

CountyNews

HOT topics

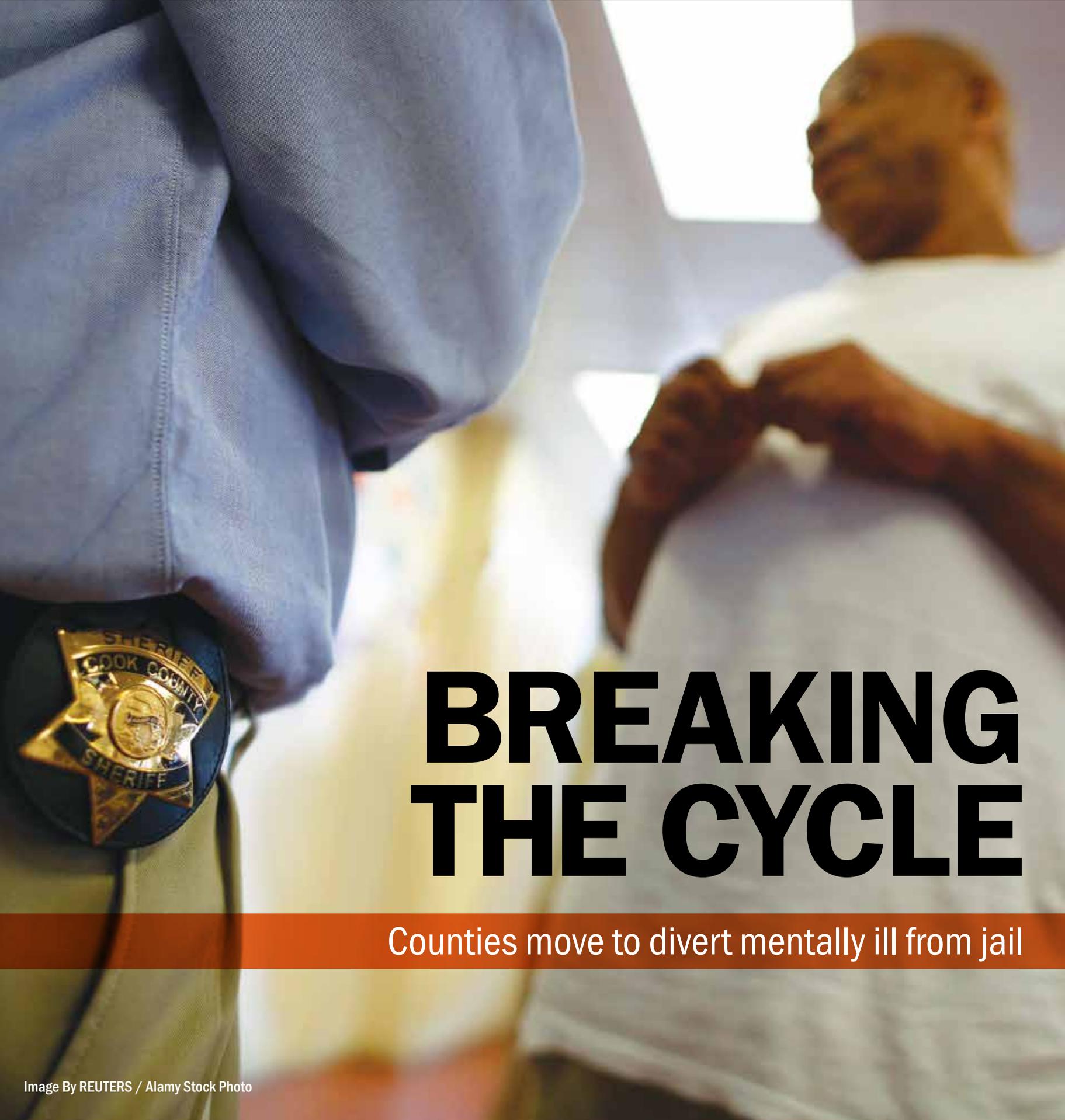
MENTAL ILLNESS IN JAILS

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NATIONAL ASSOCIATION of COUNTIES

MAY 1, 2017



BREAKING THE CYCLE

Counties move to divert mentally ill from jail

STEPPING UP JAMMING THE REVOLVING DOOR



By **Mary Ann Barton**
senior staff writer

The revolving door of jailing the mentally ill is one of the foremost challenges faced by counties across the country, sucking up valuable budgets, time and space, not to mention the toll it takes on mentally ill residents and county employees.

Incarceration has largely replaced hospitalization for thousands of individuals with serious mental illnesses, with county jails holding as many as 10 times more of these individuals than state psychiatric hospitals, according to a report from Public Citizen's Health Research Group and the Treatment Advocacy Center.

Because those with serious mental illnesses are predisposed to committing minor crimes, experts say, many end up being detained in county jails with limited or no mental health treatment until a state hospital bed becomes available for them, according to the Public Citizen report.

Counties step up to the challenge

A push to reduce the estimated 2 million mentally ill who cycle in and out of county jail cells was started two years ago with the launch of the Stepping Up initiative in May of 2015. Groups leading the effort include NACo, the American Psychiatric Association Foundation and the Council of State Governments' Justice Center. Stepping Up's goal is to elevate the issue on a national stage and give counties the resources to attack the problem successfully.

Since it started, the initiative has attracted participation from 350 counties of every size from 43 states. The coun-

ties represent 125 million people or 40 percent of the U.S. population. Counties must pass a resolution to be formally recognized as participants in the initiative, as a sign of support in their communities.

Sheriff John Layton of Marion County, Ind., with a population near 1 million, recently told President Donald Trump that 40 percent of his inmates suffer from mental illness, according to a report by *The New York Times*. The jail dispenses about 700 prescriptions a day and the county spends \$8 million a year on care for the mentally ill, the *Times* reported.

There are glimmers of hope across the country, where counties are moving ahead on programs and seeing results.

In Los Angeles County, the Board of Supervisors voted unanimously in January to double the number of its law enforcement teams that include mental health clinicians. The county began a pilot program in the 1990s and since then, its Department of Mental Health has partnered with 35 law enforcement agencies to develop teams with mental health expertise.

The Sheriff Department's Mental Evaluation Teams responded to 1,154 calls from July 2015 to July 2016, Supervisor Kathy Barger said. Of those calls, fewer than 1 percent resulted in an arrest, she said. The Los Angeles County Sheriff's Department has 10 Mental Evaluation Teams and wants to increase that to 23 and also add a "triage desk."

North of L.A., in Santa Barbara County, the jail saw improvements toward treatment of the mentally ill, after they hired a part-time grievance coordinator. The Sheriff's Office created a grievance oversight committee made up of activists who communicated with the coordinator. One year into the program, some of the

improvements include mentally ill prisoners receiving their needed medications within hours (instead of weeks) and an increase in the number of days a psychiatrist is made available to jail inmates (from three days to five days).

In Montana, Gov. Steve Bullock (D) signed into law a bill putting a Crisis Intervention Team (CIT) training program that trains law enforcement on how to respond to mentally ill people, operated by a nonprofit organization, under governmental control. By putting it under government control, officials can keep track of data to see how effective the training is and open access to additional government funding.

"We're super excited," Gallatin County Sheriff's Sgt. Jim Anderson, executive director of CIT Montana, told the *Bozeman Daily Chronicle*. "It's just a great program, and it's out there to make communities better and help people who suffer from mental illness. It's the right thing to do."

In Colorado, the state Legislature is considering a proposal that would support two-person mobile crisis teams, made up of a law officer and a behavioral health specialist, to intervene on mental health-related police calls and de-escalate situations more appropriate for mental health treatment than arrest.

The proposal also calls for expansion of a pre-booking criminal justice diversion program to treat mental illness, as well as additional training for law enforcement and other first responders. They would also expand crisis stabilization centers to make sure they can help people 24/7 and put the centers closer to rural areas.

Some remote counties in Colorado were having to hold the mentally ill in jails because the nearest mental health beds were hundreds of miles away. Under the

proposal, mobile crisis units would transport people having a crisis to the closest treatment option.

Stepping Up Attracts Participation from Counties Big and Small

Counties big and small are coming up with solutions — it's not just a big-city problem, said Nastassia Walsh, NACo program manager, who leads NACo's Stepping Up effort. "About half of the counties that are participating have populations of less than 100,000."

Since the program began, counties are at various starting points in implementing their plans to reduce the number of mentally ill in their jails, she said. "Some are just starting from scratch, some have been at it for decades. There is one county that jokes they're an overnight success, they've only been at it for 15 years."

No matter where your county might be in the process, know that "it takes a lot of time, it takes a lot of effort — there's no quick Band-Aid for this," Walsh said.

The work is made easier though with collaboration among counties being carried out by Stepping Up, which makes available resources, networking opportunities and examples of what's working through its reports, webinars, conferences and Web site.

Launching an Initiative: Six Questions

In January, Stepping Up came out with six questions a county needs to ask as it embarks on implementing a strategy to keep the mentally ill out of jail, providing a jumping off point. Those questions are:

- Is our leadership committed?

See **STEPPING UP** page H3

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- Do we conduct timely screening and assessments?
- Do we have baseline data?
- Have we conducted a comprehensive process and inventory of services for people with mental illnesses who are booked into our jail?
- Have we prioritized policy, practice and funding improvements to connect the appropriate people to the right criminal justice and behavioral health interventions?
- Do we track progress to ultimately ensure successful outcomes for people with mental illnesses who are booked into our jail?

Getting the Word Out, Sharing Ideas

Even “model” counties that find themselves being visited by other counties to check out their programs for keeping the mentally ill out of jail find they “still have a lot of work to do,” Walsh said. And because counties operate in a variety of ways, Stepping Up tries to provide a variety of “best practice” options to fit every scenario. One way they do that is by bringing participating counties together to share ideas.

Stepping Up holds quarterly webinars, focusing on implementing specific strategies, and follow-up phone calls for counties, which are divided into three net-

works — rural, midsize and large counties. The calls attract county commissioners, county sheriffs and members of county health and human services departments. Only counties that have passed a resolution can take part in the calls.

On the calls, participants share what’s working and also their challenges.

