconsequences.org/CollateralConsequences/index.html>.

During 2012, legislation was championed by Republican and Democratic state lawmakers to scale back the collateral consequences of convictions. This paper documents the important reforms enacted and introduced throughout the country during the 2012 legislative session.

This paper is organized into the following policy categories: (1) [“ban the box”](#); (2) [employer negligent hiring protections](#); (3) [expungement and sealing](#); (4) [federal public benefits opt-out legislation](#); (5) [felony enfranchisement](#); and (6) [Uniform Collateral Consequences of Conviction Act legislation](#). Key developments include:

- One state (Colorado) adopted a “ban the box” policy, which delays background checks until later in the hiring process, while seven states introduced legislation to adopt or expand the policy.
- At least eight states considered new limitations on negligent hiring liability (Colorado, Minnesota, New Jersey, New York, Ohio, Vermont, West Virginia, and Wisconsin), though only one—Ohio—ultimately adopted new protections.
- Eight states (Delaware, Georgia, Louisiana, Ohio, Maryland, North Carolina, Tennessee and Utah) enacted provisions to expunge or seal criminal history information in an effort to eliminate barriers to employment. At least three states—New Mexico, South Carolina, and West Virginia—vetoed measures while at least eight states introduced legislation.
- At least four states—Alabama, California, Missouri, and Pennsylvania—introduced measures to improve access to public benefits for persons with felony convictions.
- One state (Delaware) enacted the first part of a two-year process to repeal the five-year waiting period for persons with certain felony convictions to have their voting rights restored. At least three states introduced measures to restore voting rights for persons with certain convictions.
- Five states—New York, Minnesota, Wisconsin, West Virginia, and Vermont—introduced legislation that would significantly mitigate the effects of collateral consequences for individuals who plead guilty.

(1) “Ban the box”: Fair Hiring and Occupational Licensing Standards

Widely known as “ban the box,” this fair employment policy typically removes the question on the job or licensing application about an individual’s conviction history and delays the background check until later in the hiring or licensing process. The purpose of this reform is to provide applicants a better chance of being evaluated based on their qualifications. To date, [seven states](#) (California, Colorado, Connecticut, Hawaii, Massachusetts, Minnesota, and New Mexico) and [about 40 local jurisdictions](#) have implemented some form of a “ban the box” policy. In addition, seven states introduced legislation in 2012 to adopt or expand “ban the box” policies. Although these bills were not passed, advocates laid the foundation for future efforts. Numerous organizations such as [All of Us or None](#), a leader in these efforts, have contributed to successful “ban the box” campaigns across the country.

Model: Out of the [seven states](#) with “ban the box” policies in place, Massachusetts’ policy is the most comprehensive. Significantly, the state’s policy applies to both private and public employers and sets sensible limits on the information that can be made available in the criminal record. It also requires that denied applicants receive a copy of their records, paralleling one component of the federal consumer protection law, the [Fair Credit Reporting Act](#), which applies to commercially-prepared background checks.

Successful Legislation

Colorado House Bill 1263 (2012) (applies to state employment and licensing; job-related factors)

Signed on May 29, 2012 by Governor John Hickenlooper (D), [HB 1263](#) prohibits state agencies and licensing agencies from performing a background check until the agency determines that the applicant is a finalist for the position or receives a conditional offer. In determining whether a conviction disqualifies an applicant, the state or licensing agency must consider (1) nature of the conviction; (2) direct relationship of the conviction to the job; (3) rehabilitation and good conduct; and (4) time elapsed from date of conviction. The law further prevents agencies from using arrests not leading to conviction in deciding whether to deny or withdraw an offer. Agencies may not disqualify an applicant based on an expunged, sealed, or pardoned conviction or charges dismissed pursuant to a deferred judgment, unless the agencies first consider the four factors listed above.

This law does not apply where a statute bars licensing based on criminal convictions nor to certain public safety or correction-related jobs. Consideration of criminal history information that the applicant voluntarily provides is permitted. The law addresses blanket bans in job ads by prohibiting the advertisement of a position with a statement that a person with a criminal record may not apply. The legislation was supported by the [Colorado Criminal Justice Reform Coalition](#). Introduced by Rep. Claire Levy (D), see [bill information](#).

Commentary: Before passage of this law, Colorado state employment applications omitted inquiries about applicants’ convictions or arrests. Thus, unlike the typical ban the box legislation, this bill does not include language that requires removing the question about convictions on the application.

Introduced Legislation

California Assembly Bill 1831 (would have applied to city and county employment)

[AB 1831](#) would have required city and county agencies to delay consideration of an applicant’s criminal history until after the agency determines that the applicant is minimally qualified for the position. The bill exempts agencies that were required by law to run a criminal background check and all positions within a criminal justice agency. After passing through the Assembly, the bill was held in the Senate Committee on Governance and Finance. On the day of the hearing,

an influential local newspaper supported the bill with an [editorial](#). Introduced by Asm. Roger Dickinson (D), see [bill information](#).

Commentary: Nine cities and counties in California implement some form of ban the box, which makes California the state with the most ban the box local jurisdictions without statewide legislation. Since 2010, California has had an [administrative directive](#) in place, which removed the conviction history question from the initial application for state agency jobs.

Illinois House Bill 1210, House Committee Amendment No. 1 (would have applied to state employment)

A prior version of [HB 1210](#) was passed out of the legislature but vetoed by former Governor Rod Blagojevich (D). With the addition of [House Committee Amendment No. 1](#), which offers stronger protections than HB 1210, the bill will likely be considered in the months to come. It would prohibit state employers from asking on job applications whether an applicant has a criminal conviction. The threshold for inquiry into an applicant's criminal background is after the interview or conditional offer for a position. If federal or state law disqualifies a person from holding a position or if an applicant is applying to be a peace officer, then the positions are exempted. Introduced by Rep. La Shawn Ford (D), see [bill information](#).

Commentary: As legislation is being considered, advocates are exploring administrative options. The [Illinois Commission on the Elimination of Poverty](#) and groups such as [Safer Foundation](#) and [Heartland Alliance](#) are supporting these efforts.

Maryland Senate Bill 671/House Bill 800 (would have applied to state employment)

[SB 671/HB 800](#) was introduced for the third year. It would have prohibited the branches of the state government from inquiring into the criminal history of an applicant for employment until the applicant is selected for an interview. The bill exempts public safety and corrections positions, positions for which a criminal history records check is statutorily required, and certain positions determined by the Secretary of the State Personnel Management System. The bill passed the Senate Finance Committee but stalled in House Appropriations. Introduced by Sen. Catherine Pugh (D) see [bill information](#).

Commentary: As [noted](#) by the [Job Opportunities Task Force](#), the bill had bipartisan support and went further this year than prior attempts.

Minnesota House File 1448/Senate File 1122 (would have applied to private employment)

[HF 1448/SF 1122](#) would have prohibited private employers from inquiring into or considering the criminal history of an applicant until the applicant has been selected for an interview. The bill exempts those employers who have a statutory duty to conduct a criminal background check or consider the criminal records of applicants during the hiring process. The bill stalled in committee. Introduced by Rep. Carol McFarlane (R), see [bill information](#).

