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Keeping Homeless People Out of the Justice System: The HCH Role

Homelessness and incarceration are inextricably linked: one increases risk for the other. Homeless people, especially those with mental illnesses and co-occurring substance use disorders, are arrested more often, incarcerated for longer periods, and released without adequate discharge plans. Clinical interventions at specific points along the criminal justice continuum can help break this cycle. This issue of Healing Hands *examines health care interventions before arrest or conviction, in correctional facilities, and on release.*

There is significant overlap between the individuals seen by Health Care for the Homeless clinicians and those incarcerated in our nation's jails and prisons. Both groups are disproportionately poor and uninsured, members of racial and ethnic minorities, with significant medical, mental health, and substance use disorders. Frequently, they cycle between the community and the criminal justice system, never receiving the health and mental health care, substance abuse treatment, or housing and social services they need to maintain stability. "These are some of the most disenfranchised people in American society," says **Henry J. Steadman, PhD**, Director of the GAINS Evidence-Based Practice Center for Persons in the Justice System.

THE NATURE OF THE PROBLEM There are several key reasons why homeless people with medical and behavioral health disorders are overrepresented in the criminal justice system, according to **Fred C. Osher, MD,** Associate Professor and Director of the Center for Behavioral Health, Justice, and Public Policy and a physician with Baltimore Health Care for the Homeless.[1]

- **We arrest them more often.** Arrest rates for homeless people with mental illnesses range from 20–75 percent.[2] Frequently, homeless people are arrested for what are called "quality of life" crimes, including public intoxication, trespassing, loitering, jaywalking, or sitting or sleeping in public spaces. Fear of being jailed or inability to pay a fine keeps some homeless people from responding to appearance tickets; this results in outstanding warrants for their arrest. Sometimes jails and prisons are the housing of last resort when treatment and services are not available. Mandatory minimum sentencing for drug offenses are also a factor.

Jail and Prison Inmates: By the Numbers

- More than 2 million people, or one in every 140 U.S. residents, are in the custody of local jails or State and Federal prisons.[3] The cost for incarcerating these individuals exceeds $40 billion each year.[2]
- 54 percent of surveyed homeless clients have spent time in a city or county jail, in state or federal prison, or in juvenile detention.[4]
- 56 percent of homeless clients with an alcohol, drug, or mental health problem have spent time in jail, and 22 percent have spent time in prison.[4]
- Native Americans are more likely than other homeless clients to spend 5 or more days in a city or county jail.[4]
- Compared to the general population, the rate of HIV/AIDS is 5 times higher among incarcerated individuals; rates of hepatitis C are 9 to 10 times higher; and rates of TB are 4 to 17 times higher.[5] Homelessness and incarceration are both risk factors for communicable diseases.
- 80 percent of inmates at the Hampden County Correctional Center in Ludlow, MA, received no regular medical care before they were incarcerated.[5]
- 43 percent of New York City jail inmates were homeless on arrest.6 33 percent of residents entered New York City shelters within a week of being released from jail.[7]
- Of the 40 percent of inmates in the Baltimore Central Booking and Intake Facility who reported receiving mental health treatment in the community, 25 percent listed HCH as their provider.[8]

- **They are incarcerated longer.** The average length of stay in the New York City jail system for inmates with mental illnesses is 215 days, compared with a 42-day average stay for all inmates.[9] In a national study, homeless people with serious mental illnesses incarcerated 6 months or more reported higher levels of long-term homelessness than those with no history of incarceration.[10]

- **They don't get access to adequate medical or mental health care or substance abuse treatment in the community or in jail.** Homeless people with a history of incarceration enrolled in the federal ACCESS demonstration program had greater medical and psychiatric problems than those who had never been incarcerated, but they used fewer outpatient medical and psychiatric services.[10] Access to and quality of institutional care is highly variable. Treatment that inmates do receive in jail or prison may end on release, especially if Medicaid-eligible inmates have had their benefits terminated, rather than suspended as federal law allows.[11]

- **They are discharged without adequate planning.** Some inmates are released in the middle of the night with nothing more than a few bus tokens. In Washington, DC, an inmate with serious mental illness was released from jail during the winter with no support services. In his confusion, he walked around the jail's parking lot for 2 days until his feet were frostbitten.[7]

- **They are re-arrested at high rates.** Recidivism is high; rates of multiple arrests are four times higher for homeless men than for domiciled men.[10] With limited options for housing and employment, people released from the justice system are vulnerable to homelessness, victimization, and re-arrest.