For example, one of the biggest problems counties find is that people who stop taking their medications tend to land in jail over and over again, Walsh noted. One tool some counties are using to solve that problem is starting a peer support program, she said. Peer support specialists are people who have been diagnosed with mental illness but have gone on to live successful lives by staying on their medications.

“They’ve gone through training, it’s almost like a mentorship, but more than that,” Walsh said. A client having problems staying on meds in the program can see that the other person, the peer support specialist, is doing well — “holding down a job, a marriage, children and a home — and that could be them if they can stay on their medication.”

One of the barriers to people taking their medications: Some people suffer from anosognosia, Walsh said; the word is Greek, meaning “to not know a disease.” Some people who are mentally ill think they don’t need to take their medication.

The National Alliance of Mental Illness

notes that it is a common symptom of certain mental illnesses, affecting 50 percent of people with schizophrenia and 40 percent of people with bipolar disorder. People with anosognosia are placed at increased risk of homelessness or arrest, the Alliance says.

Another big problem for counties is a lack of data. “Once you have the data, you can identify the problems and start to come up with some solutions,” Walsh said. Instead, county officials say they generally know they are seeing more people with mental illness in their jails but most do not have hard numbers to clearly see what’s going on.

The kind of data that counties need to be collecting includes:

- The number of mentally ill admitted to jail.
- The average length of stay for the mentally ill in jail.
- Connection to treatment of mentally ill in jail.
- Rate of recidivism.

Looking Ahead

The next network call for Stepping Up will take place in June. Anyone can ask questions on the calls and Walsh facilitates the conversations. County officials have been very forthcoming on the calls. “They’re not shy about asking questions or sharing information,” she said. “It’s encouraging and that’s exactly why we’re doing these calls.”

In addition to webinars and network calls, Stepping Up also holds workshops at annual conferences, participates in workshops at state associations of counties at their meetings and at a number of states that hold one-day statewide Stepping Up summits. “We’ve been able to get state association staff members together so they can share what’s working,” Walsh said.

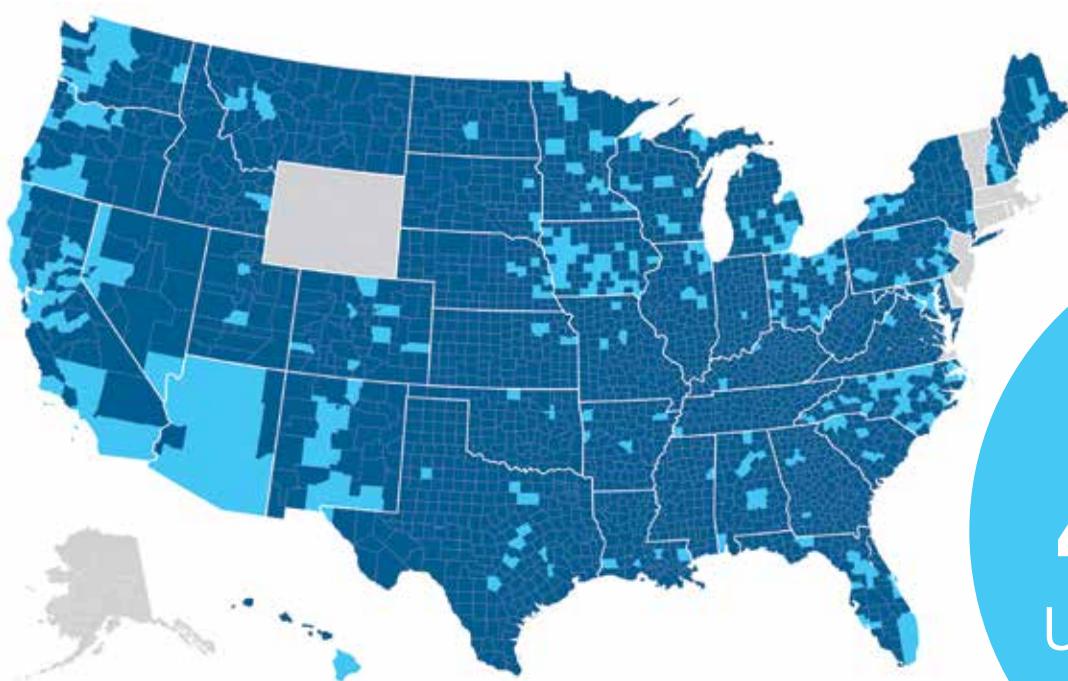
Stepping Up held a national two-day summit last year, with 50 counties participating that was livestreamed on the organization’s Web site, and there’s talk of holding another summit in 2018.

Looking ahead, Walsh said that the group anticipates helping counties to collect, analyze and use their own real-time data to identify mentally ill people in their jails, understand why they’re there and for how long, identify linkages to treatment and track progress toward reducing recidivism.

“We continue to seek ideas for tools and resources that we can develop for counties to share concrete and proven strategies,” she said.

The number one question she gets: “What are other counties doing? Are there counties like me?” We want to continue to highlight the great work that is happening in counties,” she said. 

Find out more about the Stepping Up initiative on its Web site at: <https://stepuptogether.org>

COUNTIES THAT HAVE PASSED RESOLUTIONS

350
COUNTIES

43
STATES

REPRESENTING
40% OF THE
U.S. POPULATION

IN OUR VIEW

Rural Counties Are ‘Stepping Up’

Codington County is a geographically large rural county with a population of about 25,000 in eastern South Dakota. The County Board of Commissioners passed a Stepping Up resolution in June 2015. Commissioner D. Lee Gabel from District 1 was interviewed shortly after passing a resolution about the county’s intentions with the initiative.



Commissioner D. Lee Gabel

Why did Codington County pass a Stepping Up resolution?

Codington County has been facing a number of challenges recently with our court caseload and jail population. We have an aging and small jail that is not meeting the needs of our county. The state has really begun to focus on reducing the state penitentiary population, so criminal justice reform is on everyone’s mind here. So in that context, there was already some political will to do something. When Stepping Up highlighted the issue of mental illness in jail, my fellow commissioners and I were receptive. Our welfare director did her homework and suggested the Stepping Up resolution to the Board with support of the sheriff. The initiative seemed like it would help us address some of our challenges in our jail. After some discussion, we ad-

opted the resolution unanimously.

Was there any disagreement or pushback about joining the initiative?

Because of the problems we are facing with our jail and the population, we didn’t face a lot of opposition to getting involved. I was concerned about passing a resolution with only good intentions, but once I understood the resources that were available to us through the initiative — all of the webinars and other tools — I was persuaded. We wanted to make sure that passing this resolution was going to result in real work being done to address this issue, and it has so far.

What has Codington County been doing to address this issue since passing the Stepping Up resolution?

We are very fortunate to have someone in our county — our welfare director — who has been able to really focus on this issue and help move things forward with the initiative. We have developed a small Stepping Up working group consisting of myself, the welfare director, the sheriff, the chief corrections officer, the community mental health center and our new jail mental health professional.

As a result of having access to expertise through Stepping Up, we were able to quickly identify an action that we could take immediately to get the initiative moving. We hired a part-time mental health professional to provide services at the jail. He works 20 hours per week and both the staff and the inmates at the jail have already responded well to having him on site. Anecdotally, he sees about eight inmates a day, which also shows us the extent to which this is a problem in our jail.

We are currently in the process of trying to better identify people with mental illnesses who come into the jail by researching screening tools and strategizing ways to best systematize this

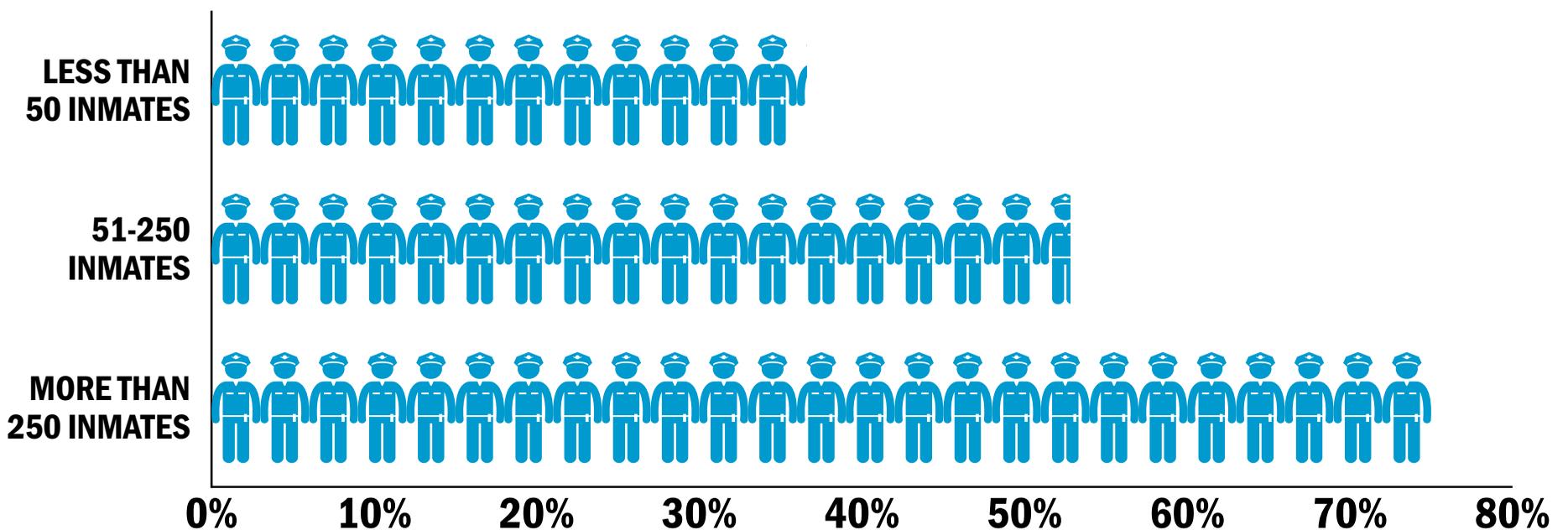
process. We want to make the process efficient and effective, while collecting data and developing outcome measures to accurately understand our efforts. We have already seen some positive results, but we want the data to show it and to help guide us in our next steps.

