North Carolina

Sentencing and Policy Advisory Commission

Study of the Intersection of Mental Health and Jails: Select Practices from Across the State

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INTRODUCTION

The General Assembly created the North Carolina Sentencing and Policy Advisory Commission ("the Commission") in 1990, and charged the Commission with the long standing duty of identifying critical problems in the criminal justice and corrections systems and recommending strategies for addressing those problems. In 2014, the Commission undertook a study of the mentally ill (MI) population in local jails, with the goal of finding strategies that could better serve this population and potentially improve recidivism outcomes. This publication serves as a vehicle to share information collected during that study; it is intended to provide stakeholders with the opportunity to learn about practices implemented in other jurisdictions or by other entities across the state and consider different methods that could be incorporated into or augment their existing practices.

The information included in this publication is the result of field research to select counties in North Carolina, discussed below. This publication would not have been possible without the overwhelming consideration and attention given to this project by those interviewed, for which the Commission and its staff offer their thanks.

This publication offers background on the creation and work of the Commission's Research and Policy Study Group, jails and the mental health system in North Carolina, and a description of its site visit project that produced the majority of the information offered here. Observations from the site visit project are then detailed, as described by area stakeholders. Observations are organized by common topics - Subsection A contains methods used to identify the MI population within the jails; Subsection B contains descriptions of how a dedicated point of contact for the MI population within the jail can be utilized; Subsection C contains methods used to promote the continuity of care for the MI population as they exit the jail. Each subsection concludes with questions for practitioners and jurisdictions to consider in the context of their own approaches to managing mentally ill inmates.

BACKGROUND

For additional context and as background to the development of this publication, the Commission's Research and Policy Study Group is described below. Also provided is a general description of North Carolina jails along with a broad overview of the mental health system in the state. The background section concludes with a detailed description of the major source of information for this publication – the site visit project.

The Research and Policy Study Group

In 2014, the Commission formed the Research and Policy Study Group to explore existing criminal justice research findings that could lend themselves to policy recommendations, with the goal of reducing recidivism. One of the issues the Study Group identified for study related to offenders with mental illness, as these offenders tend to recidivate at higher levels than offenders without a mental illness. One of the first points of contact offenders with mental illness encounter in the criminal justice system is the jail. Jails face unique challenges in handling this population. Inmates with mental illness often require more resources and have specific needs; many jails are not equipped with the resources and/or specific mental health expertise to handle them. To that end, the Study Group focused on the balance between the provision of appropriate care for these offenders and the many other responsibilities of the jail.

The Study Group worked for eighteen months studying the intersections of the mental health and criminal justice systems, deciding to specifically focus on the intersections within the context of the local jail. The Study Group acknowledged the need for and importance of initiatives focusing on the diversion of offenders prior to booking; however, it chose to focus on practices post-booking, in light of other existing and successful efforts focused on diversion. To better understand existing practices in the field, Commission staff conducted site visits to four counties in the state (discussed below). From these visits, the Study Group collected a wealth of information about different area practices and challenges related to handling the MI population in jails. The information from these visits was analyzed by staff for broad themes, and presented topically to the Study Group over the course of two meetings in the fall of 2015. The information from the site visits was further bolstered by research on best-practices on mental health and jails.

The Study Group reviewed the totality of information collected from site visits and from best-practice research, and considered whether there were policy proposals to be made that could potentially improve outcomes for mentally ill offenders in jails. The Study Group ended up making four proposals, which it submitted to the Commission in June of 2016; all were adopted. One proposal was to create a publication that could facilitate discussion among local stakeholders addressing similar issues in their communities. The Study Group wanted information collected through their work to be available to those in the field to support their ongoing efforts. Study Group members and Commission staff remain

available for questions and consultation in connection with this publication. As further background for the publication, a broad overview of jails and the mental health system is provided below.

Jails in North Carolina

Jails in North Carolina are funded at the county level and operated by local sheriffs and their staff. The state sets the standards for health and safety regulations, which are monitored for compliance by the North Carolina Department of Health and Human Services (DHHS). The jail population consists largely of inmates held under a bond while they await disposition of their case, commonly referred to as pre-trial detainees. The jail also holds inmates serving active sentences for misdemeanor convictions; offenders ordered to an active sentence for a felony conviction serve their sentence in the state prison system.[1] Many of the available sentence lengths for misdemeanor offenses are shorter than those available for felony offenses; as a result, most inmates serving active sentences in local jails are for relatively short sentences.

The jail operations most relevant to this publication include the intake and admissions process, in-custody medical services, and methods of release, described below. Depending on the county, processes can vary, and this overview should not be considered to be the same for every jail in the state.

Intake – When a person is arrested in the community, the local law enforcement officer will bring the person to the detention facility to see the magistrate. The magistrate has the authority to set the conditions of release for the offender, which could include many forms of detention, such as a bond. Some areas will give the offender time to contact family or others to determine if they can make bond before they begin the booking process, for maximum efficiency. Depending on the policies and rules of the local jurisdiction, and the charge, the offender might have another hearing with a judge to reconsider bond. Once it appears that the offender will not be able to be released, the booking process begins. The offender meets with a member of the jail staff (the intake officer), who collects information about the offender that will help the jail know how to best classify the inmate. This process can include a short form about medical or mental health conditions, usually related to suicide risk, before the offender is booked as an inmate into the jail.

In-custody medical services – After intake, the inmate meets with medical staff; depending on the facility and the time of the offender's arrest, this can be within hours of intake or take a few days. When meeting with the offender, medical staff will typically request releases from any current physicians, which can further inform the jail staff's decisions about the inmate's care and classification.[2] The size of the medical staff varies, depending on the needs of the inmate population and the resources within the county. Some areas have full time medical staff available 24/7, while others have medical staff a few

[1] There may be inmates serving an active sentence for a felony if the inmate has such a short amount of time left to serve that transport to a prison facility is impractical.
[2] After the inmate's meeting with medical, should they need to speak with the medical staff again, they can request services via sick call.

days a week. Some areas have a mental health professional on staff on campus, while others contract out for a few hours a week.

In-custody medical services and treatment are paid for by the county, usually out of the local jail's budget, and are not supplemented by other public programs such as Medicaid.[3] In North Carolina, a person's Medicaid is terminated if they are taken into custody in a local jail or detention facility. This is different from inmates incarcerated in a state prison or other correctional facility, whose Medicaid is suspended until their release.[4] The inability to use Medicaid funds for the mentally ill population, a high-cost consumer group, impacts the provision of care for these inmates. One example of such an impact relates to medication; medicines to treat mental illness can be costly, potentially straining the jail's budget for the expense of medications for just a few inmates.

Methods of release – An inmate can be released from jail prior to the resolution of their case by bonding out, as discussed above. If the inmate cannot bond out, the disposal of his or her pending case(s) determines when he or she may be released. If the inmate goes to court and is convicted, he or she could be released back into the community. He or she could be ordered to serve an active sentence, either in the jail or in the state prison system (requiring a transfer). If the disposition of the case results in the inmate's release, the inmate will be escorted back to the jail for discharge processing, and released from that facility. Because the disposition of the case is unknown until the court enters judgment, the jail usually does not receive advanced notice about an inmate's release unless it is as a result of completing an additional active sentence. Some inmates or inmates' attorneys may let the jail know of their plans for a particular court date, but the release orders are not considered final until the judgment has been ordered.