Commentary: This bill would have expanded the “ban the box” legislation adopted in 2009—[HF 1301](#)— which prohibited public employers from inquiring into or considering an applicant’s

criminal history until after the applicant has been selected for an interview by the state, its agency, or political subdivision. Advocates from the [Second Chance Coalition](#) are continuing efforts at the local level to expand ban the box to private employers.

New Jersey Assembly 2300 (would have applied to public and private employment; job-related factors; limits on information)

This [bill](#) would have prohibited employers from requesting information about criminal records on job applications unless certain convictions legally disqualify an applicant. An employer is permitted to inquire about convictions during an interview, but the employer cannot deny employment on the basis of a criminal record unless there is a direct relationship between the conviction and the employment sought (factors are specified), or if granting the employment would involve an unreasonable risk to property or safety. Time limits for certain convictions to be considered are specified. Written notice of denial and opportunity to appeal are provided. The penalty for violation is \$10,000 for a first offense and not more than \$20,000 for a second offense. Introduced by Asm. Bonnie Watson Coleman (D), see [bill information](#).

Commentary: A penalty for violation is becoming more popular; it is one means to ensure robust enforcement. Advocates are hopeful that a new bill version will be introduced. Meanwhile, advocates such as the [New Jersey Institute for Social Justice](#) have sought to educate the private employer community on these issues through business roundtables.

Rhode Island House Bill 7760/Senate Bill 2411 (would have applied to public and private employment and licensing; job-related factors)

Building on prior years' efforts, [HB7760/SB2411](#) would have prohibited licensing and public agencies, and private employers from denying an applicant because of prior convictions, unless (1) there is a "direct causal relationship" between the offense and the license or employment (an analysis that includes consideration of rehabilitation); (2) the employment is in law enforcement or corrections; (3) the individual is not bondable; or (4) issuing a license or granting employment would involve unreasonable risk to property or safety. It also prohibits conviction inquiries on applications, subject to exceptions. By request, denied applicants may be provided reasons for denial. The bill was held in committee for further study. Efforts are supported by [Direct Action for Rights and Equality](#). Introduced by Rep. Scott Slater (D), see [bill information](#).

Commentary: Of note, the factors to determine whether a "direct causal relationship" exists between the offense and the license or employment includes (1) the public policy to encourage people with records to find employment and (2) specifies that a "lack of good moral character" based solely on convictions is not sufficient for denial.

Vermont House 717 (would have applied to public and private employment)

Introduced in Vermont for the first time, this [measure](#) would have prohibited employers from inquiring into an applicant's criminal history unless the inquiry took place during an interview or the applicant was found otherwise qualified for the position. The bill exempts positions that have mandatory or presumptive disqualifications under law. The bill also provides that

employers could be fined up to \$100.00 for each violation. The bill stalled in the House committee. Introduced by Rep. Mark Woodward (D), see [bill information](#).

Commentary: Although the fine is minimal, it provides an example of enforcement.

(2) Employer Negligent Hiring Protections

Many employers hesitate to hire individuals who have been arrested or convicted of a crime—ruling out about 65 million of the country’s adults, even though they may be the best qualified for the job. In many cases, employers know that giving a person a second chance is the right thing to do, but they are concerned that hiring a person with a criminal record might expose them to liability for negligent hiring if the person commits a crime on the job. To address these concerns, five states (Colorado, Florida, Massachusetts, New York, and North Carolina) have previously passed legislation limiting negligent hiring liability for employers who hire people with criminal records. During their 2012 legislative sessions, eight states considered new limitations on negligent hiring liability (Colorado, Minnesota, New Jersey, New York, Ohio, Vermont, West Virginia, and Wisconsin), though only one—Ohio—ultimately adopted new protections.

Model: Limiting employer liability for negligent hiring has often been included as part of a legislative package that also includes new fair hiring requirements or the adoption of certificates of relief for individuals who have demonstrated rehabilitation after receiving a conviction. North Carolina’s provision limiting employers’ liability for negligent hiring, [N.C. Gen. Stat. § 15A-173.5](#), shields an employer who hires an individual with a criminal record from any claim of negligent hiring based on the criminal record if the employee has a Certificate of Relief that the employer knows about.

Successful Legislation

Ohio Senate Bill 337 (immunity from negligent hiring of employee with certificate)

Signed into law by Governor John R. Kasich (R) on June 26, 2012, this [bill](#) creates a certificate of qualification for employment that not only relieves individuals of automatic disqualifications from some state-issued occupational licenses but also provides immunity for employers from negligent hiring liability based on their hiring an individual with a criminal record when they know they are hiring an individual to whom a certificate has been issued. The certificate is available to an individual either six months or one year after completing his or her sentence, depending on the offense, based on certain specified factors. In addition to providing immunity from negligent hiring liability for employers, the certificate can be offered in other cases alleging negligence as evidence of a person’s due care. Introduced by Sen. Bill Seitz (R), see [bill information](#).

Commentary: Like the North Carolina model referenced above, SB 337 provides an employer with immunity from negligent hiring liability when the claim of liability is based on the

employer's alleged lack of due care in hiring an individual with a criminal record. Immunity is the highest level of protection an employer can receive from these claims. SB 337 does not simply reduce employers' exposure to liability for negligent hiring, it completely eliminates the criminal record as a potential source of liability for the employer.

Introduced Legislation

Colorado Senate Bill 12-105 (certificates as evidence of employer's due care)

This [measure](#) would have created certificates of rehabilitation and judicial orders of collateral relief that an employer would be able to offer as evidence of their due care in hiring the employee to whom the certificate or judicial order was issued. The bill passed the Senate on May 8, 2012, but the next day it was postponed indefinitely in the House Committee on State, Veterans, and Military Affairs where it languished until the 2012 legislative term expired. Introduced by Sen. Pat Steadman (D) and Rep. Claire Levy (D), see [bill information](#).

Commentary: At the other end of the spectrum from immunity, identifying certificates of relief as evidence of due care provides a lower level of protection for employers but still should relieve many employers' concerns about liability. Colorado adopted other protections for workers with criminal records during its 2012 session and has some negligent hiring protections already on the books, which may have made passage of SB 12-105 less urgent.

Minnesota House File 489/Senate File 1448 (certificates as evidence of employer's due care as part of UCCA legislation)

[HF489/SF1448](#) would have enacted the Uniform Collateral Consequences Act (UCCA), including a provision that would create orders of limited relief and certificates of restoration of rights that an employer could offer as evidence of due care to defend against a claim for the negligent hiring of an individual with a criminal record to whom such an order or certificate had been issued. Introduced by Rep. Steve Smith (R) and Sen. John Harrington (D), see [bill information](#).

Commentary: Unfortunately, the measure did not make it far in the legislative process in either the House or Senate, but introduction in both houses of the legislature is a promising first step toward relieving Minnesota residents of unreasonable collateral consequences. Demonstrating the momentum building behind these reforms, during their 2012 legislative sessions, [New York](#), [Vermont](#), [West Virginia](#), and [Wisconsin](#) all considered adopting the UCCA and its limitations on employers' negligent hiring liability when they hire individuals who have obtained certificates of relief.

