NACBHDD National Association of County Behavioral Health & Developmental Disability Directors
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UNDER THE MICROSCOPE

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Jailing those with mental illness and co-occurring disorders is not just a "big county" problem; Small counties also need to "Step Up"

ISSUE

There's no doubt about it: Making the decision to participate in the National Association of Counties' "Stepping Up" initiative, a nationwide effort that asks county leaders like you to collaborate in developing community based systems to reduce the incidence of incarceration, and to improve local treatment options for those with mental health and co-occurring disorders, is a huge step.

But your county's participation is also sorely needed as part of broader national behavioral health and justice reforms. "It's a huge issue. The president is working on it. Congress is interested in it—it's one of only a few issues on Capitol Hill that is gaining bipartisan support," says Patrick Fleming, a retired behavioral health executive from Salt Lake County, Utah, who now works as a Senior Fellow for NACo on the "Stepping Up" initiative.

Today, county governments tend to bear the operational and financial brunt of excessively large jail populations that have been swelled by high numbers of detainees with mental health and substance use disorders. Fleming believes that the problem dates back to the seventies and eighties, when the goal was to deinstitutionalize people with mental illness and get them living in the community with the help of adequate, community-based treatment resources. But the funds saved through deinstitutionalization were never properly reinvested in community services. Instead, they were cut at all levels of government. One result, he believes, was a substantial increase in the rate of homelessness, particularly among those with serious mental illnesses.

The failure of deinstitutionalization coincided with the launch of the nation's decades-long "War on Drugs," which cast a wider net for drug-involved individuals while substantially increasing criminal penalties for drug possession and drug use. Many national leaders now view this "war" as misguided, since it emphasized punishment instead of treatment and led to a dramatic increase in the number of non-violent drug offenders who are incarcerated nationwide.

The Stepping Up initiative recognizes the disproportionate impact that failed deinstitutionalization policy and stepped-up anti-drug enforcement efforts have had on those with mental illnesses and substance abuse problems. According to national experts, some 25% of incarcerated individuals have mental health disorders, with a substantial subset of these experiencing moderate to severe impairment. Similarly, an additional 50% of incarcerated individuals suffer from a substance abuse disorder, with most of these having symptoms of dependence or addiction.

In the vacuum that followed deinstitutionalization, Medicaid became the financial "last resort" for many people with severe mental illnesses. Yet, due to the variability of Medicaid plans across the states, huge

numbers of people with significant mental illnesses still end up falling through the cracks, Fleming says. "These individuals sometimes engage in irritating behaviors that get the attention of concerned citizens and law enforcement, and they end up getting arrested and detained in jail."

In addition, there's a large population with substance-use disorders, a population that suffers even more in states that haven't yet implemented the ACA's Medicaid expansion. "Many of those individuals – if they haven't already been diagnosed with a mental disorder and qualified for SSI -- simply don't qualify for Medicaid services at all. So, although the ACA says that we're going to treat addiction like a medical illness and the resources are available, many states, including my home state of Utah, haven't done the Medicaid expansion." He adds that counties end up being the service payers in jails because Medicaid rules ban payment for nearly all services for individuals detained in jails or prisons.

"Unfortunately, many of these detainees get their only services when they get locked up in the county jails. This is why so many county officials across the US—county commissioners, elected officials, sheriffs, county commissions—have been in getting involved with the issue of incarcerating and treating so many people with mental health and addiction problems. They're saying, "We've got to do something about this. This doesn't make any sense. That's why they are interested in working with behavioral health in the Stepping Up initiative."

Sizing up your county's opportunity to "Step Up"

SAMHSA's National GAINS Center seeks to expand access to services for people with mental and/or substance use disorders who come into contact with the justice system. The center has been pursuing the development of jail diversion and treatment options for years, and has much to share with county behavioral health leaders. One key learning is that, while no county is completely like another, many share similarities in terms of size, financial resources, challenges faced, and the availability (or lack) of diversion or treatment resources.

