CountyNews SPECIAL EDITION APRIL 21, 2014

Hot Topics

INSIDE

• In the future, behavioral and health care delivery systems will integrate ❯ Page 8

Visit with Sara Tolentino, a case manager with Henrico Area Mental Health & Developmental Services in Henrico County, Va. ❯ Page 9

Mind and body meet at the junction of county mental health

By Charles Taylor
SENIOR STAFF WRITER

Shirlee Zane has always been a strong mental health advocate. She has, after all, been a family therapist, minister and hospital chaplain at various points in her career. But even that couldn't stop her from experiencing the devastating effects of mental illness, firsthand.

A Sonoma County, Calif. supervisor, she became that much more vocal about the issue after her husband, Peter Kingston, committed suicide in 2011.

"What I had experienced with my husband, I knew the signs of depression, I had told him I was scared about suicide," she said. "I feel like I was desperately trying to save him and I couldn't.

"It's definitely made me more of an advocate. We cannot prevent suicide if we don't talk about it."

In almost half of U.S. states, 23, counties are responsible for providing behavioral health services to more than 70 percent of Americans. Nearly 19 percent of American adults (43.7 million) suffer from some form of mental illness, according to the federal Substance Abuse and Mental Health Services Administration (SAMHSA). These are defined a mental, behavioral or emotional disorders — excluding developmental and substance-use disorders. Serious mental illness (SMI) includes schizophrenia, major depression and bipolar disorders.

Suicide is perhaps the ultimate risk of untreated or insufficiently treated mental illness. In the United States, 3.9 percent of adults (an estimated 9 million individuals) in 2012 reported having serious thoughts of suicide within the year prior to being surveyed.

There's no such thing as good health without good mental health, and vice versa.

Less extreme but as important, the consequences of mental disorders can have profound effects on concurrent physical illnesses — such as diabetes, heart disease and hypertension, among other conditions.

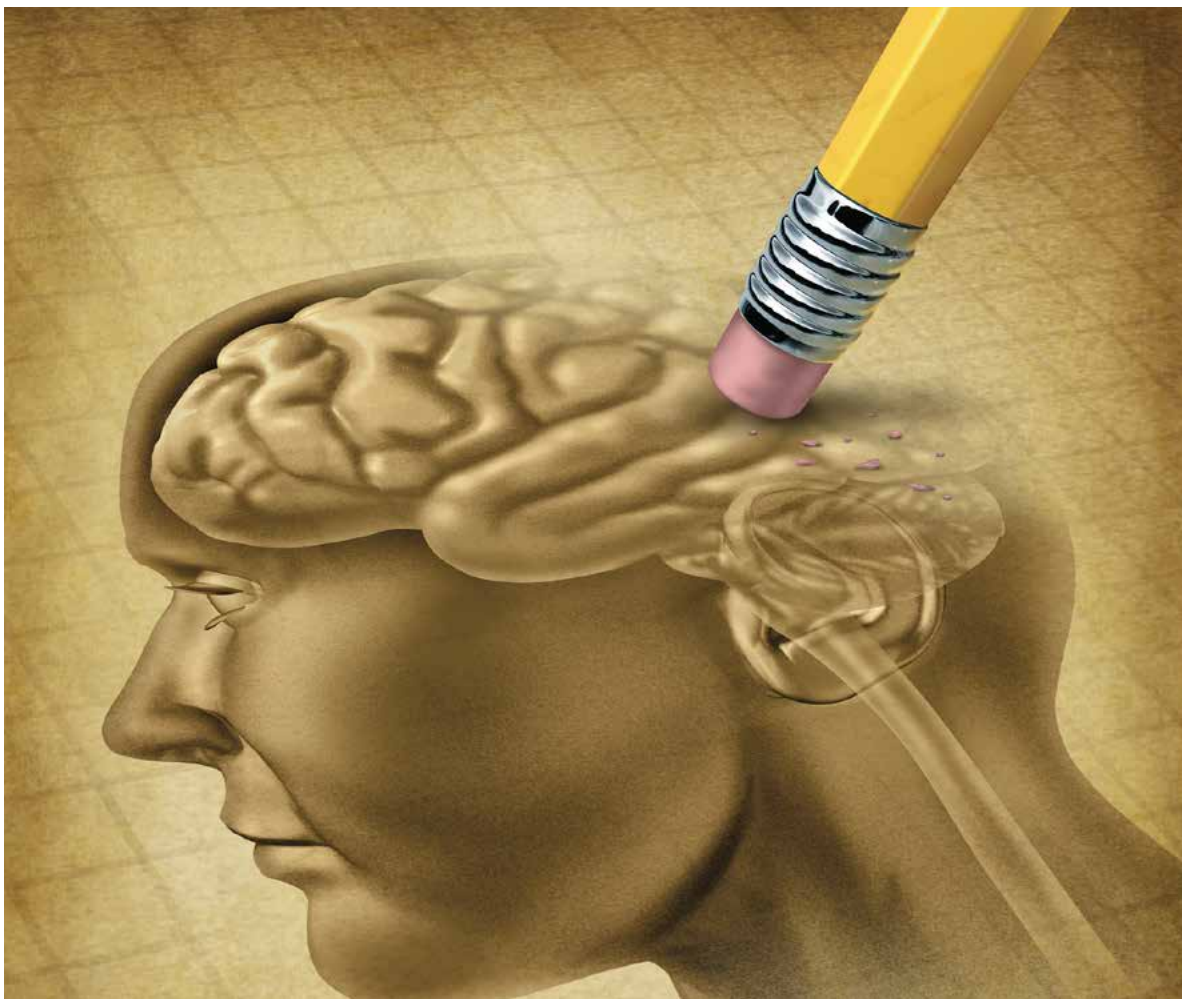
No Health Without Mental Health

As Ron Manderscheid, Ph.D., executive director of the National Association of Behavioral Health and Developmental Disability Directors (NACBHDD), puts it, "There's no such thing as good health without good mental health, and vice versa."

The Affordable Care Act is expected to jumpstart care-integration efforts nationwide (see page 8).

Among the more promising strategies being applied to address integrated care, many are at the county level. Since 2010, several counties across the country have received Primary and Behavioral Health Care Integration (PBHCI) grants from SAMHSA to develop models that treat the mind and body in a more holistic manner.

"The really great thing that's happening around the country is that there is a lot of experimentation," said Chuck Ingoglia, senior vice president, public policy and practice improvement with the National Council for Behavioral Health. "I don't talk to any of our members who aren't doing something in this area."