TYPES OF INTERVENTIONS There are three points along the criminal justice continuum at which the cycle of homelessness and incarceration can be broken: diversion from the system, care in institutional settings, and discharge planning, often called re-entry or transition planning.[12]

Diversion Diversion activities are designed to keep people from entering the justice system by redirecting them to appropriate treatment and services. According to Dr. Steadman, diversion activities can be divided into pre-booking interventions (before formal charges are filed) or post-booking interventions (after formal charges have been filed). Pre-booking diversion programs are police-based and include crisis intervention teams, homeless outreach teams, and collaboration between police and community providers (see story in this issue).

Post-booking diversion programs can be further divided into jail-based and court-based programs. Court-based programs may take place in regular courts or in specialty courts, including mental health courts, drug courts, homeless courts, and community courts. Specialty courts are based on the concept of "therapeutic jurisprudence"; defendants are sentenced to treatment or to community service in lieu of incarceration (see separate story in this issue).

Frequently, these court proceedings are aided by an individual whom Dr. Steadman calls a "boundary spanner"—someone who bridges the worlds of criminal justice and community services on behalf of the defendant. In Charleston, SC, clients of the local mental health court who are residents of the Crisis Ministries shelter have co-case managers: one with the court who helps the individual comply with court-ordered treatment and one at shelter who helps with a full range of housing and social service needs, notes **Jeff Yungman, MSW, MPH**, Clinical Director at Crisis Ministries.

Of 3,500 jails in the U.S., 260 have some type of police, jail, or court-based diversion program, Dr. Steadman says. Preliminary results of a jail diversion study conducted by the federal Substance Abuse and Mental Health Services Administration indicate reduced number of jail days, reduced rates of re-arrest, decreased substance abuse and psychiatric symptoms, and increased quality of life among people who are diverted.[12]

Institutional Services Treatment designed to stabilize medical, mental health, and substance use disorders can be provided in jails and prisons by facility staff, by private agencies that contract with the jail or prison, or by community agencies that provide "in-reach" to the facility to serve their clients/patients. This latter model is exemplified by the Hampden County Correctional and Community Health Program in Ludlow, MA, a unique collaboration between the local jail and four Community Health Centers (see separate story in this issue). Some inmates may receive their first regular health care in jail.

In Atlanta, St. Joseph's Mercy Care Services is funded by the Centers for Disease Control and Prevention (CDC) to provide HIV prevention and testing to inmates at the local jail, including those who are homeless. The most recent CDC grant will allow St. Joseph's to provide HIV services specific to African American women and to follow them when they are released, notes **Robert Mason,** Director of Programs and Services.

Discharge Planning Discharge planning can be defined as "the process of preparing a person in an institution for return or re-entry into the community and linking the individual to needed community services and supports."[13] Effective discharge planning requires close collaboration between the jail or prison and community providers.

The APIC Model of transition planning is one that may improve outcomes for people with health or behavioral health needs being released from jails. Elements of the model are:[14]

- **A**ssess the clinical and social needs and public safety risks of the inmate.
- **P**lan for the treatment and services required to address the inmate's needs
- **I**dentify community and correctional programs responsible for post-release services.
- **C**oordinate the transition plan to ensure implementation and avoid gaps in care.

The activities required for successful discharge planning are services that HCH grantees can provide.[7] In Hazard, KY, the Appalachian Homeless Assertive Services Partnership, a specialized rural Assertive Community Treatment (ACT) team that is a collaborative effort between HCH and the local mental health center, uses wrap-around funds to secure shelter and services for clients who have no other options on release from jail, notes **Ruth Woolum**, Health Outreach Program Coordinator of the Hazard Perry HCH.