What are you hoping to do through Stepping Up and beyond?

The end goal is really to have a well-operating system that is able to effectively identify people with mental illnesses who come into the jail and have options available to ensure that only the people who need to be in the jail are detained there and those who don’t can be connected to services in the community. We are currently working to bring in additional stakeholders to help meet this need.

We would also like to minimize the time that individuals spend in our jail pretrial, and provide them with the services they need to ensure that they are better connected to the community once they leave. We want to effectively use our resources for the individuals who need them most. We know that this process is going to take some time, but we are willing to put in the time to do it right.

PERCENTAGE OF JAILS CHANGING STAFF OR SIZE TO ACCOMMODATE SERIOUSLY MENTALLY ILL INMATES



Source: *Individuals with Serious Mental Illnesses in County Jails: A Survey of Jail Staff’s Perspectives – TAC 2016*
www.treatmentadvocacycenter.org/storage/documents/jail-survey-report-2016.pdf

IN OUR VIEW

Large Urban Counties Should ‘Step Up’

**By Commissioner
Maggie Hart Stebbins
Bernalillo County, N.M.**

For large, urban counties across the United States, the responsibility for running local jails often represents our biggest expense and most challenging operational issue. As we honor our promise to keep our communities safe, and to stay within budget, local governments are working to develop strategies that detain individuals who present a danger to our communities while finding alternatives for individuals who are at low risk of re-offending and who can be safely supervised outside jail walls.

Despite the enormous human and financial costs of unnecessary incarceration, counties have struggled to undertake the hard work of adopting effective alternatives for individuals with mental illness and substance use disorders in our jails. Fortunately, county governments now benefit from the resources and moral support of the Stepping Up initiative.

Bernalillo County, N.M., is a perfect example. Four years ago, our county government was facing a crisis. The Bernalillo County Metropolitan Detention Center was severely overcrowded, holding more than 2,800 inmates in a facility built for 1,950. At least half the inmates suffered from diagnosed mental illnesses or substance use disorders, making our jail the largest behavioral health pro-

vider in the state.

Jail expenses consumed nearly 50 percent of our general fund budget and the facility was operating under a 20-year-old federal class action lawsuit that was costing taxpayers more than \$1 million every year in legal fees alone. In 2013, a federal judge ordered the county to transfer inmates to other facilities, at the staggering cost of \$36,000 per day. Facing an annual cost of more than \$10 million to comply with the federal court order, Bernalillo County leaders accelerated efforts to address our jail's overcrowding issues.

In our work, NACo was a valuable ally, most importantly showing us that we were not alone in our challenges and connecting us to ideas and resources to guide our reform strategies.

Our reform started with data-driven decision making. County public safety staff worked with local judges, law enforcement, statisticians from the University of New Mexico, the district attorney, public defender and other partners in the criminal justice system to conduct an intensive analysis of our jail population: who was in our jail, what brought them there and how long did they stay in our facility? After analyzing the data, more than 20 separate initiatives were identified to speed up the criminal justice process for pretrial inmates who were waiting for their cases to be adjudicated.

At the same time, tragic encounters between the Albuquerque Police Depart-



Commissioner Maggie Hart Stebbins

ment and individuals with mental illnesses helped build public awareness of the need to provide more comprehensive, appropriate services for our residents who are living with behavioral health disorders.

In November 2014, the Bernalillo County Commission asked voters if they supported a new tax dedicated to expanding behavioral health services in our community. Almost 70 percent of voters said yes, making available nearly \$20 million in new funding for mental health and substance use disorder intervention, treatment and prevention services.

Among the most exciting projects to receive the new funding is an inmate re-entry resource center — a supportive release center that will connect individuals leaving jail with services such as transportation, health care, food and housing assistance. We are optimistic that help-

ing people stay healthy and out of the criminal justice system will save money in the long run.

Jail reform takes leadership and considerable courage. NACo and its partners have shown both in launching the Stepping Up initiative, and we have surely benefited from their willingness to tackle the issue head-on.

In May 2015, all five Bernalillo County Commissioners voted unanimously to adopt a resolution in support of Stepping Up, a decision that gave us access to the resources, support, research and strategies outlined in the initiative. With that action, we were instantly part of a close-knit team of individuals and organizations who are bonded together in our commitment to share information and find solutions.

Working with Stepping Up, we've accelerated the development and implementation of our local initiatives by taking advantage of technical assistance, conferences, webinars and focused communications with other local governments — and have shared our stories of successes and of setbacks and continuing challenges with others.

While we still have a lot of work ahead of us, Bernalillo County has made great strides in addressing our jail population concerns and we are grateful for the opportunities to work with NACo and other counties in finding solutions to this complex challenge. 

Stepping Up joins 100 Brilliant Ideas

Counties play an essential role in keeping America's communities healthy, vibrant and safe. With public and private sector partners, we pursue innovative approaches to advance public health and well-being, protect public safety and foster economic strength and resiliency.

Reducing the number of county residents with mental illnesses in our jails helps achieve all of these aims. This issue is a drain on our counties' resources, is a burden to our law enforcement and does nothing to improve public safety or the lives of individuals with mental illnesses, their families or our communities.

That is why I am working with NACo leadership to promote my presidential ini-

tiative, the "Counties Matter Challenge: Brilliant Ideas at Work." Through the initiative, we are working to identify and share 100 examples of visionary county leadership that results in improving residents' quality of life.

The plan is to build an online honor roll that highlights county innovation at its best. Every day, counties anticipate and adapt to challenges by thinking outside the box and demonstrating local leadership that makes a difference in people's lives. Though no two of America's 3,069 counties are alike, many face similar challenges and learn from one another's experiences.

Reducing the number of people with

mental illnesses in county jails is a high priority for NACo members and their residents. I hope that some of the 100 Brilliant Ideas will highlight the creative work of counties across this country to address this problem across policy, practice and funding. This is not a new problem, but we do need new solutions. Through my presidential initiative, and in partnership with Stepping Up, we are providing counties with new ideas to create sustainable and effective solutions to a crisis plaguing our counties. We are excited to share what we've found. Look for these examples to be revealed at NACo's Annual Conference in July in Franklin County, Ohio. 



Commissioner Bryan Desloge

Dutchess County, N.Y. opens 24/7 walk-in mental, substance abuse health center

By **Mary Ann Barton**
senior staff writer

The Dutchess County Stabilization Center, designed to keep people with mental health or drug problems out of jails or emergency rooms, opened earlier this year in Poughkeepsie, N.Y. In its first six weeks, the center saw 175 clients. Most of the people treated there are in significant emotional distress but not an imminent danger of harm to themselves or others, the county said.

The center serves as an initial entry into detox and other substance abuse services, as well as other behavioral health services.

The \$5.6 million center is part of the county's behavioral and community health department's mental health division. The county partnered on the center with MidHudson Regional Hospital, Mid-Hudson Addiction Recovery Centers, Astor Services for Children & Families and People Inc., the county's non-profit human services agency. State funding also was used to get the center launched.

"This Stabilization Center is the result of a unique public-private collaboration, and we thank our community partners for their cooperation in bringing this life-saving facility to fruition," said Dutchess County Executive Marcus J. Molinaro.

"This facility is a model for New York and the nation, one that can be replicated throughout America as we improve the lives of our neighbors living with mental health and substance abuse issues," Molinaro said.

The center was dedicated to former longtime County Commissioner of Mental Hygiene, Dr. Kenneth M. Glatt, who was the driving force behind the creation of a Mobile Crisis Intervention Team. He retired in 2015 after 35 years in the job.

How It Works

A resident in distress can get to the center several ways. If they call or text the county's 24/7 crisis helpline, a crisis intervention team can be dispatched, responding immediately to individuals in crisis to help avoid an ER visit or an arrest. The center is also accessible by Dutchess County Public Transit bus service and people often come in either alone or with family members or friends. Law enforce-

ment officers have also been trained to bring people there to avoid a trip to the ER or jail especially when responding to calls of intoxication, domestic conflicts or altered mental status.

Some of the services made available at the center include:

- Crisis counseling.
- Mental health assessments.
- Supervised outpatient withdrawal services.
- Addictions and substance abuse counseling.
- Peer advocacy and support.
- Help contacting community-based resources.

The crisis intervention team also helps people over the phone, assisting with prescriptions, counseling and even attending court arraignments to help divert an individual into mental health treatment services rather than being incarcerated.

Tracking How the Center Is Used

Dutchess County tracks the use of the center using an electronic medical record system, which was set up by the county's Office of Central and Information Services. The county tracks several data points including age, gender, arrival time, length of stay, disposition, number of individuals being brought to the center by police as well as other referral sources. The county is monitoring the number of individuals who are substance abusers vs. those with mental health needs. The county also tracks the number of referrals it makes for ongoing services once the person leaves the center as well as repeat visits.

Financial Considerations

Services at the center are Medicaid billable; however, no one is turned away based on an inability to pay. "Because this is a new service, we are working with insurance companies to include the services at the center in their benefit packages," the county noted.

Dutchess County Department of Behavioral and Community Health has county staffing and operational costs associated with the center included in its budget. The county also has several community partners who also provide staffing at the center, including MidHudson Regional Hospital, part of the Westchester Medical Center network, which provides



Dutchess County Executive Marcus Molinaro speaks at opening of Stabilization Center.

Photo courtesy of Dutchess County, N.Y.

four full-time nursing staff at the Center at their cost. The goal of the center is to be self-sustaining through billable services as well as continued community partnership agreements for staffing and services.

Follow-up Care

People who visit the center can stay for up to 23 hours and will receive follow-up care from staff after they leave. "We create follow-up plans that meet the guest's stated needs," the county said.

"If a referral to the adult partial hospitalization program is indicated, we can make a next-day connection; the same is true for the adolescent partial hospitalization program."

Referrals and connections are made to a variety of services such as intensive or outpatient substance abuse services, rehab programs, children's services, public and private providers in the community and care management. "We do

follow-up calls to ensure that after-care appointments are kept and assist with rescheduling them when indicated," the county said.