In 2010, the Washtenaw Community Health Organization (WCHO) — a public, nonprofit organization created by the University of Michigan and Washtenaw County — received a four-year PBHCI grant of $496,862 and state funding to establish an integrated health care delivery system that provides mental health, substance abuse, primary and specialty physical health care and health education to Medicaid, low-income and indigent county residents.

Washtenaw County, Mich. Integrates Care

Trish Cortes, WCHO's director of Community Support and Treatment Services, said the county had been planning for integrated care since 2000 — long before receipt of the federal grant — and "went live" in 2004 with its first integrated health clinic. Initially, WCHO embedded behavioral health staff into its primary care clinics. It worked, but not for the most seriously ill, she said. The model has evolved through several iterations since then.

"Currently what we're doing is our physical health people are embedded in our behavioral health teams and are actively working with the (mental health) care managers," Cortes said. "So it's care manager-to-care manager to try to coordinate everything that's going on in both systems."

This model has been in place for about two years. WCHO's integrated care model uses nurses, who are supervised by physicians, to work in the mental health center. "We deliberately hire and recruit nurses out of the physical health world," she said. "But when we do that, before we give them an offer letter, we send them out with our homeless team. And before we commit to them and they commit to us, they need to know, first and foremost, who it is that we're seeing."

Other counties that received PBHCI grants include Sarasota County, Fla., Cobb County, Ga., Marion County, Ind., and San Mateo County, Calif. The FY14 federal budget includes $50 million for an additional round of grants of up to $500,000 each from SAMHSA.

States Have Cut Mental Health Spending

Among all Americans, 36.2 million people spent $57.5 billion

See **MENTAL HEALTH** *page 8*

Care Integration: An Imperative for County Health Service Delivery

Ron Manderscheid, Ph.D.
EXECUTIVE DIRECTOR, NACBHDD

The Affordable Care Act (ACA) can be expected to foster a dramatic transformation in health service delivery systems operated and supported by counties, including mental health, substance use, and intellectual development/developmental disability (ID/DD) programs.

A primary feature of this transformation will be the creation of integrated service systems that combine these separate services into medical homes operated by primary care entities or health homes operated by behavioral health entities. This article will discuss these developments and how counties can prepare for them.

We have known for more than a decade that separation of primary and behavioral care can lead to very significant adverse consequences. Clients with severe mental illness and substance use conditions who are served by public systems die 25 years earlier than other people.

Although lifestyle factors and the adverse effects of "second-generation" psychotropic medications (developed in the 1980s) can contribute to early mortality, lack of needed primary care services clearly is a key factor.

At the same time, persons with serious medical conditions, like heart conditions or diabetes, also have worse prognoses and die earlier when they suffer from untreated or poorly treated mental and substance use conditions, such as depression. Hence, service integration is not only advisable; it is absolutely essential for longevity and wellbeing.

The Affordable Care Act can be expected to foster a dramatic transformation in health service delivery systems operated and supported by counties ...

Services integration has gone through several stages of development during the past decade. Early service integration efforts included behavioral treatment for mental or substance use conditions, followed by referral to a unrelated primary care practice.

Generally, this approach worked very poorly because most clients never appeared at the site to which they were referred.

To solve the problems of referral, a co-location approach (also called bidirectional integration) has been adopted more recently. Behavioral health care service units are placed next to primary care service units, or vice versa. This second approach suffers from two problems: lack of sustainability because funding comes primarily from grants, and ineffective service coordination because primary care and behavioral health service units remain separated and do not constitute actual service teams.

Since behavioral healthcare funds are "carved out" or separated from health care funds, payment mechanisms for integrated care are complex, at best, and ineffective, at worst. Grant funds provide a very unstable foundation for this work. Also, co-location does not assure close teamwork on complex cases, and primary care services are not likely to learn about whole health, recovery and resilience.

Because of the problems of treat-refer and co-location, a new approach to care integration is beginning to be implemented. Called "simply full integration," this approach is based on an integrated service delivery team and integrated

See **INTEGRATION** *page 11*

Bill in Congress would direct more resources to serious mental illness

MENTAL HEALTH *from page 7*

for mental health services in 2006, the latest data available from the Agency for Healthcare Research and Quality's Medical Expenditure Panel Survey, cited by the National Institutes of Mental Health. That's a big number, but public behavioral health programs are hurting.

States cut more than $1.6 billion in general funds from their state mental health agency budgets for mental health services between FY09 and FY12, according to the National Alliance on Mental Illness (NAMI). At the same time demand for such services has increased significantly.

SAMHSA Administrator Pamela Hyde, speaking at a NACo Health Steering Committee meeting, said, "Instead of dealing with a public health issue, we're building more jails; we're dealing with homelessness issues. We're dealing with institutional oversight we're talking about managing gun safety, background checks, and in fact, that's not going to get us a solution to the public health issue."

As a result, emergency rooms, homeless shelters and jails have become the primary treatment option for vulnerable populations. County jails in many states have become the de facto mental health providers. "The county jail has become the largest mental health facility in the county," said Sheriff Mike Emery, McLean County, Ill. (pop. 169,572) (see page 10). McLean County is considering its options, including adding a mental health wing to its jail. In much larger Cook County, with 5.2 million residents, on any given day 30 percent to 35 percent of inmates suffer from a serious mental illness such as bipolar disorder and schizophrenia, according to Sheriff Tom Dart.

The Sandy Hook Effect

The Obama Administration heightened its focus on mental health issues as a sometime-root cause of violence after the Sandy Hook school shootings in late 2012. These and other incidents aside, mental health experts say statistics show that the mentally ill are more likely to be the victims of violence than the causes of it.

Sandy Hook is also largely responsible for a bill currently making its way through the U.S. House of Representatives, The Helping Families in Mental Health Crisis Act (H.R. 3717), sponsored by Rep. Tim Murphy (R-Pa.), a clinical psychologist. And the Affordable Care Act is also drawing attention to mental health needs.

In early 2013, the House Energy and Commerce Subcommittee on Oversight and Investigations, which Murphy chairs, launched a probe of federal mental health policy. One of the committee's findings was that families and caregivers often are unable to share vital information with a physician about a loved one's medical history because of misinterpretations of the privacy rule under HIPAA.

"My legislation strengthens HIPAA by empowering parents to talk about and receive information about a mentally ill loved one, which will allow physicians to make an accurate diagnosis," he wrote in a published op-ed.

