DATA-DRIVEN JUSTICE PLAYBOOK

HOW TO DEVELOP A SYSTEM OF DIVERSION

DISCUSSION DRAFT

DEVELOPED BY THE DATA-DRIVEN JUSTICE INITIATIVE

DECEMBER 2016

VERSION 1.0

TABLE OF CONTENTS

INTRODUCTION

Talk to police officers, EMTs, doctors and nurses all across the country, and they will tell you that patients with mental illnesses are cycling through hospital emergency rooms, shelters, jails, and in turn our health, housing, law enforcement and criminal justice systems. Whether in jails, or hospitals, shelters or police encounters, the uncoordinated ways in which systems interact with the mentally ill result in fragmented, misaligned care that costs us billions of dollars each year and more often than not this approach often makes vulnerable individuals worse off and does not improve public safety.

Every year, more than 11 million people move through America's 3,100 local jails, many on low-level, nonviolent misdemeanors, costing local governments approximately $22 billion a year. In local jails, 64% of people suffer from mental illness, 68% have a substance abuse disorder, and 44% suffer from chronic health problems. With seven times more people with mental health problems in jails or prison than there are in mental health treatment facilities, local police, emergency medical teams, and jails across our nation have become the front lines for people in mental health crisis, and, too often, the only response.

Communities across the country have recognized that a relatively small number of these highly-vulnerable people cycle repeatedly not just through local jails, but also hospital emergency rooms, shelters, and other public systems, receiving fragmented and uncoordinated care at great cost to American taxpayers, with poor outcomes. To face these challenges, a growing, bipartisan coalition of 138 communities covering a population of over 94 million Americans have committed through the Data-Driven Justice (DDJ) initiative to tackle some of the root-causes driving, and keeping, people in our jails.

This new community of practice is committed to sharing best practices as each region works towards achieving outcomes that are more effective and humane than repeated arrest and incarceration. City, county, and state leaders across the county have developed a range of innovative strategies, which have measurably reduced jail populations in several communities, help stabilize individuals and families, better serve communities, and, often, save money in the process. Data-Driven Justice communities played a key role in helping develop this playbook, sharing lessons learned and emerging best practices, so that more communities can build from the work already underway and accelerate progress towards impactful solutions for some of our nation's most vulnerable individuals.

WHY DO WE FOCUS ON HIGH-UTILIZERS?

Local leaders from across the country recognize the challenge of a nationwide over-representation in local jails of people who repeatedly cycle through multiple systems. These individuals often have histories of mental illness, other health problems, unstable housing, and many have also struggled with substance abuse and repeated criminal justice involvement.

Research has demonstrated that even a short stay in jail can impact a person's health, job, and family stability and can increase the likelihood of future incarceration. This is especially true for individuals with mental or substance use disorders. Their

> **"High-Utilizer"** is used in this document to describe individuals with complex behavioral, physical, and/or social needs who are frequent users of a broad range of social services and may have a high number of contacts with emergency medical technicians and law enforcement. Despite the large amount of resources devoted to this population, they are often provided in fragmented ways that do not lead to stabilization or improved outcomes for individuals.

conditions often worsen in jail settings, leading to further, and reoccurring, interaction with emergency medical services, law enforcement, and other services upon their release. This comes at great cost to those individuals and to communities and is counterproductive to enhancing public safety and improving individuals' health and well-being.

WHO IS THIS PLAYBOOK DESIGNED FOR?

This playbook was developed with and for local leaders and practitioners, so that more communities across our country can better meet the needs of individuals who repeatedly cycle through systems including jails, hospital emergency departments, shelters, and other services. With a focus on highlighting "what works," the interventions, policies, and approaches included in this playbook have already been deployed in local communities across the country that have seen improving outcomes and efficiencies as a result.

We highlight a few specific jurisdictions as examples at the end of each section, including contact information for each so you can get in touch to learn more.

The strategies and many use cases covered in this playbook cover pre-arrest diversion, crisis stabilization, and housing and social supports, and were developed through substantial collaboration with community, behavioral health, and law enforcement leaders across the country. The playbook provides steps and community examples that have been used to successfully divert high-utilizers away from the criminal justice system. Together, with recommendations for potential funding sources, they are organized into **six key strategies**:

1. ONBOARD PEOPLE IN YOUR COMMUNITY TO HELP
2. IDENTIFY THE PEOPLE YOU HOPE TO SERVE
3. BUILD A DIVERSION STRATEGY
4. CREATE WARM-HANDOFFS
5. INITIATE AND DELIVER ONGOING SERVICES EFFECTIVELY
6. LEVERAGE AVAILABLE FUNDING STREAMS TO OPTIMIZE CARE

In addition to the interventions outlined in this playbook, there are many more strategies, approaches, and innovations available across federal, state, and local governments in the areas of criminal justice, health and behavioral health. For example, the U.S Department of Justice released a [toolkit](https://pmhctoolkit.bja.gov/home)[1] to help law enforcement leaders learn more about community collaboration on issues of mental health.

We hope that you, the reader, use this playbook as a jumping off point to connect with and build on existing efforts and innovations across the country, whether the county next to you or a city on another coast. If your community is not yet a member of the Data-Driven Justice (DDJ) initiative, please [visit the National Association of Counties (NACo) page](http://www.naco.org/data-driven-justice)[2] for a list of current jurisdictions and how to join.

---

[1] https://pmhctoolkit.bja.gov/home

[2] http://www.naco.org/data-driven-justice

A FEW NOTES BEFORE GETTING STARTED

1. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), mental and substance-use disorders are health conditions best served through effective prevention and treatment services. Mental and substance use disorders affect people from all walks of life and all age groups. These illnesses are common, recurrent, and often serious, but they are treatable, and many people recover.

2. Relapse is a common and expected part of the recovery process for substance use disorders, as it is with other chronic illnesses, and its occurrence should not be grounds for denying access to treatment or care.

3. This document provides a high-level overview of the steps necessary to implement pre-arrest diversion and related interventions. The appropriateness of specific models or interventions will vary from community-to-community. We encourage you to consider, try, and adapt the resources to your unique circumstances.

STRATEGY 1. ONBOARD PEOPLE IN YOUR COMMUNITY TO HELP

Building community support and collaboration is a critical first step in creating successful strategies and initiatives to serve high-utilizers. These initiatives require strong relationships among a diverse set of people including law enforcement, behavioral health providers, housing and homelessness services, faith-based organizations, advocates, people with lived experience, and other community resources and service providers. These groups often have limited experience collaborating with each other and do not typically share data, staff, or mandates. Below are three critical steps for getting started.

1. BRING TOGETHER A DIVERSE GROUP TO MOBILIZE INTEREST IN TACKLING THIS ISSUE AND DEVELOP A SHARED VISION.

   - **Identify who can bring people together:** A convening of major stakeholders or a community town-hall style event is a great starting place. A community leader such as a Police Chief, Mayor, County Commissioner, Sheriff, or Judge are among those who can use their convening power to bring all relevant parties together and help establish a shared vision.

   - **Connect with relevant groups in your community:** Identify individuals from each group that should be involved, such as law enforcement, homeless services, behavioral health providers, and hospitals. Be inclusive of all stakeholders. These representatives can connect with leaders and organizations in their fields to build support before the convening and to follow-up after.

   - **Involve the people you are aiming to serve:** Consider how best to bring in the voices and perspectives of individuals and families with lived experience – they truly are the experts!

WHO SHOULD BE AT THE TABLE?

✓ Law Enforcement Leaders	✓ Local Federally Qualified Health Centers & Clinics
✓ Mayors and County Commissioners	✓ Reentry Organizations
✓ District Attorneys and Prosecutors	✓ Housing Authorities
✓ Behavioral Health Leaders	✓ Homeless Service Organizations
✓ Public Defenders	✓ Faith-based Organizations
✓ Jail Directors & Jail Health Care Providers	✓ Consumer Advocates
✓ Judges	✓ Data Scientists
✓ EMTs	✓ Local Tech Innovators
✓ Hospitals	✓ Local Universities

2. USE DATA AS A CONVERSATION STARTER.

   - **Use data to tell the story of challenges your community faces:** Early in the process, ideally before your initial convening, your community should work to combine utilization and cost data from multiple sources — ER visits, arrests and jail bookings, homeless shelters, behavioral health services, and other

available sources — to identify the high-utilizer population, their patterns of service use, and the resulting economic impact. Case examples are a great supplement to hard data, bringing alive the human stories behind the data.

- At this stage, the purpose of data analysis is to describe and understand the problem, not to enroll individuals into a program. Once data sets have been linked, the resulting matched data can be de-identified before analysis and exploration begins.

- **Use data to show that change is needed:** Bring together the leading service providers — governmental and non-governmental — to analyze the data and identify the pressure points within the system and areas that need immediate attention. Begin discussions to develop a robust plan for working together to address these problems.

- The combined data often reveal the intertwined systems providing services and the significant costs associated with fragmented care. Often the overlap of clients is so significant and the associated service costs are so high that it creates an "ah-ha" moment among community leaders about the need to better serve high-utilizers.

- Many communities use the **Sequential Intercept Model**[3] to assess gaps and potential strategies to address them. Across the criminal justice system, the model identifies five key intercept points where individuals with mental and use disorders can be identified and linked to appropriate services and supports; that intercept is law enforcement and pre-arrest intervention.

3. ESTABLISH AGREEMENT THAT IMPROVING OUTCOMES FOR THE HIGH-UTILIZER POPULATION IS A PRIORITY AND REQUIRES CROSS-SECTOR COLLABORATION.

- **Develop a purpose statement or other guiding framework:** A purpose or mission statement — or other similar frameworks — can build trust, foster collaboration, and focus the group on clear goals, objectives, and activities. Develop this statement collaboratively.

- **Set clear actionable milestones:** Leave the first convening with clear next steps and priority actions. Ensure that everyone has an understanding of who "owns" or will drive each step or activity. Additionally, have a joint commitment among stakeholders to take action together. Reconvene as regularly as needed to discuss progress and set next steps. Creating an actionable plan with milestones can help your community take the necessary steps to move the program forward.

- **Agree on what success looks like:** Recognize that change takes time and adjusting to new ways of doing business does not happen overnight.   Likewise, providing effective support to an individual after years of fragmented, cross-system interactions may not have an immediate impact. Acknowledge and manage expectations at the onset and celebrate small successes along the way.

- **Start learning each other's language:** In many instances, the people and entities around the table have not traditionally worked together and have their own approaches, issues, and budgets. Part of building support and trust involves listening, learning about each other's different approaches and processes, and finding ways to work together considering these factors. Observing the way each

---

[3] https://prainc.com/wp-content/uploads/2015/10/SIMBrochure.pdf

other's organizations and services work on the ground can deepen understanding, empathy, and relationships. Where applicable and feasible, consider some level of cross-training.

- **Build ways to maintain regular communication:** As conversations and joint activities progress, clarify roles and key processes, develop working groups and committees, and consider whether Memoranda of Understanding (MOUs) to formalize policies and procedures may be helpful. Work to reach a point where colleagues are comfortable picking up the phone or sending quick emails to ask questions or flag issues for each other in between formal, in-person meetings.

PORTLAND, MAINE

Melissa Skahan
Vice President of Mission Integration
Mercy Hospital
skahanm@emhs.org

The Greater Portland Addiction Collaborative (GPAC), led by Mercy Hospital, was created in response to the opioid epidemic in the greater Portland area. A steering committee for GPAC was created to streamline action and decision-making to improve outcomes for the community's target population: high-utilizers with substance-use disorder who are at risk, or have a previous history of, criminal justice involvement and/or overdose. The steering committee has representatives from the local hospitals, community detox center, treatment providers, crisis providers, housing and employment providers, and the peer recovery center. Additionally, the City of Portland and the City's Police Department were part of the steering committee.