Unity Health Care in Washington, DC, provides discharge planning at the Central Detention Facility (the DC Jail) and the Correctional Treatment Facility. Unity hired a nurse case manager who maintains an office in the DC Jail. For those inmates who have the most serious health needs, she develops a treatment plan prior to discharge and helps them enroll in the DC Healthcare Alliance, which provides health care for uninsured individuals. On release, inmates meet with a doctor and with social services staff at the Integrated Care Center, which Unity operates as the entry point for individuals transitioning from jail. "Ideally, we're meeting individuals' needs before they become homeless," says **Rodney Scales, RN**, Unity Director of Clinical Support Services.

Elements of Successful Discharge Planning.[13]

Discharge planning must:

- begins on admission;
- be tailored for different needs of different individuals;
- address all of the individual's needs in the discharge plan;
- create a system that is continuous and coordinated; and
- prevent individuals from falling into homelessness.

CROSS-CUTTING PRINCIPLES The following principles are central to all interventions mentioned above:

Collaboration "You can only make substantive changes in the context of community partnerships," says **Major Sam Cochran**, Coordinator of the Crisis Intervention Team (CIT) for the Memphis Police Department. CIT began in Memphis and is the most replicated police-based diversion program (see separate story in this issue).

A crisis involving an individual or group of individuals may galvanize the community into action. In Philadelphia, advocates helped refocus the debate around a proposed ordinance that would have criminalized sitting, lying, and "aggressive panhandling" on city sidewalks. Working together, they convinced city leaders that "if you want homeless people off the streets, they have to have housing and services," says **Elaine R. Fox**, Vice President of Specialized Health Services for the Philadelphia Health Management Corporation.

After vigorous debate, the ordinance passed in June 1998, but the penalties had been reduced from criminal to civil. Further, the city pledged $5.6 million for expanded outreach, treatment, and residential services and called for special training for police officers. Before issuing a citation, police officers are required to contact outreach workers. Thus far, no one has been arrested under the ordinance, Fox says. "The ordinance was a win-win for everybody because we built bridges with the community."

Many HCH clinicians are active in their community's efforts to develop 10-year plans to end homelessness. Often, these plans include a focus on diversion and discharge planning. Cost-effectiveness can be a compelling reason for local legislators to support diversion and discharge planning efforts. Thresholds, a Chicago psychiatric rehabilitation program that uses ACT to provide services to individuals with mental illnesses who have been arrested, costs $26 per person per day, compared to $70 per day in jail.[15]

Training Training is a significant element of most diversion efforts. After passage of the Philadelphia sidewalk ordinance, the HCH project was called on to train police officers and business district goodwill ambassadors in outreach, engagement, and referral. **Jeanne Ciocca, MSW**, Director of Resources for Children's Health at the Philadelphia Health Management Corporation, coordinated the training when she was a social work supervisor at HCH. The core training was 3 days, with additional time for site visits to shelters and drop-in centers. "We presented a fairly comprehensive overview of the issues, availability of services, what you can do, and how you can do it," Ciocca says. Subsequently, elements of the training have been included in the Central City District ambassador orientation program.

In Tampa, training for local law enforcement agencies is coordinated by the Homeless Coalition of Hillsborough County, says **John Darby**, Director of Homeless Services for Tampa Community Health Centers, Inc., and president of the Coalition. The weeklong program is presented three times a year. The Broward Partnership for the Homeless developed "Homelessness 101" training for all police officers in Ft. Lauderdale (see separate story in this issue).

Infrastructure Lack of services and housing is the biggest obstacle to successful diversion and discharge planning efforts. "When there are no services, people will go to jail," Major Cochran says. Police officers must be able to refer or transport individuals to services that are willing and able to receive them.[16]

In Memphis, CIT officers take people they believe need mental health treatment to a crisis triage center based in the emergency department of the regional medical center. Homeless Outreach Team officers in Ft. Lauderdale transport homeless people they might otherwise arrest to the city's Homeless Assistance Center, a multi-service shelter which includes an HCH clinic and is set up to receive referrals 24 hours a day.

Case managers are a key link in the chain to connect individuals to available community resources. In Seattle, HCH funds an intensive case management program called REACH at the back door of a sobering station (an alternative to sending intoxicated people to local jails and hospitals). Six case managers and a full-time nurse provide outreach and engagement and help get individuals into housing and treatment and connected to primary care, reports **Janna Wilson**, Program Manager for the HCH Network. Many REACH clients have outstanding warrants and are at risk of further involvement with the criminal justice system without the support they receive.