New Jersey Assembly 1434/Senate 863 (use of multifactor employment test would have created rebuttable presumption against employer negligence)

[A 1434/S 863](#) would have required public and private employers to use a multifactor test established to evaluate job applicants with criminal convictions for employment suitability. Under the measure, unless a position was subject to a legal barrier based on a criminal record, employers who used criminal history information to make hiring and retention decisions would have to consider a number of factors, including the state's policy favoring employment for

people with criminal records and job-related factors. Employers who used the multifactor test would be protected from liability by a rebuttable presumption that the employer was not negligent. Introduced by Reps. Bonnie Watson Coleman (D), Albert Coutinho (D) and Grace Spencer (D); and Sen. Sandra Cunningham (D), see [bill information](#).

Commentary: Modeled largely on New York’s approach ([N.Y. Correct. Law § 752](#)), this bill would have required public and private employers who use criminal history information to make employment decisions based on job-related factors, similar to those highlighted in the “ban the box” section. The bill creates a rebuttable presumption that an employer who conducts this analysis has demonstrated an appropriate level of care in determining the suitability of the worker with a criminal record.

(3) Expungement and Sealing: Reducing Employment Barriers

There are more than two million individuals incarcerated in the United States and an estimated 700,000 will be released from prisons this year, with an additional 12 million being released from local jails. As research has shown, the mark of a criminal record is so stigmatizing that the majority of employers will be deterred from hiring a worker because of it. Sealing or expunging criminal history information so that employers are unable to obtain those records may eliminate a barrier to employment, and can serve to ease reentry into the community, reduce recidivism, and improve public safety.

During 2012, at least eight states—Delaware, Georgia, Louisiana, Ohio, Maryland, North Carolina, Tennessee and Utah—adopted measures that authorize or expand expungement relief for criminal convictions. These provisions range from establishing expungement relief for certain felony drug offenses to expanding expungement for defendants whose cases are not handled exclusively in juvenile court. At least eight other states, including Alabama, Florida, Kentucky, Louisiana, Missouri, New Jersey, New York and Rhode Island, introduced expungement provisions during 2012. However, three measures—in New Mexico, South Carolina, and West Virginia—were adopted by the legislature, but vetoed by the governor.

Model: The state of Connecticut offers a model. Advocates there made a successful push for legislation to seal or expunge arrests that did not lead to conviction and old or minor conviction records. The state’s statute, [Conn. Gen. Stat. § 54-142a](#), stipulates that records of arrest not leading to conviction are automatically “erased” and the individual with the erased record may assert that he or she has not been arrested. These types of efforts afford individuals with criminal records a fairer opportunity to rebuild their lives, support their families, and become productive members of their communities.

Successful Legislation

Delaware House Bill 285 (technical fix of juvenile expungement provision)

This [bill](#) enhances the provisions in [House Bill 177](#), enacted in 2011, which dealt with juvenile expungement provisions. The measure addresses confusion that arose following the enactment of a 2011 bill regarding whether a Family Court judge may order expungement of charges arising in other counties. HB 177 authorized expungement for certain juvenile felony and misdemeanor offenses in Family Court. The correction allows the Court to order expungement of charges originating in a different county. Introduced by Rep. Michael Barbieri (D), see [bill information](#).

Commentary: HB 285 offers an example of the need and opportunity to improve upon previously enacted legislation. Additionally, targeting expungement policies to persons with juvenile convictions can offer a second chance and reduce the stigma associated with a youthful conviction.

Georgia House Bill 1176 (sealing of arrest that did not lead to conviction)

This [bill](#) authorizes the sealing (suppression) of cases that were never referred for prosecution, dismissed or nolle prossed, no true bills, and certain low-level drug possession offenses after completion of probation after a certain period of time. "Youth offender" cases with one misdemeanor or a series of misdemeanors stemming from one arrest may be sealed after a period of time. Additionally, the bill authorized "dead docket" cases that are older than 12 months to be sealed at the request of the subject of the record. Introduced by Reps. Golick (R), Neal (R), Willard (R), Lindsey (R), Oliver (D), and Jacobs (R), see [bill information](#).

Commentary: These provisions were part of a larger criminal justice reform bill that included sentencing and reentry reforms. The [Georgia Justice Project](#) worked for almost three years to advocate for major changes to the state's record restriction laws. The original sealing bill was introduced by Rep. Jay Neal as a stand-alone but the provisions were eventually added to the Governor's criminal justice reform package and passed by the Georgia General Assembly earlier in 2012.

Louisiana Senate Bill 403 (expungement for persons with eligible offenses)

[Senate Bill 403](#) authorizes expungement for persons convicted of their first, nonviolent felony offense for certain drug crimes including low-level drug possession, manufacturing, and selling offenses. This bill allows individuals with one felony conviction for possession, distribution or possession with intent to distribute 28 grams or less of cocaine, amphetamines, oxycodone or methadone to apply to have their records expunged. To qualify for expungement, the individual must also have completed a "boot camp" rehabilitation program while in prison. A process already exists for expunging misdemeanor convictions. Introduced by Sen. Jean-Paul Morrell (D), see [bill information](#).

Commentary: The bill drew opposition from the Louisiana District Attorney's Association and lawmakers who encouraged a legislative study of the issue. Other opponents emphasized that

clearing a state criminal record does not necessarily translate into a cleared commercially-prepared report, and thus this bill would generate confusion. An employer may find evidence of a prior conviction on a background check report although the applicant expunged the conviction. If the individual indicated he or she did not have a conviction on the application, then the individual might be accused of dishonesty. Some states have addressed this problem by prohibiting the reporting of dismissed convictions by consumer reporting agencies.

Ohio Senate Bill 337 (authorizes sealing of criminal records)

This [measure](#) includes several expungement provisions to improve reentry outcomes for persons with prior convictions. One provision modifies eligibility requirements for the sealing of a criminal record. The act stipulates that persons are eligible only if convicted of specified offenses and only if they do not have more than one felony conviction, or two separate misdemeanors, or not more than one felony conviction and one misdemeanor conviction in Ohio or any other jurisdiction. Violent and sex offenses are not eligible for expungement. The law will also help persons with juvenile convictions by authorizing expungement after six months instead of two years except in cases involving murder, attempted murder, and rape. The measure expands judicial authority to seal the records of juveniles convicted of certain sex crimes. Introduced by Sen. Bill Seitz (R), see [bill information](#).

Commentary: The measure garnered significant bipartisan support, passing the Ohio Senate by a 27-4 vote at the end of May and legislation mirroring the bill, House Bill 524, passed 96-1 in the Ohio House. Officials who supported the juvenile provisions of the Act emphasized that it will enhance the ability of teens to reenter the community in a constructive way following their incarceration.

Maryland House Bill 708 (expands expungement relief for juvenile convictions)

This [bill](#) authorizes a person to file, and “requires a court to grant,” a petition for expungement of a juvenile criminal charge that was not handled exclusively in juvenile court. Prior to reform, Maryland law authorized expungement relief for cases that were handled exclusively in juvenile court. Introduced by Del. Geraldine Valentino-Smith (D), see [bill information](#).

Commentary: This measure garnered support from children’s and sentencing reform advocates. The bill affords individuals with juvenile convictions access to opportunity through education and other pursuits that build healthy lives, families, and communities. Expanding expungement relief helps to reduce the adverse effects of a criminal record on a person’s ability to lead a productive and meaningful life.

North Carolina House Bill 1023 (expungement for certain low-level offenses)

This Act allows individuals with nonviolent misdemeanors or felonies to expunge their records after 15 years.