At a series of three meetings from December 2015 to February 2016, facilitated by a strategic planner, this group defined the need in the community, which was to reduce incidents of overdose and increase treatment capacity. They designed what an ideal community-based system of care would look like, developed and refined the treatment model they each would contribute to, created a governance structure and an evaluation model for the system of care, and determined Portland's funding needs to fulfill this vision. By having every critical stakeholder's voice at the table from the start, these decisions were made collaboratively and with a shared sense of trust and responsibility — opening the door for candid discussions about identifying necessary resources to fulfill GPAC's goals and for partnerships across silos. All the organizations that serve the vulnerable population, were at the table for weekly work sessions, enabling an unprecedented level of collaboration and coordination.

Through these relationships, representatives from across systems were able to agree on new ways to leverage existing assets and eliminate waste, committing to lower costs and improved outcomes through optimization of existing services and capacity. Some notable changes have been made as a result including, the police department hiring a full-time Substance Use Disorder Liaison, building capacity at the local detoxification center, opening structured sober living environments, and integrating addiction services in primary care to ensure that patients have access to comprehensive health care services.

KING COUNTY, WASHINGTON

Jesse Benet, M.A., LMHC
Diversion & Reentry Services Coordinator, Diversion and Reentry Services
King County Behavioral Health & Recovery Division
Jesse.Benet@kingcounty.gov

In King County, a concerted effort was made to refocus services that were fragmented and "cobbled together," frustrating users and system operators alike. An initial data matching effort demonstrated that 94% of individuals in the King County jail had a mental or substance use disorder. This initial data match created a high degree of consensus for the need to ensure people have access to necessary resources so they don't cycle through costly crisis systems, particularly jails. As a result, the high-utilizer — or "familiar faces" — population grew to be of particular interest for a number of government and community health, human services, and criminal justice stakeholders in King County.

Taking note of the incentives in the Affordable Care Act for achieving the "Triple Aim" — better health, better care, and lower costs — King County community services and public health leaders started by convening both a management guidance team from relevant organizations as well as a project design team. This led to the Familiar Faces initiative, which is centered on creating a system of integrated care for complex health populations that can eventually benefit any user of publicly-funded health services.

An implementation strategy under this new future state vision includes a demonstration of the flexible care management team approach which will be replicated as new funding opportunities become available (possibly via a Medicaid waiver). This flexible approach is rooted in the strong community consensus that was developed early on in King County's process. It features base staffing, which includes peer support, a social worker skilled in mental health and substance use, and an individual with prescribing authority to address both behavioral health and primary care needs. This base team can expand and contract to include other health and social services in response to the wants and needs of the individual under their care. This cross-disciplinary team also draws on relationships within the community, called the "golden thread," that the individual under their care trusts and has an ongoing relationship with– such as clergy or a family member.

Another example of implementation strategies under Familiar Faces includes a cross-sector data integration project, that will allow the integration of various disparate data systems that include behavioral health, housing, some criminal justice information The integrated data system will allow for the following functions: (a) enabling individual client "lookup" for direct care coordination, (b) identifying high risk groups based on flexible criteria, for system-level care coordination, and (c) extracting datasets, based on flexible criteria, for analysis of population health, program evaluation, and costs.

Finally, there is a strategy under way to implement a "Single Diversion Portal" for a health and human services triage center that law enforcement can use to help answer "Divert to What?" when they come into contact with a high-utilizer. This single portal concept will help law enforcement quickly identify which of the diversion options in the county is most appropriate for the individual they have come into contact with at any point. The intent of this is to make it as convenient as possible for law enforcement to divert high-utilizers to the appropriate systems of care.

STRATEGY 2. IDENTIFY THE PEOPLE YOU HOPE TO SERVE

Communities should develop and implement plans to combine data across organizational silos to identify the highest utilizers of multiple services and their needs. This will require navigating legal, privacy, and security concerns and matching data across different systems and more.

1. BUILD CONSENSUS AND DOCUMENT THE SPECIFIC USES FOR SHARING DATA.

- To build public trust and evaluate use over time, responsible use of data begins with outlining the specific purposes for which data will be used. Clearly defining the data uses will inform the types of agreements that must be made among data owners, analysts, leadership, and community members. Understand that data owners have been charged as stewards of the data and are responsible for safeguarding their use.

- Collaborators can start by building consensus around what problems will be addressed by data sharing. Is it to identify the scope of the problem in the community? Is it to identify the highest-need individuals in the community for proactive outreach? Will the data be used to track outcomes?

- To accomplish this, it is important to bring in the appropriate legal, policy, and technology leaders at the start of your conversations. They will be best positioned to help develop the proper agreement for sharing data across systems.

2. IDENTIFY THE MINIMUM TYPES AND AMOUNTS OF DATA YOU ACTUALLY NEED TO ACHIEVE YOUR PURPOSE.

- To address privacy concerns, identify the fewest data elements needed to achieve the specified purposes. Data minimization builds public trust around data management, privacy, and security, and can reduce organizational concerns about sharing data.

- Identify the data sets that have needed information to achieve the specified purpose(s) and what unique identifier fields are available to link data sets. Some data systems may have most, or even all, of the data needed to get started, while in other systems, some valuable information is not yet captured or stored consistently in systems. For example, many communities have started by matching two data sources: jail data and one health data source such as 911 calls, mental health service use, or emergency department use.

- A new source of data should add concrete and explicit value or be excluded. In the cases where data are not available today, opportunities exist to work collaboratively to begin collecting valuable information for the future.

3. PROVIDE ONGOING OPPORTUNITIES TO INFORM INDIVIDUALS AND THE PUBLIC ABOUT HOW THEIR DATA ARE BEING USED TO GAIN TRUST.

    - Studies have shown that data use notices made at the onset and consent forms do not lead to real understanding of data utilization and that they undermine trust in data systems. Therefore, it is important to design both front end and ongoing processes to inform people about how their personal data are being used and how to opt out of these uses at any point in the program.

    - It is also important to educate and engage the public. Communities should post clear public explanations of the uses of data and train staff to respond to questions about the purposes and limits of data sharing.

4. BUILD PRIVACY, SECURITY, AND CIVIL LIBERTY PROTECTIONS INTO THE DESIGN OF THE DATA SHARING SYSTEMS FROM THE START.

    - Invite privacy and civil liberty stakeholders into early stage design meetings to help craft protections and protocols. Set up ongoing check-in meetings to review implementation and obtain feedback.

    - Conduct a privacy impact assessment. A privacy impact assessment is an analysis of how information will be stored and shared to ensure handling conforms to applicable legal, regulatory, and policy requirements regarding privacy; to determine the risks and effects of the proposed data sharing; and to examine and evaluate protections and alternate processes to mitigate potential privacy concerns.

    - Connect with other programs with experience in privacy and data collection and use to discover best practices.

5. USE THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) AS A TOOL.

    HIPAA is frequently mischaracterized as a barrier to implementing a smarter, more data-driven, approach to diverting and treating the high-utilizer population. The U.S. Department of Health and Human Services (HHS) has responded by providing answers to many of the most common questions, and misperceptions, regarding what HIPAA restricts and more importantly how HIPAA can be used as a tool to better serve vulnerable community members. This is available on the HHS webpage "May a covered entity collect, use, and disclose criminal justice data under HIPAA?"[4] and in Appendix C.

---

[4] www.hhs.gov/hipaa/for-professionals/faq/2073/may-covered-entity-collect-use-disclose-criminal-data-under-hipaa.html

JOHNSON COUNTY, KANSAS

Robert Sullivan
Criminal Justice Coordinator
Johnson County, KS
Robert.Sullivan@JoCoGov.org

During summer of 2016, Johnson County collaborated with the University of Chicago on a project to apply machine learning methods to predict which individuals in the community were most at risk of entering jail in the coming year. In order to prepare for this project, Johnson County worked with the University of Chicago to collect raw data from the county mental health center, county ambulance service, and the Justice Information Management System, and then de-identified it before transferring it to the University of Chicago.

Their population of interest consisted of individuals who had previous encounters with both the mental health and criminal justice systems. Linking records across systems enabled Johnson County to compile timelines for individuals' interactions with all three of the systems that contributed data. Using these records, the University of Chicago generated individual-level scores corresponding with the likelihood of a future jail booking. Their first model used data from 2010-2015 and classified 200 individuals as at risk of having a police encounter in the next twelve months. By adding 2016 data, retrospective analysis showed that 104 of the 200 were actually booked into jail in 2016 (the next 12 months), meaning that the model was 52% accurate.

These individuals accounted for nearly 7,000 jail days and were incarcerated twice as long as the general population. Johnson County also learned this population had not been connected to services for an average of 28 months. Moving forward, Johnson County intends to add data from other record management systems (municipal police departments, municipal courts, hospital billing and claims data, etc.) in order to gain additional insights to help reduce repeat interactions with these systems and increase the precision of the models. Ultimately, Johnson County will utilize this information to enable qualified mental health professionals embedded in local police departments to proactively contact individuals that the models flag to reengage them in community-based services before they have another police encounter.

LOUISVILLE, KENTUCKY

Jamie Allen
Public Protection Coordinator
Louisville Metro Criminal Justice Commission
Jamie.Allen@louisvilleky.gov

Louisville-Jefferson County Metro developed a collaboration of community partners to pursue innovative solutions to identify, coordinate, and deliver care to high-utilizers with mental and substance use disorders based on information sharing. This collaboration, known as the Dual Diagnosis Cross-Functional Team (DDCFT), is comprised of government agencies, behavioral health professionals, and community organizations. With knowledge that the current service delivery system was fragmented, the DDCFT proposed the creation of a new Community Care Management Network (CCMN) to coordinate care for high-utilizers using the existing Homeless Management Information System (HMIS) as the backbone technology for cross-agency intervention. Many of the involved service providers already had HMIS licenses, making it the logical choice; however, agencies that were not part of the HMIS network agreed to purchase licenses.

As part of the project, participating agencies, including the HMIS network and the Metro Criminal Justice Commission acting as the representative for the DDCFT entered into data-sharing agreements. Based these agreements, the names of the top 100 high jail utilizers, individuals with eight or more episodes of incarceration, are cross-referenced with emergency room data to identify individuals with ten or more admissions. These individuals are then asked to sign a release of information which was developed by the DDCFT and used to authorize the disclosure of encounter or transaction records to specified agencies involved in the delivery of community based services. These agencies include providers of mental health, substance abuse, medical, homelessness and vocational services in addition to criminal justice partners. A Case Manager Quarterback is designated to oversee service delivery and development of a coordinated care plan for addressing the specific needs of the individual.

Since the approach is in the early stages of implementation, no outcome data are available at this time; however, care providers anecdotally report increased access to information and reduction of duplication of services.

STRATEGY 3. BUILD A DIVERSION STRATEGY

Pre-arrest diversion strategies offer alternatives to incarceration for individuals with mental and substance use disorders. A pre-arrest diversion strategy includes tools for first responders to determine whether an alternative to arrest and potential incarceration in the criminal justice system is appropriate and, if appropriate, to link individuals to treatment and services. Communities should identify what types of procedures and services will best address the issues discovered through data analysis and conversations with community leaders.

The goal of a successful pre-arrest diversion strategy for a high-utilizer population is to reduce the rates of emergency health and public safety service usage, while increasing linkages across health, behavioral health, housing, and other social supports so that an individual gets the services they need (e.g. if someone needs substance abuse treatment but regularly comes into contact with homelessness services, they can be directed to treatment through the homeless service). Such a strategy should also aim to improve the health and well-being of individuals while promoting better public safety outcomes and a more efficient use of public resources.

The approaches listed below are complementary and can be done in alignment with harm reduction and trauma-informed approaches.