Mental Health in North Carolina[5]

Mental health services in North Carolina are managed through local management entities - managed care organizations (LME-MCOs).[6] DHHS contracts with the LME-MCOs to manage the public dollars used to fund mental health services and evaluate mental health services needed within their catchment area. While the LME-MCOs contract with local providers for the provision of those services, the LME-MCOs monitor and authorize the specific services providers request for individual clients as an administrative function of managing the public funds. Ultimately, LME-MCOs are responsible for ensuring access to core services for all people in their catchment areas.[7, 8]

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[3] Eligibility requirements for Medicaid include people with a disability, which can include certain mental illnesses. *See* www.medicaid.gov for more information.

[4] N.C. D.H.H.S., Adult Medicaid Manual, MA-2510, Sec. III, available at https://www2.ncdhhs.gov/info/olm/manuals/dma/abd/man/MA2510.pdf.

[5] The following section draws on information from a presentation to the Research and Policy Study Group by Professor Mark Botts, "Overview and History of LME/MCO Structure," presented on April 17, 2015.

[6] In 2011, the General Assembly required all LMEs to implement the "1915(b)(c) Managed Care Waiver," which added a managed care function to the LMEs, now referred to as LME-MCOs.

[7] Core services are defined by N.C.G.S. §122C-115.2(b).

[8] As of July 1, 2013, an area authority's catchment area must have a minimum population of 500,000. G.S. §122C-115(a).

The current structure of management of public mental health services is the result of the evolution of the system over several years. In 1963, the North Carolina General Assembly authorized local communities to create mental health clinics, which were operated with support of state government. Local county involvement was intended to ensure that services offered through the clinics were tailored to the needs of that community. In 2001, the General Assembly passed a law requiring the separation of the delivery of mental health services from the management of those services; local management entities were created to manage public dollars and oversee the network of providers who would see public patients. This General Assembly action is commonly referred to as "divestiture." At the time of this publication, there were seven LME-MCOs representing the entire state; however, in March of 2016, DHHS recommended a consolidation into four LME-MCOs, which would again impact the structure of the system moving forward.

The public dollars that LME-MCOs manage come from three main sources of funding: Medicaid, block grants (State and Federal), and county contributions. Much of the funding comes from Medicaid reimbursements, which operate based on a capitated model.[9] The individual client must qualify for Medicaid and the service provided must be medically necessary for the LME-MCO to be able to use Medicaid to reimburse the provider. Block grants are given to the LME-MCOs in a lump sum, with varying eligibility requirements. County contributions are also usually given in lump sum, with fewer eligibility requirements attached. Although contributions from the county are mandated by statute, the statute does not specify any particular amount the counties must allocate.[10] As such, levels of contribution from the counties vary across the state. The LME-MCO determines how to best allocate the funds for the persons in their catchment area, which requires extensive budgeting and balancing of which funds can be used for whom and which services.

Most LME-MCOs direct some funds to clients involved in the criminal justice system. LME-MCOs have positions dedicated to care coordination, which focuses on providing clients with the appropriate level of care and assists with making client care decisions at critical treatment junctures.[11] Many areas visited designated inmates as qualifying for care coordination services categorically; others had a more discerning definition of eligibility. Another common position, discussed below in the section on Dedicated Point of Contact, is the jail liaison. While this position had several different iterations, it was common for areas to have a specific person or team as the connecting contact between the LME-MCO and the jail. Overall, the provision of mental health services in North Carolina is comprised of local and state partnerships and contracts, multiple sources of funding, and the determinations by LME-MCOs of what providers their unique catchment areas need.

[9] A capitated model pays the provider a set amount for each person assigned to them, usually through a health maintenance organization (HMO), regardless of whether a particular individual seeks care.
[10] G.S. §122C-115(b) ("counties shall and cities may appropriate funds for the support of programs that serve the catchment area").
[11] Critical treatment junctures are defined in G.S. § 122C-115.4(b)(5).

Site Visit Project

As noted above, to learn more about the intersection of the mental health and criminal justice system at the local level, specifically within jails, site visits were conducted at select sites across the state. The site visit project involved selecting jurisdictions to visit, identifying stakeholders to interview, designing interview protocols, conducting interviews and gathering information, and finally, compiling and analyzing the information obtained during the project. In choosing the sites for the project, Commission staff sought maximum variety, while recognizing that it would not be possible to visit enough sites within the project timeframe to obtain a representative sample of North Carolina counties. Selected sites had different population densities (urban, rural), were in different areas of the state (east, west, piedmont), and had different LME-MCOs representing their area.[12] The Study Group also defined the population of interest for the project as MI inmates who were not in crisis (i.e., posing an immediate threat of danger to themselves or others). The Study Group recognized the issues related to offenders in crisis were substantial; however, they were also different from those issues related to inmates with MI that were relatively stable at intake.

In the selection of whom to interview, staff identified stakeholders that might interact with any aspect of the intersection of the mental health system and the local jail. Within each county, staff met with the following:

- The County Sheriff's Office, particularly staff serving the jail, to understand the mental health issues facing local jails;
- The LME-MCO responsible for the mentally ill in that county, to learn about their role, if any, in the criminal justice system and/or in jails;
- A County Commissioner, to understand the landscape of mental health services within the county, and the county's perspective of jail services;
- Service providers, public or private, to learn about the services they provide, the constraints on those services, and their interaction with the LME-MCO and the jails, if any;
- Pretrial or other court and/or county-based agencies that might be involved with the MI population, if the county had such services, to see any existing practices that might be serving this population

For each stakeholder group, staff developed questions tailored to each agency or practice. The questions were designed to help gain an understanding of current practices as well as any initiatives specifically focused on mental health and jails.

After completion of the interviews, staff compiled and analyzed the information into broad categories that were relevant to all areas. From those categories, observations were developed that captured many of the common issues facing stakeholders. Those observations were presented to the Study Group, which considered and developed policy proposals where relevant.[13]

[12] For a list of the stakeholders interviewed for this project, as well as diagrams used by the Study Group illustrating the relationships between the stakeholders by county, *see* Appendix A.

[13] For the policy proposals and commentary ultimately adopted by the Sentencing Commission, *see* Appendix B.

As noted above, the Study Group suggested a compilation of area practices be published from the rich information obtained from the site visit project. As such, most of the information included in this publication stems from observations and reports from stakeholders interviewed during the site visits to these four counties. The information gleaned from these extensive interviews is interesting and informative; however, due to the limited number of sites visited it cannot be generalized to be indicative of practices across the state. Practices detailed in the Observations from Select Sites section following depend on the available resources within each area, among other factors, which is important in considering the variations between jurisdictions. The information included here is as it was presented to Commission staff in the summer and fall of 2015; practices and methods may have changed since that time.

OBSERVATIONS FROM SELECT SITES

This section contains information obtained from the Site Visit Project (*see* above) bolstered by research on best-practices on mental health and jails, where noted. Information is presented topically, based on three major areas of foci that emerged from interviews – Identification, Dedicated Point of Contact, and Continuity of Care. Each section details local approaches as described by stakeholders and offers an analysis of the challenges and benefits of the respective approaches. Each topic concludes with suggested questions jurisdictions could consider as they work to process the information with area stakeholders and determine if any of the practices mentioned could or should be incorporated into their existing practices. As noted previously, the information included here is not intended to be representative of North Carolina as a whole; instead, it is offered as a resource for practitioners to understand the approaches other jurisdictions utilize to manage the mentally ill population in jails. Jurisdictions might consider whether any of these approaches could fit within or augment their existing practices. As a reminder, jurisdictions were selected in part because of their unique composition (urban/rural, east/west, etc.); thus, practices described below are reflective of the available resources within each jurisdiction. The Commission does not advocate or endorse any particular practice over another.