Commentary: The bill garnered bipartisan support and was signed after a two-month wait. It passed through both the House and the Senate after being amended four times, and was a victory for its Republican champion. There were efforts to get the 15-year wait time reduced,

but that timeframe was the only number that garnered the support needed for enactment. The measure had failed during the 2009-2010 legislative cycle. Introduced by Rep. Leo Daughtry (R), see [bill information](#).

Tennessee House Bill 2865 (expungement for low-level misdemeanors and felonies)

This [bill](#) authorizes expungement relief for individuals convicted of certain first-time, non-violent and non-sexual misdemeanors, and Class E felonies after a five-year waiting period. At the time of application for expungement, the individual must have met all conditions of supervised or unsupervised release, including the payment of all fines and restitution. Introduced by Rep. Karen Camper (D), see [bill information](#).

Commentary: This measure garnered broad support, including an endorsement from the Tennessee District Attorneys General Conference, which worked with the bill sponsors to create the list of eligible offenses and the steps necessary to have the crimes expunged. The measure requires a \$350 filing fee for expungement that is expected to fund costs associated with the process, as well as provide revenue for the state's general fund.

Utah Senate Bill 201 (expands expungement relief under certain circumstances)

[SB 201](#) expands expungement relief to include specified traffic offenses. The measure authorizes individuals to petition the Bureau of Criminal Identification of the Department of Public Safety for a certificate of eligibility to expunge records of arrest, investigation, and detention, subject to specified conditions. Introduced by Sen. Curtis Bramble (R), see [bill information](#).

Commentary: Until passage of this bill, Utah motorists could not have their driving records cleared, although specified criminal offenses could be expunged after a certain amount of time. Senator Curtis Bramble, a Republican, agreed to pursue a change in the law after hearing from a constituent who was denied employment as a truck driver because of a 5-year-old citation for running a red light.

Vetoed Legislation

New Mexico Senate Bill 2 (would have authorized expungement relief)

Governor Susana Martinez (R) vetoed this expungement [measure](#). The Act would have codified the authority of the courts to expunge an individual's criminal conviction in specified circumstances. One provision of the bill authorizes expungement for the wrongfully convicted or for individuals convicted of certain misdemeanor or felony offenses. The Governor, a former prosecutor, said she could not sign a bill that would "fundamentally and negatively alter the New Mexico criminal justice system." Introduced by Sen. Michael Sanchez (D), see [bill information](#).

Commentary: With bipartisan support, the bill passed the New Mexico Senate 35-4 and the House 41-27. Lawmakers also said the bill was an important tool to help people move forward from petty crimes committed years earlier. Twice before, the legislature had approved bills to

allow criminal record expungement, but those measures were each vetoed by former Governor Bill Richardson (D).

South Carolina House Bill 3127 (would have authorized expungement relief)

Governor Nikki Hayley (R) vetoed this [measure](#), authorizing persons seeking a pardon also to apply to the South Carolina Board of Pardons and Paroles for expungement if ten years had passed since the completion of all terms and conditions of their sentence. The bill also would have authorized prosecuting attorneys and law enforcement agencies to file an objection opposing an individual's expungement application. Introduced by Rep. Todd Rutherford (D), see [bill information](#).

Commentary: Law enforcement fiercely opposed the bill. The goal of the legislation, supporters said, was to make it easier for people who made youthful mistakes to get a job. However, lawmakers opposing the bill argued it had an overly broad list of eligible offenses. The Governor has committed to working with the bill's champion to develop a narrower bill that would improve employment opportunities for pardoned individuals convicted of eligible offenses.

West Virginia Senate Bill 547 (would have authorized expungement for certain offenses)

Governor Earl Ray Tomblin (D) vetoed this [measure](#). This bill would have removed the current age restriction (18-26) and expanded possible expungement relief to those convicted of certain nonviolent felonies three years after the end of any sentence or probation, whichever is later. Introduced by Sen. Mark Wills (D), see [bill information](#).

Commentary: Lawmakers should consider the benefits of reducing the stigma associated with prior convictions for individuals who have demonstrated rehabilitation before rejecting such changes in policy.

(4) Federal Opt-Out Legislation: Restoring Public Benefits

The federal welfare law imposes a lifetime ban on anyone convicted of a drug-related felony from receiving federally funded food assistance (Supplemental Nutrition Assistance Program, or SNAP) and cash assistance (Temporary Assistance to Needy Families, or TANF). Unless a state passes legislation opting out of the federal law, individuals with these convictions are permanently barred from receiving benefits even if they have completed their sentence, overcome an addiction, been gainfully employed and subsequently laid off, or earned a certificate of rehabilitation or other form of clemency. Denying persons with felony drug convictions food, clothing, and shelter makes it more difficult for them to support themselves as they leave the criminal justice system and reenter society. An additional barrier can arise when states institute suspicion-based drug testing programs for people applying for different forms of public benefits and consider a criminal record or drug felony conviction a form of "reasonable" suspicion.

A majority of states have eliminated or modified the lifetime ban on SNAP and TANF for people with felony drug convictions because of the recognition that public assistance is sometimes

essential in the lives of indigent individuals with a prior criminal conviction. Modifications include permitting an individual to receive benefits if he or she has completed the sentence or drug or alcohol treatment, limiting the duration of the ban, or permitting individuals with convictions for simple possession to receive benefits. However, 9 states maintain the federal ban for SNAP, and 10 states maintain the federal TANF ban without modification. These states permanently deny benefits, even if the underlying crime occurred years before and regardless of an individual's successful job history, participation in drug and alcohol treatment, or other evidence of rehabilitation.⁶

During 2012 at least four states—Alabama, California, Missouri, and Pennsylvania—introduced measures to improve access to public benefits for persons with felony drug convictions. Unfortunately, none of these measures was adopted in 2012. However, [Georgia](#), [Oklahoma](#), [Tennessee](#), [Utah](#) and [West Virginia](#), all adopted measures that require drug testing for individuals applying or receiving public benefits ranging from cash assistance to workforce readiness programs. While no state opted out of the drug felony ban in 2012, champions of the opt-out legislation in states that introduced measures worked to shift the mood and potentially laid the groundwork through advocacy and public education for future legislative cycles.

Model: Fifteen states and the District of Columbia have eliminated the SNAP ban and thirteen states have eliminated the TANF ban.⁷ The [Maine](#) and [Ohio](#) statutes are good examples of laws that “opt out” of the federal ban on people with drug felony convictions receiving food stamps or TANF. These measures specifically reference the federal law as required by statute, yet Ohio in particular avoids raising “red flags” by omitting potentially controversial language such as “people with drug felony convictions are eligible to receive benefits.” States wishing to eliminate the federal ban should model language on these statutes.

Introduced Legislation

Alabama House Bill 53 (eligibility for federal benefits for certain persons)

[HB 53](#) would have modified eligibility for SNAP and TANF for persons with felony drug convictions if they met certain conditions. Specifically, the measure would have authorized eligibility upon completion of a sentence, or upon the applicant satisfactorily serving a sentence of probation including participating in mandatory drug or alcohol treatment. Introduced by Sen. Coleman (D), see [bill information](#).