More controversially, H.R. 3717 calls for more states to adopt so-called "assisted outpatient treatment" (AOT) laws, such as New York's Kendra's Law. AOT laws establish a procedure for obtaining court orders for certain individuals with mental illness to receive and accept outpatient treatment.

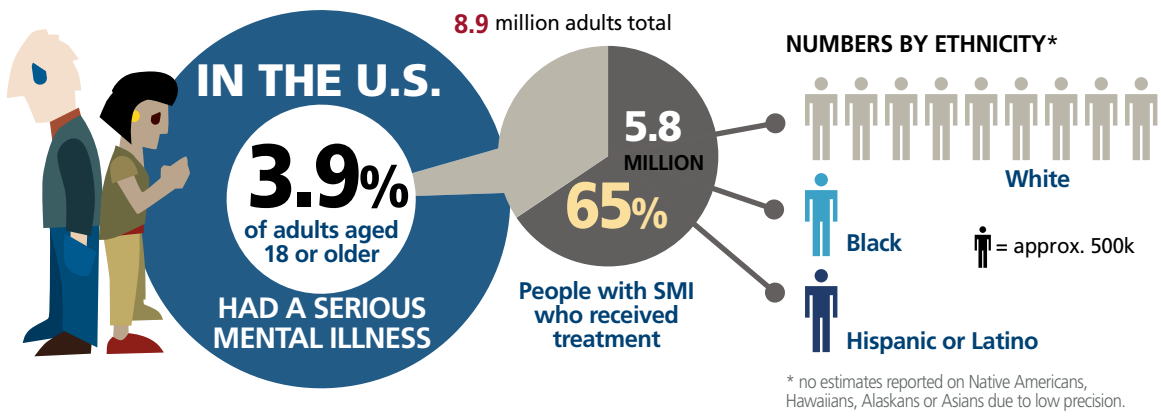
While the Murphy bill has attracted bipartisan support and has been endorsed by entities ranging from the National Alliance of Mental Illness, American Psychiatric Association and the National Sheriffs' Association, it is not without its detractors. Critics, including mental health advocates and civil libertarians, call AOT the equivalent of "forced treatment."

"I believe that the AOT section is probably written for those that may need it, which are a very small percentage of the population," said Gina Nikkel, president and chief executive of the Foundation for Excellence in Mental Health Care. "But the way that the bill is written, it might be interpreted that a lot of people will need that."

The Affordable Care Act and H.R. 3717 have both served to heighten the profile of the need for integrated care — and mental health in general. Whether one agrees or disagrees with either, or both, they have made positive contributions to the dialogue about the importance treating the whole person.

SAMHSA's Hyde said too many people still see behavioral health as a social problem rather than a public health issue. "What does that mean? It means the public sees the social consequences rather than the health consequences," she said. "So they see homelessness, gangs, jails, the tragedies, the disability, the lost productivity in the workplace, all of these kind of things. And what that gets us is inadequate responses."

Number of Adults Aged 18 or Older with Serious Mental Illness (SMI) • 2008–2012



Data from SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2008–2012

A Day in the Life: County mental health caseworker chronicles the job's risks, rewards

By Charles Taylor
SENIOR STAFF WRITER

Helping people to sort out and stabilize their lives is all in a day's work for Sara Tolentino, a case manager with Henrico Area Mental Health & Developmental Services in Henrico County, Va.

Or in some cases, all in many years of work.

One of her most memorable successes began with a client in August 2005 —

working with a belligerent, mentally ill homeless woman who wasn't taking her medications, was in and out of court and had served jail time, more than once, for trespassing.

"She would cuss people out and just go up and punch people in the face. She was very sick," Tolentino recalled recently.

"We were able to get her temporary housing and then get her disability, get her insurance, get her a (permanent) place to live. We hooked her up with our psychosocial program, which is a day program where folks go for socialization and vocational training," she added.

The client successfully completed that program, and eight years later — her case was closed in June 2013 — the woman is working at a church, cleaning and doing secretarial work and "is absolutely adored by the church community and loves what she does and has a really healthy life now," Tolentino said.

She now sees a private doctor to get her medication and no longer requires case management services. The woman also has reconnected with family members, from whom she had been estranged when Tolentino first met her, and now babysits her grandchildren.

"We want to get folks integrated into the community. We want them to not need us anymore," Tolentino said. That includes helping to find social supports for people who may have become isolated because of mental illness, or a dual diagnosis of mental problems and a substance use disorder. This could include making referrals to volunteer or paid jobs. "There's not a lot we don't do."

Photo by Joel Archibald, Henrico County Public Relations & Media Services

With a caseload of 15, Sara Tolentino (r) does intensive case management with Henrico Area Mental Health & Developmental Services in Virginia, working with severely mentally ill clients.

A 16-year veteran of the department, she has experienced exhilarating highs as well as soul-crushing lows of working with people suffering from some of the most challenging disorders, such as schizophrenia, major depression and bipolar disorder.

> **I think when you have success it breeds success. And when we see people and you know they can be in a better place, it just kind of keeps you going, motivates you.**

"I like being involved in people's lives and being able to make an impactful difference in a way that's really meaningful and it's really important," she said. "Not only do I help them with their illness and their treatment, I look at people really holistically and help them get their lives back together."

But not every outcome is a successful one. She has had clients who have committed suicide.

Case managers like Tolentino provide supportive counseling, help clients work through trauma or other issues that impede their ability to function in society. She does intensive case management, with about 15 clients at any given time. Henrico mental health also serves neighboring Kent City and New Charles counties.

A typical day for Tolentino begins around 7:30 a.m. "A lot of times start in the field going to people's houses and watching them take their medicine, and helping them get up and get ready for the day," she said. "I might see two or three people, bring a client into the agency to see a psychiatrist, lead them to the pharmacy to get their meds. Some folks I see every day Monday through Friday."

She also helps her clients to make medical appointments and manage any concurrent health issues they might have — since behavioral health issues can affect a patient's compliance with their treatment for medical conditions, and vice versa.

Case managers also assist people who are unable to work apply for disability, Social Security Disability Insurance or Supplemental Security Income (SSI). They also navigate entitlement programs such as food stamps and helping with applications for Medicaid. "Some of those systems are really kind of cumbersome and difficult to manage," Tolentino said, "especially for folks who are suffering from a mental illness."