Getting Started – It may be helpful for jurisdictions to analyze existing practices and challenges and identify goals at the outset to build a foundation from which all parties can work. Although not specifically listed as an observation below, a strong theme echoed throughout all jurisdictions was **collaboration**. The issues facing the mental health and criminal justice systems are complex, particularly (and perhaps more so) when they collide. Trying to tackle complex issues that span multiple entities and involve numerous stakeholders, necessitated collaboration – working together on shared problems, towards common goals (improved outcomes, more efficient use of resources, etc.).

While much of the collaborative effort observed as part of this project occurred organically, it is worth noting that a national effort has been developed – the *Stepping Up* initiative – the purpose of which is to reduce the number of mentally ill persons incarcerated in local jails.

Stepping Up, supported by the National Association for Counties, the Council of State Governments Justice Center, and the American Psychiatric Association Foundation, provides assistance to localities to engage stakeholders in a collaborative process, develop an actionable plan, and track outcomes. The recent Stepping Up initiative was being rolled out during the same timeframe as the site visit project. Many counties in North Carolina, including some of the sites visited as part of this project, are engaged with this national effort. As was found during the site visit project, the importance of collaboration to address issues facing the MI population in jails, is also a critical component to the Stepping Up initiative.

For collaboration to be successful, stakeholders need to be on the same page about the processes, procedures, and issues surrounding the MI population in jails as well as what strategies to employ to address any issues. Below are some questions to consider to jumpstart a collaborative effort.

Who needs to be at the table?

Areas created advisory groups and task forces to work together to address common challenges facing the MI population in jails. Memberships reflected the different stakeholder interests interacting with the population. Groups included, most commonly, health care professionals, such as representatives of the LME-MCO and local mental health providers, judges, law enforcement, attorneys and other victim advocates groups. The most successful collaborative efforts shared another commonality - strong, committed leadership. The

specific leader varied across the areas – in some areas, the champion was a sheriff's deputy, and in others it was a passionate county commissioner or the LME-MCO.[14]

What is our process for offenders moving into and out of the jail?
Where are our gaps where offenders may not be receiving optimum care?

Sketching a map or flow chart of the criminal justice process can be an effective way to make sure all parties at the table have an understanding of what happens to an inmate when they are taken into custody. Some areas had received financial support to go through the Sequential Intercept Mapping Process, which helps identify different points of the process groups could focus on (*see* Appendix C for the flow chart used by the Study Group to map a general criminal justice process, as well as an example of the Sequential Intercept Model from Wake County).

What are our goals for this population?
What are our priorities for these goals?

Identifying goals for the group, and priorities within those goals, can help root the group in a common effort. This process can also make a daunting task more manageable.

These questions are one way area stakeholders may initiate or expand upon a collaborative effort. Having many perspectives represented and all with an understanding of the locality's unique system and processes will allow the methods listed below to be fully considered for how they may function in any particular community.

Beyond collaboration, jurisdictions may consider the following observations as they work towards addressing issues related to the MI population incarcerated in jail. Each section offers a detailed analysis of the benefits and challenges and existing approaches to address those challenges (where they existed). It is important to remember the information provided below is intended to be a resource, but not reflective of all practices occurring across the state.

A. IDENTIFICATION OF THE POPULATION

Identification and a tailored approach to the mentally ill population are critical components to maintaining a safe environment in the jail, both for the inmates and for staff. To serve this population, stakeholders need to know who the mentally ill are and what kinds of services or treatment they may need. Addressing the needs of the population involves first understanding the scope within each locality – the who, how many, and their diagnoses – to determine what kind of treatment they may need.

Understanding the scope is the first step in improving the process for inmates with mental health diagnoses. Many inmates that come to jail will self-report to the booking officer and/or medical professionals that they have a mental health provider and/or that they are on medications. Some inmate's families will notify the jail of the inmate's mental illness. While this type of identification is

[14] Having a strong leader is also recognized by the national Stepping Up Model in their suggested questions county leaders should ask to assess their current practices addressing this population. For more information on the Stepping Up Initiative, visit www.stepuptogether.org.

welcome and helpful, there is little the jail and other stakeholders can do to promote it. As such, this section focuses on methods that are within the control of the jail and other stakeholders.

Inmates with mental illness come to the jail with differing levels of connection to services, which can affect how they are identified as a mental health patient. Some inmates are connected to a provider when they are taken into custody, some inmates are previous consumers of mental health services, but are not currently enrolled with a provider, and some may be completely new to the mental health system. Additionally, inmates come to the jail with varying levels of severity of their current mental health state. Inmates have different diagnosed mental illnesses, such as diagnoses considered severe mental illness (e.g., schizophrenia, major depressive disorder, etc.) or diagnoses of MI that rise to the level of severe and persistent mental illness.[15] Other inmates arrive undiagnosed, but exhibiting symptoms or signs that could be symptoms of mental illness. These diagnoses should not be confused with whether someone is in crisis or not – a person can be in crisis regardless of their diagnosis. As discussed earlier, identification methods for those in crisis were not contemplated as part of this project, though inmates and people in crisis are generally readily identifiable.

While the stakeholders interviewed for this project all recognized the importance of identification, they were also aware that despite their efforts, they likely were not identifying all of the mental health population in custody. No one identification practice used was completely comprehensive; some methods were more adept at identifying new clients to the mental health system while others were better at catching those that had been in the system before. As such, most areas visited took a multifaceted approach to identifying the population. Methods used by jurisdictions are described below, as well as analysis of some of the benefits and challenges with each method, and any specific approaches utilized to address those challenges.

Methods of Identification

Training in Recognition of Mental Health Symptoms

Facilities can use arresting officers' and booking officers' impressions of offenders to identify those that may have mental health issues. Some symptoms are quite obvious, particularly when someone is in crisis. However, areas reported positive effects from training officers on how to notice some of the more nuanced symptoms and how to engage with the offenders to potentially recognize symptoms that might surface post-booking.

There are two main training courses available that can help law enforcement and detention officers recognize signs of mental illness: crisis intervention team training (CIT) and mental health first aid. CIT is traditionally a model for community policing that works to improve law enforcement officers' responses to people in crisis to ensure the safety of the officer responding and the individual involved. Some have started developing CIT programs tailored to needs of jail detention facilities, but those need to be

[15] Severe and persistent mental illness is a term mental health professionals use to describe mental illness with complex symptoms that require ongoing treatment and management.

validated independent of the traditional model. Mental health first aid targets the public at large, and trains its participants to recognize the symptoms of someone who may be experiencing a mental health crisis and connects them with resources who may be able to assist the person in crisis. Along with different target audiences for these trainings, they have different resource requirements. CIT is a 40-hour training for officers, while Mental Health First Aid is 8 hours. LME-MCOs reported they did have state funds to offer both CIT and Mental Health First Aid at no cost to those attending.