Bringing It All Together Like No One Else

The establishment of the Stabilization Center is part of the county's ongoing efforts to drive down the rate of recidivism and to intervene and divert individuals in crisis from hospital emergency rooms and jails.

There has been a great deal of interest in the county's Stabilization Center since it opened, from other communities, and the county has already had visits from representatives of the New York City Division of Mental Hygiene and the Bureau of Mental Health.

After visiting several other communities, they noted that Dutchess County "has created the foundation to bring it all together like no one else has." 

ABOUT THE CENTER

Construction of the center started in early 2016, after a \$4.8 million bond resolution was adopted by the Dutchess County Legislature. "Dutchess County is leading New York State with our approach to addressing mental health issues," said Dutchess County Legislature Chairman Dale Borchert. "The County Legislature was proud to support the funding for this innovative center and are proud of the work being done there by our dedicated employees as well as our community partners. The Stabilization Center is going to make a positive difference in the lives of many people."

In addition to providing four full-time nursing staff at the center, MidHudson Regional Hospital has also provided more than \$100,000 in financial support.

The center is housed with the Dutchess County Department of Behavioral & Community Health mental health division offices, as well as the County's 24/7 helpline and Mobile Crisis Intervention Team.

Community health survey kick-starts rural mental health treatment options

By **Charlie Ban**
senior staff writer

Late at night, the only thing open in Appanoose County, Iowa was the Hy-Vee grocery store. Not much else, and certainly not a 24-hour facility where people with mental illness could go for help. For that matter, they didn't even have that during daylight hours.

Instead, they would have to go to the hospital or jail, or on a long ride out of town with a deputy to find an open psychiatric bed somewhere, maybe as far away as South Dakota. There was nowhere else to go. In a rural county of roughly 12,000 people, it was hard to expect more.

"Nobody was getting any mental health care," said Jackie Sharp, a clinical therapist and executive director of Centerville Community Betterment — Centerville is the Appanoose County seat. "We were spending all of this money transporting people four hours away to facilities, only to find out they were being discharged within 24 to 48 hours back to their home community without any treatment."

But these people weren't as far out of mind as it would seem. The results of the local hospital's Community Health Needs Assessment — mandated by the Patient Protection and Affordable Care Act — revealed that Appanoose County residents prioritized what the county didn't have — mental health care options. In the nearly four years since, therapists are available to emergency room doctors around the clock and five beds are available at a short-term crisis stabilization house in the middle of town, one that has become a model for the state.

"It was a big wakeup call for the county," said Diane Buss, the central point coordinator for mental health in Appanoose County who started in that position soon after the needs assessment. "We knew there was a need but we couldn't put our finger on it."

Digging Out

But the signs were there. Four-month waits to see a psychiatrist who had to travel up from Kansas City once a month, for a week at a time. Days during which a sheriff's deputy would

have to accompany a patient who was sitting around all day waiting to be committed for treatment, then the 77 times deputies had to drive patients elsewhere for treatment in 2012 and 2013.

"We don't have a lot of deputies in town, but one of them had to spend all day with a patient while they waited to be treated," Sharp said. "Usually, they were just sitting around the emergency room, waiting. It meant a lot of overtime costs for the sheriff's office."

In that same two-year span, 144 out of 180 Appanoose County residents committed to inpatient facilities for mental health or substance abuse issues ended up not needing that level of care. It all totaled roughly \$1.2 million per year, and that wasn't even paying for top-of-the-line care that was appropriate for patients' needs.

"Everyone thought like there wasn't anything we could do, and the hospitals were frustrated for many years, law enforcement was frustrated for many years," Sharp said. "We all complained about what we don't have — we don't have a psychiatrist, we don't have this and we don't have that and we don't have these therapists, we had all these reasons why we weren't going to be able to do anything in this rural county."

The mounting costs and the needs assessment results prompted the formation of a mental health coalition, which included Buss, Sharp, Sheriff Gary Anderson, Ann Young of Mercy Medical Center-Centerville Medical Center — the local 25-bed hospital — and Dewey McConville, president of the South Central Iowa chapter of the National Alliance on Mental Illness. The goal: reduce the number of commitments by 80 percent — the proportion of patients who had been improperly committed.

Eighty percent was a little short of the 85 percent average proportion of commitments for mental health issues in rural counties statewide compared to the 15 percent Polk County — Des Moines — committed, according to a nonprofit that the coalition consulted. The rural-urban mismatch was striking to Buss and Sharp, who betted there was a way to cut down Appanoose's



Deb King (right) attends to an Oak Place patient in Appanoose County, Iowa. Photo by Anne Howe

emphasis on inpatient care.

"We went to Des Moines (and talked to mental health workers there) and they told us that the majority of the people that rural counties sent there could be treated in our community with our resources," Sharp said. "They told us to design our program to what we have and what we can do."

Helping the Helpers

The first step was getting trained mental health therapists in the emergency room to help doctors properly diagnose mental illnesses and direct patients to the right treatment. Sharp initially filled in, on-call 24 hours a day, until Buss recruited more therapists to help out. She invited every one she knew working in Appanoose County to lunch.

Four therapists are now available to perform on-call evaluations, find permanent supportive housing options and locate open inpatient facility beds if a patient's diagnosis calls for it.

"Therapists work in their own little box," Buss said. "You know (which patients) you work with but there wasn't a community of therapists here. I got them together for lunch, I dangled the carrot, and I said 'there's money available...this is what we're looking for.'"

Finding locally-based therapists was helpful not just logistically, but made the emergency room less chaotic when

residents with mental illness came in.

"A lot of our emergency room doctors aren't local and they don't know the mental health community," Buss said. "The therapists, on the other hand, really get to know the people, especially those with chronic illnesses, so they know their backgrounds and their issues. For a long time, there wasn't much follow-up so people would just wind up back in the emergency room again. The therapists add a comprehensive level of care."

Sharp said the community at large is recognizing the value in mental health treatment options.

"They know there were major gaps in treatment," she said. "They're going beyond just being afraid of 'crazy people' and they're actually supporting actions to get help for people with mental health difficulties."

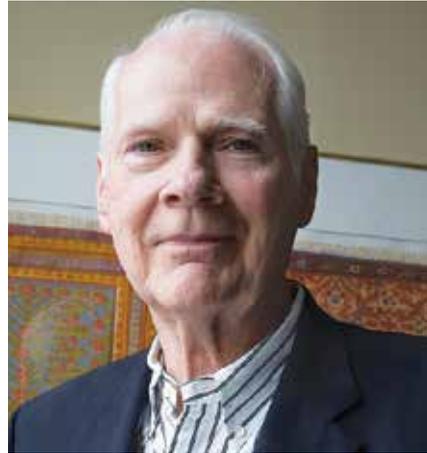
Their 80 percent reduction goal? They blew right by it, some months cutting 90 percent from the pre-2014 average commitments. But that still left a remaining population that needed more.

Safe at Home

If a patient does need more than a hospital therapist or out-patient treatment provider can offer, there is now an option in Appanoose County.

Pilot project from NACo affiliate aims to stop incarcerations before they happen

By Ron Manderscheid, PhD
 executive director
 NACBHDD



Ron Manderscheid, PhD

In concert with the *NACo Stepping Up Initiative*, the National Association of County Behavioral Health and Developmental Disability Directors (NACBHDD) has been implementing its NACBHDD ‘Decarceration’ Initiative.

Our first year of this initiative has included focus groups, webinars and direct technical assistance with counties. This work has taught us that we must focus our efforts on “Intercept 0”. This first intercept involves mobilization of county behavioral health programs to address mental health, substance use and intellectual development/developmental disability (ID/DD) issues before a person comes into contact with the police.

NACBHDD Pilot Project

Thus, we are very pleased to announce a special pilot project in 2017 to promote the decarceration and full community integration of persons with these conditions.

This pilot project will examine system and service management, care coordination, service configuration, including crisis response services and county drug formularies, as well as any impediments that exist in the correctional or court systems.

A primary emphasis will be directed toward improving the crisis response capacity of county behavioral health programs to prevent persons with these conditions from becoming engaged or re-engaged with the police or the correctional system.

A range of services comprise a county’s behavioral health crisis response ca-

capacity. These services include so-called ‘warm lines’ operated by peers, hot lines operated by professionals, mobile crisis response teams, respite beds for persons with these conditions or their family members, crisis intervention training for police, a restoration or sobering center, effective care coordination for all clients, good outpatient treatment, medication-assisted treatment, community residential care and inpatient hospital care.

Our pilot project will help participating counties to develop the services they need from along this continuum.

The pilot project will identify four medium-sized counties (20,000–200,000 population) and four small, rural counties (fewer than 20,000 population) to participate in the pilot. Counties will be given preference if they are part of the NACo Stepping Up Initiative, if they have identified incarceration as a problem, are motivated to address this problem, and are willing to devote personnel and financial resources to solving it. Participating counties should expect to remain

involved in this pilot for up to one year.

For each of the eight counties in the pilot, we also will seek to identify a mentor county that can provide guidance on solving the common problems that lead to excessive incarceration of persons with mental illness, substance use or ID/DD conditions. Mentor counties will work directly with the eight counties participating in the pilot project.

A cadre of senior county behavioral health leaders will offer direct technical assistance to counties participating in the pilot project.

These county behavioral health leaders will form the first cadre of NACo Senior Fellows, a new initiative to deploy the skills of county behavioral health experts when they retire from their county roles. Linkages also will be developed with appropriate federal programs to help counties address issues that require expertise or technical assistance from these programs.

New Related Activities

Beyond the pilot project, NACBHDD has also been engaged in a range of additional activities in support of its initiative. These include:

■ **Development of Simulation Models:** In collaboration with the Department of Justice (DOJ) Bureau of Justice Statistics (BJS) and Bureau of Justice Assistance (BJA), and the National Association of State Mental Health Program Directors (NASMHPD) Research Institute, we have undertaken a project to develop simulation models to project future jail caseloads, including estimates for persons with behavioral health conditions.

Currently, we are identifying pilot sites for this modeling.

Simulation modeling can be very useful to county managers because it permits assessment of the effects of “what if” scenarios before they actually occur.