One of the biggest challenges Tolentino and other case managers face is finding housing for clients. "You can't get apartments very often for under $600 a month where we're located" — which can account for 85 percent of the average monthly SSI check of $710. Inevitably, some clients will run out money for other needs.

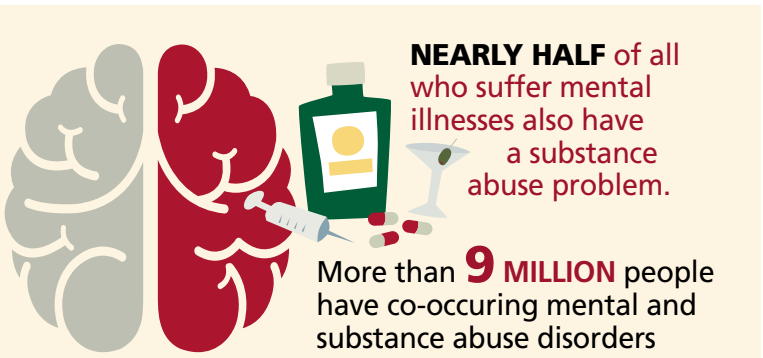
This was the case on one recent day, when a paranoid schizophrenic client — with visual and auditory hallucinations — ran out of food a few days before her next food stamps were to arrive. Tolentino took her to a food pantry, but the client had lost her identification, making her ineligible. "I ended up going to another place and kind of begged to get some stuff to tide her over for a couple of days," Tolentino said.

The biggest change she has seen in the last 16 years is diminishing financial support. "We used to be able to supplement folks more and to help them more with resources, and there's just not as much money as there once was for anybody, in the public sector or private sector."

As with all helping professions, caregiver fatigue and burn out can set in. Tolentino said she can tell when things are getting to her: "My stomach's hurting; I have headaches." That's when she makes a beeline to her colleagues for some team support.

"I think sometimes you just have to talk to people, our colleagues obviously, about cases and brainstorm ideas and try to stay fresh. I think you have to take vacations, and I think you have to take days off," she said. "Caring for the caregiver is important because it is difficult work. We see a lot of really bad things.

"I think when you have success it breeds success. And when we see people and you know they can be in a better place, it just kind of keeps you going, motivates you."



Officials see mental health as economic development issue

By Charles Taylor
SENIOR STAFF WRITER

For seven years now, a group of officials from McLean County, Bloomington, its county seat, and the town of Normal, Ill. — known as One Voice — has trekked to Washington, D.C. to meet with members of Congress and federal agencies.

Their agenda in past years has included seeking funding for transportation, landfill diversion and exploring economic development opportunities. The group is led by the Bloomington-Normal Economic Development Council, which is funded largely by the private sector but derives some funding from the county.

See **ONE VOICE** *page 14*

The One Voice Mental Health team from McLean County, Ill. meets with federal officials in Washington, D.C. at the Hubert H. Humphrey Building, headquarters of the Department of Health and Human Services.

Mental illnesses compound challenges for county jails

By Charlie Ban
STAFF WRITER

In April 2014, the Treatment Advocacy Center (TAC) and National Sheriffs' Association (NSA) declared prisons and jails "America's new asylums," based on a recent study finding that 44 states house more people with a severe mental illness in their prisons or local jails than state psychiatric hospitals.

The study estimated 149,000 of 744,524 county or city jail inmates suffered from severe mental illness in 2012.

The Treatment of Persons with Mental Illness in Prisons and Jails concluded that not only are the numbers of mentally ill in prisons and jails continuing to climb, the severity of inmates' illnesses is on the rise as well.

In addition, many inmates with mental illness need intensive treatment, and officials in the prisons and jails feel compelled to provide the hospital-level care these inmates need. The report attributes the problem to the continuing closure of state psychiatric hospitals, among other factors.

These pressures are bad enough in a jail that is moderately full, but overcrowding exacerbates the problems. California's 2011 decision to release its non-violent, non-sexual and non-serious offenders to county jails has necessitated a major transformation on the part of the jails as they struggle with the challenges of an increased prisoner population, doing more time than the typical jail inmate waiting for trial.

"Those types of transformations really require a lot of investment," said Kenna Ackley of Los Angeles County's office of intergovernmental affairs. "When you talk about medical and mental health care, moving from an acute, episodic approach to a focus on long-term and chronic care management, it's a major transformation and a major requirement for resources. It's put a huge strain on our county jail system."

We're receiving word that people with immediate mental health needs are on their way to our doorstep and we're left scrambling to make sure they have the services they need when they get here.

Though Ackley's themes echo in counties throughout the state, Los Angeles County operates on a vastly different scale because of its high population. She frames the shift of roughly 8,300 additional inmates to the county's jail system — which had an average daily population of approximately 19,000 before the shift — as akin to the county jail becoming a state prison, or two state prisons.

"Mental health is something that I don't think was entirely anticipated in terms of both the acuity of the folks coming out of state prison and going into (probation)," she said of legislators' thought process while crafting the justice realignment. "We're receiving word that people with immediate mental health needs are on their way to our doorstep and we're left scrambling to make sure they have the services they need when they get here. We don't want to just 'make do.' The county is really invested in providing effective supervision."

Without adequate funding from the state to serve the rapidly growing mentally ill population, Los Angeles County has tried to leverage funding sources to supplement its budget.

"The [Affordable Care Act] has provided some interesting opportunities, but it still remains to be seen how we can lay that out to its fullest extent," she said. "Jail beds are expensive, and a mental health bed in jail is even more expensive."

The TAC-NSA report demonstrated how expensive that can be. For example, Broward County, Fla's mentally ill inmates cost $130 per day compared to $80 per day for healthy inmates in 2007, with much of the additional costs coming from medication.

Elsewhere in Florida, Alachua County benefits from a robust treatment and diversion program. Its jail is not overcrowded — in fact its population has been 10 percent – 15 percent below its previous high over the last year and a half, according to Court Administrator Tom Tunkavich.

"We credit that, in large part, to the work our mental health forensic diversion team has been doing," he said. "Treating the mentally ill in the appropriate setting has been the best way to cope with demand for jail space, but we couldn't do it without these grants."

Alachua County has been contracting with a private service provider for six years, funded by grants from the state. A new three-year $1.2 million grant will fund a program in which mentally ill offenders who committed a minor offense will have the option to go to a social services treatment center in lieu of jail.

"It's going to be what will help them rehabilitate and leave space in the jail for inmates who don't need that help," Tunkavich said. "Adding mentally ill inmates isn't always a matter of subtracting one bed, because sometimes they can't be housed with someone else."