Commentary: According to recent reports, of Alabama's more than 4.7 million residents, 1.7 million are receiving assistance for food. SB 328 would have relaxed eligibility requirements for persons with felony drug convictions. Critics of SB 328 said the ban should be kept because it deters people from becoming involved in illegal drug activity. Supporters argued the assistance helps individuals with felony drug convictions sustain themselves and their families and obtain

⁶ Legal Action Center. 2011. “Opting Out of Federal Ban on Food Stamps and TANF,” available at <http://www.lac.org/toolkits/TANF/TANF.htm>.

⁷ *Ibid.*

drug and alcohol treatment and other essential services, which increase public safety and reduce crime.

California Senate Bill 1060 (eligibility for federal benefits for certain persons)

CalWORKS eligibility would have been expanded to include persons with felony drug convictions, if they met certain requirements for eligibility under this bill. CalWORKS is a welfare program that gives cash aid and services to eligible needy California families. The grants are primarily used by families to pay some of their housing costs. SB 1060 would have allowed California to join 13 other states in opting out of the federal lifetime ban on receiving TANF funding for those with past drug felonies. California already allows those with certain drug-related felonies to receive SNAP or CalFresh benefits. Introduced by Sen. Loni Hancock (D), see [bill information](#).

Commentary: California’s “realignment” shifts responsibility from the state to counties for the custody, treatment, and supervision of individuals convicted of specified nonviolent, non-serious, non-sex crimes. Counties believed that SB 1060 would have provided an important tool post-realignment by supporting individuals’ reintegration into the communities. Supporters of SB 1060 believed that in the long-term, the bill would have assisted in reducing recidivism. The bill passed out of the Senate Human Services Committee, but stalled in the Senate Appropriations Committee.

Missouri House Bill 1238 (eligibility for federal benefits for certain persons)

This [bill](#) would have modified eligibility for persons with felony drug convictions if the Missouri Department of Social Services determined the individual satisfactorily completed drug treatment, was accepted for treatment, or was on the waiting list for treatment. Introduced by Rep. Bob Nance (R), see [bill information](#).

Commentary: Bills were introduced in both chambers. HB 1238 was championed by a Republican legislator who garnered bipartisan support for the bill and shepherded the measure out of committee. The bill made it farther in 2012 than in previous sessions when it was amended and made part of a larger crime bill. Unfortunately, the legislation did not move in the Senate. Supporters of the bill included the Missouri Association for Social Welfare and the Kansas City Metropolitan Crime Commission.

Pennsylvania Senate Bill 1173 (eligibility for federal benefits for certain persons)

This [bill](#) would have expanded eligibility for federal public assistance to include individuals with felony drug convictions if they complied with certain conditions including participating in court ordered substance abuse treatment and submitting to drug testing. Introduced by Sen. Donald White (D), see [bill information](#).

Commentary: Pennsylvania has modified the federal drug felon ban. People convicted of felony or misdemeanor offenses are eligible for cash or food stamps once they have “satisfied the penalty” (i.e. remain in compliance with probation/parole obligations, completed their sentence and/or paid any fines, costs and/or restitution imposed). Expanding eligibility while

also institutionalizing drug testing requirements is regressive and may further stigmatize persons with felony convictions who are attempting to reintegrate into the community.

(5) Felony Enfranchisement: Restoring Voting Rights

As of 2010 a record 5.85 million people⁸ were ineligible to vote as a result of a felony conviction. The number of disenfranchised persons has increased dramatically in recent decades, rising from an estimated 1.17 million in 1976 to 5.85 million today, as the number of people under correctional control has sky-rocketed. In recent years, significant reforms in felony disenfranchisement policies have been achieved at the state level. Increased public exposure has resulted in legislative initiatives that expand civil rights to individuals with felony convictions and in neighborhood-level efforts to educate and register people with felony convictions.

This escalation in attention to felony disenfranchisement policies has translated into substantial state-level reform. Since 1997, twenty-three states⁹ have amended felony disenfranchisement policies in an effort to reduce their restrictiveness and expand voter eligibility. During 2012, several states, including Virginia, Kentucky, and Oklahoma, introduced measures to expand voting rights to persons with felony convictions. However, only one state legislature—Delaware—authorized a measure to extend voting rights to persons with felony convictions.

Model: Only two states, Maine and Vermont, allow incarcerated persons the right to vote. While it is unlikely that many states would consider extending voting rights to people in prison in the short run, it may be possible as the experiment of American democracy continues. As noted, twenty-three states have enacted some type of reform to their felony disenfranchisement practices since 1997—a remarkable pace of activity in a relatively short period.

Successful Legislation

Delaware House Bill 9 (repeals waiting period to have voting rights restored)

This [Act](#) amends the Delaware Constitution to eliminate the five-year waiting period for persons with certain felony convictions who have fully discharged their sentences, before their voting rights are restored. The same version of HB 9 must pass next year in order to be enacted as a constitutional amendment and does not have any force of law until then. Introduced by Rep. Keeley (D), see [bill information](#).

Commentary: Currently, Delaware disenfranchises approximately 46,600 individuals, including over 28,000 who have completed their sentence. In Delaware, African Americans constitute

⁸ Uggen C., Shannon S. and Manza J. 2012. “State-Level Estimates of Felon Disenfranchisement in the United States, 2010.” The Sentencing Project. Washington D.C.

⁹ Porter N. 2010. “Expanding the Vote: State Felony Disenfranchisement Reform, 2010.” The Sentencing Project, Washington D.C.

about 45% of those disenfranchised, an estimated 20,862 persons. Delaware is one of only 11 states in which a felony conviction can result in the loss of voting rights post-sentence. This measure would align Delaware with a majority of states, including Pennsylvania, Maryland, and West Virginia—states with less restrictive disenfranchisement policies. Supporters of HB 9 included the Delaware Center for Justice, ACLU of Delaware, League of Women Voters, Delaware Commission for Women, and the NAACP Delaware State Conference.

Introduced Legislation

Kentucky House Bill 70 (would have amended constitution to authorize voting rights)

This measure would have amended the Kentucky constitution to restore voting rights for people with convictions after expiration of probation, final discharge from parole, or maximum expiration of sentence, unless the person was convicted of treason, intentional killing, a sex crime, or bribery. Introduced by Rep. Jesse Crenshaw (D), see [bill information](#).

Commentary: Currently, Kentucky disenfranchises over 243,000 individuals with felony convictions. HB 70 passed out of the Kentucky House in 2012 but did not advance beyond the committee level in the Senate. Supporters of the Kentucky voting rights amendment included the Kentuckians for the Commonwealth, ACLU of Kentucky, Kentucky State Conference of the NAACP, and the League of Women Voters.

Virginia House Bill 16 (would have authorized voting rights for persons with certain offenses)

Delegate Greg Habeeb, a conservative Republican, championed this bill to extend voting rights to individuals with eligible offenses. HB 16 would have authorized automatic restoration of civil rights to persons convicted of nonviolent felonies (excepting felony drug and election fraud crimes) upon completion of their sentence. Currently, in Virginia all persons convicted of a felony are barred from voting for life, absent gubernatorial action. Introduced by Del. Greg Habeeb (R), see [bill information](#).

Commentary: Legislation was also introduced in 2012 to amend the constitution to extend rights to all individuals with felony convictions. More than 451,000 individuals are disenfranchised in Virginia. The Governor has the sole discretion to restore a person's civil rights under the Virginia Constitution. While there is no process for appealing his decision, a person may reapply after one year. Governor Bob McDonnell (R) reports that he has restored voting rights to more than 3,000 individuals with felony convictions since taking office.¹⁰ Organizations working to restore voting rights in the state include the Advancement Project, ACLU of Virginia, and the NAACP State Conference of Virginia.