Fleming says that Hank Steadman, President of Policy Research Associates (PRA) and a leading developer of the "sequential intercept" model that guides many jail diversion programs, breaks counties into four categories, based primarily on size:

County/Parish/ Borough category	**Number in Category**	**Example: City/County**	**Funding Strategy**
Metropolitan counties (Pop. > 2 million, per 2010 Census)	12	New York, Queens, Bronx , Los Angeles (Los Angeles), Chicago (Cook)	Resource shifting
Urban counties (Pop. 1-2 million)	27	San Antonio (Bexar) Columbus (Franklin) Salt Lake City (Salt Lake)	
Mid-sized counties (Pop. 125,000-1 million)	400	Charlotte (Mecklenburg) Mt. Pleasant, MI (Macomb) Portland, OR (Multnomah)	
Small/Rural/Frontier Counties (Pop. > 125,000)	2,704	Spotsylvania County, VA Worcester County, MD Codington County, SD Tuolumne County, CA	

For the 40 or so large metropolitan and urban counties, taking on the Stepping Up initiative is logical. By and large, Fleming says that these large counties, as well as many mid-sized counties, have the size and the wherewithal in terms of infrastructure, funding base, jails, courts, hospitals, and providers to pilot, then scale up jail diversion and treatment initiatives funded by shared savings. But for mid-sized and particularly for the smallest, most rural counties, Fleming says that "you really need some creativity, not only in terms of exactly what you can accomplish, but especially in how you're going to pay for it."

The basics of jail diversion and treatment programs, including the need to assemble a broad base of stakeholders and conduct a Sequential Intercept Mapping (SIM) workshop, were discussed in the October 2015 issue of Under the Microscope.

But to be successful, county initiatives need more than a means of developing infrastructure, processes, and system-wide cooperation. In the end, they've also got to develop and implement best-practice behavioral health services, facilities, and supports that can deliver results. To ensure that this knowledge and technical assistance is available to counties who step up, NACBHDD is now working with Policy Research Associates (PRA). Fleming says that the NACBHDD/PRA effort is "taking a deep dive into the behavioral health best practices involved in the diversion and treatment process."

ANALYSIS

Best-practice "basics" for community diversion and treatment programs

What are best practices for the behavioral health services necessary for Stepping Up? While sequential intercept and diversion systems in metropolitan or urban counties may include many and varied capabilities and services, Fleming says that budget-conscious small, rural, or frontier counties can build effective early intervention and diversion systems based on several simpler and more modest "basics." Among the most important "basics" are these:

Best practice intervention/ (Sequential Intercept Level)	**Definition**	**Impact**
Peer-operated "warm lines"	Trained mental health peers offer supportive conversation with mental health population, can refer to "hotline" if crises occur.	Inexpensive, effective way to resolve many day-to-day problems and prevent or reduce incidence of mental health crises.
Professionally-staffed "hot lines"	Clinical professionals handle calls from people in crisis or at risk for harm/suicide, often eliminating the need for officer intervention.	Next level telephone help for more serious cases. Professionals are linked to local resources and can recommend assessments or make referrals.
Crisis Intervention Trained Officers (Intercept 1)	Instead of regular officers, CIT-trained officers are dispatched to handle calls involving people with apparent mental health or intoxication/drug problems.	CIT-trained officers can recognize behavioral health disorders and use CIT skills to de-escalate situations without force or injury. They can identify candidates for diversion.
Mobile Crisis-Response Team (Intercept 1)	Team includes clinical professional and a trained peer. Deployed together with a CIT-trained officer	A more capable addition or alternative to CIT-trained officers in crisis situations. Team may also