Funding for such jail programs is often a pastiche of grants, appropriations and recently, tax revenue. In Washington State, for example, the Legislature in 2007 gave its counties authority to raise money for new or expanded mental health programs through a one-tenth of 1 cent sales tax. That brings in an additional $50 million to King County's $240 million mental health budget. Almost 18 counties in Washington have passed similar taxes, but none come close to King County's population or sales tax volume.

"That tax (to fund our mental illness and drug dependency program) was accompanied by five clear policy goals and chief among them were reducing the number of people with mental illness using the wrong costly interventions like the jail," said Jim Vollendroff, division director for King County mental health and substance abuse. "That population is also likely to reoffend, so getting them treatment is a good start to reducing recidivism."

Of the 17 strategies the county developed to achieve those policy goals, 11 are specifically jail and hospital diversion strategies.

Though the sales tax was successful in raising additional funding, in anticipation of increased funding for mental health services available after Medicaid expansion, the Legislature slashed mental health funding for counties.

"It's going to be a rocky two years until the expansion fully takes effect, because we're in transition," Vollendroff said.

That will include restructuring mental health treatment facilities to have fewer beds so they can qualify for additional funding.

"You work around challenges and try to make use of what resources you have any way you can adapt to access more," he said.

Improving Mental Health in Jails

The study by the Treatment Advocacy Center and National Sheriffs' Association makes several recommendations for improving public mental health systems in jails:

- Reform mental illness treatment laws and practice to eliminate barriers to treatment for the mentally ill to receive care if they are too ill to realize it
- Reform jail treatment laws so inmates with mental illnesses can receive treatment as easily as any traditional medical care
- Implement and promote jail diversion programs
- Use court-ordered outpatient treatment
- Encourage cost studies to compare costs of treating the mentally ill in and out of jail
- Establish careful intake screening
- Institute mandatory release planning
- Provide appropriate mental illness treatment

**See this story at www.countynews.org to read the report The Treatment of Persons with Mental Illness in Prisons and Jails*

Substance Use Problems Among Persons Enrolled in Treatment: Single-Day Count • 2012

Among persons enrolled in substance use treatment in the United States in a single-day count in 2012 ...

38% were in treatment for a drug problem only

18.1% were in treatment for an alcohol problem only

43.9% were in treatment for problems with both drugs and alcohol

Data from SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2008–2012

County Innovations in Mental Health and Substance Use Treatment

California

Riverside County's Prevention and Early Intervention Mobile Services clinics provide prevention and early prevention outreach services to families who find it difficult to visit a county facility. The clinics, which are specially designed recreational vehicles, bring mental health services to families with children up to seven years old. The program meets a need to develop services outside the standard clinic model, according to Emma Girard, senior clinical psychologist for Riverside County, who helps lead the project.

Each unit is equipped with a playroom and a room with a one-way mirror for observation, a playroom camera and microphone to facilitate communications between the therapist and family and to record the interventions. Wireless audio allows the therapist in the adjoining observation room to coach parents in the playroom while interacting with their child.

Studies show that delays in treating early socio-emotional development can lead to mental health issues that worsen over time.

In Riverside County, Calif.'s Prevention and Early Intervention Mobile Services clinics, a therapist behind a two-way mirror can watch kids and parents interact, and coach the parent via a wireless earpiece.

This converted recreational vehicle serves as a clinic on wheels for families with children, up to age 7, who can't make it to a centralized clinic. The program was recognized with a Challenge Award by the California State Association of Counties.

Kansas

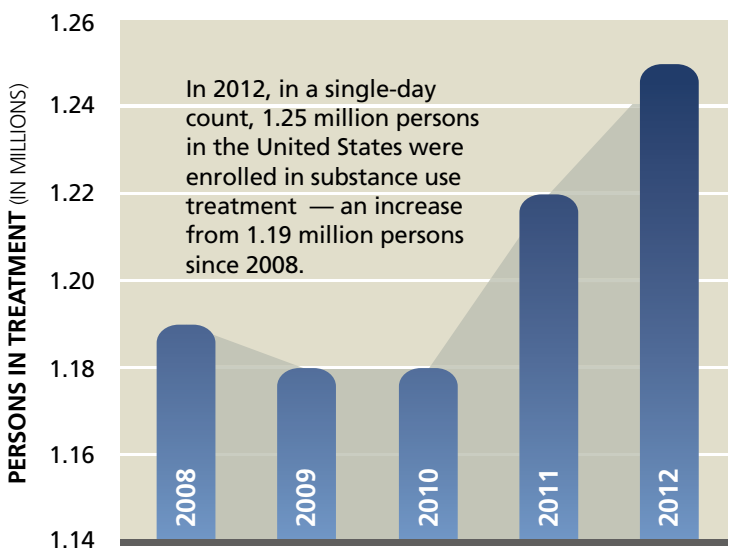
The Proud of Me program in Sedgwick County is for young children ages 2-1/2 to 5 years old who have challenging behaviors at home, at preschool or child care or in the community. The purpose of the program is to provide a supportive environment where children can develop and practice the social, emotional and behavioral skills needed to succeed in school, at home and in the community. It's designed to work in conjunction with academically based preschools.

Proud of Me has morning and afternoon programs operating Monday through Wednesday. Children generally attend for 12 months, however, length of service and frequency of service per week are both based on each child's individual needs.

As part of the program, each child receives a case manager to coordinate the treatment team and advocate for the child and family. Children can receive individual support and assistance with meeting goals at school, in the home, and in the community. In addition,

See **BEST PRACTICES** *page 14*

Enrollment in Substance Use Treatment: Single-Day Counts • 2008–2012



County collaboration is key to solving regional behavioral health issues

INTEGRATION *from page 8*

funding. Full integration can be implemented in either a primary care or behavioral health setting.

At the present time, only about 30-35 percent of persons with behavioral health conditions are seen in behavioral care settings. The balance receive their care from primary care physicians. We envision that this distribution will change even more with ACA implementation. By 2025, only 10 percent of behavioral care will occur in health homes operated by specialty providers.

County service delivery systems will need to adapt to these changes by developing medical and health homes for the populations they serve. Although several different approaches to achieve this goal could be taken here, it is very important to keep in mind that these changes primarily need to occur at the point of service delivery. Several proposals have been provided below with this in mind.