■ **Collaboration Across Federal Agencies:** In the fall of 2016, NACBHDD and DOJ-BJS convened the key federal programs in the Department of Health and Human Services and the DOJ that work at the behavioral health-criminal justice interface. The purpose was to acquaint staff with each other and to share essential information about each program. This initial meeting was so successful that a second meeting is being planned for late in the spring this year. This second meeting will introduce discussion of some key issues and solicit agency support in their resolution.

■ **New Research Center on Criminal Justice:** As a long-standing NACBHDD partner, the NASMHPD Research Institute has developed a strong interest in the problem of decarceration of persons with behavioral health conditions.

In 2016, the Institute’s Board approved the creation of a new research center on criminal justice that will undertake research, evaluation, and statistical projects to help resolve the problem of incarceration of behavioral health populations in city and county jails, and in state prisons. This new center will work closely with NACBHDD. 

If your county is interested in participating in NACBHDD’s pilot project, please contact rmanderscheid@nacbhd.org or call 202.942.4296

1 IN 5 ADULTS IN THE U.S. EXPERIENCE A MENTAL ILLNESS



DID NOT RECEIVE TREATMENT in the past year

1 IN 25 ADULTS IN THE U.S. EXPERIENCE A SERIOUS MENTAL ILLNESS



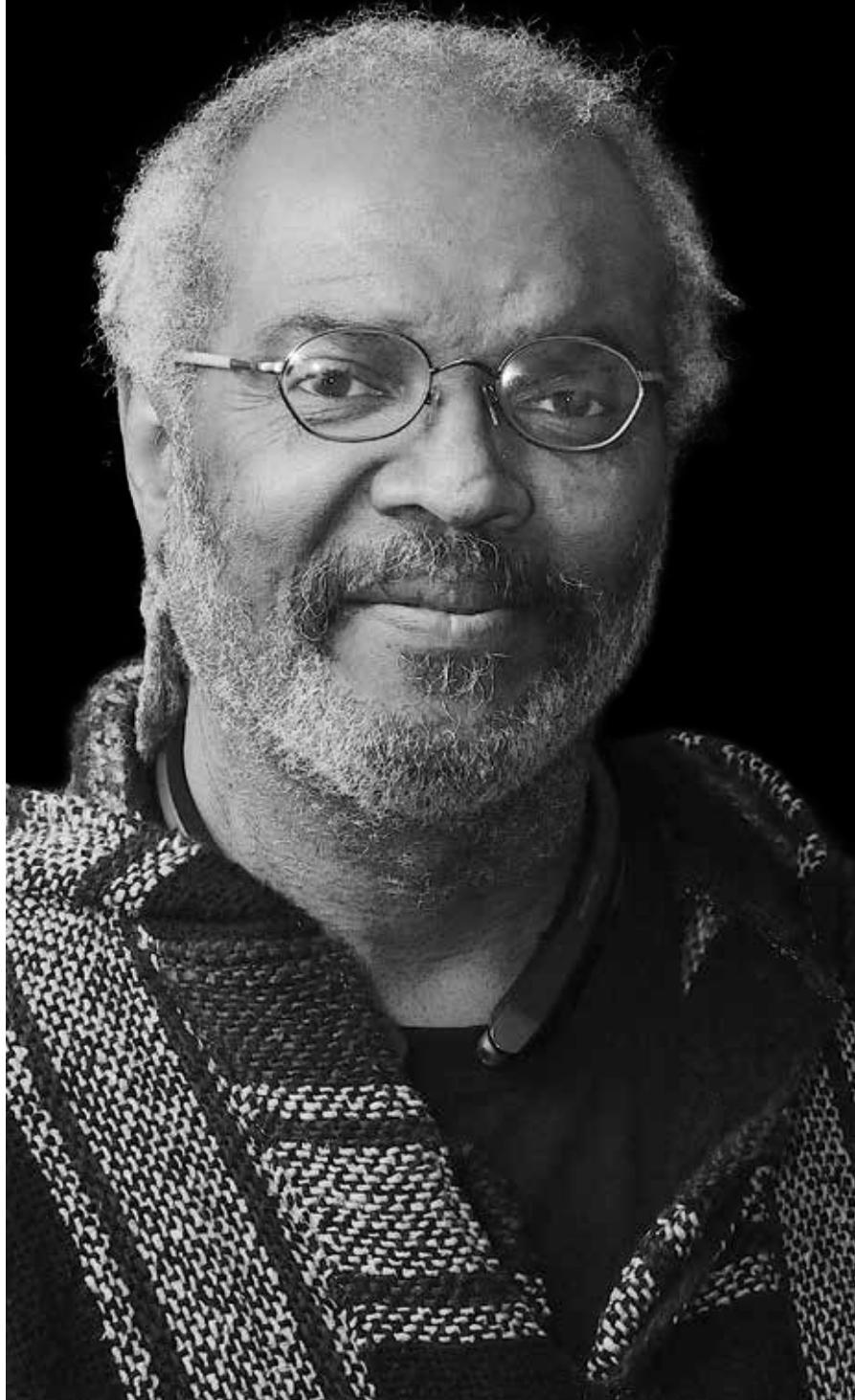
DID NOT RECEIVE TREATMENT in the past year

1 IN 10 ADULTS IN THE U.S. EXPERIENCE A SUBSTANCE ABUSE DISORDER



DID NOT RECEIVE TREATMENT in the past year

THERE'S ONLY ONE WAY TO TREAT A PERSON WITH A MENTAL ILLNESS... LIKE A PERSON



By Ray Lay

I was first diagnosed with paranoid schizophrenia at the age of 15 after I committed some terrible anti-social acts and was committed to a state-run mental institution. I stayed there for three years. My doctor and my parents didn't ever tell me what I was diagnosed with. I didn't know why I was being made to take all that medication.

When I was released, I joined the Marine Corps. I was a good Marine until I had a psychotic break. I was discharged from the Marines without treatment and I started self-medicating. The drugs and alcohol led me to an eventual charge for robbery and confinement. I was sentenced to state prison for seven years. The closest thing I got to treatment while in prison was when the guards would gang up on me, put me in shackles and beat me.

We are still human beings. We just have an illness, like a person with cancer, diabetes, Crohn's disease, or a brain tumor, except those are treated in different ways.

I left prison in 1986, and I've stayed away from the criminal justice system since then, but I did have some run-ins with drugs and alcohol. And I never sought treatment, because I didn't think anything was wrong with me. I thought everyone heard voices. I didn't understand that I was experiencing delusions.

Ultimately, I got treatment because I wanted to be housed. With all my drug abuse and alcoholism, I was homeless for 10 years. I started going through the changes of trying to get clean and sober, but not addressing the mental health issues. When I went to the VA hospital, I was told that to get mental health treatment, I needed to be clean. But I wasn't strong enough to be clean. When I finally got into treatment, the doctor diagnosed me with schizophrenia, and I filed for Social Security.

The social worker at my homeless shelter filed for a service-related disability claim for schizophrenia. The VA denied my claim, but Social Security approved me. I took the Social Security paperwork to the VA and wrote "The Marine Corps made me worse" on the back and appealed. This year, after 13 years, I finally got an answer — the VA accepted my claim.

After my first appeal, I got to look at my service medical records. I saw that I had two psychotic breaks in the service. The Corpsman wrote down everything that he saw and heard those day — how I was talking to people who weren't there and how I was saying things that didn't make sense. How I was beaten during one of the episodes. When I read those records, I realized that was where I got these other voices that I hear. That's when I stopped drinking and doing drugs

and decided to get treatment to stop the voices.

The voices don't go away, but I accept my condition. I know that treatment could have helped me much earlier. I will be taking medication and going to therapy for the rest of my life. I have been with the same doctor for 10 years and the same therapist for nine years. I exercise, watch what I eat and give back.

Today, I'm a peer support specialist, and I engage people who have mental health or substance abuse issues, and try to motivate them to get into recovery and stay in recovery. Where I used to be homeless, I now help house people. Being a peer support specialist is better than any drug I ever had in my life.

I am a member of our VA Medical Center's Mental Health Intensive Case Management team. Many of the vets that I work with remind me of myself. I used to reject medication. I used to be in total denial of my condition. One thing that I do is utilize the one-page diagnostic sheets from the National Alliance on Mental Illness website, and take them to the veterans. I say, "Be honest with yourself, do you see yourself on this paper? You don't have to say anything to me, but be honest with yourself." Most of them see their symptoms.

I also get their attention by telling my story. I tell them I used to be a raging drunk and drug addict, and I used to be locked up on the inpatient unit. A lot of people who are self-medicating want to stop, but they don't know how. I give them hope and an example. I tell them I haven't been on the inpatient unit for 13

See PEER SUPPORT page H13

WHAT ABOUT DATA?

By **Nastassia Walsh**
program manager

While this Hot Topics contains much information about the issues related to individuals with mental illnesses in jails, one important piece is missing: the current number of people with mental illnesses in county jails across the country. Is the number getting smaller? Is it getting bigger? The answer is this: On a national level, we just don't know.

National Data... Or Lack Thereof

The most recent national data from the Department of Justice indicate that 64 percent of the jail population has a mental health problem. These data are based on personal interviews with 6,982 local jail inmates in 2002 — 15 years ago — where mental health problems were defined by a recent history or any symptoms of a mental health problem that occurred within the 12 months prior to the interview. This national number is used widely, but does not reliably measure the number of individuals in jail who have been diagnosed as having a mental illness by a health professional such as a psychiatrist.

The federal government recognizes the intersection of incarceration and health and has an interest in better understanding the social determinants of health. While the Justice Department does not systematically collect health

data in inmate surveys or conduct annual surveys of inmates, many national health surveys are conducted with regular frequency. In March of 2016, the Department of Health and Human Services convened a steering committee on improving the collection of data on justice-system involvement in population health-data programs.

The major challenge in attempting to include justice-system involvement questions in health surveys is developing a consistent definition of such involvement. For example, in the annual National Survey of Drug Use and Health, criminal justice involvement is defined to include an arrest and booking at any time, but does not distinguish between individuals who were released shortly after booking — sometimes within a few hours — and individuals who were detained for longer periods of time and make up the population of individuals in a jail. Additionally, because the survey asks whether the respondent was ever arrested and booked, it does not reliably provide information on the most recent profile of the jail population.