	or by request of an officer on the scene.	make routine visits with at-risk individuals to pre-empt/prevent future crises.
"Receiving" center (Intercept 2)	Safe alternative to booking and jail where officers can "drop off" people with non-violent behavioral health crises or acute intoxication for stabilization, nutrition, and a reconnection to treatment. (Some centers may evolve to provide "walk in" care for self-referred individuals.)	Offers immediate diversion to short-term (0-48 hours) stabilization care that connects (or reconnects) individuals to needed mental health or SUD treatment. Drop off model cuts booking/jail costs while keeping officers "on the street."
Wellness and Recovery Center (Intercept 5)	Non-hospital, non-jail location that provides support and treatment for people with mental health or substance-use disorders who are long-term community residents.	Health promotion, prevention, and wellness services for at-risk individuals provided at a fraction of the cost of a hospital ED visit, a psychiatric hospital stay, or an arrest and jail term.

All of these approaches aim to "get people out from the highest-cost resources, such as hospital emergency rooms or jails, and getting them into community based facilities and services," Fleming explains. The earliest interventions – warm and hot lines – help individuals prevent or manage behavioral health crises using immediately available community resources, eliminating or minimizing the need for law enforcement altogether.

The other interventions become resources in the "sequential intercept" process: The presence of CIT-trained officers, or better yet, a mobile crisis team that works in concert with law enforcement dispatchers and officers, is a proven method for identifying and diverting non-violent individuals with behavioral health problems at Intercept 1: the point of first contact with law enforcement.

For these or other Intercept 1 interventions to be effective in diverting people away from booking and jail, Fleming says that "there's got to be a place where these people can go. The simplest type of place is what he calls "a receiving center" – a safe and appropriately staffed location that offers law enforcement 24/7 access to "drop off" individuals that need crisis mental health or SUD treatment, not jail.

And, to help people beyond the scope of the receiving center (24-48 hours), he suggests development of a local wellness and recovery center, with non-hospital residential services suited to crisis stabilization and early-stage addiction treatment, followed by a transition to other longer-term care.

Patience, Patience, Patience

The new NACBHDD/PRA technical assistance effort takes into account that it's often impossible for one county to simply replicate what another county is doing. So, the NACBHDD/PRA effort will identify and analyze best practices, helping counties understand and implement solutions that are scalable, customized to meet unique local requirements, and consistent with available funding for implementation.

For most counties, Fleming says that implementation will involve long-term planning, patience, and incremental scale-up of processes, funding streams, and program elements. "If you can't do things on a

grand scale right away, what can you do incrementally?" Citing the best practice of a community based "receiving center," he suggests, "You may have to start small. If you don't have the ability to take walk-ins and referrals for treatment, perhaps you should just focus on law enforcement needs. Start by providing a place where officers can 'drop off' an individual with a mental health or substance use problem instead of having to book them into jail."

The same thing applies for winning the support of elected officials: Can you start a treatment program, even on a small scale? Are you willing to speak with elected officials and demonstrate the cost offsets involved in diverting an individual into treatment with a cost that's a fraction of the $30,000 annual cost of a jail cell? Are officials willing to consider whether there's a way to cost-shift within county government to create the chance to do treatment, even on a limited scale, as a proof-of-concept until you have the ability to scale up? In addition to cost offsets, are there other dollars available that might help?

Delivering technical assistance to hundreds of counties in different states "is going to be a pretty tall order because of all the ways in which counties differ – their service delivery organizations, funding methods, different facility licensing requirements, different Medicaid plans and a host of other factors," Fleming says, adding "We may end up with a 1,500 or 2,000 different solutions." However, despite the fact that every county is unique, many of the nation's small counties face similar problems, problems that Fleming says they are overcoming by thinking creatively and finding new ways to work together.

By sharing solutions, making site visits to existing programs, and exploring alternatives, county leaders often recognize that "we could do this, this, and this, but we can't do that, or we'll have to do that in a different way." Fleming cites a number of small counties that are involved in the planning and execution process:

- Tuolumne County, California — This county of about 53,000 residents, located east of the Bay Area in the foothills of the Sierra Nevada, found that citizens with mental illnesses lacked adequate housing opportunities in the community. So, Tuolumne County is joining the ranks of many larger counties in launching a SOAR (SSI/SSDI Outreach Access and Recovery) program.