1. ## SPECIALIZED POLICE-BASED RESPONSE MODELS

    Specialized police-based response models are law enforcement models that: (1) provide a new set of response options for frontline personnel that are tailored to the needs of people with mental illnesses; (2) establish a link when appropriate for people with mental illnesses to services in the community; and (3) create strong collaborative ties between law enforcement agencies and mental health partners, other criminal justice agencies, and community members. Specific models include:

    - **Crisis Intervention Team (CIT) Training:** CIT trains law enforcement and other first responders to respond appropriately in interactions with individuals with mental and substance use disorders. The training emphasizes de-escalation techniques and partnerships with behavioral health providers. In some communities, all law enforcement is trained, while in other jurisdictions a specific cohort of law enforcement is CIT trained — special CIT units that are dispatched in response to crisis or mental illness related calls for service. Jurisdictions provide training to law enforcement officers and other first responders including EMTs, 911 dispatchers, and community-based service providers.

    - **Co-Responder Model:** These specially trained units, comprised of law enforcement officers and behavioral health professionals, respond to calls for service involving individuals with mental and substance use disorders. To best assist law enforcement, these resources may be available around the clock, or as-needed, to work with individuals in crisis and avoid arrest them.

2. ## MOBILE CRISIS TEAMS

    These teams provide acute mental health crisis stabilization and psychiatric assessment services to individuals within their own homes or in the community. These teams are staffed by behavioral health

professionals and often include peer specialists as key team members. Clinicians are trained to assess and triage individuals in crisis, and to provide critical linkages to mental health, substance use, health care services, and housing.

Mobile crisis teams can be dispatched with, or instead of, law enforcement to crisis calls. If appropriate, law enforcement may call mobile crisis teams to take over a call. Teams focus on de-escalation, crisis stabilization, and referral, and when appropriate, provide transportation to a crisis treatment or stabilization center.

3. LAW ENFORCEMENT TOOLS

Officers use a variety of tools, training, and protocols to support and standardize diversion decisions. Examples include:

- **Field-Administered Mental Health Screenings** are short lists of questions that can easily be administered in the field and help officers determine if diversion is appropriate. Law enforcement agencies should collaborate with behavioral health professionals or researchers in preparing the screening to ensure that the indicators are valid and reliable.

- **Standard Diversion Protocols** give law enforcement clear steps and information for how and where to divert. These protocols can include screening tools and formalized policies indicating the types of circumstances and low-level offenses for which officers are encouraged to use their discretion to divert individuals instead of detaining them.

4. 24/7 CRISIS HOTLINES AND WARM-LINES

- The Substance Abuse and Mental Health Services Administration (SAMHSA) defines a hotline as a direct service delivered via telephone that provides a person who is experiencing distress with immediate and confidential support or facilitated referrals. Warm-lines are telephone lines that are run by trained mental health peer specialists.

- Both hotlines and warm-lines provide low-barrier mechanisms for immediate crisis assistance and referral. Hotlines and warm-lines can serve as effective diversion resources by providing early intervention and linkages to community-based services.

BEXAR COUNTY, TEXAS

Gilbert R. Gonzales
Director, Mental Health Department
Bexar County
grgonzales@bexar.org

The Bexar County Sheriff's Office, the San Antonio Police Department and all other law enforcement agencies in Bexar County have implemented procedures to help divert individuals suffering from mental illness away from criminal justice involvement and into treatment and care.

They did this by instructing officers to administer and document the Law Enforcement screening questionnaire (known as LE4) prior to submitting the required booking slip. The LE4 questions appear on the back of the booking slip. The booking slips are then provided to a pretrial assessment officer for review as the detainee proceeds through the booking process.

The LE4 consists of four questions that function as an initial screen administered by the arresting officer. Its purpose is to flag persons who are suicidal and or may have a mental health issue. The LE4 tool is the initial step of the intake process at magistration. Based on the person's responses, they may be referred to more in-depth assessments, which are completed by a licensed mental health professional.

The most direct benefit from the LE4 questionnaire for Bexar County is the ability to identify early signs of suicidal ideation and/or mental illness so that the person can be further evaluated and appropriately processed, avoiding unnecessary jail. Over the first five months in which the LE4 was used, 626 individuals were identified as needing further assessment, according to the Bexar County Mental Health Department. Of those, 505 were referred to a clinician based on the follow-up assessment results.

Bexar County Sheriff Susan Pamerleau and San Antonio Police Chief William McManus have been actively engaged in the community's efforts to provide appropriate jail diversion for persons who need treatment rather than incarceration. Under their leadership, field officers took the lead in asking community stakeholders to improve the process so more persons with mental illness could be helped instead of jailed. As a consequence of these improvements, LE4 was embraced by law enforcement field officers, who are also Crisis Intervention Team (CIT) trained. The tool was developed by the Bexar County Mental Health Department.

POLK COUNTY, IOWA

Annie Uetz
Program Planner
Polk County Health Services
a.uetz@pchsia.org

In 2012, the Des Moines Police Department made a commitment to train all new recruits in Crisis Intervention Team (CIT). An additional 40 hours of training was added to the Academy training curriculum. CIT training has better prepared officers to work with individuals with mental illness. This has resulted in fewer arrests of people with mental illness; and increased understanding of mental illness and awareness of what to look for in people who might be in crisis.

In addition, Polk County funds a Mobile Crisis Response Team that consists of two units, with assessments billed to Medicaid when applicable. The county contracts with the local public hospital which provides the crisis observation center, the crisis stabilization center and the mobile crisis response team. Each Mobile Crisis Response Team unit is staffed by either a registered nurse or a licensed masters-level clinician. The units are available 16 hours a day (8 a.m. to 12 a.m.), seven days a week, and are requested via police dispatch. The main responsibility of this program is to provide assessments and linkages to resources and treatment. Clinicians determine the next step for each individual with whom they come into contact. In FY16, the Mobile Crisis Response Team responded to 2,181 requests. Only 15 of those individuals went to jail, while 882 (by far the largest cohort) were stabilized in the community. The remaining 454 were taken to the hospital.

Polk County calculates their cost avoidance for those 882 individuals who were stabilized in the community to be: $4,074,840 if they had gone to jail, and $3,528,000 if they had gone the hospital. These results have helped maintain support for the program over time.

STRATEGY 4. CREATE WARM HAND-OFFS

After the decision is made to divert an individual, the question for the first-responder becomes:

<div align="center">DIVERT TO WHAT AND WHERE?</div>

Law enforcement and other first responders need a place and trained staff for warm-handoffs of individuals in crisis. These are key elements of successful diversion programs and ensure that individuals are directly and immediately connected to treatment services. While some communities already have facilities that can accommodate drop-off treatment, stabilization, and referral, others may have to build new capacity to facilitate warm-handoffs. Options communities can consider include:

1. CRISIS STABILIZATION PROGRAMS

- **Crisis Stabilization**, **Detoxification Centers** or **Psychiatric Emergency Programs** provide short-term (24-72 hours) psychiatric stabilization for individuals in crisis, and may include detoxification.

- **Community Respite Programs** offer moderate-term (1-2 weeks) psychiatric stabilization as an alternative to psychiatric hospitalization. Referrals are made by behavioral health professionals (including those at Crisis Stabilization Centers), and individuals are provided with psychiatric, peer, and recovery support services.

- **Peer Crisis Programs** are operated by people with lived experience of mental illness or substance use disorders, known as peer specialists. Peer crisis programs are designed as calming environments with supports for individuals in crisis. They are delivered in community settings with treatment supports. Services are intended to last less than 24 hours, but may extend up to several days, if needed.

2. SERVICE CENTERS

Service or "Solutions" Centers are central intake hubs that help connect individuals to a variety of services and supports through direct coordination, referral, or onsite services. These services may include:

- Mental health services (including crisis stabilization for short stays of 24-72 hours)
- Peer support
- Detoxification
- Supportive housing
- Employment services
- Medicaid enrollment
- Assistance with Social Security benefits
- Referral to other community and provider services, including veterans' assistance and substance use treatment

3. SERVICE-BASED DIVERSION AND REFERRAL, OR "NO WRONG DOOR" LINKAGES

Service-Based Diversion and Referral (SBDR) is an approach to providing referrals and diversion from emergency departments (ED), jails, detox centers, and mental health clinics into more appropriate types of care, based on the needs of the patient. SBDR ensures there is "no wrong door" to get help. For

example, if a high-utilizer comes into the ED in crisis, an SBDR approach could entail a warm-handoff referral to a community-based crisis stabilization program, rather than processing individuals and then discharging them.

SBDR practices can include having a peer specialist or other mental health professional staff a hospital ED to provide patients with links to community-based services and resources and provide follow-up. SBDR can include emergency medical services diversion programs that train emergency medical technicians (EMTs) to identify high-utilizers and refer them to treatment and support, tapping into available resources in every community. Another example of this approach is ensuring that shelter services, and other community social service providers, are empowered and knowledgeable on how and when to provide warm-handoffs and referrals for high-utilizers who would benefit from treatment and other social services.

4. SUPPORTIVE HOUSING AND HOUSING FIRST

Supportive Housing combines affordable, subsidized housing and support services for people with serious mental illness, substance use disorders, or chronic physical health issues. This intervention helps people live with stability and independence in their communities. While it is generally targeted at homeless individuals, this intervention can be used to assist the high-utilizer population in achieving recovery and stability if they lack stable housing. Supportive housing services may include case management, mental health and substance use treatment services, and coordination with health care providers, as well as employment, education, transportation, and other services. Many supportive housing providers adopt Assertive Community Treatment (ACT) and Intensive Case Management (ICM) models, utilize peer supports, and partner with community health providers to provide tenants access to critical physical and behavioral health care.

Housing is a basic human need. Once that basic need is met, individuals can address their health care and other needs more effectively. Through this understanding, communities following the Housing First approach provide immediate housing with no preconditions (other than complying with a leasing agreement) to individuals with behavioral health issues and unstable housing situations, allowing them to achieve enough stability to work on their recovery process. When coupled with a Supportive Housing model, this becomes an intervention into which a high-utilizer can be diverted. Housing First is a proven method of ending all types of homelessness. Housing First yields higher housing retention rates, lower returns to homelessness, and significant reductions in the use of crisis service and institutions. By coupling a Housing First model with treatment services such as ACT, the whole individual's needs can start to be addressed. ACT is described in further detail in Strategy 5: Initiate and Deliver Ongoing Services Effectively.

CHARLESTON, SOUTH CAROLINA

Deborah S. Blalock
Executive Director
Charleston Dorchester Mental Health Center
deborah.blalock@scdmh.org

The Charleston Dorchester Mental Health Center is reopening a crisis stabilization center (CSC) that was closed in 2009. When it closed, psychiatric inpatient admissions at one of the local hospitals increased by 900 in that same year. The hospitals' costs from these additional patients exceeded the CSC's annual budget of $1.1 million. As a result, most of the area hospitals are committed to helping fund the CSC as a cost-savings measure.

Additionally, as an excellent example of cross-system collaboration, the Sheriff's office will provide all patient meals and 24-hour security by a law-enforcement officer. This unit benefits the Sheriff's office by helping to reduce the jail population and the time officers spend waiting for patient evaluations in hospital emergency rooms. Also, the unit will be housed in the Charleston Center, Charleston county's Alcohol and Drug Commission, in an effort to better serve those with co-occurring substance use disorders.

The Charleston CSC will feature 10 beds (15 once larger accommodations are found) with four clinicians on-duty during the day and two on duty during evening and night hours. A registered nurse will always be in the clinician complement.

PINELLAS COUNTY, FLORIDA

Tim Burns
Division Director, Planning & Contract Services
Department of Human Services
tburns@pinellascounty.org

The Pinellas County Mental Health Jail Diversion Program was developed by the Public Defender's Office in 2004. It is a partnership across systems to stabilize and divert individuals whose legal involvement may be a result of untreated mental illness or co-occurring mental and substance use disorders.

Once an individual is identified and referred to the program, their needs are identified and they are connected to appropriate services, which include: face-to-face assessments, transportation, transitional housing, psychiatric evaluations, treatment plans, prescription medication therapy, intensive case management, court liaison services and referral to additional community resources. Upon the disposition of the individual's case, a psychiatric evaluation will be administered to identify what appropriate mental health medications and other services might be necessary such as SSI/SSDI Outreach, Access, and Recovery (SOAR) or chronic inebriate assistance. Based on these results, warm handoffs will be made to service providers such as housing facilities and case-management services.