Outside of the federal government, several academic studies have been completed to try to better understand the scope of the problem with various definitions and groups. One study from 2007 found that over two-thirds of individuals in jails met criteria for a lifetime psychiatric disorder. Another from 2009 estimated that the rate of serious mental illness (SMI) was 14.5 percent for males in jail and 31 percent for females. While these studies can give a

more reliable estimate, they also are from several years ago and use various definitions of mental illness, making it difficult to extrapolate to today's general population or to identify national trends.

As a result of the lack of national data, we often rely on other measures for identifying trends in the national jail population. For example, the Treatment Advocacy Center (TAC) conducts regular surveys of key stakeholders to help nail down some of the challenges.

In a 2011 survey of 230 sheriffs' departments that operated jail facilities or detention centers in 39 states, three quarters of jails reported seeing more or far more numbers of seriously mentally ill inmates, compared to five to 10 years ago. This was particularly true in medium and large jails. More than half of the jails responding to TAC's survey had imple-

mented housing or staffing changes as a result of supervising seriously mentally ill inmates. This trend was more pronounced in larger jails, where 86 percent had made changes due to the prevalence of serious mental illnesses in the population.

What About Local Data?

One of the biggest challenges counties face when trying to develop or enhance a plan to reduce the number of people with mental illnesses in their jails is collecting, sharing and using data. Counties can use and share data on individuals who enter jail to effectively respond to a person's needs. For planning and budgeting purposes, the effective use of data can help counties to understand who is in their jail and trends in the jail population, identify

See **DATA** page H11

MAKING PROGRESS IN DATA COLLECTION

■ The Familiar Faces initiative in **King County, Wash.**, is a systems coordination effort for individuals who are frequently in jail and who also have a mental illness and/or substance use disorder. As part of this initiative, three distinct King County departments, the City of Seattle and other housing and social service partners broke down their traditional data silos to share information and performed a data-matching exercise to create a more comprehensive picture of the individuals they were trying to serve with the initiative.

An initial data-matching effort demonstrated that 94 percent of individuals in the King County jail had a mental illness or substance use disorder. The initiative partners are currently working on a cross-sector data integration project that will allow the integration of various disparate data systems, including behavioral health, housing and some criminal justice information. The integrated data system will allow for the following functions: enabling individual client "lookup" for direct care coordination, identifying high risk groups for system-level care coordination and extracting datasets for analysis of population health, program evaluation and costs.

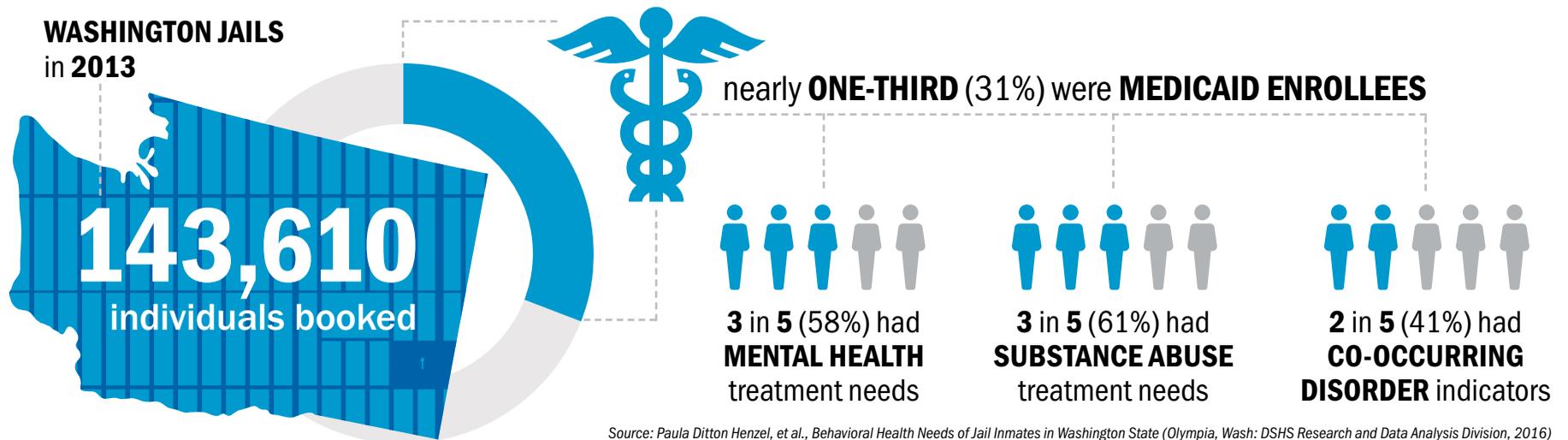
■ **Louisville-Jefferson County Metro, Ky.**, developed a cadre of com-

munity partners to share information and pursue innovative solutions to identify, coordinate and deliver care to individuals who frequently use public services. This collaboration, known as the Dual Diagnosis Cross Functional Team (DDCFT), is composed of government agencies, behavioral health professionals and community organizations serving people with mental illnesses and substance use disorders.

Knowing the service delivery system they were using was fragmented, the DDCFT proposed the creation of a new Community Care Management Network (CCMN) to coordinate care for these individuals using the existing Homeless Management Information System (HMIS) as the technology platform for cross-agency intervention. Many of the involved service providers already had HMIS licenses, making it a logical choice, and 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 a data-sharing agreement. Based this agreement, the names of the top 100 people with eight or more episodes of incarceration are cross-referenced with emergency room data to identify individuals with 10 or





From DATA page H10

potential policy or practice changes and track progress of their reform efforts.

Counties face several challenges when trying to accurately collect and share this data:

- **Lack of a system-wide definition of mental illness.** Each state has its own definition of mental illness that is used to determine eligibility for state-funded treatment and services, and in many counties—but not all—the county health

department uses this definition to determine service-delivery options. Health providers in the jail may use their own definition or use a definition based on screening tools used to identify a mental illness. Without one agreed-upon definition, it can be difficult for counties to accurately identify and share information on the mental health needs of individuals who come into the jail.

- **Inability to identify individuals with mental illnesses and collect and store information.** While mental health

screening and assessment tools are becoming more prevalent, many counties still do not have a system in place to objectively identify a person with a mental illness or substance use disorder in their jail. Screening and assessment processes vary from county to county, with some using validated mental health screening tools and others relying on other indicators of mental illness such as medication or suicidal tendencies.

The way that counties collect and store information gleaned from these tools also

varies. Some counties have sophisticated electronic jail management systems in place to help collect and store—and sometimes share—information about the individuals in their jail, including their mental health status. Other counties do not have access to this type of tool and struggle with how to collect information in a way that can be easily accessed, analyzed or shared. Even when systems are in place, they do not always have the capacity to maintain confidential mental health records in compliance with HIPAA.

- **No mechanisms for information sharing.** Many counties struggle with developing confidential and useful mechanisms for sharing information about the individuals they supervise in jails or serve in the community. Concerns over HIPAA regulations and privacy often stall attempts to share information between different agencies. Nonintegrated electronic systems and the lack of common definitions also do not help these ef-

See DATA page H13

more admissions.

These individuals are then asked to sign a release of information that authorizes the disclosure of records to 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 then designated to oversee service delivery and development of a coordinated care plan for addressing the specific needs of the individual.

- In **Coconino County, Ariz.**, the Criminal Justice Coordinating Council (CJCC) reached an agreement with the Arizona Criminal Justice Information System (CJIS) to get the criminal history of every person arrested in their county, which the county uses, along with data from the jail, health department, education system and their budgeting department, to initiate research partnerships. The CJCC is working with Northern Arizona University to use the available data to look at the effectiveness of health and behavioral health interventions in the jail.

These data mean that the county will be able to address questions like, “How well does mental health court work?” with the ultimate goal of building a model

for how to most effectively treat and fund the health and behavioral health needs of individuals in the jail.

- In **Athens-Clarke County, Ga.**, Advantage Behavioral Health Systems (“Advantage”), the 10-county regional community behavioral health provider, worked with the Clarke County Sheriff’s Office on a data-matching project for people with mental illnesses in the jail. Staff at Advantage reviewed jail intake data over a three-month period and used names and dates of birth to match individuals to their electronic health record. This allowed them to identify individuals with a mental health diagnosis who were being admitted to the jail.

HIPAA regulations prohibit the community provider from sharing this individual data with the jail, but the jail is free to share names and dates of birth with the provider, putting the onus on the provider to do this analysis.

Advantage found that around 700 individuals in the jail (38 percent of the records reviewed) were their clients, meaning they had some sort of mental health diagnosis. From there, they were able to review the criminal history records of a random sampling of these individuals to better understand when they were being arrested, their average length of stay per arrest and specific charges.

They are using this data to have conversations with law enforcement and probation to identify potential solutions to high arrest rates and high probation revocations for people with mental illnesses in the county and are planning to implement a case management system that can be accessed by the jail to share more of this information.

- **Washington, D.C.**, uses administrative records to identify frequent users of public crisis systems such as emergency departments, homeless shelters and jails. The D.C. Department of Corrections (DOC) and The Community Partnership for the Prevention of Homelessness (TCP), the agency that houses the city’s homeless management information system, have a data-sharing agreement that allows them to identify individuals who meet certain criteria for eligibility in the D.C. Frequent Users Service Enhancement (FUSE) program. Upon receiving a request for potential clients, DOC staff generates a list of individuals who meet the FUSE eligibility criteria and are currently incarcerated in the jail. During the program planning phase and initial six months of program implementation, five administrative searches of frequent users were conducted, which identified 196 eligible men.

RESOURCES

Both the Stepping Up initiative and the Data-Driven Justice initiative, focused on promoting data-driven strategies through peer sharing and discussion, have resources available to help counties jumpstart or enhance their efforts to collect, use and share accurate data on individuals with mental illnesses in their community and their jail. Find out more:

Stepping Up Resources Toolkit

www.StepUpTogether.org/Toolkit

Data-Driven Justice Initiative

www.NACo.org/Data-Driven-Justice

The Federal Outlook

By Commissioner Sally Heyman
Miami-Dade County, Fla.