- Codington County, South Dakota — Although it is a small county (population 28,000), Codington is the largest county in its region and it is surrounded by a number of even smaller counties. Today, Codington is at the heart of an innovative five-county arrangement, in which Codington does the jailing for the other counties to reduce incarceration costs for all. This effort created a basis for cooperation on improving regional services and taking other steps to reduce the regional jail population.

- Williamson County, Illinois – This rural county in southern Illinois (population 66,000) has formed a coalition to provide housing to the homeless, including those with mental illness. Lack of good and safe housing for the mentally ill was identified as a principal issue that was driving up the use of local jail cells. Minus more housing, the county found that there was simply no other place for the homeless mentally ill to go.

- Dunn County, Wisconsin – This county (population 44,000) in west-central Wisconsin is developing an integrated treatment court and other services for individuals with mental health, substance abuse and co-occurring disorders as a means of diverting them out of jail and providing a means of safely re-integrating them into the community.

ACTION

- **Get your county leadership on board.** "Most county commissioners don't know anything about

behavioral health. That's the place to begin telling your story." By sharing solutions, making site visits to existing programs, and exploring alternatives, county leaders involved with a Stepping Up initiative often recognize that "we could do this, this, and this, but we can't do that, or we'll have to do that in a different way." Go to the NACo website for details: http://www.naco.org/resources/programs-and-initiatives/stepping-initiative

- **Look at the counties around you and start a conversation**. "If you're all sharing similar burdens, is there a way to pool your dollars and other resources?" Fleming asks. A lot of times, small rural counties form cooperatives around things like public health and behavioral health services, so that they can share infrastructure and pool funding.

- **Leverage the expertise of state behavioral health organizations.** As you work with other counties and learn that many of their concerns and needs are similar to yours, bring those needs to your state association. "They can support you in the political process, ensuring that there's one unified voice speaking for all of the counties in the state. Unlike Congress, where it is difficult to move legislation, states are much more willing to take action," says Fleming. "There's a growing recognition among legislators, judges, prosecutors and others that behavioral health is at the center of justice-reform and justice reinvestment efforts, and they're getting tuned into the lack of providers and resources. If you can join with other counties to lay out a vision, identify barriers, and request legislative changes, there's a strong chance that legislators will hear you and take action."

- **Embrace new partners and reinvest in systems.** "As the ACA takes hold, I think you'll see more and more managed care organizations stepping into county service-management roles," Fleming says. "Some people see managed care organizations as a threat to county-delivered services. But we've got to learn how to work with them, because if done correctly, they can really complement county services, in part because they can do some things that counties can't.

  "Five years ago, we went out to buy services for Salt Lake County, and several big managed care organizations decided to bid. We went through a very creative process on that RFP because the county had two big requirements: The county was seeking to keep people out of jail and did not want to assume liability for our large uninsured population.

  "After a rigorous RFP, we hired Optum Health, who showed us how they had used diversion programs in Pierce County, Washington," Fleming continues. "We started all of the basic programs in Salt Lake County — things like a warm line, hot line, mobile crisis team, CIT training, and a receiving center. Through the design of our contract, Salt Lake County retained overall control over expenditures, but used Optum Health to deploy available funding with far greater flexibility. When care management efforts produced savings, for example in reducing hospitalizations, Optum offered the capability to retain and pool those funds, which we as a county couldn't do. Eventually, we used those savings to fund new programs.

  "What you don't want to do is turn over control of your county behavioral health system to managed care," he warns. Instead, counties should provide leadership that empowers the MCO to do what it does best – allocate and manage resources -- while retaining the right to decide how best to use those savings – not as MCO profits, but as a source for reinvestment in county care systems."

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