¹⁰ Bryan A. and Jones S., "Would restoring felon voting rights change VA's political landscape?" WTVR.com July 25, 2012. Download online on August 23, 2012: <http://wtvr.com/2012/07/25/would-restoring-felon-voting-rights-change-vas-political-landscape/>

(6) Uniform Collateral Consequences of Conviction Act Legislation

As discussed above, collateral consequences, such as employment barriers and public benefit restrictions which are often not disclosed during sentencing or pleading—can follow an individual for a lifetime. Because of this, the American Bar Association incorporated several standards that equip jurisdictions with information and resources to regulate the breadth and impact of collateral consequences on individuals who are convicted of crimes. In accordance with these standards, the Uniform Law Commission drafted what became the [Uniform Collateral Consequences of Conviction Act](#) to address the impact of collateral consequences on an individual after criminal sentencing and to provide a relief mechanism for those affected.

Model: The Uniform Collateral Consequences of Conviction Act (UCCCA), published in 2009, has six key provisions including the collection and notification of collateral consequences at critical times in a criminal case. It requires that collateral sanctions be authorized by statute and that an individual convicted of a crime can be disqualified from the receipt of a benefit or opportunity, but only if it is closely related to the conviction(s). It further ensures that pardoned or overturned convictions may not be subject to collateral consequences and gives jurisdictions a choice about other types of relief based on rehabilitation or good behavior. Finally, it provides two mechanisms of relief which begin as early as sentencing and another after a period of law-abiding conduct, entitled An Order of Limited Relief and a Certificate of Restoration of Rights, respectively. Though UCCCA has not been enacted in its entirety by any state, advocates are hopeful that the next legislative session will achieve this milestone.

Introduced Legislation

Minnesota House Bill 489/Senate Bill 1448 (would have enacted the UCCCA in its entirety) [HB 489/SB 1448](#) was introduced for the second time this year. It would have implemented the UCCCA and other laws regarding collateral consequences and the rehabilitation of criminal offenders, which conformed to the uniform act. If it had passed, it would have repealed all statutes in chapter 609B surrounding collateral sanctions. Introduced by Rep. Steve Smith (D) and Sen. John Harrington (D), see [bill information](#).

Commentary: This bill was brought forward to the committee by the [Uniform Law Commission](#) but received considerable opposition from lawmakers concerned that adopting such a measure would appear too soft on crime. Advocates from the ULC will be meeting in September to determine the best way to proceed with this legislation next year.

New York Assembly 8546 (would have required the collection and notification of collateral consequences)

This [bill](#) would have required the Division of Criminal Justice Services to compile an exhaustive list of collateral consequences that can affect an individual at guilty plea and that such individuals would be advised of collateral consequences that flow from a particular conviction.

It also would have required access for defendants to existing online resources. Introduced by Asm. Joseph Lentol (D), see [bill information](#).

Commentary: If passed, this bill would have supplemented the online resources New York currently provides that explain the impact of collateral consequences with a mechanism for calculating sanctions or disqualifications specifically in immigration and housing eligibility. It is currently being revised and will be introduced again next year.

Vermont Senate 38 (would have enacted the UCCCA in its entirety)

This [bill](#) received bipartisan support in the House and was unanimously passed. In the Senate, there was concern about whether the study of collateral consequences was extensive enough to act on. Further action was deferred until the next legislative session. Introduced by Sen. Dick Sears (D), see [bill information](#).

Commentary: The first portion of the Collateral Consequences of Conviction Study conducted by the American Bar Association will be released in late September and is expected to address concerns raised in the Senate regarding the lack of documentation of collateral consequences.

West Virginia House Bill 2010/Senate Bill 340 (would have enacted the UCCCA in its entirety)

[HB 2010/SB 340](#) was originally recommended by the Joint Standing Committee on the Judiciary, though no action was taken. It was reintroduced this year but never received a public hearing and stalled in committee. Introduced by Del. Tim Miley (D), see [bill information](#).

Commentary: Advocates of this bill continue to be hopeful that more headway can be gained next session with additional support from local organizations and individuals.

Wisconsin Senate Bill 304 (would have enacted the UCCCA in its entirety)

This [bill](#) would have provided a list of collateral consequences that result from the application of state law and administrative rules. It provides the charged individual with information about collateral consequences when he or she is charged or indicted. The bill did not receive a public hearing and stalled in committee due to opposition from the chair. Introduced by Sen. Lena Taylor (D); Sen. Jim Holperin (D); Sen. Fred Risser (D), see [bill information](#).

Commentary: Criminal justice reform has been slow moving in Wisconsin due to polarized views on the rights of individuals previously incarcerated. Sponsoring offices will reintroduce this legislation next year.

Summary of State Reforms: 2012 Legislative Round-Up

State	Bill Numbers	Category of State Reform
Alabama	HB 53 (introduced)	Federal opt-out
California	(1) AB 1831 (introduced) (2) SB 1060 (introduced)	(1) Ban the box (2) Federal opt-out
Colorado	(1) HB 1263 (passed) (2) SB 12-105 (introduced)	(1) Ban the box (2) Employer negligent hiring protections
Delaware	(1) HB 285 (passed) (2) HB 9 (passed)	(1) Expungement (2) Felony Enfranchisement
Georgia	HB 1176 (passed)	Sealing
Illinois	HB 1210 (introduced)	Ban the box
Kentucky	HB 70 (introduced)	Felony Enfranchisement
Louisiana	SB 403 (passed)	Expungement
Maryland	(1) SB 671/HB 800 (introduced) (2) HB 708 (passed)	(1) Ban the box (2) Expungement
Minnesota	(1) HF 1448/ SF 1122 (introduced) (2) HF 489/ SF 1448 (introduced)	(1) Ban the box (2) Employer negligent hiring protections; UCCCA
Missouri	HB 1238 (introduced)	Federal opt-out
New Jersey	(1) A 2300 (introduced) (2) A 1434/ S 863 (introduced)	(1) Ban the box (2) Employer negligent hiring protections
New Mexico	SB 2 (vetoed)	Expungement
New York	A 8546 (introduced)	UCCCA
North Carolina	HB 1203 (passed)	Expungement
Ohio	SB 337 (passed)	Employer negligent hiring protections; Sealing
Pennsylvania	SB 1173 (introduced)	Federal opt-out
Rhode Island	HB 7760/ SB 2411 (introduced)	Ban the box
South Carolina	HB 3127 (vetoed)	Expungement
Tennessee	HB 2865 (passed)	Expungement
Utah	SB 201 (passed)	Expungement
Vermont	(1) H 717 (introduced) (2) S 38 (introduced)	(1) Ban the box (2) UCCCA
Virginia	HB 16 (introduced)	Felony Enfranchisement
West Virginia	(1) SB 547 (vetoed) (2) HB 2010/ SB 340 (introduced)	(1) Expungement (2) Felony Enfranchisement; UCCCA
Wisconsin	SB 304 (introduced)	UCCCA

About the Organizations

The [ACLU](#) is our nation's guardian of liberty, working daily in courts, legislatures and communities to defend and preserve the individual rights and liberties that the Constitution and laws of the United States guarantee everyone in this country.