Benefits:

- ✓ Arresting officer usually first on the scene and can intervene quickly and appropriately
- ✓ Improve officers' ability to gauge behavior and report impressions
- ✓ Proper training can encourage offenders to self-report, and to self-report more accurately
- ✓ Can offer a diversion point for offenders whose symptoms are too serious at the time for admission into the detention facility

Challenge: Time to train officers

The standard CIT training is a 40-hour training over one week. In many counties, particularly those with smaller staffs, there may not be the manpower or financial resources to send a deputy away for a week for training. Areas also struggled with officer retention, so the investment of training officers was sometimes short-changed when the position turned over. Considering turnover and to ensure fidelity to the practices promoted in trainings, facilities must continuously invest in staff training, further increasing demands on time. The following approach is currently used by select sites to respond to this challenge:

Utilize shorter training options[16]

- **Mental Health First Aid** (an 8-hour course) teaches participants how to identify, understand and respond to signs of mental illnesses and substance use disorders. Specialty courses include public safety and rural audiences, although at this time, there is not one specifically tailored to detention officers. Most LME-MCOs will offer this course for free upon request.
- LME-MCOs can accommodate officer schedules by offering the **CIT course in five single day segments**, as opposed to one full week, which was more convenient for some areas.
- Other entities are experimenting with developing CIT models specifically geared for correctional and detention officers. The North Carolina Department of Public Safety has developed a model for correctional officers and all prison staff. Alliance Behavioral Healthcare has created a **24-hour module** specifically for jail detention officers.

[16] Other training options may be available as well. Visit www.aca.org for information regarding the American Correctional Association's Behavioral Health Certification, which can be completed online.

Screening Process

All areas interviewed included in the booking process a screening for offenders with mental health issues. The areas used a mental health screening instrument (a "screener") to help identify inmates with potential mental health histories, who were currently experiencing mental health issues, and/or those who were engaged in treatment. The purpose of the screener is to flag people for further follow-up; it itself is not a diagnostic tool.

Most of the areas interviewed were using the Brief Mental Health Screener, which could be the holdover of a requirement from a 2007 Session Law to use a statewide standardized evidence-based screening instrument. Because the Session Law was not codified into statute, the requirement sunset at the end of the biennium. Many areas still believed the use of the screener was required; it was not clear whether the information regarding the provision's sunset would change their practices.

Benefits:

- ✓ May help to identify persons otherwise unknown to the mental health system, e.g., have never been in services or have a record with a provider
- ✓ Relatively short to administer
- ✓ Can be administered by non-health professionals
- ✓ Evidenced-based (reliable)

Below, a more nuanced description of the administration of the screener and associated benefits and challenges are provided. Additional analysis of some of the challenges related to the screener itself and next steps following the screening process is also provided.

Administration of the Screener

Challenge: Honesty and accuracy of self-reporting

Personnel administering the screener felt some inmates were not comfortable disclosing some of the information required by the screener. Others reported that some of the inmates would manipulate their answers in hopes to get what they perceived as "better" treatment. Counties were interested in approaches that might allow for a more truthful exchange of information during the screener process. The following approaches are currently used by select sites to respond to this challenge:

Timing of administration

Some areas are experimenting with administering the screener 24 or 48 hours after booking. The process of arrest and booking can be upsetting and stressful for an inmate; a delayed screening can be more effective after giving them time to adjust and acclimate to their new surroundings. It can also help to distinguish between symptoms of mental illness and signs of upset accompanying arrest and being booked.

Best practices for the administration of the screener support "re-screening" of inmates at varying intervals. This can help those inmates who need more time to acclimate to their surroundings to feel comfortable enough to share medical/mental health information; it can also address inmates who may begin to experience symptoms of mental health issues in connection with a longer stay in the custody of the jail.

Administrator of the screener

Some areas reported positive results from having a nurse or medical professional conduct the screening. It may be difficult for a person being booked into the facility to trust a uniformed officer with such personal information. Inmates may be more inclined to fully and honestly report sensitive information to someone in the medical community (i.e., a nurse or another medical representative).

Location of administration

When the screening was performed by a nurse or other medical provider, it was typically done in their private office, rather than the booking area. This change of location came with additional benefits: inmates had a more discrete setting and there were fewer disruptions than in the booking area. As such, areas that did not have the resources available to use nurses or medical staff to conduct the screening were exploring ways they could move the screening process to a more secluded area.

Challenge: Sensitivity of the screener

Detention officers across the areas visited noted that the screener seemed almost redundant for those inmates who were presenting symptoms at the time. Instead, they looked to the screener as a method to identify the inmates who were not presenting symptoms upon arrival or through intake. Some reported their impression that the screener was not identifying the "less severe" cases. However, a more thorough screening practice would compromise some of the benefits offered with the current screener instrument used – namely, the speed and ease of administering the screener. The following approaches are currently used by select sites to respond to this challenge:

Incorporate approaches above

Adjustments suggested in the approaches above regarding the timing, administrator, and location of the screener could improve some of the results of the screener.

Experiment with other screeners

There are many validated screening instruments designed to flag possible mental health issues. Some areas have started to look at other validated screening instruments to see if the screening process could be made more successful using a different tool. For a non-exhaustive list of other validated screening devices, *see* Appendix D.

Responding to the results of the screener

The screener is intended to screen for possible mental health issues, it is not designed to provide an in-depth assessment or diagnosis. Following the screening process, jurisdictions had different responses or next steps for those offenders that were flagged as potentially in need of mental health services. The level of response to positive screens was often dependent on the resources available within the county. Thus, further assessment and diagnosis, prioritization of response, and in-custody services and treatment varied by facility (as described below).

Challenge: Finding a medical professional to follow up with those flagged during the screening process

To assess inmates that screened positive, all areas relied on medical professionals, either on contract as part of their medical care providers or on some other arrangement with the county. The following approaches are currently used by select sites to respond to this challenge:

Contract with a psychiatric nurse or psychiatrist

For areas with the most limited of resources, a contracted psychiatric nurse or psychiatrist for as little as a few hours a week can further evaluate inmates who flag positive on the screeners.

Create a mental health provider position for the jail population

Some areas had a mental health treatment professional(s) assigned to serve the jail population and would have that professional conduct further evaluations of those inmates flagged through the screening process. Counties where there was a mental health professional dedicated to the jail provided for the position either directly through the county budget or through the county's contribution to the LME-MCO. These positions brought the added benefits of a tangible point of contact and the ability to provide a wider range of services (*See* Section: Dedicated Point of Contact for more information).

Challenge: How to manage the size of the population needing responses

Even if the screener may not be sensitive enough to pick up some portion of the mentally ill population, it also suffers from an over identification problem. Areas reported that the screeners were flagging such a large proportion of the inmate population that it was difficult to respond to all the inmates that the screener flagged. There was also concern about liability or other implications if inmates were flagged as needing follow up but the facility was not able to provide any follow up care. The following approach is currently used by select sites to respond to this challenge:

Develop a triage system for responses based on severity of mental health screening

Some areas reported developing a priority ranking for offenders who screen positive and need follow up. This allowed those providing follow up care a way to ensure they were addressing the most urgent first. Prioritization for further evaluation was given to those inmates who posed a suicide risk (often determined through a separate assessment), inmates who exhibited psychotic behavior, and/or those who reported being on medications or having an outside mental health provider.