Patience and Persistence Successful collaborative efforts that keep homeless people from unnecessary involvement in the criminal justice system take time to develop. "You can't achieve this overnight," cautions **Scott Russell**, Coordinator of the Homeless Outreach Team and Crisis Intervention Team for the Ft. Lauderdale Police Department. "It took us 6 years to get where we are. Think of this as a walk you're beginning to take."

Diversion Programs Highlight Treatment and Services

"I don't think the criminal justice system was intended to be the entry point for mental health and social services," Major Sam Cochran of the Memphis Police Department says. Still, that's often what happens when police officers are faced with community pressure to clean up the streets.

"We used to do what we called 'bum sweeps' of the beaches, arresting homeless people for life-sustaining misdemeanors," says Officer Scott Russell with the Ft. Lauderdale Police Department. "We had no other tools." Today, police departments around the country have begun to recruit and train officers for special response teams designed to divert individuals from the criminal justice system.

THE CRISIS INTERVENTION TEAM IN MEMPHIS The Crisis Intervention Team (CIT) program began in Memphis in 1988 in response to public outcry after police shot and killed a 27-year-old man with mental illness. Developed in partnership with the Memphis chapter of the Alliance for the Mentally Ill, mental health providers, and two local universities, CIT puts specially trained members of the Uniform Patrol Division on the streets to respond to emergencies involving people with mental illnesses, many of whom are homeless.

The CIT officer on the scene is in charge of the situation and is often able to resolve the crisis without further intervention, Cochran notes. Only 2 percent of CIT officer encounters result in arrests, compared to 16 percent for typical police encounters.[12] Training is an important element of CIT, but so is officer attitude and community ownership of the program. CIT officers who volunteer for this assignment "have a passion for their work. Many have a mentally ill family member," Cochran explains. Further, he notes, a community that says "no" to criminalizing homelessness also must say "yes" to supporting the infrastructure for treatment, housing, and services. CIT's success had led to its replication nationwide. For more information, contact Cochran at *SamCIT@memphispolice.org*.

THE HOMELESS OUTREACH TEAM IN FT. LAUDERDALE The leap from "bum sweeps" of the beaches to a homeless-specific police response team took money and a change of heart. A $50,000 Local Law Enforcement Block Grant in 1999 spurred development of the Homeless Outreach Team, which features uniformed officers and a formerly homeless person who patrol the city to engage homeless people and offer help. "We no longer see homeless people as prob-

Problem-solving Courts Give People a Second Chance

Donna Cartwright, RN, an HCH community health nurse, wears two hats in her assignment with the Philadelphia Community Court. She is both a nurse—conducting health education classes, handing out condoms, and doing HIV and STD testing—and an advocate for her patients who are not appropriate for community service by virtue of a medical or mental health problem. "Many people don't expect to see a nurse when they come to court," Cartwright says.

Modeled after the first Community Court in Manhattan, Philadelphia's Community Court "sentences" defendants who plead guilty to misdemeanors or summary offenses (similar to a moving violation in a vehicle) to conduct 24–36 hours of community service and pay $142 in court costs. Individuals who can't afford the fine can make a good faith payment. "The goal is to address the underlying cause of the crime," Cartwright says. Individuals are referred to shelter, medical care, and mental health and substance abuse treatment.

In her role as nurse, Cartwright meets with all defendants charged with prostitution; many are homeless young men. She conducts HIV and STD testing at the court and refers them to HCH's Mary Howard Clinic for more extensive workups. She also assesses individuals for their fitness to perform community service. In many cases, proof of involvement in a mental health program can be substituted for community service. She recommends that homeless veterans do their community service at a local Veterans Affairs multipurpose center so they become familiar with the staff and services available to them. For more information, contact Cartwright at *Donna.Cartwright@phila.gov.*

lem people," Russell says. "We see them as people with problems."