The passage of the 21st Century Cures Act last December with broad, bipartisan support was a victory for local efforts to reduce mental illness in our jails. The bill included the Mentally Ill Offender Treatment and Crime Reduction Act (MIOT-CRA), which is the main source of federal support and funding for local jail diversion programs, mental health courts, in-jail treatments, transitional services and crisis intervention training. By reauthorizing this important program through FY20, the Cures Act made the goals and objectives of the Stepping Up Initiative more achievable for local governments across the country.

Legislative victories like this are not easy to come by, especially at a time when bipartisan lawmaking in Washington seems increasingly like a relic of the past. The success of the 21st Century



Commissioner Sally Heyman

Cures Act speaks to the breadth of support at all levels of government for reducing mental illness in jails, but the bill's passage would not have been possible without impactful and persistent advocacy from stakeholders including NACo and its county leaders.

Over the last several years, NACo uplift-

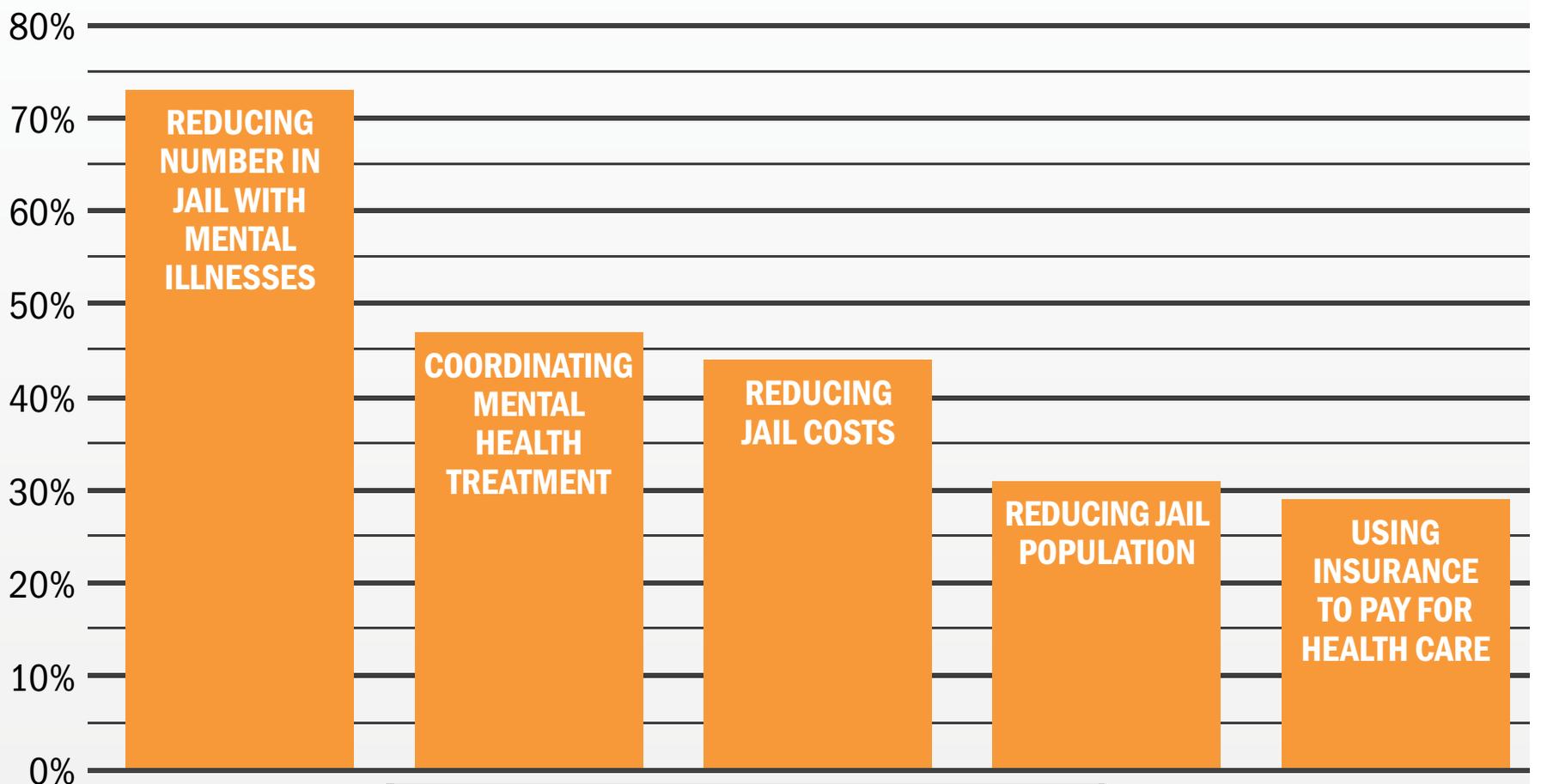
ed the issue to an organizational priority and held numerous briefings in Congress to educate staffers about mental illness in the justice system. County leaders throughout the nation spoke with their senators and House members about the impact of this issue on their local communities. The 21st Century Cures Act is, in part, the fruit of this labor.

However, our work is far from over. Although the reauthorization of MIOTCRA — as well as several other programs that help to address mental health and co-occurring substance abuse issues in the community — is a major victory, Congress must still appropriate funding for these programs through the annual appropriations process. Given the uncertainty that surrounds the budgeting process in Washington, and the wide array of programs that must be funded each year, it is imperative that we continue our persistent advocacy for federal justice and mental health grants.

As lawmakers consider appropriations bills over the next several weeks and months, county leaders should urge their members of Congress or congressional staffers to provide full funding for MIOT-CRA to support local efforts to reduce mental illness in jails. NACo offers numerous resources to aid this advocacy, including a comprehensive policy brief available at www.naco.org/reducementalillness.

The Stepping Up Initiative is a testament to the commitment of county leaders to reducing mental illness in our jails and to driving change on this critical issue from the local level. But we must not lose sight of the fact that our efforts are more effective and impactful with support from the federal government, and we should be persistent in reminding our members of Congress of this fact. 

Heyman chairs the Justice and Public Safety Policy Steering Committee.



TOP 5 CHALLENGES OF COUNTY JAILS
PERCENT OF RESPONDING COUNTIES
MARCH - APRIL 2015

SEQUENTIAL INTERCEPT MODEL



Intercept 1

PRE-BOOKING DIVERSION

Crisis intervention (crisis intervention team, mobile crisis unit, and first responders)



Intercept 2

POST-BOOKING DIVERSION

Arrest (booking, screenings, and arraignments)



Intercept 3

JAIL AND COURT

Identification, assessment, planning, and consultation with attorneys and judges and referrals to specialty courts such as mental health and drug court



Intercept 4

REENTRY

Transition, case management, assertive community treatment, medication management, therapy, coordination



Intercept 5

COMMUNITY CORRECTIONS/ CONTINUED SUPPORTS

Supported employment, wraparound services, stabilization, and self-sufficiency

The Stepping Up program uses the Sequential Intercept Model, which was developed as a way to understand how those with mental illness interact with the criminal justice system. Each intercept addresses where interventions can be made to help prevent people with behavioral disorders from falling through the cracks. The model describes five intercepts where jail diversion can occur.

The Sequential Intercept Model was developed by Mark Munetz, MD, and Patty Griffin, PhD, in collaboration with Henry J. Steadman, PhD

'We are still human beings...'

From PEER SUPPORT page H9

years; I've been clean and sober for 10 years. I learned to tell my story through NAMI's In Our Own Voice program, and everywhere I go, people tell me it's very powerful.

And I'm an ambassador for recovery out in the community. Even though I've had some negative interactions with police, just yesterday I was helping to train new police recruits at the Indiana State Police Academy. I also help train newly hired Department of Corrections officers on mental health issues. I go back into the facility and see where I was once locked up. I can't say I get used to it. There's a lot of work to do. It's sad that the biggest provider of mental health services in Indiana is the Indiana Department of Corrections.

I believe that there's only one way to treat a person with a mental illness –

that's like a person. We are still human beings. We just have an illness, like a person with cancer, diabetes, Crohn's disease, or a brain tumor, except those are treated in different ways. People with mental health and substance abuse issues need a different type of care, but it's still care. It's as old as the Earth is, and it's not going away.

Counties are going broke trying to treat people with mental health issues in jails. I think peer support specialists – people who have that experience of mental health conditions – can help, by bringing the human element. We can work with doctors, lawyers, judges and the justice system to try something different.

Ray Lay is an Indiana certified recovery specialist, and a veteran peer support specialist. He serves on the board of directors for NAMI Indiana and for the Indiana Balance of State Continuum of Care.

Data key to measuring success

From DATA page H11

forts. If two data systems cannot talk to each other, some analyses must be conducted manually, with redacted names and identifying information – the time required to process this information by hand can be prohibitive.

While many counties are making progress on using data to identify individuals with mental illness in their justice systems, not all counties are at a place where they can perform these functions. Many are without some of the tools they need to create compre-

hensive, data-driven and systems-level plans to reduce mental illness in their jails, or to be competitive for state and federal grant opportunities to help further their work in this area.

Despite progress in individual jurisdictions, there still isn't an answer to the question on everyone's minds: Are all activities and efforts happening at the county, state and federal levels having the desired impact of reducing the number of people with mental illnesses in jails? Leadership on and investment in the use of data is absolutely critical to answering this important question.

People with mental illness now have a place to go in Appanoose County, Iowa

From HOUSE page H7

In 2014, Centerville Community Betterment, a nonprofit social services agency, opened Oak Place, a five-bed crisis stabilization center inside a ranch house. A \$50,000 grant from Appanoose County funded the starting costs until the South Central Behavioral Health Region – the state's mental health funding mechanism for Appanoose, Davis, Wapello and Mahaska counties – stepped in to fully fund the house and pay for Sharp to work as the house's therapist.

What wasn't spent on rent went to furnishing the house and buying things visitors would need, including hygienic

supplies. A subsequent \$221,000 grant from Catholic Health Initiatives helped with funding before the region's funding kicked in.