Challenge: Funding therapeutic services and treatment for inmates

If a Medicaid client enters a local confinement facility, his or her Medicaid will likely be terminated, and cannot cover the cost of services while they are in custody. Alternate funding must be used, which means either county dollars from the jail side or non-Medicaid dollars from the LME-MCO's budget must be used. Across the board, stakeholders described the difficulty in securing funds for treatment for this population. The following approaches are currently used by select sites to respond to this challenge:

Focus on creating opportunity for evaluation upon discharge

All LME-MCOs have a care coordination department that manages services for high risk-high cost consumers. Some LME-MCOs qualify all offenders who are exiting from jail or prison as eligible for care coordination services; others have worked to develop the criteria to qualify for care coordination with local stakeholders, such as the sheriff's office. If the offender qualifies for care coordination, a representative from the LME-MCO can meet with the offender prior to their exit to set up a referral appointment for when the offender is released back into the community. Care coordinators are not authorized to provide services; instead, they focus on creating a path towards services and serving as a point of contact for the providers to report whether the offender needs an adjustment in their service level.

Use a county funded position to provide services while in custody

Some areas dedicated resources to providing a mental health treatment professional(s) to serve the jail population. Because these professionals cannot bill for services, the ability to have these types of position relies on local funding. Areas that had jail mental health providers that were county funded provided a wide range of services, including conducting diagnostic assessments, providing short term counseling, as well as discharge planning. (*See* Section: Dedicated Point of Contact for more information).

Review of Jail Logs for Former and Current Clients

As recently as 2007, LME-MCOs or their designee were charged with reviewing the jail logs for the jails in their catchment area to see if mental health staff recognized any of the inmates as a current or former client pursuant to S.L. 2007-323, (*see* above*,* Screening Process). As was often the case with this population, staff reported that they had some clients that resurfaced in the jail more often than others, and that they were familiar enough with their client base to be able to recognize some by name. While some areas manually reviewed paper jail logs, other areas, particularly larger areas, developed different methods for review to reduce error or overlooking clients. While this practice may have developed out of the mandate from the budget bill, most areas visited continue to use jail log review as a method of identification, despite the sunset of the requirement.

Benefits:

- ✓ Can counteract some self-reporting error in the screening process (for known LME-MCO clients)
- ✓ Brings in the entity with the experience and background to address the needs of the mental health population, the LME-MCO

- ✓ Can alert and engage providers if inmate is already connected to services, who are more informed and more capable to assist the inmate

Challenge: Manual review of jail logs is cumbersome and time intensive

All areas visited during this project had electronic jail records; the LME-MCO representative or designee reviews the records manually. For this process to be successful, the reviewer must have extensive familiarity with their client database to recognize an inmate. Most LME-MCOs' catchment areas encompass several counties, which might have multiple databases from several jails to review, databases that may be in differing formats. Reviewing jail logs takes significant time and resources. The following approaches are currently used by select sites to respond to this challenge:

Provide LME-MCO access to the jail logs as directly as possible (*See* Appendix B)

Some LME-MCOs reported that they did not have access to the jail logs for all the jails in their catchment area. It was not clear whether the jail logs were unavailable because the jails would not allow review or because the logs were not provided directly to them (e.g., by email). All areas visited for this project had electronic records, but noted other facilities across the state may not, affecting how jails could share records to other entities for review. Local jails could consider ways to submit daily population logs to the LME-MCOs similar to how information is provided to the District Attorney or clerk's office via email or fax.

Develop an automated system for review of the jail population

Through a grant, Alliance Behavioral Healthcare (the LME-MCO for Wake, Durham, Johnston, and Cumberland counties), developed a crosswalk of their data system (ALPHA) with Criminal Justice Law Enforcement Automated Data Services (CJLEADS). CJLEADS, a program already in place in the Wake County Jail System, can be used to track offenders as they enter into custody across the state. Through this data matching, Alliance is able to run a report to determine the following:

- Whether the person is currently assigned or has ever had a provider from Alliance
- Whether that provider has submitted a claim in the last 90 days for treatment (indicating if the inmate is assigned to a provider but is not engaged in treatment)
- Whether the person is currently assigned or has ever had a Care Coordinator from Alliance
- The person's diagnosis
- The person's criminal charges
- The number of times they have been booked statewide
- County of origin
- Insurance type
- Hospital or institutional history

From this report, Alliance and the Wake County Sheriff's office developed criteria for prioritizing care with the jail mental health provider. A jail care coordinator facilitates this process. This process only covers inmates who are known to the LME-MCO system; if someone is identified by a screener, for example, but has never been in services, both data matching and/or a manual

review of the jail logs would not affect him or her. Alliance and the Wake County Sheriff's Office are working on a parallel process for those who might be new to the system and using this automated process to free up resources to address those inmates previously unknown to the system.

Keep Records for Inmates Flagged as MI from Prior Visits

Many interviewees reported that with all the efforts used to identify persons with mental illness in the jail, it would be useful to retain that information electronically, instead of starting over if an inmate returned to jail. Some areas built a flag into an inmate's electronic record alerting staff of a history of mental health issues. While the flags added a lasting component to the methods of identification of the population, they also raised their own complications.

Benefits:

- ✓ A flag indicating mental illness in the electronic record allows jails using the same medical providers to access information that may have been collected at a different facility
- ✓ Keeping records can helps develop prevalence rate

Challenge: Privacy concerns about inmate's health records

Retaining a flag could create a stigma for inmates; stakeholders wanted to ensure the flag did not stay in the system longer than needed for helping the inmate. Privacy concerns were also reported related to the level of detail in the electronic record related to the diagnosis and who had access to it. The following approach is currently used by select sites to respond to this challenge:

Restrict access to records

While some areas keep this information in the inmate's medical record, so that only persons treating the inmate have access to the information, other areas reported that it could be helpful to the booking officers for safety concerns to be on the lookout for particular inmates who are known to have had issues in the past.

Summary

Before any adjustments or improvements can be made to the care provided to the MI population in jails, it is critical to be able to identify the inmates within the population. This includes understanding the types of diagnoses local inmates have, their severity, and their current connection to services within the community. Identification methods can target different populations and as such, areas visited were typically using a variety of methods to define and identify their population. The chart below provides a snapshot of the methods discussed here for consideration.

QUICK REFERENCE: IDENTIFICATION

METHOD	BENEFITS	CHALLENGES	APPROACHES
Training in Recognition of Mental Health Symptoms	• Officer can respond quickly • Improve officer's ability to recognize symptoms • May improve accuracy and frequency of self-reporting • Possible diversion point for offenders with severe symptoms to be admitted	Time to train officers	Shorter training options
Screening Process	• Help identify those unknown to system • Short to administer • Can be administered by non-health professionals • Evidenced-based (reliable)	Honesty and accuracy of self-reporting	• Timing of screening • Administrator of screening • Location of administration of the screener
		Sensitivity of the screener	• Experiment with timing, administrator, location • Experiment with other screeners
		Follow up on flagged screeners by medical professionals	• Contract with a psychiatric nurse or psychiatrist • Create a mental health provider position for jail
		Manage population needing response	Develop a triage system for responses based on severity of mental health screening
		Funding for therapeutic services and treatment	Focus on opportunity for evaluation upon discharge Use county funded position to for services in custody
Review of Jail Logs	• Can counteract self-reporting error in screening process • Brings in the entity with the experience and background, the LME-MCO • Can alert and engage providers if inmate is already connected to services	Manual review of jail logs is cumbersome and time intensive	• Provide access to the jail logs to LME-MCO or their designee as directly as possible • Develop an automated system for review of the jail population
Keep Records for Inmates Flagged as MI from Prior Visits	• Incorporating a flag for mental illness in the electronic record allows jails using the same medical providers to access information about the inmate that may have been collected at a different facility • Keeping records can helps develop prevalence rate	Privacy concerns about inmate's health records	Restrict access to records

Questions for Consideration

The following are suggested questions jurisdictions may consider in the context of the approaches used in individual communities. They are not meant to be exhaustive, but instead to begin the conversation about identification methods and the information included above.