At about the same time, local businesses helped support development of the Homeless Assistance Center (HAC), a multi-service shelter for 200 men, women, and families run by the Broward Partnership for the Homeless. HAC's screening unit has 24-hour nursing coverage and 14–15 beds so that individuals can be served when they are referred, says **David Freedman, M.Ed., CAP**, Chief Program Officer for the Partnership. Facility services include case management, meals, medical care from an on-site HCH clinic, day care, and a hair salon.

The first year the Homeless Outreach Team operated, misdemeanor arrests in Ft. Lauderdale were down by 1,200; that number doubled the following year. For more information, contact Russell at *srussell@fortlauderdale.gov*.

THE HOMELESS EVALUATION LIAISON PROJECT IN LAS VEGAS. Homeless people deserve the same level of police protection as other citizens but "they can't call us and they can't lock their door," says **Sergeant Eric W. Fricker** with the Las Vegas Metropolitan Police Department. The police department's Homeless Evaluation Liaison Project or HELP team was established to serve the estimated 8,000 to 10,000 people who are homeless in Las Vegas.

HELP officers make their rounds in bright yellow uniforms with members of what they call the "crisis team"—service providers who may include a mental health worker, a medical provider, and/or a case manager. **John Farrell**, outreach case manager with the Nevada Health Centers' Las Vegas Outreach Clinic, and **Denise Beckwith, LPN**, outreach nurse, are HCH clinicians who ride with HELP officers.

"Las Vegas streets are lined with gold, but people get stuck here," Farrell says. "HELP enhances our outreach efforts." He explains available resources to homeless people, and Beckwith treats minor medical problems with over-the-counter medications and wound care supplies. She refers or helps transport people with medical problems that can't be treated on-site to the HCH clinic or to the emergency room. For more information, contact Fricker at *E2664F@LVMPD.com*.

Treating Community Members in Jail: The Public Health Model at HCCC

When staff at Community Health Centers in Springfield, MA, were approached with the idea of providing health care to inmates in the local jail, they had an "aha!" moment, says **Thomas Lincoln, MD**, attending physician at Bay State Medical Center and Brightwood Health Center and primary physician at the Hampden County Correctional Center (HCCC) in Ludlow, MA. "The Community Health Centers considered it both their mandate to provide services to these individuals, who are their patients, and a wonderful opportunity to provide public health measures to a receptive audience."

The Hampden County Correctional and Community Health Program grew out of an effort to provide continuity of care for patients with HIV before, during, and after incarceration. Previously, these patients were not being treated in jail because they were unwilling to reveal their HIV status or jail health providers were not comfortable working with them, Dr. Lincoln says. Today, clinicians from four Community Health Centers provide medical, dental, and hospice care, mental health services, and substance abuse treatment to inmates while they are incarcerated and after they are released. They focus on early detection, comprehensive treatment, education, prevention, and continuity of care.

The HCCC program is neighborhood-based; inmates are assigned to a jail health team based on zip code or prior association with a Community Health Center. Team members include those who are based in the jail—nurses and nurse practitioners—and those who are based both in the jail and in the community—physicians and case managers. A person's physician in jail becomes his or her physician in the community. For those inmates who are eligible for Medicaid, the case manager completes an application with the inmate before release, Dr. Lincoln notes. This helps ensure continuity of care.

Inmates at HCCC are a medically disenfranchised group. Half of the inmates served by the program rated their health as only good, fair, or poor; diabetes, hepatitis, asthma, hypertension, heart disease, cirrhosis, and renal disease are common. Prior to incarceration, many individuals avoided regular medical care because of cost but visited emergency rooms during health crises.[17, 18]

After their involvement in the program, 55 percent of patients saw a health care provider in the 30 days post-release.[19] In 1998, the cost of health care at HCCC was $7.23 per day per inmate; in contrast, a 2001 study of the 30 largest jails in the country showed an average cost of $7.89 per day.[5]

Dr. Lincoln acknowledges that this is a unique program. Most jails are overwhelmed and underfunded, and health care typically is provided by private agencies that contract with the jail. In recognition of its achievements, the HCCC program was awarded a 2000 Ford Foundation Innovations in American Government Award. For more information, contact Dr. Lincoln at *silklinc@massmed.org*.

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