Build County or Intercounty Health Collaboratives

A single county or several counties joined together could develop a health collaborative to serve the health needs of public sector clients. County agencies participating in the collaborative could include health, mental health, substance use, ID/DD, and even public health. The agencies could contribute staff who would participate in service delivery teams or funding to purchase needed services. In this model, county agencies would exercise oversight on appropriate credentialing and quality assurance.

Supplement Local Federally-Qualified Health Centers (FQHC) and Rural Health Centers (RHC)

For single counties or sets of counties that are small or that lack public health infrastructure, a formal relationship could be developed with local FQHCs/RHCs to configure medical homes using the infrastructure already provided by the federal government.

Typically, these entities will lack sufficient mental health and substance use services. The formal agreement could provide either staff or funding to add these latter services. In addition, effort should be made to extend the work to include public health prevention and promotion services.

Combine Local Services and Virtual Services

For single counties or sets of counties that have some services but not others, it may be possible to configure the on-the-ground services with virtual services so that the minimum array of services needed for a medical or health home is available to public sector clients. Typically, this will mean use of telemedicine to add virtual mental health or substance use services, including the use of some related online services done without a provider.

It should be obvious that these three models could be combined in different ways depending upon county needs and capacities. The most important point is to begin planning now so that medical home and health home services can be made available to public clients in the short-term future.

Some federal funding is available to help with service implementation. ACA Section 2703 provides 90 percent federal Medicaid funds for two years from the Centers for Medicare and Medicaid Services to develop medical and health homes for particular disability populations.

The Health Resources and Services Administration provides federal funds to FQHCs or RHCs to add necessary mental health and substance use services. These opportunities ought to be explored.

Full integration has tremendous implications for counties and for the programs they operate and fund. Counties need to begin immediately to prepare for the landmark changes that are beginning to occur.

GLOSSARY

As county leaders, you may hear these terms when behavioral health professionals talk about their programs. To help reduce any confusion, NACo President Linda Langston, Linn County, Iowa supervisor, and Leon Evans, president and CEO, Center for Health Care Services, Bexar County, Texas, compiled this list. Many thanks to them for sharing their expertise and knowledge.

ACC – accountable care communities — a space many counties are becoming ascendant in driving collaboration to serve the needs of clients on a community-wide basis.

ACO – accountable care organizations — often hospital based.

Adult Foster Care (AFC) – provides a supervised, 24-hour living arrangement in an adult foster home for people who are unable to continue living independently in their own homes because of a physical, mental or emotional limitation.

Adjunct Services – clinically indicated services that are customized and may be delivered to support the recovery of the individual.

BI – brain injury.

Case management – usually services provided to an individual that assists the client in a variety of decisions from where to live, how to get transportation, where they might work, how to manage money and perhaps medical and or drug needs.

Counseling – individual, family, and group therapy focused on the reduction or elimination of a client's symptoms of emotional disturbance and increasing the individual's ability to perform activities of daily living.

Cognitive Behavioral Therapy (CBT) – the selected treatment model for adult counseling services.

Cognitive Processing Therapy (CPT) – the selected treatment model for adults with PTSD, including but not limited to military veterans.

Crisis Intervention Services – interventions in response to a crisis in order to reduce symptoms of severe and persistent mental illness or emotional disturbance and to prevent admission of an individual to a more restrictive environment

Crisis Follow-up and Relapse Prevention – supported services provided to individuals who are not in imminent danger of harm to self or others but require additional assistance to avoid reoccurrence of the crisis event.

Crisis Residential Treatment – Short-term, community-based residential treatment to individuals with some risk of harm who may have fairly severe functional impairments and who require direct supervision and care but do not require hospitalization.

Crisis Stabilization Unit – short-term residential treatment designed to reduce acute symptoms of mental illness provided in a secure and protected clinically-staffed, psychiatrically-supervised, treatment environment.

Crisis Transportation – transporting individuals receiving crisis services or crisis follow-up and relapse prevention services from one location to another.

Day Activity and Health Services (DAHS) Facilities – provide daytime services to people who live in the community as an alternative to living in a nursing home or other institution.

Day Habilitation – services provided to give people with significant disabilities a place to be and activities to engage in.

Day Programs for Acute Needs – programs that provide short-term, intensive treatment to individuals who require multidisciplinary treatment in order to stabilize acute psychiatric symptoms or prevent admission to a more restrictive setting.

Developmental Disabilities (DD) – onset early in life (before 22); affects three major life activities; often co-occurs with intellectual disability, but not always.

Dual diagnosis – people who may have two presenting issues — a mental health issue and potentially a drug dependency.

Dual eligible – people who are eligible for both Medicaid and Medicare — usually very poor and in need of long-term supports.

ECI – early childhood intervention.

Engagement Activity – face-to-face activities with the individual or collaterals (in accordance with confidentiality requirements) in order to develop treatment alliance and rapport with the individual.

Extended Observation – up to 48-hour emergency and crisis stabilization service that provides emergency stabilization in a secure and protected, clinically-staffed (including medical and nursing professionals), psychiatrically-supervised treatment environment.

Family Case Management – activities to assist the client's family members in accessing and coordinating necessary care and services appropriate to the family members' needs.

Family Partner Supports – peer mentoring and support provided by Certified Family Partners to the primary caregivers of a child who is receiving mental health community services.

Family Training – provided to the client's primary caregivers to assist the caregivers in coping and managing with the client's emotional disturbance. This includes instruction on basic parenting skills and other forms of guidance.

FQHC – Federally Qualified Community Health Centers.

Health homes – placing clients so that they have comprehensive health care — a central doctor so that the client is not always in the ER.

Home and Community-based Services (HCS) – provides individualized services and supports to people with intellectual disabilities who are living with their families,

See **GLOSSARY** *page 13*

In disasters, counties minister to wounded spirits, psyches

By Beverly Schlotterbeck
EXECUTIVE EDITOR

Ken Stark was at home on a Saturday in late March when the enormous mudslide in Snohomish County, Wash., known as Slide 350, crumpled homes and trees and roads and in the end, scattered a mile-wide debris field across the area, blocking its main highway. "The emails started flying," Stark said and the emergency operations center was activated.

As director of the county's Human Services department, Stark participates in two groups charged with providing human services and medical care, including mental health care, in disasters. The teams began work on Monday. "After the crisis emergency counselors leave, we take over." And they are still at it.

In Monmouth County, N.J., Hurricane Sandy, the deadliest and most destructive storm of the 2012 Atlantic hurricane season, left 1,800 evacuees and 100 pets in two county shelters for a week or more.