The program has diverted 5,489 clients from jail since 2004 with a 93% success rate having no further criminal justice involvement. Its operation is a collaboration between the public defender, state attorney, Pinellas County Sheriff, the judiciary, and local service providers. Initiated under a grant from the Bureau of Justice Assistance, its success has led to continued funding and support from the Pinellas Board of County Commissioners.

STRATEGY 5. INITIATE AND DELIVER ONGOING SERVICES EFFECTIVELY

The next strategy in developing a strong foundation of support for high-utilizers is to provide effective services and treatment on an ongoing basis.[5] As mentioned previously, a key characteristic of the high-utilizer population is the fragmented, episodic and partial care they receive, which results in their continued cycling through services that are not fully meeting their underlying needs.

Developing coordinated and comprehensive community-based treatment is the only way to break this cycle and respond to the multiple and complex health, behavioral health, housing, and other needs that high-utilizers often have. Five treatment and support services that have been demonstrated to be effective for the high-utilizer population are:

1. ASSERTIVE COMMUNITY TREATMENT (ACT)

Assertive Community Treatment (ACT) is a highly integrated mental health service delivery model with demonstrated positive outcomes from randomized controlled trial (RCT) studies. ACT uses a multi-disciplinary team comprised of psychiatrists, psychologists, social workers, nurses, substance abuse specialists, vocational rehabilitation specialists, service coordinators, and peer support specialists. Services are delivered in the community, are available 24/7, and can be delivered to people in supportive housing.

2. INTENSIVE CASE MANAGEMENT (ICM)

Intensive Case Management (ICM) offers high-intensity mental health services, care coordination, and case management provided by a case manager with a small caseload. Unlike ACT, ICM does not utilize a multi-disciplinary team, but does share the same focus on clients versus systems and the coordination of multiple and varied treatment and social services. ICM can be delivered to people in supportive housing.

3. MEDICATION-ASSISTED TREATMENT (MAT)

Medication-Assisted Treatment (MAT) is the use of medications, in combination with counseling and behavioral therapies, to provide a "whole-patient" approach to the treatment of substance use disorders. MAT has been documented as an impactful and successful form of substance use intervention.

- Substance use disorder is a medical condition, and in response to the current opioid crisis, the Obama Administration has made significant investments[6] in expanding MAT programs around the country.

- Patients who receive treatment in an Opioid Treatment Program (OTP) are required by Federal regulations to receive medical, counseling, vocational, educational, and other assessment and

---

[5] The interventions discussed in this section will overlap with services that benefit a post-arrest and reentry population as well.

[6] https://www.whitehouse.gov/the-press-office/2016/03/29/fact-sheet-obama-administration-announces-additional-actions-address

treatment services, in addition to medication for opioid addiction. Medications involved in MAT programs must be administered by a medical professional.

4. PEER SUPPORT SERVICES

Peer Support Services are delivered by individuals who share common life experiences with the people they are serving. People with mental and substance use disorders have a unique capacity to help each other based on a shared affiliation and a deep understanding of this experience. Some states offer certification for peer support specialists. SAMHSA has identified five core competencies for peer services; they are: recovery-oriented, person-centered, voluntarily self-identified peers, relationship-focused, and trauma-informed. Peer support specialists can be employed in a number of settings, including mobile crisis units, call-lines, crisis stabilization centers, and crisis programs.

5. PRE-RELEASE COORDINATION OF SERVICES

Pre-Release Coordination of Services involves connecting individuals reentering their communities with key community resources. These resources can include enrollment in Medicaid, scheduling of medical appointments, referral and introduction to mental health service providers, referrals to health care, supportive housing, and other support services before release. Dedicated staff or mental health and social work professionals in the correctional facility assist individuals in identifying the services for which they are eligible and assist them in enrolling in these services.

For justice-involved individuals with mental and substance use disorders, facilitating access to health care and coordinating treatment and support services prior to release from jails and prisons improves the likelihood of a successful return and tenure in the community. When individuals return to their communities, they should have access to the medication, treatment, and services they need to maintain a stable and healthy life. An effective pre-release coordination plan will coordinate an individual's discharge from jail or prison to a community-based service provider or case manager. Both correctional and community provider staff facilitate a warm-handoff for the individual's transition.

6. HARM REDUCTION

Harm Reduction is an approach to criminal justice and health care, which recognizes that, while certain behaviors like drug and alcohol use may have harmful effects on individuals and communities, not every person is ready, willing, or able to abstain from such behaviors immediately. Using tools such as motivational interviewing and stages of change models, providers and individuals can address the complex behavioral health issues and other health and social service needs an individual may have while avoiding the traditional sanctions for "non-compliance" and relapse. Success within a harm reduction framework is defined by engagement in the process and incremental goal achievement, building self-efficacy, and removing stigma from the provider-client relationship.

7. SUPPORTIVE HOUSING AND HOUSING FIRST

Supportive Housing, when combined with a Housing First approach, as discussed earlier, acts as an effective intervention to which high-utilizers that are unstably housed can be diverted immediately. However, Supportive Housing also can serve an important role in a community's strategy for providing ongoing and sustained care to help break the cycle of high-utilization by stabilizing the lives of individuals who lack stable housing and have struggled with fragmented care and support. To learn more about Supportive Housing, please refer back to Step 4. Create Warm Hand-Offs.

NEW JERSEY

Anthony Marchetta
Executive Director
New Jersey Housing and Mortgage Finance Agency
amarchetta@njhmfa.gov

NJ Housing and Mortgage Finance Agency (NJHMFA) administers the federal Low Income Housing Tax Credit (LIHTC) program, the largest source of funding for affordable housing in the United States. Across the nation, an estimated 3 million homes have been created for low/moderate income households since the program's inception in 1986, including 60,000 in the state of NJ. NJHMFA awards approximately $21 million in tax credits competitively to developers each year. This valuable resource can generate private investor equity of over $220 million per year to construct and rehabilitate affordable housing.

One of the most effective features of the LIHTC program is that each state is able to craft their own Qualified Allocation Plan (QAP) and define the criteria for awarding tax credits according to each state's needs. NJHMFA utilizes the QAP and its points/ranking system as a way to guide affordable housing growth in expanding access to decent, safe and affordable housing, with a focus on doing so for the state's most vulnerable residents — often high-utilizers of public systems.

NJHMFA has long been a champion for supportive housing with its own dedicated application cycle, but the impact was limited by the Agency's ability to fund only a handful of projects each year. The challenge of constructing support housing was compounded by the difficulty of also operating and maintaining it. A lack of rental vouchers, operating subsidy, and funding for support services can make supportive housing for very low income households infeasible.

As an incentive to build more supportive housing for those earning less than 30% of area median income for the county, NJHMFA introduced the innovative idea to award points for integrating 5% or 5 units (whichever is larger) supportive housing units within traditional family and senior developments in 2011. In 2013, that point category was amended to specifically provide housing for homeless individuals and families, many of whom suffer from mental illness or struggle with substance use disorder.

Due to the highly competitive nature of the tax credit program, over 93% of projects awarded since 2011 have created more than 400 supportive housing units in 70 communities across the state, more than doubling NJ's supportive housing production and tripling the available locations. NJHMFA leverages the LIHTC program to subsidize the cost of stable permanent supportive housing, including consumer-centered support services that improve quality of life by providing varied housing choices for those able to live independently in integrated communities, and help reduce rates of high utilization of costly public systems and services.

DAKOTA COUNTY, MINNESOTA

Kristi Hamilton
Director, Marketing Communications
Guild Incorporated
KHamilton@guildincorporated.org

The Hospital to Home pilot initiative began in 2010 through a partnership between two St. Paul, Minnesota non-profit organizations (Guild Incorporated and Hearth Connection) and a hospital (Regions Hospital). This initiative was formed to address the urgent need to reduce costs and better serve patients by targeting the highest need and highest cost patients with alternative interventions that address the complex issues affecting their health. The focus patients for this initiative include those experiencing long-term homelessness, chronic health conditions, mental health issues, and frequent visits to the emergency department.

Hospital to Home addresses this need of this population with a person-centered, multi-disciplinary Mobile Community Health Services Team that provides individually tailored care based on participant needs and preferences. Serving as the central hub of comprehensive care coordination, the Team must either provide directly, or arrange for and coordinate, all needed services including physical health, behavioral health, housing, social, and employment services. Mobile outreach and engagement strategies help to build and sustain trusting relationships with participants and remove barriers to success.

The pilot initiative began with seven individuals, and the results from the pilot evaluation were promising enough to leverage additional funding to expand to 25 openings. During the pilot, a team of partner agencies convened monthly to track referrals and participant progress, and evaluation reports were developed annually by an independent evaluation firm (Wilder Research). For the expansion, outcome and process data from the pilot initiative were used to modify referral and engagement processes, including broadening the eligible chronic health conditions and increasing the braiding of funding to serve as many participants as possible. This braided funding model includes a HUD grant for both rental assistance and support services. For participants who are eligible, Medicaid is also billed for targeted case management.

As of July 2015, there were a total of 31 Hospital to Home participants with approximately 12 months of outcome data. Despite long histories of homelessness, all participants moved into stable housing within four months of enrollment in Hospital to Home, and 87%were living in apartments. In addition, while 76% of participants have a criminal history, most participants (82%) had no criminal charges after enrolling in Hospital to Home. With regard to health care use, the total number of emergency department visits by participants decreased by 74% (from 333 to 85) after enrollment. However, aggregated clinic use increased from 615 to 647 during that time, supporting the goal of helping participants access care in primary care clinics rather than emergency departments, when appropriate. Nearly two-thirds of participants (65%) had an inpatient hospital stay in the six months prior to enrollment. However, this dropped to one third (32%) with an inpatient stay in the six months after enrollment, and further fell to 13% between six and twelve months after enrollment.

STRATEGY 6. LEVERAGE AVAILABLE FUNDING STREAMS TO OPTIMIZE CARE

Much is contingent on identifying resources to move your community's initiatives forward. However, many resources can also be identified through engaging all of your community's stakeholders and helping show that every one of them derives value from helping your high-utilizer population. We urge you not to allow the question of funding to paralyze progress. To assist with this conversation, we outline a number of federal grants and technical assistance programs available through federal agencies and departments that communities can use to provide services and improve outcomes for high-utilizers in Appendix A.

In addition, there are broad-based funding streams that can work together and separately to help fund necessary treatments and support services for your community's highest utilizers. The primary funding streams for this are **Medicaid**, **Medicaid/Medicare Dual Eligibility**, **Supplementary Security Income**, and resources from the **Department of Veterans Affairs**. Below we discuss each funding stream in depth.

MEDICAID

Medicaid is a broad federal and state partnership that provides financial support for medical and behavioral health care services to all eligible beneficiaries. All state Medicaid programs cover people that have low-incomes and are seniors, persons with disabilities, pregnant women, children and their custodial parents. Through the Affordable Care Act (ACA), states gained the ability to expand coverage to low-income people who do not meet these categorical eligibility criteria. As of February 2016, 32 states have expanded their Medicaid coverage to this new group. Specific information by state can be found here at: https://www.medicaid.gov/medicaid-chip-program-information/by-state/by-state.html.

Leveraging Medicaid to Help High-Utilizers

State Medicaid plans may cover many of the services high-utilizers need including: crisis services, community mental health services, substance use disorder treatment services, primary care, medications, some case management, etc. State-specific coverage information can be found through the link provided above.