[Crossroad Bible Institute](#) is the largest prison mentoring program in the United States and abroad, providing faith-based reentry education to incarcerated persons for successful reentry upon release since 1984. CBI educates the church, religious communities and the public on criminal and restorative justice issues. We break down barriers for formerly incarcerated persons by informing and influencing state policy with the help of affiliates nationwide.

The [Legal Action Center](#) is the only non-profit law and policy organization in the United States whose sole mission is to fight discrimination against people with histories of addiction, HIV/AIDS, or criminal records, and to advocate for sound public policies in these areas. LAC's [National HIRE Network Project](#) focuses on public policy advocacy for people with criminal records.

The [National Employment Law Project](#) is a national organization that conducts research, education and advocacy on issues affecting low-wage and unemployed workers.

[The Sentencing Project](#) is a national organization that works for a fair and effective U.S. criminal justice system by promoting reforms in sentencing policy, addressing unjust racial disparities and practices, and advocating for alternatives to incarceration.

Appendix 11

Supportive Housing Saves Money, Reduces Homelessness

EMBARGOED UNTIL
November 1, 2007

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New Study: Supportive Housing Saves Money, Reduces Homelessness

*HousingWorks RI forum explores effectiveness of programs that help
chronically homeless individuals live independent and stable lives*

PROVIDENCE, R.I., Nov. 1—A new study demonstrates the effectiveness of supportive housing—which provides rapid access to permanent housing and services that help chronically homeless citizens live independent, stable, and productive lives—as a cost-effective solution to the problem of chronic homelessness in Rhode Island. The report by Providence College professor of sociology Eric Hirsch, Ph.D., was released today at a HousingWorks RI forum in the State House.

“Rhode Island’s Housing First Program: First-Year Evaluation” examines the effectiveness of Housing First Rhode Island, a pilot program which provides supportive services and access to permanent homes for nearly 50 chronically homeless individuals. Housing First is spearheaded and funded in part by the United Way of Rhode Island and the State of Rhode Island.

“In the first year, we saw dramatic results: not only is the Housing First program saving the state money, but residents report better physical and mental health once enrolled,” Dr. Hirsch said. “Residents reported a dramatic decline in the use of hospitals, emergency rooms, mental health facilities, jails and prisons, drug and alcohol treatment facilities, and emergency shelters.” Dr. Hirsch and his co-author, Roger Williams University anthropology professor Irene Glasser, Ph.D., interviewed Housing First residents, case managers, and program managers.

Dr. Hirsch and Dr. Glasser estimate that, in the year prior to entering supportive housing, the program’s participants spent a combined total of 534 nights in hospitals and 9,600 nights in homeless shelters—for an annual institutional cost of approximately \$31,600 per client. By contrast, during the first year of the Housing First program, study participants reported a combined total of only 149 nights in hospitals and 640 nights in shelters—for an annual cost of homelessness of approximately \$7,635 per client.

Including the cost of supportive services (\$9,500 per person) and housing subsidies (\$5,643 per person), the Housing First program costs the state \$22,778 per client—or \$8,839 less than the institutional cost of homelessness. For all 48 participants, the total savings of the Housing First program versus the institutional costs of one year of homelessness are approximately \$424,272.

-more-

HousingWorks RI

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"The success of the Housing First initiative speaks directly to what Rhode Island Housing and our partners have always believed -- that a good home involves more than four walls and a roof," said Richard Godfrey, executive director for Rhode Island Housing. "In order to work towards resolving our state's homeless crisis, we need to work together to provide more than shelter. We need education, healthcare and job training. In taking a comprehensive approach, Housing First does just that and saves money. It's a win-win."

Also taking part in today's forum was Armeather Gibbs, chief operating officer of the United Way of Rhode Island. Gibbs opened the forum with the story of "Million Dollar Rhody"—the true tale of a chronically homeless Rhode Islander whose medical bills alone totaled \$134,877 from December 15, 2006, through April 15, 2007, a period of four months. "This story illustrates exactly the wrong use of resources," said Gibbs. "The good news is with programs like Housing First in place we are working our way towards a solution."

Janice Elliott, managing director of program support for the Corporation for Supportive Housing (CSH), also participated in the forum. Elliott was the architect of Connecticut's award-winning Supportive Housing Pilots Initiative.

Two supportive housing residents, Bill and Carl, shared their personal stories with the audience. Don Boucher, director of the Housing First program at Riverwood Mental Health Services, was in attendance as well. "I believe the Housing First approach to supportive services housing provides the best long term solution to ending the homeless epidemic plaguing Rhode Island individuals and families. This has been proved in Rhode Island over the past two years and around the nation in the last decade," said Boucher.

About HousingWorks RI

HousingWorks RI is a coalition, unprecedented in its breadth and depth. It is also a campaign, intended to end the state's severe shortage of quality affordable housing. HousingWorks RI taps the talents, experience, information, influence, networks, and energies of more than 120 member organizations, institutions, corporations, agencies, and advocates. Through its members, activities, and website, HousingWorks RI:

- draws attention to housing issues in Rhode Island;
- provides a one-stop, authoritative source of information about affordable housing in Rhode Island;
- hunts down new ideas and best practices from across the nation;
- celebrates housing progress in our communities; and
- advocates for solutions that will end the housing crisis.

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Appendix 12

Getting Out With Nowhere to Go: The Case for Reentry Supportive Housing

Getting Out With Nowhere to Go



*The Case for Re-entry
Supportive Housing*





Dead-Ends

Lavelle Conner, 46, estimates he's been arrested 150 times. While struggling with schizophrenia, depression, and drug addiction during his 12 years of homelessness, he slept in abandoned buildings and ate out of garbage cans. With little if any support on the outside, Lavelle faced one dead end after another. "The drugs helped my pain, so I kept taking things that weren't mine to support my habit."

"Do I go back to the abandoned houses and the garbage cans? That was always my first thought on release. And I found myself back in the same situation."

—Lavelle Conner

Lavelle's story is not unusual. Every year, our prisons and jails release almost 10 million people. **Like Lavelle, many return to impoverished neighborhoods and are trapped in a cycle of homelessness, incarceration, and health and mental health crises.** More often than not, these individuals find themselves right back in prison or jail for parole violations and quality of life crimes. Taxpayer dollars are wasted as the status quo continues and peoples' lives spiral out of control.

Of all issues facing parolees reentering communities, studies suggest that none is more immediate than the need to find a place to live. Without stable housing, returning to jail or prison is almost a given in a system where homeless people find themselves arrested again and again for violations related to homelessness, untreated mental illness, and addiction.



“Re-entry supportive housing is essentially a public safety initiative; serving to stabilize people in the community and reduce recidivism.”

—Gordon Bass, Director, Jacksonville, FL Sheriff’s Office

In addition to the mind-boggling costs in lost human potential, productivity, child and family stability, and public safety, states and cities are spending billions as a result of failed policies. Among the 20,000 mentally ill parolees exiting California prisons each year, about 3,500 become homeless. Ninety-four percent return to prison within 24 months. This alarming recidivism rate results in an equally shocking expense to the state: the average annual cost of housing a mentally ill inmate in California is \$110,000. Pricy prison mental health care does not alleviate the state’s over-burdened system. On the contrary, in 2007 the California Legislature approved a \$7.4 billion prison expansion to build 40,000 more beds. Keeping an individual incarcerated in a Chicago jail or at New York’s Riker’s Island is no less expensive and averages more than \$47,000 a year, without considering the added costs of mental health treatment.