What methods of identification are we using?

Are our current methods accomplishing our goals?

What challenges are we facing using those methods?

Which approach(es) sound most promising to address those challenges?

What impediments would we face if we tried to implement these approaches?

What would need to happen to make those approaches possible?

B. DEDICATED POINT OF CONTACT

Stakeholders in all the counties visited through this project recognized the challenge and importance of addressing the issues surrounding the mentally ill in jails. Creating a stable environment for the mentally ill was important for everyone; an inmate's stability creates a safer environment for not only the inmate but the detention staff interacting with him or her. One practice all the areas engaged in, to different degrees, was identifying or creating a point of contact for this population. For all the areas visited, the point of contact had a mental health background, with varying levels of services the position could provide. This position created a tangible contact for officers to refer inmate issues to, which provided relief to the officers who wanted to help the inmates but did not have the knowledge or skills necessary to address their mental health issues. Referring the inmate to the point of contact helped to lay the groundwork for facilitating care when the inmate returned to the community and developed a process for handling a situation that can often be complicated.

The areas visited had different ways of structuring this dedicated point of contact (based on resource availability), each with unique benefits; the approaches are discussed below.

LME-MCO Based Point of Contact

For some areas, the point of contact is a jail liaison (or some other title) on staff within the LME-MCO. In the areas visited that had this structure, the jail liaison served an administrative role for the mental health population; they reviewed the jail logs (*see* above) for known and past clients and worked to notify any current providers the inmate may have had.

Benefits:

- ✓ Identifiable focus of resources specifically for the mentally ill population
- ✓ Draws on expertise of the mental health field to provide better care for this population
- ✓ Tangible contact and plan for officers in facility

Challenge: Can be responsible for multiple counties (and jails), limiting what can be offered to an individual area

In Richmond County, the jail liaison on staff with Sandhills Center, the LME-MCO for the area, also covered eight other counties. Visiting the jails in person to meet with staff or inmates on a regular basis was not feasible.

Challenge: LME-MCO based jail liaison often unable to provide services or treatment to inmates

As discussed earlier, much of federal and state dollars are available only as a fee per service basis, and only for particular services; otherwise, LME-MCOs have to find a different way to pay for the services. The job duties of the jail liaison under this model are not considered services to individual clients, and therefore must be paid out of their administrative budget. As such, these positions cannot provide services, or rather, would not be compensated for any services provided.

Challenge: Identifying inmates not currently or previously served by the LME-MCO

In Richmond County, the screeners administered as part of the booking process (*see* above) were reviewed by the nurse on site in the jail, and were not forwarded onto the jail liaison or another department within the LME-MCO. This could be because the liaison did not have the time available to review the screeners or to follow up with those inmates that screened positive because of their limited resources. However, without having a way for any inmates identified through the screening process to connect with the LME-MCO, there is a missed opportunity to link this new population into services when the inmate is released back into the community.

County Based Point of Contact

Mecklenburg County maintained a structure similar to what existed prior to divestiture, when counties and/or local area authorities provided services instead of focusing only on the administration of funds. Housed within a department of the county, the jail liaison reviewed jail logs, reviewed positive screeners, provided clinical assessments when necessary, and worked to make connections with community programs upon release. This often included a referral to the LME-MCO's Care Coordination department that may assist in the connection of services to the community.

Benefits:

- ✓ Direct link of county dollars to services within the county
- ✓ County dollars are typically unrestricted by federal or state requirements, allowing for maximum flexibility in what services/programs they can fund
- ✓ County control/direction can be well situated to respond to needs of local community

Challenge: Connection to services upon release

Although a county employee may serve as the point of contact for the mentally ill population while the inmate is in the local jail, the services they will receive when they return to the community are likely controlled by an entity outside of the county department. It can be challenging to establish a role-sharing process when working with another entity(s), albeit towards a common goal. The following approach is currently used by select sites to respond to this challenge:

Decision tree/handoff with LME-MCO

Areas developed a process tree for how the information and progress of the inmate while in custody would travel from within the facility to their provider in the community. One method was for the Jail Programs department to transfer the information to Care Coordination within the LME-MCO. These process trees identified a person of contact within the jail and a person of contact for the LME-MCO from the Care Coordination department. For example, in Mecklenburg, all inmates exiting from the jail qualified for Care Coordination services, so it followed that this would be the entity to initiate the transfer of care to. The process tree also specified the timing and other details to prevent information from being lost as it moved from one entity to another. The process was considered successful because of the individuals working in the positions, but having the tree available served as a safeguard in case someone else needed to step in, in their absence.

Hybrid Model Point of Contact

The hybrid model point of contact includes a county funded position(s), with funds passed through the LME-MCO for the area. Burke County contributes funds to employ a mental health liaison that is on staff with a local provider.[17] Initially the jail liaison serving Burke County was on staff with the LME-MCO, but the county wanted the position to provide direct services to the inmate population. The LME-MCO shifted the position to a local provider, using the county contribution to the LME-MCO to fund the position. The position can now provide assessments and diagnoses, short-term individual counseling, and assists in discharge/aftercare planning.

Benefits:

- ✓ Counties without a separate department for criminal justice and/or mental health can draw on resources from the LME-MCO
- ✓ Multiple stakeholders are invested in the position, which develops and sustains support it
- ✓ Liaison is on staff with a medical practice the inmate can visit upon return to the community

Challenge: Resource intensive

The hybrid model versions observed in two counties had the benefit of county funds to support the additional positions and services provided to inmates. Without the separate funding, and the level of funding, the positions would not be sustainable.

[17] Although Burke County has adopted this approach, not all the counties in the catchment area of Partners Behavioral Health Management, the LME-MCO for that area, have adopted the same strategy.

Challenge: Coordination of multiple stakeholders' services

To implement the hybrid model, several entities must work together to develop a process flow for providing care for this population. This involves learning about the other industry, and frequently, learning to "speak the same language." Prior to this undertaking, the entities may not have had the need presented to coordinate their services. The following approach is currently used by select sites to respond to this challenge:

Develop a standing advisory group

Many of the counties visited during this project had developed advisory groups that represented the various positions within the criminal justice system, as well as the agencies and programs they may frequently interact with. Members of the groups often included judges, prosecutors, defense attorneys, representative(s) from the Sheriff's office, representative(s) from the local police, and staff from the area mental health and/or the LME-MCO. The purpose of these groups was to discuss common challenges and identify shared priorities and goals. Having a forum to address recurring issues proved to be beneficial for all members involved, by establishing working relationships and enhancing trust between stakeholders.