- Many states are developing Medicaid waiver proposals, specifically under the 1115 waiver authority, to Centers for Medicare & Medicaid Services (CMS) that will broaden service coverage for specific subgroups. This waiver authority is for states seeking to improve their programs by expanding eligibility to individuals who are not otherwise Medicaid- or Children's Health Insurance Program (CHIP)- eligible, providing services not typically covered by Medicaid, and/or using innovative service delivery systems that improve care, increase efficiency, and reduce costs. Learn more about the 1115 waiver at: https://www.medicaid.gov/medicaid-chip-program-information/by-state/by-state.html.

  Some notable provisions of the 1115 waiver include adding low-cost services such as case management and peer support services that increase engagement in health services, and paying for habilitative services within supportive housing programs (also referred to as "Assistance in Community Integration" programs in some cases). CMS is also considering proposals to reimburse release planning services delivered within jails. CMS requires waivers to be cost-neutral, so these can improve outcomes for higher utilizers while also being financially beneficial to the Medicaid program. Search for waivers available in your state at:

https://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/waivers_faceted.html. *Note: some waivers are still pending release; the status of each waiver is listed on the above webpage.*

- Another tool many states have taken advantage of is the Home & Community-Based Services 1915(i) benefit, or 1915(i) for short. States can submit an amendment to their state plan to include the 1915(i) benefit to help provide needed long-term care services for Medicaid beneficiaries. These services include in-home or alternative living arrangements in the community, which can often be less costly than institutional care. To learn more about 1915(i), see https://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/home-and-community-based-services/home-and-community-based-services-1915-i.html.

- Many states use Medicaid managed care plans to manage care, coordinate care, and contain costs. Because of their many needs for medical and behavioral health services, high-utilizers can be high cost members within Medicaid managed care health plans. Managed care plan representatives are, therefore, important partners to engage in this work and may be willing to pay for additional care coordination services offered in the community. To see a profile of Medicaid managed care plans in your state, go to https://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/managed-care-profiles.html.

- To build health information exchange (HIE) infrastructure that supports providers in sharing health information when they refer patients or need to coordinate care, most states have taken advantage of what is commonly known as 90/10 Health Information Technology (HITECH) funding through the Medicaid Electronic Health Record Incentive Program. States may receive 90% federal matching funds for two purposes related to HIEs 1) on-boarding, and 2) design, development, and implementation of health information exchange infrastructure used by providers serving Medicaid enrollees. To learn more, see https://www.medicaid.gov/medicaid-chip-program-information/by-topics/data-and-systems/federal-financial-participation-for-hit-and-hie.html. Some examples of how states might use this funding to support justice-involved individuals:

  ✦ A state Medicaid agency could on-board Emergency Medical Services (EMS) to a statewide Health Information Exchange which would allow EMS teams to have access to medication histories, prescription drug monitoring programs, problem lists, etc. This information could be used for diversion to mental health providers or substance use treatment providers.

  ✦ A state Medicaid agency could build a correctional health registry that could help coordinate the post-release care of incarcerated patients and connect them to care for HIV, Hepatitis C, behavioral health issues, or substance abuse treatment. The registry could also capture this information for statewide public health reporting.

- The Centers for Medicare & Medicaid Services (CMS) launched a collaborative between the Center for Medicaid and CHIP Services and the Center for Medicare & Medicaid Innovation called the Medicaid Innovation Accelerator Program (IAP). The goals of IAP are to improve health and health care for Medicaid beneficiaries and to reduce associated costs by supporting states in their ongoing payment and service delivery reforms. One of its focus areas includes Medicaid Beneficiaries with Complex Care Needs and High Costs (BCN). States participating in this program area receive targeted program support on their ongoing efforts to improve care coordination for Medicaid beneficiaries with complex needs and high costs. Medicaid IAP's specific goals are to (1) enhance state capacity to use data analytics to better serve

the BCN population; (2) develop/refine payment reforms to support BCN programs; and (3) facilitate the replication/spread of BCN programs demonstrating promising results. To learn more see: https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/beneficiaries-with-complex-needs/beneficiaries-with-complex-needs.html.

Resources for Individuals Applying for Medicaid Coverage

- In expansion states, many high-utilizers will be eligible for Medicaid based on income alone. In non-expansion states high-utilizers are also likely to be eligible for Medicaid, but through the disability category which requires demonstration of disability and low-income. These Medicaid enrollees can become eligible for Medicare two years after they qualify for Social Security Disability Insurance (SSDI).

- For people with disabilities, the application process begins with applying for a determination of disability. Here is information on the disability determination process: https://www.ssa.gov/disability/determination.htm.

- Accessing Medicaid based on disability and SSI/SSDI benefits can be challenging for many, especially those experiencing or at risk of homelessness and/or with mental illness and co-occurring substance use disorder. However, the SSI/SSDI Outreach, Access, and Recovery (SOAR) technical assistance center has proven to be an invaluable resource for communities that want to increase access for these populations. SOAR is a nationally recognized organization that provides technical assistance for increased success in applications for eligible persons, especially the high-utilizer population. States that want to take advantage of this approach can learn more at the following link: http://www.samhsa.gov/soar.

- In states that expanded Medicaid to low-income adults, regardless of disability, high-utilizers can begin in the state's ACA expansion program, which provides them with coverage pending their determination, and then can be transferred into the state's program for seniors and persons with disabilities once their disability determination is complete.

- **Presumptive Eligibility (PE)** is another tool that states may use to increase high-utilizer access to Medicaid coverage. PE allows qualified entities, which can include service providers and hospitals to determine a person eligible for Medicaid for a temporary period of time, assist the individual with filing a full Medicaid application, provide immediate services covered by Medicaid, and facilitate long-term access to health care for individuals with high service needs. A qualified entity, as designated in a state's state plan, uses a simplified application or screening tool to collect preliminary information to determine if an individual is presumptively eligible for PE Medicaid. The ACA requires that all states develop processes for allowing hospitals that choose to offer PE to do so, and any state can elect to allow other designated entities to offer PE too (*e.g.* local health clinics, service providers, EMTs, etc). Generally, states must provide PE to pregnant women or children; if the state provides PE for one of those groups, then the state may elect to make additional groups eligible for PE, such as adults. PE coverage generally ends at the end of the month after the month in which PE determination was made. During this time, the patient is encouraged to submit a full Medicaid application for ongoing coverage. If the patient files a full application, the PE coverage does not end until a decision is made on their full application.

MEDICARE/MEDICAID DUAL ELIGIBILITY

People who are currently disabled, have a work history, and have a low income are likely eligible for both Medicaid and Medicare coverage, even if they are younger than age 65. Medicare is a federally-run program and may cover different or complementary services to Medicaid. Some high-utilizers may qualify for both Medicaid and Medicare coverage; it is important to understand how these plans cover services for dual-eligible persons in your state.

- When someone is dually enrolled, Medicare is the primary coverage. Medicaid may cover services not covered by Medicare or any other insurance coverage the individual has. This could allow for an expanded spectrum of services available to high-utilizers. Individuals can opt in to different levels of Medicare coverage, but the basic coverage includes hospitalizations and medical necessities, including mental health care. Additional information is available at https://www.medicare.gov/what-medicare-covers/.

- The Centers for Medicare & Medicaid Services provide technical assistance to states coordinating care for dual eligible individuals who rely heavily on these programs. Additional information about this technical assistance can be found at https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2011-Fact-sheets-items/2011-07-08.html?DLPage=6&DLSort=0&DLSortDir=descending.

- Many states have demonstration projects to provide for better coordination of services and financing for this particular population. Find information on this initiative at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/index.html.

SUPPLEMENTAL SECURITY INCOME (SSI)

People who meet criteria for disability may also be eligible for SSI, depending on their income and resources. Managed by the Social Security Administration, SSI is a federal income program which provides critical support, including funding that can be used towards housing. Given the overlap between homelessness and health, SSI can be an important resource to help treat high-utilizers.

- High-utilizers are often in need of stable housing, which is critical to establishing stability. SSI can provide resources for necessities including food. Additional SSI information, including a benefit-eligibility screening tool and application resources, is available at https://www.ssa.gov/ssi/.

- Individuals who are homeless can get SSI, even if they do not have an address. Local SSA offices will coordinate payment in these cases.

U.S. DEPARTMENT OF VETERANS AFFAIRS (VA) RESOURCES

In recognizing the impact of homelessness on health, the VA has made substantial commitments to ending veteran homelessness as a means to improve overall health. The VA is a large federal health care system that provides many of the services needed by high-utilizers. Information on eligibility requirements for VA health care can be found at http://www.va.gov/healthbenefits/apply/veterans.asp. It is likely that some high-utilizers are veterans, or dependents/survivors of veterans, who are eligible to receive VA benefits.

- VA centers provide necessary medical services, including mental health and substance abuse services, to eligible individuals. VA coverage includes preventive, acute, and long-term services (such as community-based care), among other services. VA health resources are explained further at http://www.va.gov/opa/publications/benefits_book.asp.

- The Veterans Justice Outreach program (VJO) provides outreach and case management for veterans with mental illness and/or substance abuse who are involved in the justice system. VJO helps link these individuals to available VA resources. Additional information on VJO can be found at http://www.va.gov/HOMELESS/VJO.asp.

- The VA and the U.S. Department of Housing and Urban Development (HUD) jointly provide housing vouchers and assistance to homeless veterans and their families through the Housing and Urban Development-VA Supportive Housing (HUD-VASH) program. The VA also provides personalized support services to link HUD-VASH beneficiaries to health care and other resources. Information on HUD-VASH can be found at http://www.va.gov/HOMELESS/HUD-VASH.asp.

- HUD and the VA keep databases of contacts for VA housing resources to coordinate federal, state, and local efforts. These databases can be accessed at the HUDVet website: http://portal.hud.gov/hudportal/HUD?src=/program_offices/comm_planning/veteran_information.

- Health care and housing are just two VA benefits. Links to information about all VA benefits, including a map of VA locations, can be accessed at http://www.va.gov/opa/publications/benefits_book.asp.

CONCLUSION

Communities across the country are recognizing that the current way we are meeting the needs of people with mental illness is not working. Not for those with mental health conditions. Not for the police officers that are tasked with responding to complex mental health and substance use issues. Not for the tax-payers that have to pay for uncoordinated services getting poor results at high cost.

This playbook was both inspired and guided by DDJ communities, who have demonstrated the value and impact of working across diverse stakeholders to help improve the lives of some of the highest need populations, while improving and sustaining public safety in the long term.

It will take hard work to reverse the decades of policy and funding decisions that have resulted in jails acting as *de facto* mental health facilities, but we hope this playbook helps more communities will help provide the roadmap you need to begin. We will continue to work with the federal government, philanthropy, the private sector, non-profits and academia to provide support and resources to DDJ. We know that innovation will continue to happen across the country and we remain committed to identifying and sharing new advances and emerging best practices.

If you have suggestions, ideas, or feedback on this playbook, please visit the [NACo DDJ site](http://www.naco.org/data-driven-justice)[7].