With them from the start were members of the Disaster Response Crisis Counselors team, deployed by the Monmouth County Office of Mental Health and designated as first responders by the state. DRCC members are volunteers who undergo training and certification in trauma-related support by the state division of mental health services.

When Sandy struck, the usual 60-person complement was down to about seven, according to Steve Horvath, assistant director, Office of Mental Health. "I couldn't get in touch with half of them. And of the other half, about two-thirds were unable to help," he said. Horvath, himself, was stuck at his father's house for a day and a half corralled by a fallen tree and telephone wires that had blocked the entrance to his father's cul-de-sac.

> **You see people struggling to be resilient, to keep a stiff upper lip. It's so sad. Things are not quite the same.**

His counterpart in Atlantic County where Sandy first made land fall, Sally Williams, the county mental health administrator, was already with her DRCC team at a special needs shelter that had been set up before the storm struck. Williams is especially proud of the shelter and the special needs registry the county established to assist the more vulnerable county residents.

Both administrators talked about the need for long-term recovery and their participation in FEMA's Hope and Healing groups that provide informal, but very much needed counseling. "You see people struggling to be resilient, to keep a stiff upper lip. It's so sad. Things are not quite the same. You can't re-capture a way of life," Williams said. "We have learned that we need to go out and find these people."

Stark, Horvath and Williams — and people like them in counties across the country — typify a new riff to an old concept in emergency management, "whole community planning," according to Bruce Lockwood, USA president, International Association of Emergency Managers, a NACo-affiliate.

In the past, Lockwood said, mental health services were considered a post-disaster event. But, after Katrina, that all changed. "There's really been a shift in the mindset. We're really understanding what partners you need to bring to the table when deploying mental health teams."

The shift in emphasis has also been noted by FEMA, the country's primary agency for disaster response.

Naomi Johnson, lead program specialist, Crisis Counseling Program at FEMA, recently said: "County mental health officials play an integral role during disasters from coordinating resources to meet immediate needs during disaster response to meeting longer-term needs during disaster recovery phases.

"These officials know their communities and resources, what is available, what is lacking, and how best to bridge those gaps when meeting the physical and mental health needs of a community struck by a disaster."

FROM THE CDC

Coping with Disasters or Traumatic Events

Mental Health Resources

See complete list with links at
http://emergency.cdc.gov/mentalhealth

Information for Responders

- **Disaster Mental Health for Responders: Key Principles, Issues and Questions** – Responders needs, reactions, symptoms in a disaster
- **Field Manual for Mental Health and Human Service Workers in Major Disasters** – Resources from SAMHSA, HHS
- **Self-Care Tips for Emergency and Disaster Response Workers** – Signs that you need stress management assistance & ways to help manage stress from SAMHSA, HHS
- **Surviving Field Stress for First Responders Webcast** – Describes stress, coping with field related stress, and information for families of responders
- **Traumatic Incident Stress: Information for Emergency Response Workers** – How to take care of yourself onsite & at home; developed by the National Institute for Occupational Health (NIOSH), CDC

Information for Health Professionals

- **Coping With a Traumatic Event** – How to help patients cope with a traumatic event
- **American Psychiatric Association: Disaster Psychiatry** – Features publications on disaster psychiatry as well as recommendations for broader involvement of psychiatrists in disaster work.
- **Psychological First Aid: Helping People Cope During Disasters and Public Health Emergencies** – Online course from NACCHO

Information for States and Local Health Departments

- **Disaster Mental Health Primer: Key Principles, Issues and Questions** – Overview of general principles and reactions to disasters
- **Disaster Mental Health for States: Key Principles, Issues and Questions** – What should happen in the first four weeks, roles, and reaction in a disasters

Natural Disasters

- **Preventing Violence after a Natural Disaster** – Preventing child maltreatment, shaken baby syndrome, managing stress in relationships, sexual violence, suicide & youth violence

Hurricanes

- **Hurricane Aftermath Resources** – A collection of resources for the Public, Volunteers, Health Professionals & Schools compiled by the Suicide Prevention Resource Center
- **Psychosocial Concerns after Hurricane Katrina: Tips for Medical Care Providers** – A collection of resources for Medical Providers, Survivors, Response Workers, Military, Family of Military & more from the National Center for Post-Traumatic Stress Disorder
- **Center for the Study of Traumatic Stress: Hurricane Disaster Care Resources** – Resources provided by the Uniformed Services University of the Health Sciences
- **Maintain a Healthy State of Mind (Developed in partnership with the American Red Cross)** – Publications on Mental Health & Disaster Issues for responders, adults, families, older adults and schools from SAMHSA, HHS
- **MedlinePlus: Coping with Disasters**
- **National Institutes of Health (NIH)**
- **MedlinePlus: Post-Traumatic Stress Disorder**
- **National Institutes of Health (NIH)**

GLOSSARY *from page 12*

in their own homes or in other community settings.

Intellectual Disability (ID) – previously known as mental retardation, it is a condition diagnosed before age 18 that includes below-average intellectual function and a lack of skills necessary for daily living.

Inpatient Hospitalization Services – hospital services staffed with medical and nursing professionals who provide 24-hour professional monitoring, supervision and assistance in an environment designed to provide safety and security during acute psychiatric crisis.

Intermediate Care Facility – provides residential and habilitation services to people with intellectual disabilities and/or a related condition.

Involvement Recovery – describes an individual's participation in his or her recovery process.

Involuntary commitment – when a person is committed — often by court order — to a treatment facility.

LAR – Legally Authorized Representative.

Medication Training and Support Services – education and guidance about medications and their possible side effects.

Parent Support Group – routinely scheduled support and informational meetings for the child/youth's primary caregiver(s).

Pharmacological Management – service provided by a physician or other prescribing professional that focuses on the use of medication and the in-depth management of psychopharmacological agents to treat an individual's signs and symptoms of mental illness.

PMI – Persistent Mental Illness.

Pre-voc or pre-vocational services – services provided to train people to be able to go into the workforce.

PTSD – Post Traumatic Stress Disorder.

Psychiatric Diagnostic Interview Examination – an assessment that includes relevant past and current medical and psychiatric information and a documented diagnosis by a licensed professional practicing within the scope of his/her license.

Psychosocial Rehabilitative Services – social, educational, vocational, behavioral and cognitive interventions that address deficits in the individual's ability to develop and maintain social relationships, occupational or educational achievement, independent living skills and housing that are a result of a severe and persistent mental illness.