Challenge: Information sharing between entities

An inmate's mental health history is considered part of their confidential medical record; waivers from the inmate may be necessary for their provider to share this information with another entity (e.g., the jail). Obtaining a waiver can be difficult, depending on the inmate's mental state, lack of information sharing, however, creates a barrier to those caring for the inmate in having the most complete and up-to-date information about the inmate's health. The following approach is currently used by select sites to respond to this challenge:

Develop a Memorandum of Understanding/Agreement regarding information sharing

Some areas reported working towards MOUs/MOAs that would allow for the transfer of certain health information, without violating legal privacy protections.

Summary

Identifying or creating a point of contact specifically for the MI population in jails is becoming a common practice with great benefits. Having a dedicated point of contact loops a mental health expert into the process, which can create better responses for inmates and increases safety for the inmates and detention staff. What services the point of contact could offer depended heavily on the level of county contributions because their funds were usually the least restrictive. Areas visited structured these points of contact differently; the chart below recaps the variations on the positions observed and their accompanying benefits and challenges.

QUICK REFERENCE: DEDICATED POINT OF CONTACT

METHOD	BENEFITS	CHALLENGES	APPROACHES
LME-MCO Based Point of Contact	• Identifiable focus of resources specifically for the mentally ill population • Draws on expertise of the mental health field to provide better care for this population • Tangible contact and plan for officers in facility	Position can be responsible for multiple counties, and therefore, multiple jails, making it challenging for the liaison to offer much to any individual area	None reported
		LME-MCO based jail liaison often unable to provide services or treatment to inmates	None reported
		Identifying inmates not currently or previously served by the LME-MCO	None reported
County Based Point of Contact	• Direct link of county dollars to services within the county • County dollars are typically unrestricted by federal or state requirements, allowing for maximum flexibility in what services/programs they can fund • County control/direction can be well situated to respond to needs of local community	Connection to services upon release	Decision tree for handoff with LME-MCO
Hybrid Model	• Areas that may not have a separate department for criminal justice and/or mental health can draw on resources from the LME-MCO • Draws on buy-in from various stakeholders which develops broad based support, which helps to sustain the new position(s) • The liaison is on staff with a medical practice that the inmate can use when they return to the community	Resource intensive	None reported
		Coordination of multiple stakeholders' services	Develop a standing advisory group
		Information sharing between entities	Develop a Memorandum of Understanding regarding information sharing and privacy concerns

Questions for Consideration

The following are suggested questions jurisdictions may consider in the context of the approaches used in individual communities. They are not meant to be exhaustive, but instead to begin the conversation about identification methods and the information included above. For this topic, the questions for consideration are divided between jurisdictions that currently have a Dedicated Point of Contact and jurisdictions that do not have a Dedicated Point of Contact.

Jurisdictions with a DPOC	Jurisdictions without a DPOC
What is the DPOC's role?	*What are our goals for having a DPOC?*
Is the DPOC achieving its goals?	*What challenges prevent having a DPOC?*
What are their challenges and limitations?	*Which approaches sound most promising to address those challenges?*
Which approaches sound most promising to address those challenges?	*What impediments would we face if we tried to implement these approaches?*
What impediments would we face if we tried to implement these approaches?	*What would need to happen to make those approaches possible?*
What would need to happen to make those approaches possible?	

C. CONTINUITY OF CARE

Continuity of care, as defined in this publication, refers to the continuous care of the MI population both as offenders enter into the jail and upon their release into the community. When a person enters a jail, any time in custody interrupts the provision of services received in the community and changes their provider, albeit temporarily, to the jail's medical team. This change affects the services the inmate receives, as well as available medications.[18] The interruption can also affect the inmate's mental illness in other ways. The custodial environment can create new triggers and exacerbate pre-existing conditions, which could leave the inmate in a much worse place when they are released back into the community. Approaches discussed above relating to identifying the population and providing in-custody services focus on continuity of care as the inmate enters the jail (and are briefly detailed below).

For inmates that enter jail that have not been engaged in services prior to their incarceration, the time they spend in jail be used as an opportunity for stabilization, to engage or reengage these inmates with

[18] Some of the medicines used to treat mental illness are considered too dangerous to be used in custody, because they could be considered contraband. Changing an inmate's medication, because of cost and/or safety concerns, carries its own inherent risks, of which jails were cognizant.

community providers, and to prepare the inmate for discharge, so that they are better equipped for their reentry. The key to reframing the jail as an opportunity for offenders was to focus on establishing a reliable transfer of care, which meant maintaining a continuous level of medications and other services for the inmate through their exit from the jail and into services within the community. The transition period had been identified as a particularly vulnerable time for a person with mental health issues to relapse. Stakeholders reported positive benefits from focusing on this transition period by using the various approaches discussed below.

This bulk of this section focuses on establishing continuous care upon release – i.e., facilitating the care inmates will receive when they return to the community. Different types of positions are used to connect inmates to services in the community upon release; some areas had multiple types of positions focusing on this intercept. Each of the positions is discussed below, with the accompanying benefits they provide. Despite the iteration of the position, all positions had common challenges faced when trying to facilitate care plans for return to the community; those challenges, and the approaches to address those challenges, follow.

Methods of Facilitating Continuity of Care

Identifying the Population

The first step to ensuring those who need mental health treatment when they return to the community receive it is identifying the population that need to be connected to services. Counties visited approached this in several ways (*see* above*, Identification of Population)*.

Providing Services While in Custody

If the inmate was receiving services prior to being taken into custody, a sudden drop in treatment or medications can be detrimental to their mental health. Ideally, the inmate would receive the same or substantially similar treatment and medications while in custody to prevent any deterioration of their mental health condition or relapse. However, as mentioned earlier, in many areas, services available while in custody were nonexistent or markedly different from what the inmate was receiving in the community. Some areas have addressed this by developing a dedicated point of contact that can provide services while in custody (*see* above, *Dedicated Point of Contact*).

Utilizing Care Coordination

Care coordination staff of the LME-MCO can set up referrals for inmates to community providers to engage in services in the community. Typically, if the inmate is new to services, or has been out of services for more than a year, a clinical assessment is necessary to diagnose the inmate and place him or her with the appropriate provider. Unless the county had a mental health provider for inmates, (*see* above, *Hybrid Model*), it is unlikely the assessment can be completed in custody. Therefore, the referrals in these areas were usually for clinical assessments, not for treatment.

There is often a backlog of clients waiting for appointments for assessments, which makes it difficult to sustain an inmate's treatment plan and medications as he or she returns to the community. Although scheduling an appointment for a referral helps to advance the process, there may still be a wait time. This wait could cause an inmates' relapse; some areas focused resources on providing methods for the assessment and intake to happen while in custody, so that the inmate can flow seamlessly into treatment soon after their release (*see Hybrid Model)*. Additionally, areas that provided assessments for inmates while in custody were able to set up a plan for release that included treatment (*see* below).

Benefits:

- ✓ Establishes a person of contact for the inmate while they are in custody, giving them a name and a face to follow up with
- ✓ Begins the process for setting up care in the community, either by making an appointment for a clinical assessment or re-engaging with their provider

Discharge Planning

One of the methods used to prevent a gap in an inmate's mental health care was to focus on creating a discharge plan that would guide the inmate as they exited the jail. Discharge planning involved connecting the inmate to services in the community, not limited to mental health treatment, but could also include housing assistance, substance abuse therapy, job readiness, parenting classes, or other ways of responding to the needs of the inmate. Discharge planning can be achieved in a variety of ways, such as through a specialized position such as in Durham County or through peer support in Burke County.