---

[7] http://www.naco.org/data-driven-justice

APPENDIX A. FEDERAL RESOURCES THAT CAN BENEFIT COMMUNITIES

Description	Amount	Category	What This Could Fund	Contact
CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)				
Money Follows the Person (MFP) Demonstration https://www.medicaid.gov/medicaid/ltss/money-follows-the-person/index.html The Money Follows the Person (MFP) demonstration, established by Congress through the 2005 Deficit Reduction Act, provides state Medicaid programs the opportunity to help Medicaid beneficiaries who live in long-term care institutions transition into the community and gives people with disabilities more choice in deciding where to live and receive long-term services and supports (LTSS). In 2007, CMS awarded MFP demonstration grants to 30 states and the District of Columbia. As part of the Affordable Care Act, Congress in 2010 increased total MFP funding to $4 billion. This additional funding allowed CMS to award additional grants to a total of 47 grantees.	**$4 billion** Congress increased funding through the Affordable Care Act (ACA)	**Medicaid**	• A transition program that identifies Medicaid beneficiaries in institutional care who wish to live in the community and helps them make the transition • An initiative designed to support the rebalancing of long-term services and supports towards community-based care	N/A
Emergency Room Diversion Grant Program (ED Diversion) https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Grant-Programs/ER-Diversion-Grants.html States were encouraged to apply for grant funds to implement projects that would: (1) establish new community health centers; (2) extend the hours of operation at existing clinics; (3) educate beneficiaries about new services; and (4) provide for electronic health information exchange between facilities for better coordination of care.	**$50 million** Authorized by Congress in 2005	**Medicaid**	• Crisis services • Care coordination	Contact info is provided by state: https://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/grant-programs/downloads/er-diversion-contacts.pdf

Description	Amount	Category	What This Could Fund	Contact
Testing Experience and Functional Tools (TEFT) https://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/grant-programs/teft-program.html With the total grant program nearing $42 million, the TEFT grants to nine states test quality measurement tools and demonstrate e-health in Medicaid community-based long term services and supports (CB-LTSS). The grant program, spanning four years through March 2018, is designed to field test a cross-disability experience of care survey and a set of functional assessment items, demonstrate personal health records, and create an electronic LTSS service plan standard. This is the first time CMS is promoting the use of health information technology (HIT) in CB-LTSS systems. TEFT will provide national measures and valuable feedback on how health information technology (HIT) can be implemented in this component of the Medicaid program.	**$42 million**	**Medicaid**	• Data exchange and using data • Care coordination	N/A
U.S. DEPARTMENT OF JUSTICE (DOJ)				
Second Chance Act (SCA) https://www.bja.gov/ProgramDetails.aspx?Program_ID=90 The Second Chance Act of 2007 (SCA) was enacted to break the cycle of criminal recidivism; improve public safety; and help state, local, and tribal government agencies and community organizations respond to the rising populations of formerly incarcerated people who return to their communities.	**$5.2 million** Based on FY16 grant announcement	**Federal Grant**	• Behavioral health treatment and services • Targeted case management • Care coordination	Andre Bethea Andre.Bethea@usdoj.gov or support@grants.gov (202) 353-0583
Encouraging Innovation: Field-Initiated Programs https://www.bja.gov/ProgramDetails.aspx?Program_ID=105 Since FY 2009, BJA has competitively awarded grants under the Encouraging Innovation: Field-Initiated Programs solicitation. Through the Field-Initiated Program, BJA collaborates with the criminal justice field to identify, define, and respond to emerging or chronic crime problems and systemic issues. Additional information: https://www.grantsnet.justice.gov/programplan/html/Item.htm?ForecasterId=8987	**$4 million** Based on FY16 grant competition	**Federal Grant**	• Collaboration strategies • Data exchange and using data	Priya Sarathy Jones priya.sarathy-jones@usdoj.gov (202) 307-0648
Swift, Certain, and Fair Sanctions Program https://www.bja.gov/funding/swiftandcertain.pdf This program furthers the Department's mission by providing resources for state, local, and tribal governments to establish or enhance programming focused on modifying and reducing criminal behavior and enhancing public safety.	**$2.8 million** Based on FY16 grant competition	**Federal Grant**	• Collaboration strategies	N/A

Description	Amount	Category	What This Could Fund	Contact
Smart Supervision https://www.bja.gov/ProgramDetails.aspx?Program_ID=122 The Smart Supervision Program provides grants and assistance to states, units of local government, and federally recognized Indian tribes to develop and implement more effective and evidence-based probation and parole practices that effectively address individuals' needs and reduce recidivism.	**$5 million** Based on FY16 grant announcement	**Federal Grant**	• Collaboration strategies • Data exchange and using data • Behavioral health treatment and services • Supportive Housing Services and Housing First	Juliene James juliene.james@usdoj.gov (202) 353-9248
Smart Policing Initiative (SPI) http://www.smartpolicinginitiative.com/ SPI is a collaborative consortium composed of the BJA, CNA, and over 30 local law enforcement agencies that are testing solutions to serious crime problems in their jurisdictions.	**N/A**	**Federal Grant**	• Data exchange and using data	Catherine McNamee catherine.McNamee@usdoj.gov (202) 598-5248
Police-Prosecution Partnership Initiative https://www.bja.gov/Funding/PPPI16.pdf This program furthers the Department's mission by assisting state and local jurisdictions in reducing crime and improving the functioning of the criminal justice system.	**$2 million** Based on FY16 grant announcement	**Federal Grant**	• Data exchange and using data	N/A
Justice and Mental Health Collaboration Program (JMHCP) https://www.bja.gov/ProgramDetails.aspx?Program_ID=66 The Justice and Mental Health Collaboration Program (JMHCP) supports innovative cross-system collaboration for individuals with mental illnesses or co-occurring mental health and substance abuse disorders who come into contact with the justice system.	**$7.25 million** Based on FY16 grant announcement	**Federal Grant**	• Collaboration strategies • Behavioral health treatment and services	N/A
Community Policing Development (CPD) Program http://www.cops.usdoj.gov/default.asp?Item=2450 CPD funds are used to advance the practice of community policing through training and technical assistance, the development of innovative community policing strategies, applied research, guidebooks, and best practices that are national in scope.	**$8 million**	**Federal Grant**	• Specialized police based response models • Community policing	N/A

Description	Amount	Category	What This Could Fund	Contact
The Edward Byrne Memorial Justice Assistance Grant (JAG) Program https://www.bja.gov/Funding/15JAGLocalSol.pdf The Edward Byrne Memorial Justice Assistance Grant (JAG) Program (42 U.S.C. § 3751(a)) is the primary provider of federal criminal justice funding to state and local jurisdictions. The JAG Program provides states and units of local governments with critical funding necessary to support a range of program areas including law enforcement, prosecution and court programs, prevention and education programs, corrections and community corrections, drug treatment and enforcement, crime victim and witness initiatives, and planning, evaluation, and technology improvement programs. Note, that a priority area for JAG is "Recidivism reduction, Pretrial Reform, and Justice System Realignment."	**$255.7 million** Based on FY15 funding announcement	**Federal Grant**	• Specialized police based response models • Evidence based risk-assessment tools • Integrating evidence into a law-enforcement program • Data-integration	N/A
Residential Substance Abuse Treatment for State Prisoners (RSAT) Program https://www.bja.gov/ProgramDetails.aspx?Program_ID=79#horizontalTab1 The Residential Substance Abuse Treatment (RSAT) for State Prisoners Program (42 U.S.C. §3796ff et. seq.) assists states and local governments to develop and implement substance abuse treatment programs in state, local, and tribal correctional and detention facilities. Funds are also available to create and maintain community-based aftercare services for offenders.	**$8,637,752** Based on FY14 amount appropriated	**Federal Grant**	• Behavioral health treatment and services • Targeted Case Management	BJA Justice Information Center JIC@telesishg.com (877) 927-5657
U.S. DEPARTMENT OF LABOR (DOL)				
Homeless Veterans' Reintegration Program https://www.dol.gov/vets/programs/hvrp/ Grantees provide an array of services utilizing a case management approach that directly assists homeless veterans in gaining employment as well as provide critical linkages for a variety of supportive services available in their local communities.	**$38 million** in grant funds authorized	**Veterans-specific Housing Employment**	• Referral to, and in select cases provision of, temporary, transitional, and permanent housing • Referral to medical and substance abuse treatment • Employment and training activities • Supportive services to assist homeless veterans in completing grant-funded activities and in obtaining employment	N/A

Description	Amount	Category	What This Could Fund	Contact
U.S. DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT (HUD)				
Continuum of Care Program https://www.hudexchange.info/programs/coc/ The Continuum of Care (CoC) Program is designed to promote community-wide commitment to the goal of ending homelessness, quickly rehouse homeless individuals and families experiencing homelessness, minimize the trauma and dislocation caused by homelessness, promote access to and effect utilization of mainstream programs by homeless individuals and families; and optimize self-sufficiency among individuals and families experiencing homelessness. Funding is made available through an annual competition and state and local governments, public housing agencies, and nonprofit organizations are eligible to apply.	**$1.9 billion** Based on amount available in FY16 NOFA	**Federal Grant**	• Permanent Supportive Housing • Rapid Re-housing • Transitional Housing • Safe Havens • Supportive Services, including Street Outreach • HMIS (data collection) • Homelessness Prevention (in limited circumstances)	Your local HUD field office http://portal.hud.gov/hudportal/HUD?src=/program_offices/field_policy_mgt/localoffices
Juvenile Reentry Assistance Program (HUD and DOJ) http://portal.hud.gov/hudportal/HUD?src=/program_offices/administration/grants/fundsavail/nofa2015/jrap The Juvenile Re-entry Assistance Program (JRAP) aims to support successful transition to the community by reducing barriers to public housing, employment, and/or educational opportunities.	**$1.75 million** Based on amount available in FY15	**Federal Grant**	• Supportive Housing Services and Housing First	JRAP@hud.gov
Pay for Success Permanent Supportive Housing Demonstration Program (HUD and DOJ) http://portal.hud.gov/hudportal/HUD?src=/program_offices/administration/grants/fundsavail/nofa2015/pfspshdemo DOJ and HUD are partnering to advance Pay for Success (PFS), one promising model for financing services that can attract additional, non-traditional sources of funding. The Consolidated Appropriations Act, 2014 (Pub. L. 113-76) and the Consolidated and Further Continuing Appropriations Act, 2015 (Pub. L. 113-235) authorized DOJ to make funds available for a PFS initiative implementing the PSH model for a population continuously cycling between the criminal justice system and homeless services. DOJ and HUD entered into an interagency agreement that designates HUD as the agency responsible for implementing the PFS Demonstration, and through this NOFA, HUD is making $8,679,000 available.	**$8,679,000** Based on amount available in FY16	**Housing**	• Behavioral health treatment and services • Targeted Case Management • Care Coordination • Supportive Housing Services and Housing First	Marlisa Grogan Marlisa.M.Grogan@hud.gov

Description	Amount	Category	What This Could Fund	Contact
SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION (SAMHSA)				
Offender Reentry Grant Program http://www.samhsa.gov/criminal-juvenile-justice/samhsas-efforts Expands and enhances substance use treatment services for individuals reintegrating into communities after being released from correctional facilities.	**$13.6 million** Based on amount made available in FY16	**Federal Funding Opportunity**	• Behavioral health treatment and services • Peer services • Assertive Community Treatment • Targeted Case Management • Medication-Assisted Treatment • Care Coordination	SAMHSA Center for Substance Abuse Treatment Targeted Population Branch (877) 726-4727
Screening, Brief Intervention and Referral to Treatment (SBIRT) http://www.samhsa.gov/sbirt SBIRT is an approach to the delivery of early intervention and treatment to people with substance use disorders and those at risk of developing these disorders. Screening quickly assesses the severity of substance use and identifies the appropriate level of treatment. Brief intervention focuses on increasing insight and awareness regarding substance use and motivation toward behavioral change. Referral to treatment provides those identified as needing more extensive treatment with access to specialty care.	**$13,267,000** Based on amount made available in FY16	**Federal Funding Opportunity**	• Behavioral Health Treatment and Services	SAMHSA Center for Substance Abuse Treatment Health Systems Branch (877) 726-4727
Targeted Capacity Expansion (TCE) – Technology Assisted Care (TAC); Short Title: TCE-TAC Program http://www.samhsa.gov/grants/grant-announcements/ti-16-001 The purpose of the program is to enhance and/or expand the capacity of substance use disorder treatment providers to serve youth and adults with substance use disorders or co-occurring substance use and mental disorders who have been underserved and/or have special needs (e.g., elderly, ethnic and racial minorities, criminal justice involved individuals, etc.).	**$3.6 million** Based on amount made available in FY16	**Federal Funding Opportunity**	• Data exchange and using data • Behavioral health treatment and services • Medication Assisted Treatment • Care Coordination	SAMHSA Center for Substance Abuse Treatment Health Information Technology Team (877) 726-4727