Respite – providing services to families who do round-the-clock care so that they can get a break from constant care.

Residential Treatment – twenty-four-hour specialized living environments. Residential treatment includes administration of medications, room and board, and all daily living needs.

Safety Monitoring – ongoing observation of an individual to ensure the individual's safety. An appropriate staff individual must be continuously present in the individual's immediate vicinity, provide ongoing monitoring of the individual's mental and physical status, and ensure rapid response to indications of a need for assistance or intervention.

SAMHSA – Substance Abuse and Mental Health Services Administration.

Self Care – an individual's ability to perform basic self-care activities such as bathing, grooming, feeding and toileting.

Sheltered work – workshops providing a working environment that is segregated from the general workforce — often piece work done at sub-minimum wage.

Skills Training and Development – training provided to an individual that addresses the severe and persistent mental illness and symptom-related problems that interfere with the individual's functioning.

Social Functioning – an individual's social skills and relationship functioning; includes age-appropriate behavior and the ability to make and maintain relationships.

Special Needs Offender – an individual with mental illness or mental retardation for whom criminal charges are pending or who after conviction or adjudication is in custody or under any form of criminal justice supervision.

Subacute care – treatment beds in facilities for people after they get out of hospital who are not yet ready to be on their own.

Supportive community living – providing a variety of supports so that people can effectively live within a community. Sometimes includes housing supports, transportation supports or people who go to the home to assist with daily living activities.

Supported Employment – intensive services designed to result in employment stability in regular community jobs.

Supported Housing – Activities to assist individuals in choosing, obtaining, and maintaining regular, integrated housing.

Voluntary commitment – when people make a personal decision to check into a hospital or treatment facility.

Mental health is also important to workforce development

ONE VOICE *from page 9*

This year, a regional airport's needs were on the agenda, and so was mental health. County Board Chairman Matt Sorensen was part of the delegation of 37 people including business and labor leaders.

"As we look each year, when we go out for One Voice, what are those issues that are important to my county," said Mike O'Grady, the EDC's vice president for external relations. "And mental health is critical not only to quality of life but also workforce development.

"If we have mental health issues in our community or a lack of resources to provide mental health, that affects employment. It can be as simple as sick days, lower production from employees. So we saw mental health as truly a part of economic development in our community."

The visit to Washington came at a time when the County Board has created two advisory committees to help assess the county's mental health needs and identify best practices, whether in the community or elsewhere.

County Board Member Sondra "Sonny" O'Connor chairs the 15-member best practices advisory committee. The panel's mission statement is: "To identify the components of a holistic, integrated continuum of mental health care model for all populations in McLean County."

"What we're finding is that we have a lot of pieces of what would be considered best practices, but they're somewhat siloed," she said. "So how do all these other communities that have all these wonderful things pull them all together to play well in the sandbox together?"

In McLean County (pop. 169,572), an estimated 20 percent of the population is at risk for having a mental health episode in their lifetime, according to the Illinois Project for Local Assessment of Needs (IPLAN), a community health assessment and planning process that is conducted every five years by Illinois' local health jurisdictions.

One factor that has highlighted the need for more and better coordinated services is the situation at the county jail. Sheriff Mike Emery serves on the needs assessment advisory committee. A National Institute of Corrections assessment that he requested earlier this year found that on the first day of the evaluation, 28 percent of the jail population comprised "inmates diagnosed with mental illnesses that are on some type of psychotropic medication," Emery said.

"To decrease the mental health illnesses in the jail you need to start in the community on what are we doing to address the lack of services in the delivery side of the community," he said, "because if we do better there, we're going to do better in the jail."

Recommendations of the NIC assessment include promoting stakeholder meetings to engage key community providers to develop and strengthen partnerships, and offering community education to physicians and service providers on mental health, suicide prevention and the local resources available to clients.

Emery conveyed the results to a receptive County Board, which has been working on jail mental health issues, including securing federal and state grants for jail diversion and drug court programs, according to County Administrator Bill Wasson.

"We have seen a decrease in state funding for mental health services," he said. "We've seen the closure of facilities and the reduction of access to facilities both on the civil commitment side and for individuals who come through the criminal justice system," he said, "so we were feeling those types of issues irrespective of whether we were talking about the criminal justice system or not."

He expects the two advisory panels will complete their work by June, when both groups will come together to discuss possible solutions and implementation.

Emery said: "I've never seen a government move this quick on one individual concern and it's just amazing how fast the county's moving on that — and it's attributed to the leadership."

EMT program diverts mentally ill from hospital ERs

BEST PRACTICES *from page 11*

families can choose to participate in individual or family therapy, coordinated through their child's case manager. The case manager includes the parent in coaching sessions with the child to help the parent learn the therapeutic interventions used in the program.

North Carolina

Wake County Emergency Medical Services' uses Advanced Practice Paramedics (APP) in a larger mobile integrated health care effort. As part of an alternative destination program, first responders have been trained to assess patients for potential psychiatric issues, consult with doctors and can bypass hospital emergency departments (ED) and go straight to a psychiatric facility.

If transported to an ED, this type of patient will spend an average of 14 hours before transfer to an appropriate counseling or care center — more than four times longer than the average chest pain patient, according to Jeffrey Hammerstein, public information officer and paramedic, Wake EMS.

In a recent one-year period, Wake County EMS bypassed the ED and redirected 252 patients to a more appropriate counseling or care center (or arranged a follow up with some type of care). EMS officials cite the successful example of a homeless man with a history of alcohol abuse, who between July 1, 2010 and June 30, 2012 placed 221 calls to 911.

Advanced Practice Paramedics began working with him in 2011 and got him into an alcohol treatment. The man has since been discharged, and is living a clean and sober life with family. In FY12, he made 30 EMS calls and none since August 2013.

Minnesota

In 2010, the Ramsey County Substance Abuse Court (ASAC) was selected by the National Drug Court Institute to serve a three-year term as one of 10 adult mentor courts in the United States.

Begun in October 2002, ASAC provides individuals the opportunity to improve their lives and break the cycle of substance abuse. The court uses assessment, treatment (chemical and mental health), strict supervision, random drug and breath testing, regular court hearings and immediate sanctions and incentives to help participants maintain a drug-free lifestyle.

The program represents a closer working relationship between criminal justice partners (judges, prosecutors, defense attorneys, case managers and treatment providers) than is traditionally seen in criminal courts. ASAC serves approximately 55 participants on any given day.