Homelessness, Disability, and Incarceration

- More than one in three jail inmates report a disability.
- Prisons and jails treat more people with mental illness than hospitals and residential treatment facilities combined, making our jails and prisons the primary provider of mental health care in the U.S.
- Rates of shelter use are higher for people exiting prison than for people exiting mental hospitals.
- Parolees released to homelessness are at greater risk of returning to jail or prison than parolees who do not experience homelessness.
- 54% of homeless persons in shelters report previous incarceration.
- 43% of defendants with mental disorders were homeless when committing the crime for which they were arrested.
- 22% of New York City inmates were homeless the night before their arrest.

Getting On the Right Track

With the right help, Lavelle was able to turn his life around. He became a permanent supportive housing tenant through Thresholds, a Chicago-area nonprofit. Since obtaining housing, counseling, and other support services he has been living with stability for three and a half years. Lavelle no longer abuses drugs and has remained out of trouble. He has served as president of the tenant council and a consumer

“Placing people into supportive housing costs about half as much as keeping someone in jail or prison, while also promoting public safety and improving life outcomes for people”

—Martin F. Horn, Commissioner of New York City Department of Correction



Supportive housing—permanent, affordable housing linked with services that meet the needs of individuals—has emerged as a real solution that works. Services are tailored and coordinated and provide health, mental health, substance use, vocational services and benefits advocacy, and other supports necessary to help people succeed. Successful programs often begin to engage and provide services while the participant is still incarcerated.

With thousands of Lavelles ready to reenter communities across the nation every year, it’s time to ask ourselves if we can afford to continue our reliance on systems that are not working, wasting public dollars, and creating generations of people robbed of hope. Supportive housing changes the paradigm by building a bridge that allows those reentering society to cross over to more stable and productive lives.

Supportive Housing Works

Among mentally ill individuals experiencing homelessness and substance addiction, one study revealed that supportive housing yielded the following results:

- 81% of participants remained housed after one year and 63% remained housed after two years.
- Participants experienced a 56% decrease in their number of visits to the emergency room.
- Participants were admitted to the hospital 45% less frequently than before tenancy.

Other data shows that supportive housing produced:

- A 76% reduction in days spent in jail/prison in Denver.
- A 57% reduction in the rate of prison incarceration and a 30% reduction in the rate of jail incarceration among those with mental illness in New York.
- A decreased recidivism rate from 50% to 7% in Maryland.

Trail-Blazers

Nationwide, more and more cities, counties, and states are investing in supportive housing for people reentering their communities from jails and prisons. Political leaders, agencies, and nonprofit partners are breaking the cycle of incarceration and homelessness. These visionaries are providing a home and hope to people who otherwise would have no place to turn.

In **NEW YORK CITY**, the Department of Corrections partners with the Departments of Homeless Services and Mental Health and Hygiene and others to break the cycle of crime and despair. Using Section 8 rental subsidies and local funding to offer services through collaborating service providers, the City sponsors a pilot program that provides supportive housing to 175 people exiting jail.

In **CHICAGO**, the Chicago Low Income Housing Trust Fund, in conjunction with the Mayor's Office on Re-entry and the city's housing department, uses housing vouchers (as part of the City's Plan to End Homelessness) to provide supportive housing to people cycling between homelessness and incarceration. This effort is complemented by support and resources from the state's Division of Mental Health, Cook County Criminal Courts, Cook County Jail, Cermak Hospital, and community-based organizations and providers.

In **OHIO**, the Department of Rehabilitation and Corrections has invested in a supportive housing pilot program targeted to parolees at risk of homelessness. The program is linking and integrating the efforts of corrections with housing, mental and behavioral health and other agencies to more effectively and efficiently transition people back into the community.

In **LOS ANGELES**, the L.A. County Sheriff's Department is investing \$1.5 million and partnering with non-profit providers to create linkages to housing and services for people cycling between incarceration and homelessness.

Promising Outcomes

After six months of New York City's supportive housing reentry program:

- 89% of tenants remained stably housed.
- 100% of tenants avoided return to shelter.
- 89% of tenants avoided return to jail.
- 94% of tenants stayed in housing longer than the average time previously spent in the community before returning to jail or shelter.

In Rhode Island, early findings from a supportive housing program targeted to the state's most vulnerable population indicated:

- A decrease of about 42 days spent in jail or prison per person.
- Decreased costs in the use of other public systems by \$8,839 per person, per year.

In Seattle, studies of supportive housing at 1811 Eastlake demonstrate:

- 52% reduction in jail bookings.
- 45% reductions in days spent in jail.

Destination Supportive Housing



Photo of Project Renewal, courtesy of The Robert Wood Johnson Foundation, *More than a Place to Live*.

“They met me coming out of jail and showed me that I don’t have to go back to these abandoned houses. I learned that it took guidance and support to help me get my life back together...I prefer opportunities over privileges.”

—Lavelle Conner

Supportive housing is a proven method that can help reduce the high rates of recidivism experienced by people with histories of homelessness, mental illness, and other health conditions. Working together, those of us who care about our communities have a solution we can turn to and end the cycle of homelessness and incarceration. Achieving success requires commitment and action from a variety of stakeholders.

Government agencies can be aggressively involved in:

- Identifying populations with histories of homelessness, de-stabilizing health conditions, and high recidivism through multi-agency data sharing and matching.
- Promoting inter-agency collaboration between agencies with programs serving people with criminal histories, including corrections, housing, human services, and the judiciary.
- Investing criminal justice (and other agency) resources into supportive housing
- Developing pilot programs that serve this population.
- Supporting evaluations to document costs and impacts on individuals and the community.

Nonprofit and community organizations are vital contributors as well and offer:

- **HELP** — Supportive housing developers and others working with corrections officials successfully place people into the community.
- **LINKAGES** — Organizations focused on people with criminal histories partnering with supportive housing providers to better serve the population.
- **SUPPORT** — Local, grassroots groups engaging elected and appointed officials to promote successful re-entry efforts.
- **KNOWLEDGE** — Experts sharing best practices to create positive outcomes.



“The time is right to end the cycle of homelessness and incarceration in this country. It will require commitment and imagination, but will generate a transformation in the lives of everyone who gains a place in the community and gets the chance to live with dignity.”

**—Deb DeSantis,
CSH President & CEO**

CSH is the Leader in Supportive Housing

CSH is working in a number of states to end the cycle of incarceration and homelessness. CSH can assist your community by:

- Helping identify populations with high recidivism rates who could benefit from supportive housing.
- Collaborating with government and partner agencies to promote more effective programs.
- Providing technical assistance.
- Sharing best practices.
- Developing cutting-edge models for attracting investments in supportive housing.
- Conducting comprehensive evaluations to document cost savings.
- Steering philanthropic and government funds to projects.



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For information about how your
community can learn more
contact reentry@csh.org or
visit our website www.csh.org

*"We can either waste money
keeping people homeless, or
we can spend those dollars
on long-term solutions that
produce positive results."*

**—Ohio State Supreme Court
Justice Evelyn Stratton**