Description	Amount	Category	What This Could Fund	Contact
Behavioral Health Treatment Court Collaboratives (BHTCC) http://www.samhsa.gov/gains-center/grants-grantees/behavioral-health-treatment-court-collaboratives BHTCC helps adults with mental and/or substance use disorders involved with the criminal justice system by supporting collaboration between courts and community-based providers.	**$4,874,000** Based on amount provided in FY14	**Federal Funding Opportunity**	• Behavioral Health Treatment and Services • Peer services • Law Enforcement and Behavioral Health Partnerships • Care Coordination • Medication-Assisted Treatment • Targeted Case Management	SAMHSA Center for Mental Health Services (877) 726-4727
Law Enforcement and Behavioral Health Partnerships for Early Diversion http://www.samhsa.gov/gains-center/grants-grantees/early-diversion The Early Diversion grant program works to keep people with mental and/or substance use disorders out of the criminal justice system.	**$2.9 million** Based on amount provided in FY13	**Federal Funding Opportunity**	• Specialized Police Based Response Models • Behavioral health treatment and services • Peer services • Targeted Case Management • Care Coordination	N/A
Cooperative Agreement to Benefit Homeless Individuals (CABHI) http://www.samhsa.gov/homelessness-programs-resources/grant-programs-services/cabhi-program SAMHSA's Cooperative Agreements to Benefit Homeless Individuals (CABHI) programs help people with behavioral health issues find housing and supportive services.	**$19,576,000** Based on amount provided in FY16	**Federal Funding Opportunity**	• Supportive Housing • Behavioral Health Treatment and Services • Assertive Community Treatment • Targeted Case Management • Peer services	SAMHSA Center for Mental Health Services Homeless Programs Branch (877) 726-4727
Grants for the Benefit of Homeless Individuals-Services in Supportive Housing (GBHI-SSH) http://www.samhsa.gov/homelessness-programs-resources/grant-programs-services/gbhi-program SAMHSA's Grants for the Benefit of Homeless Individuals–Services in Supportive Housing (GBHI–SSH) program expands community treatment and recovery services. GBHI-SSH supports the development and/or expansion of local implementation and community infrastructures that integrate treatment and services for: substance use, co-occurring mental and substance use disorders, permanent supportive housing, and other critical services.	**$9,981,470** Based on amount provided in FY14	**Federal Funding Opportunity**	• Supportive Housing • Behavioral Health Treatment and Services • Assertive Community Treatment • Targeted Case Management • Peer services	SAMHSA Center for Mental Health Services Homeless Programs Branch (877) 726-4727

Description	Amount	Category	What This Could Fund	Contact
Projects for Assistance in Transition from Homelessness (PATH) http://www.samhsa.gov/homelessness-programs-resources/grant-programs-services/path SAMHSA's Projects for Assistance in Transition from Homelessness (PATH) funds services for people with serious mental illness (SMI) experiencing homelessness.	**Unknown**	**Federal Funding Opportunity**	• Supportive Housing • Behavioral Health Treatment and Services • Assertive Community Treatment • Targeted Case Management • Peer services	SAMHSA Center for Mental Health Services Homeless Programs Branch (877) 726-4727
GAINS Center for Behavioral Health and Justice Transformation http://www.samhsa.gov/gains-center The GAINS Center focuses on expanding access to services for people with mental and/or substance use disorders who come into contact with the justice system.	**Does not provide direct funding, instead provides direct technical assistance**	**Training and Technical Assistance**	• Training and Technical Assistance Services for Behavioral Health Providers, Criminal Justice Practitioners, Peers, Policymakers and Cities, Counties, and States • Behavioral Health Treatment Services and Service Delivery • Specialized Police Based Response Models • Peer services • Crisis services	GAINS Center for Behavioral Health and Justice Transformation (800) 311-4246
National Center for Trauma-Informed Care and Alternatives to Seclusion and Restraint (NCTIC) http://www.samhsa.gov/nctic NCTIC works to eliminate the use of seclusion, restraints, and other coercive practices and to develop the knowledge base on trauma-informed care.	**Does not provide direct funding, instead provides direct technical assistance**	**Training and Technical Assistance**	• Training and Technical Assistance Services for Behavioral Health Providers, Criminal Justice Practitioners, Peers, Policymakers and Cities, Counties, and States • Behavioral Health Treatment Services and Service Delivery • Trauma-Informed Care	National Center for Trauma-Informed Care and Alternatives to Seclusion and Restraint (866) 254-4819

Description	Amount	Category	What This Could Fund	Contact
SSI/SSDI Outreach, Access, and Recovery (SOAR) TA Center http://www.samhsa.gov/soar SSI/SSDI Outreach, Access, and Recovery (SOAR) increases access to Social Security disability benefits for people experiencing or at risk of homelessness.	**Does not provide direct funding, instead provides direct technical assistance**	**Training and Technical Assistance**	• Training and Technical Assistance Services for Behavioral Health Providers, Criminal Justice Practitioners, Peers, Policymakers and Cities, Counties, and States • Behavioral Health Treatment Services and Service Delivery • Social Security	SOAR TA Center (518) 439-7415
Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS) http://www.samhsa.gov/brss-tacs In 2011, SAMHSA launched the Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS) to promote the widespread adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental health conditions.	**Does not provide direct funding, instead provides direct technical assistance**	**Training and Technical Assistance**	• Training and Technical Assistance Services for Behavioral Health Providers, Criminal Justice Practitioners, Peers, Policymakers and Cities, Counties, and States • Behavioral Health Treatment and Service Delivery • Peer services • Crisis services	SAMHSA Center for Mental Health Services (877) 726-4727
Homelessness and Housing Resource Network (HHRN) http://www.samhsa.gov/homelessness-programs-resources The HHRN provides information and resources related to homelessness and housing.	**Does not provide direct funding, instead provides information and resources**	**Resource**	• Resources for Behavioral Health Providers, Criminal Justice Practitioners, Peers, Policymakers and Cities, Counties, and States	SAMHSA Center for Mental Health Services (877) 726-4727

Description	Amount	Category	What This Could Fund	Contact
Addiction Technology Transfer Center (ATTC) Network http://attcnetwork.org/home/ Established in 1993 by SAMHSA, the ATTC Network works to unify science, education and service to transform lives through evidence-based and promising treatment and recovery practices.	**Does not provide direct funding, instead provides direct technical assistance**	**Training and Technical Assistance**	• Training and Technical Assistance Services for Behavioral Health Providers, Criminal Justice Practitioners, Peers, Policymakers and Cities, Counties, and States • Behavioral Health Treatment and Service Delivery • Medication Assisted Treatment	SAMHSA Center for Substance Abuse Treatment (877) 726-4727
Assertive Community Treatment (ACT) Evidence-Based Practices (EBP) Kit http://store.samhsa.gov/product/Assertive-Community-Treatment-ACT-Evidence-Based-Practices-EBP-KIT/SMA08-4345 Provides tools to implement the evidence-based practices of Assertive Community Treatment (ACT), which offers customized, community-based services for people with mental illness. Includes DVD, CD-ROM, brochures in English and Spanish, and PowerPoint presentation.	N/A	**Resource** **Not a funding opportunity, a resource only.**	• Assertive Community Treatment	SAMHSA Center for Mental Health Services (877) 726-4727
National Survey on Drug Use and Health (NSDUH) http://www.samhsa.gov/data/population-data-nsduh/about The NSDUH is a primary source of statistical information on the use of illegal drugs, alcohol, and tobacco by the U.S. civilian, noninstitutionalized population aged 12 or older. The survey also collects data on mental disorders, co-occurring substance use and mental disorders, and treatment for substance use and mental health problems. The data can be used to identify correlates of these substance use and mental illness measures and provide estimates at the national, State, and substate level. The data can also be used to determine the prevalence of substance use or mental illness among demographic or geographic subgroups, as well as provide estimates of the need for substance abuse or mental health treatment services.	N/A	**Resource** **Not a funding opportunity, a resource only.**	• Data exchange and using data	SAMHSA Center for Behavioral Health Statistics and Quality (240) 276-1250

Description	Amount	Category	What This Could Fund	Contact
Permanent Supportive Housing Evidence-Based Practices (EBP) Kit http://store.samhsa.gov/product/Permanent-Supportive-Housing-Evidence-Based-Practices-EBP-KIT/SMA10-4510 Outlines the essential components of supportive housing services and programs for people with mental illness. Discusses how to develop new programs within mental health systems that are grounded in evidence-based practices. Kit includes eight booklets.	N/A	**Resource** **Not a funding opportunity, a resource only.**	• Supportive Housing	SAMHSA Center for Mental Health Services (877) 726-4727
National Registry of Evidence-based Programs and Practices (NREPP) http://www.samhsa.gov/nrepp SAMHSA's National Registry of Evidence-based Programs and Practices (NREPP) promotes the adoption of scientifically established behavioral health interventions.	N/A	**Resource** **Not a funding opportunity, a resource only.**	• Behavioral Health Treatment and Service Delivery	SAMHSA (877) 726-4727
U.S. INTERAGENCY COUNCIL ON HOMELESSNESS				
HHS Transitional Living Program (HHS) http://www.acf.hhs.gov/programs/fysb/resource/tlp-fact-sheet Family and Youth Services Bureau (FYSB) aims to support the organizations and communities that work every day to put an end to youth homelessness, adolescent pregnancy and domestic violence.	$43.6 million Based on amount available in FY14	Housing	• Extended residential shelter • Mental and physical health care • Individual and/or group counseling and parent/child counseling	National Clearinghouse on Families & Youth http://ncfy.acf.hhs.gov/
The Emergency Solutions Grant (HUD) https://www.hudexchange.info/programs/esg/ The Emergency Solutions Grants (ESG) program provides funding to engage homeless individuals and families living on the street; improve the number and quality of emergency shelters for homeless individuals and families; help operate those shelters; provide essential services to shelter residents; rapidly re-house homeless individuals and families; and prevent individuals and families from becoming homeless. Funding is made available through a formula to state, metropolitan cities, urban counties, and territories.	$270 million Based on amount available in FY16	Housing	• Street Outreach • Emergency Shelter • Rapid Re-housing • Homelessness Prevention • HMIS (Data collection)	Your local HUD field office http://portal.hud.gov/hudportal/HUD?src=/program_offices/field_policy_mgt/localoffices
Mainstream Affordable Housing Grants (HUD) http://portal.hud.gov/hudportal/HUD?src=/program_offices/public_indian_housing/centers/gmc/categorical/ms Mainstream vouchers provide rental assistance to enable persons with disabilities (elderly and non-elderly) to rent affordable private housing.	$10.9 million Based on amount available in FY15	Housing	• Rental Assistance for persons with disabilities	Donna Hines donna_hines@hud.gov

Description	Amount	Category	What This Could Fund	Contact
McKinney-Vento Homeless Assistance Act - Education for Homeless Children and Youth Program http://www2.ed.gov/programs/homeless/index.html With subgrant funds, LEAs offer such activities as coordination and collaboration with other local agencies to provide comprehensive services to homeless children and youths and their families. LEAs also offer expedited evaluations of the needs of homeless children to help them enroll in school, attend regularly, and achieve success.	**$65 million** Based on amount available in FY15	**Housing**	See description.	HomelessEd@ed.gov
U.S. DEPARTMENT OF VETERANS AFFAIRS (VA)				
Supportive Services for Veteran Families (SSVF) http://www.va.gov/homeless/ssvf/index.asp Supportive services grants have been awarded to selected private non-profit organizations and consumer cooperatives that will assist very low-income Veteran families residing in or transitioning to permanent housing. Grantees will provide a range of supportive services to eligible Veteran families that are designed to promote housing stability.	**$300 million** Based on amount provided in FY16	**Federal Grant**	• Behavioral health treatment and services • Case management • Supportive housing services/ Housing First	N/A
U.S. Department of Housing and Urban Development-VA Supportive Housing Program (HUD-VASH) http://www.va.gov/homeless/hud-vash.asp HUD-VASH is a collaborative program between HUD and VA combines HUD housing vouchers with VA supportive services to help Veterans who are homeless and their families find and sustain permanent housing.	**$60 million** Based on amount appropriated by Congress for 2016	**Housing Specific**	• Case management • Supportive housing services/ Housing First	N/A
VA Medical Centers http://www.va.gov/directory/guide/division.asp?dnum=1 This is in reference to the VA Medical Centers available across the country.	**N/A**	**Veteran-specific**	• Collaboration strategies • Crisis services • Behavioral health treatment and services • Peer services • Case management • Medication-Assisted Treatment • Care Coordination • Supportive Housing Services and Housing First	N/A