It became a safe place for people in the middle of mental health crises to stay for up to seven days, during which time they can be under the care of therapists and have help managing medication and figuring out their next step. Oak Place does not accept commitments, and all patients are free to leave.

"They write their own care plan, their own emergency plan before they're discharged," Sharp said. "We thought it might not work in the beginning, but we've found that if they have the ability to self-determine their outcomes and

make decisions about the plan, they do a lot better and are a lot motivated than if they're court ordered."

The crisis-stabilization house model debuted in Appanoose County is now required in each of Iowa's 15 behavioral health regions, and 11 others have opened so far.

Sharp has been proactive about paving the way for a smooth introduction into the neighborhood for Oak Place.

"We knew there would be some concerns, but keeping lines of communication open and letting the neighbors know you're open to feedback helps build the neighborhood relationship."

Oak Place is open to residents of the region's three other counties. The coal-

ition has added a four-bedroom transitional housing apartment in Davis County to which Oak Place residents can move.

"It's a place people in a mental health crisis can go and get the help they need, any time of day," Buss said. "It's a long way from where we started, and we're showing that being in a rural area doesn't mean not having options."

Sheriff Gary Anderson agreed that the new mental health options have eased the burden on his deputies.

"We get some (emergency) calls and all they need is someone to sit down with them and give them some of the services (we now offer) and not tie up the services they don't need from an emergency committal," he said.

The Doctor Is In:

The role of psychiatrists in the Stepping Up Initiative

By **Charlie Ban**
senior staff writer

Dr. Altha Stewart sees the Stepping Up Initiative not only as a way for counties to improve the treatment of the mentally ill, but as a challenge to the psychiatric community to generate solutions. She discussed that and other topics with *County News* a year after she spoke at the 2016 Stepping Up summit in Washington, D.C.

Stewart is on the faculty at the University of Tennessee Health Science Center department of psychiatry and serves as the university's chief of social and community psychiatry and director of the Center for Justice Involved Youth. She is president-elect of the American Psychiatric Association. Previously, she led Defending Childhood Shelby County (Tenn.), an initiative that developed supports and services for children with mental illness and their families, defragmenting the social service system to ease families' navigation.

Her answers have been condensed. See a video at www.countynews.org.

In your opinion, why are so many people with mental illnesses involved in the justice system?

It's the default mental health treatment system now; that's where the money is.

People with mental illness tend to have behaviors or do things or create situations that bring them to the attention of law enforcement.

While the law enforcement may understand or even recognize that they have a mental health problem, there are so few places where these folks can be taken and treated that the default system becomes the law and legal system.

We have such a limited number of resources in our community that if you've been through a couple of times and you've got a reputation as being difficult,



Dr. Altha Stewart Photo by Allen Gillespie, University of Tennessee Health Science Center

aggressive, assaultive, non-adherent, after a few times, people kind of give up on you, which puts you back on the streets.

What do you see as the role of psychiatrists in helping counties to reduce the number of people with mental illnesses in jails?

Psychiatrists can be much more involved in the community level. We don't have enough resources in the community to do all of these specialized areas, so we have to get creative.

In Shelby County, Tenn., we have a few things, thanks to some long-term planning: crisis intervention teams; thanks to a very proactive county mayor, we have a mental health court that addresses issues at the front door.

How do you think counties can incentivize psychiatrists to work with the justice-involved population, many of whom are often indigent or under-insured?

People are coming out of medical school and residency with hundreds of thousands of dollars in debt. Counties have to get really creative, with loan re-

payment being part of the comprehensive recruitment process.

For rural counties and smaller jurisdictions, this is a possibility that hasn't been fully explored.

It's doable, because counties are going to pay for this service anyway, importing some temporary, very expensive staff. How much does it really cost to pay a psychiatrist a decent wage plus loan repayment over three years, compared to what you spend on transportation for two patients, three or four times a month to the only treatment three or four times a month.

How do you think the Stepping Up initiative has helped localities bring attention to this issue?

It certainly has started and will maintain a dialog about being creative. Starting to ask and answer those questions (about what counties can do) at that first summit was a great first step. It got together 50 teams from counties that are struggling with the same issue, many of whom were more similar than they knew.

It has also established, within the psychiatrist community, a conversation about what could be done. It opens the door to becoming a much broader discussion.

What do you think is the biggest gap for counties looking to reduce mental illness in their jails? What is the biggest opportunity?

If most counties were aware of this problem, they'd start a diversion program for people with mental illness, because that's a potential reallocation of funds that would support better outcomes. People with mental illness simply don't fare well in the criminal justice system, they don't do well in jails and prisons, they don't do well going through the court process. They aren't good about some of the things that are important if you're going to navigate the criminal justice system.

Having access to some level of technical assistance, no county should think "we don't know how to do it, therefore we're not going to do it."

There's a multitude of technical assistance opportunities out there, through NACo and the Council of State Governments Justice Center.

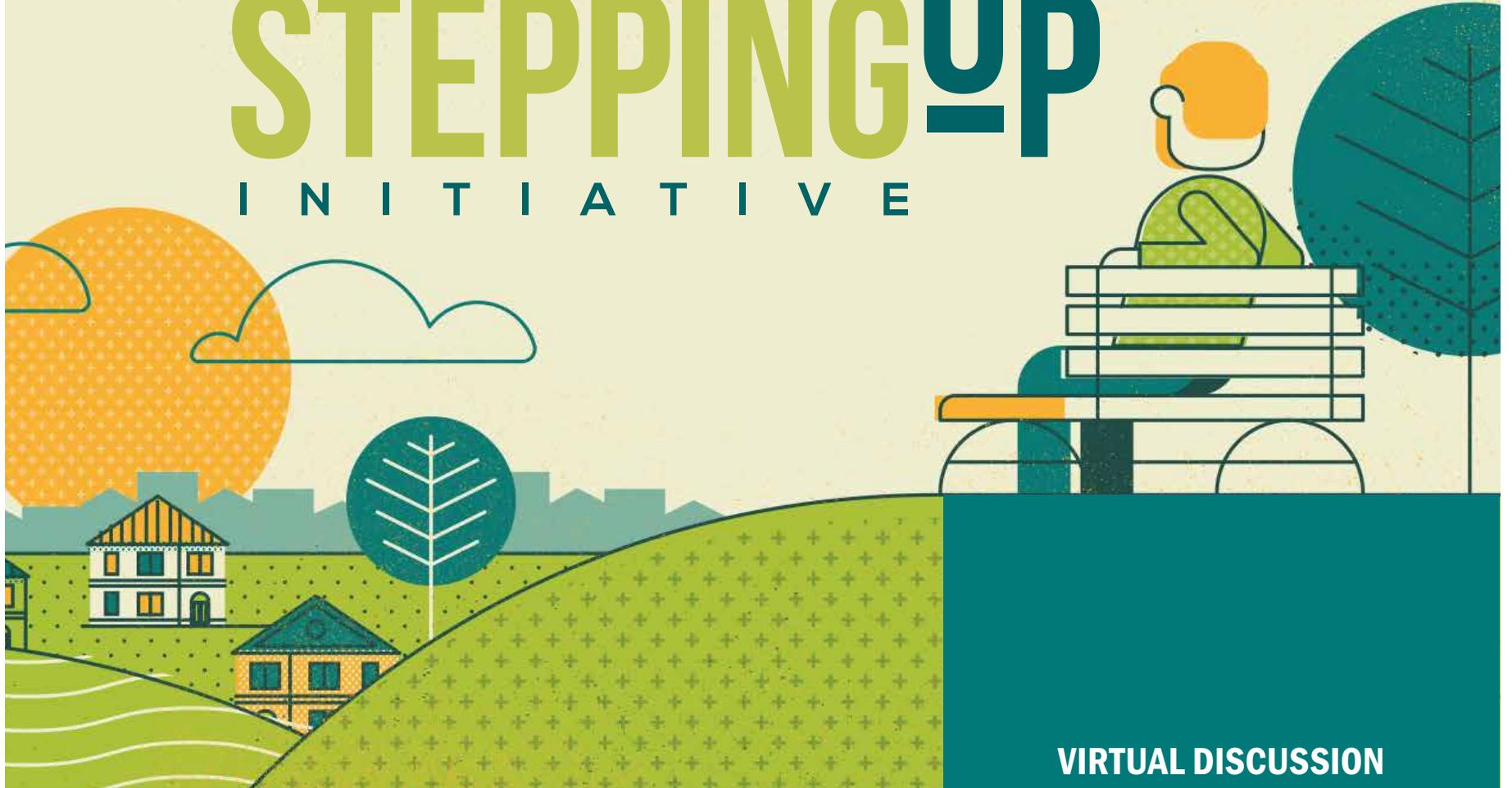
What role do you see states playing in helping counties to reduce the number of people with mental illnesses in jails?

In most states, MH services are part of the state's responsibility. I'd like to see more states go after grants available through the Department of Justice and the Office of Juvenile Justice and Delinquency Prevention.

We should look for ways to leverage dollars meant for workforce development, education and training in addition to mental health. Use HUD dollars for supervised housing, HHS dollars for addiction treatment and residential program for co-occurring disorders. Resources languish sometimes because as a system, we aren't very good at finding possible mental health dollars that aren't identified as being for mental health. 

Two Years of Stepping Up to Reduce Mental Illness in Jails

THE **STEPPING UP** INITIATIVE



VIRTUAL DISCUSSION

Wednesday, May 31
3:30 p.m. – 5 p.m. ET
at www.StepUpTogether.org

Please join us for a live virtual discussion commemorating two years of Stepping Up and highlighting the work that has happened in counties across the country.

The event will be held on Wednesday, May 31 from 3:30 p.m. – 5 p.m. ET at www.StepUpTogether.org

More information about the agenda and speakers is forthcoming.
#StepUp4MentalHealth

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COUNTY ROLES AND OPPORTUNITIES IN REDUCING MENTAL ILLNESS IN JAILS

This **new publication** outlines some of the challenges counties face when trying to reduce the number of people with mental illnesses entering jails and highlights key strategies that communities have used to address this issue.

www.safetyandjusticechallenge.org