Description	Amount	Category	What This Could Fund	Contact
Veterans Justice Outreach http://www.va.gov/homeless/vjo.asp The aim of the Veterans Justice Outreach (VJO) program is to avoid the unnecessary criminalization of mental illness and extended incarceration among Veterans by ensuring that eligible, justice-involved Veterans have timely access to Veterans Health Administration (VHA) services, as clinically indicated. VJO specialists provide direct outreach, assessment and case management for justice-involved Veterans in local courts and jails and liaison with local justice system partners. VJO Specialists serve as liaisons between VA medical centers and the local criminal justice system. Every VA medical center has at least one VJO Specialist, who can identify locally available VA resources and facilitate access for justice-involved Veterans. A closely related VA program is Health Care for Reentry Veterans (HCRV), which provides outreach to Veterans in prison, and referral and linkage to medical, mental health and other needed services upon their release.	N/A	**Veteran-specific**	• Collaboration strategies • Behavioral health treatment and services • Care Coordination	N/A
Veterans Reentry Search Service https://vrss.va.gov/ This secure Web site enables correctional and other criminal justice system entities to identify inmates or defendants who have served in the United States (U.S.) military. The U.S. Department of Veterans Affairs (VA) makes this service available to facilitate its own direct outreach to these Veterans, and to inform the development of Veteran-specific programs in the criminal justice system.	N/A	**Veteran-specific**	• Data exchange	N/A

APPENDIX B. HIPAA FAQ

The below FAQ was developed by the U.S. Department of Health and Human Services (HHS) and the most current version is accessible at the webpage: http://www.hhs.gov/hipaa/for-professionals/faq/2073/may-covered-entity-collect-use-disclose-criminal-data-under-hipaa.html

1. **Does HIPAA permit health care providers who are HIPAA covered entities to collect criminal justice data, such as data on arrests, jail days, and utilization of 911 services, and link the criminal justice data to their health data, for purposes of improving treatment and care coordination?**

    HIPAA does not limit the types of data that providers may seek or obtain about individual patients for treatment purposes. Treatment includes "the provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a patient; or the referral of a patient for health care from one health care provider to another." 45 CFR 164.501. Other standards, such as professional ethics rules or state law, may address the scope of health care providers' independent investigations and data collection pertaining to patients. Once a HIPAA covered provider obtains criminal justice data about an individual for treatment purposes, or otherwise combines the data with its PHI, the data held by the HIPAA covered entity is considered protected health information (PHI) and the HIPAA Rules would apply to protect the data.

2. **Is criminal justice data protected health information (PHI) under HIPAA?**

    In some circumstances, yes. To the extent that criminal justice data is maintained by a HIPAA covered entity or its business associate and relates to the past, present, or future physical or mental health or condition of an individual or the provision of or payment for health care to an individual, it is PHI. For example, when a covered health care provider receives criminal justice data, either directly from the individual or from another source, in order to help inform the treatment and services that the provider will provide to that individual, or otherwise links the criminal justice data with its patient information, it is PHI.

3. **Does HIPAA permit health care providers to disclose PHI that includes criminal justice data on individuals to other treating providers without obtaining an authorization from the individuals?**

    Yes, HIPAA permits a covered health care provider to disclose PHI for treatment purposes to other providers without having to first obtain an authorization from the individuals. This may include the disclosure of PHI for purposes of coordinating an individual's care with other treatment facilities or emergency medical technicians (EMTs).

4. **Does HIPAA permit multiple health care providers who are seeking to collect individuals' criminal justice data and link it to the individuals' health data to engage the services of or work with a third-party to do this on their behalf?**

Yes. Multiple covered health care providers can contract with a third party to perform data aggregation and linkage services on their behalf, as long as the providers enter into a HIPAA-compliant business associate agreement (BAA) with the third party, and so long as the aggregation is for purposes permitted under HIPAA. (Such third parties are considered to be "business associates" (BAs) under HIPAA and have direct compliance obligations with certain aspects of the HIPAA Rules.) In these cases, the participating providers may enter into one, common business associate agreement with the third party.

The BAA then governs the subsequent uses and disclosures that the BA may make with the data. For example, the BA may be authorized by its BAA to share the PHI on behalf of the participating providers with each other or other providers for treatment purposes, including care coordination, or, subject to certain conditions, for health care operations purposes. For more information on exchanging PHI for treatment or health care operations purposes, please see:

- Permitted Uses and Disclosures: Exchange for Treatment
  www.healthit.gov/sites/default/files/exchange_treatment.pdf

- Permitted Uses and Disclosures: Exchange for Health Care Operations
  https://www.healthit.gov/sites/default/files/exchange_health_care_ops.pdf

5. **Does HIPAA permit a health care provider to share the PHI of an individual that may include criminal justice data with a law enforcement official who has the individual in custody and is looking to ensure the individual is seen by the proper treatment facility?**

A covered entity is permitted to disclose PHI in response to a request by a law enforcement official having lawful custody of an individual if the official represents that such PHI is needed to provide health care to the individual or for the health and safety of the individual. For more information on permitted disclosures to law enforcement under HIPAA, see OCR's guidance on sharing protected health information with law enforcement:

- http://www.hhs.gov/hipaa/for-professionals/faq/505/what-does-the-privacy-rule-allow-covered-entities-to-disclose-to-law-enforcement-officials/index.html

- http://www.hhs.gov/sites/default/files/ocr/privacy/hipaa/understanding/special/emergency/final_hipaa_guide_law_enforcement.pdf

While HIPAA permits the disclosure of protected health information to law enforcement in these defined circumstances, other Federal and State laws may impose greater restrictions on the release of certain information, such as substance use disorder information, to law enforcement.

6. **Does HIPAA permit health care providers to disclose PHI that includes criminal justice data to other public or private-sector entities providing social services (such as housing, income support, job training)?**

In specified circumstances, yes. For example:

- A covered entity may disclose PHI for treatment of the individual without having to obtain the authorization of the individual. Treatment includes the coordination of health care or related services

by one or more health care providers, including the coordination or management of health care by a health care provider with a third party. Thus, health care providers who believe that disclosures to certain social service entities are a necessary component of or may help further the individual's health care may disclose the minimum necessary PHI to such entities for treatment purposes without the individual's authorization. For example, a provider may disclose PHI about a patient needing health care supportive housing to a service agency that arranges such services for individuals.

- A covered entity may also disclose PHI to such entities with an authorization signed by the individual. HIPAA permits authorizations that refer to a class of persons who may receive or use the PHI. Thus, providers could in one authorization identify a broad range of social services entities that may receive the PHI if the individual agrees. For example, an authorization could indicate that PHI will be disclosed to "social services providers" for purposes of "housing, public benefits, counseling, and job readiness."

7. **Does HIPAA restrict the ability of law enforcement officials to use or disclose data they maintain on health or mental health indicators to help inform incident response (g., to ensure officers are prepared to stabilize individuals and/or to support diversion)?**

In general, no. Most state and local police or other law enforcement agencies are not covered by HIPAA and thus, are not subject to HIPAA's use and disclosure rules. HIPAA, however, does apply to the disclosure of health information by most health providers to law enforcement. For more information, see OCR's HIPAA Guide for Law Enforcement at:

http://www.hhs.gov/sites/default/files/ocr/privacy/hipaa/understanding/special/emergency/final_hipaa_guide_law_enforcement.pdf

While HIPAA does not generally apply to use or disclosure of the data by law enforcement officials, other Federal and State laws may apply.

8. **In the context of pre-arrest diversion, when does HIPAA permit a health care provider to share PHI with a law enforcement official without an individual's authorization?**

Calls for service dealing with attempted suicide or a mental health complaint. Sometimes a family will call 911 for law enforcement response for a family member in a mental health crisis. Other times, a business owner or a bystander calls to report unusual behavior (which often is an individual in crisis) and responding officers would benefit from knowing if the individual has a mental health condition. This type of information may enable officers to employ crisis intervention and de-escalation techniques that could reduce the likelihood of injury to both officers and individuals in a mental health crisis.

> HIPAA permits a health care provider to share PHI with law enforcement, in conformance with other applicable laws and ethics rules, in order to "prevent or lessen a serious and imminent threat to the health or safety of an individual or the public." 45 CFR 164.512(j). For example, if an individual makes a credible threat to inflict serious and imminent bodily harm, such as threatening to commit suicide, a provider may share with law enforcement the information needed to intervene. The provider may rely on a credible representation from a person with apparent

knowledge of the situation or authority, such as a law enforcement official, when determining that the disclosure permission applies. See: http://www.hhs.gov/hipaa/for-professionals/faq/505/what-does-the-privacy-rule-allow-covered-entities-to-disclose-to-law-enforcement-officials/index.html

Other general calls: An officer is trying to determine whether an individual has a mental illness, substance abuse problem, or both, and needs to gain information about his or her condition in order to decide whether jail, emergency room, or some other program is needed.

If the individual is in lawful custody, a health care provider may disclose PHI to law enforcement pursuant to 45 CFR 164.512(k)(5) if the official represents that the information is needed to provide health care to the individual or to provide for the individual's health and safety or the health and safety of the officers.

If the individual is not in lawful custody (see 45 CFR 164.512 (k)(5)), nor is a threat to self or others (see 45 CFR 164.512(j)), these provisions would not apply and the provider would need to obtain an authorization from the individual before disclosing PHI to law enforcement, unless another HIPAA provision applies (e.g., escaped inmate, apprehension of an admitted perpetrator of violent crime, etc.). See http://www.hhs.gov/hipaa/for-professionals/faq/505/what-does-the-privacy-rule-allow-covered-entities-to-disclose-to-law-enforcement-officials/index.html for additional provisions that may apply depending on the particular situation.

We note that substance use disorder treatment information may be subject to additional protections under 42 CFR part 2.

9. **When is an individual, other than an inmate, considered to be within the "lawful custody" of law enforcement for purposes of 45 CFR 164.512(k)(5) of the HIPAA Privacy Rule? Is "lawful custody" limited to arrest and imminent arrest or does it apply to situations where an individual may be under the care or control of an officer, but not under arrest?**

For purposes of the scope of permitted disclosures of PHI to law enforcement in custodial situations under 45 CFR 164.512(k)(5), HIPAA does not define the precise boundaries of "other persons in lawful custody." As defined in HIPAA at 45 CFR 164.501, the term includes, but is not limited to: juvenile offenders adjudicated delinquent, non-citizens detained awaiting deportation, persons committed to mental institutions through the criminal justice system, witnesses, or others awaiting charges or trial. In addition to these defined situations, lawful custody also includes those situations where an individual is under the care or control of an officer. This includes instances where an individual has been arrested, as well as situations where the individual has been detained by law enforcement and is not free to go, but is not under formal arrest. For example, this would include situations when an officer has detained an individual and seeks to determine whether diversion is appropriate. Lawful custody does not encompass pretrial release, probation, or parole.

10. **Does HIPAA restrict a covered entity's disclosure of PHI for treatment purposes to only those health care providers that are themselves covered by HIPAA?**

No. A covered entity is permitted to disclose PHI for treatment purposes to any health care provider, including those that are not covered by HIPAA. In addition, HIPAA permits a covered health care provider to disclose PHI for the treatment of an individual to a third party, such as a social service agency, that is involved in the coordination or management of health care of that individual.