In Durham County, a full-time discharge planner meets with all inmates that screen positive for mental health issues at intake. The discharge planner works with the public defender or defense attorney's office to coordinate release dates and plans. Even if the discharge planner is unable to meet with the inmate prior to their release, the inmate can, and often does, call the planner upon their exit for assistance with the wrap around services mentioned above. The discharge planner in Durham County does not have a medical background, but provides support services while the mental health professionals in Durham County's Criminal Justice Resource Center (CJRC) focus on screenings, assessments, and short term counseling.

Benefits:

- ✓ Creates a point of contact for the court system to communicate information about an inmate's release
- ✓ Cost-efficient option for supportive services, allowing mental health professionals more time to focus on providing licensed services
- ✓ Most holistic method of providing wrap around services to this population

Engaging a Peer Support Specialist

In Burke County, the provider Catawba Valley Behavioral Healthcare had recently hired a Peer Support Specialist (PSS). Peer Support Specialists are people in recovery from their own addiction or mental health and can draw on their own experiences to connect and aide in the recovery of the client/inmate. The Peer Support Specialist position led substance abuse groups within the jail, and staff reported that several the participants were dual diagnosis. Additionally, the format of the substance abuse recovery had many life lessons that were helpful for those struggling with mental illness. The goal was for the Peer Support Specialist to establish a connection with the inmate while they were in custody such that they would trust them to help them gain their footing when they were released. They saw this position as being able to bridge the gap and guide the inmate through this transition period. At the time of the visit, the position was very new, so while little information was available regarding the reception of the position, all parties (the jail, the provider, and the LME-MCO) seemed optimistic as to its potential.

Benefits:

- ✓ Individual relationships can give PSS direct information regarding inmate's release
- ✓ PSS are usually a cost-efficient option
- ✓ PSS can engage more directly with clients than might be appropriate for a provider, allowing them to aid in home visits, transportation, etc.

Challenges to Facilitating the Connection to Services in the Community

All of the approaches to facilitating continuity of care at release from jail (as described above) share common challenges. Even if services can be provided while in custody, inmates are still better served by having as seamless of a transition in services into the community as possible. While the transition depends in part on the inmate's willingness to engage and his or her accountability to his or her plan, areas visited had different ways of addressing the logistical difficulties hindering the inmate's ability to connect with a provider in the community.

Challenge: Predictability of release

A significant proportion of the jail inmate population are those being held pre-trial, meaning their court case is still pending. Jail staff know when the inmate's next court date is, but there is not a systematic method for informing them if the case will be disposed of on that court date, and if they should anticipate the inmate being released. Additionally, the inmates themselves can (theoretically) be bonded out, without prior notice to the jail, or notice to the Dedicated Point of Contact or LME-MCO staff to plan appropriately. The following approaches are currently used by select sites to respond to this challenge:

Discharge Planning

An identified contact responsible for creating a discharge plan can serve as a point of contact for the court system. A judge or attorney can notify that contact if an inmate's release is pending increases the likelihood that anything that can be aligned in time for their release.

Mobile Crisis Units

The LME-MCO for Mecklenburg reported using Mobile Crisis to bridge the gap for inmates exiting jail and in need of an assessment. If inmates were released without having the opportunity to meet with Care Coordination, Mobile Crisis could respond to the jail when inmates were being released and meet with the inmate to set up an appointment with a provider for a follow up assessment. The services offered through this use of Mobile Crisis were the same as those offered by their 24/7 access to care line, but helped by meeting the inmate where they were, instead of relying on the inmate to make the call after they returned to the community.

Challenge: Reinstatement of Medicaid benefits

As mentioned earlier, when a person on Medicaid is incarcerated in jail, his or her Medicaid is terminated and must be reapplied for upon release. Reinstatement of benefits can be a timely process and difficult to navigate. A delay in benefits can mean a delay in receiving care in the community. The following approach is currently used by select sites to respond to this challenge:

Utilize SOAR workers to start the reapplication process in custody

SSI/SSDI Outreach, Access, and Recovery (SOAR) workers are federally funded positions that work to expedite this process and are located across the state. SOAR workers can assist with applications while the inmate is in custody, allowing benefits to begin as quickly as possible when the inmate is released from jail. Those areas that had SOAR workers performing this function noted positive benefits from moving the benefit application process forward.

Challenge: Availability of providers

The limited number of mental health providers across the state impacts the lag time patients may experience waiting to get into a provider's practice. Attracting providers across the state is a larger issue than providing care for this particular population and is outside the scope of this project. As discussed below, some counties used their Care Coordination or other Dedicated Points of Contact to reduce the impact of the wait time.

Challenge: Provision of medication upon discharge

Although some inmates come into the facility with prescriptions from their community provider, many inmates are prescribed medications to manage their mental health symptoms while they are in custody. Some doctors serving the jail had reservations about allowing the inmate to leave the jail with medications in hand, due to the potential for overdose and/or resale. While some doctors were willing to issue a prescription, the paper would often be lost, and the prescription was never filled. The following approach is currently used by select sites to respond to this challenge:

Partnership with local pharmacy

In Durham, the CJRC set up a system allowing mental health staff to call prescriptions into a pharmacy for offenders to pick up at no cost to them; CJRC staff reported that the overwhelming majority of those who had a prescription called in picked it up.

Challenge: Accessibility of services

Inmates in this population may have a difficult time keeping their appointments for a number of reasons. Some could be linked to their mental health condition (e.g., difficultly remembering appointments) and/or logistical (e.g., no means of transportation to get to appointments). The following approach is currently used by select sites to respond to this challenge:

Engage peer support services

At the time of this project, Burke County began utilizing peer support services to help transitioning inmates reentering their communities. The Peer Support Specialist was part of the team at Burke County Detention, and then would be available to take them home, to pick up prescriptions, or to appointments. More than just transportation, the PSS provided accountability for the inmate (*see* above).

Summary

Striving to provide inmates with a steady level of care while in custody is a challenge for all areas, even those with many resources. It requires proper identification of the MI population, working to stabilize and prevent regression of symptoms of mental illness, and coordinating connections to services for release. Many areas had focused resources on this third piece, recognizing the opportunity to engage and reengage inmates in services within the community while they were in custody. The chart below provides an overview of the methods areas are utilizing to promote continuity of care.

QUICK REFERENCE: CONTINUITY OF CARE

METHOD	BENEFITS	CHALLENGES	APPROACHES
Identifying the Population		*See, "Identification"*	
Providing Services While in Custody		*See, "Dedicated Point of Contact"*	
Care Coordination	• Establishes a person of contact for the inmate while they are in custody, giving them a name and a face to follow up with • Begins the process for setting up care in the community, either by making an appointment for a clinical assessment or re-engaging with their provider	Predictability of release	• Discharge planning • Mobile crisis units
		Reinstatement of Medicaid benefits	SOAR workers
		Availability of providers	None reported
		Provision of medication upon discharge	Partnership with local pharmacy
		Accessibility of services	Engage peer support services
Discharge Planning	• Creates a point of contact for the court system to communicate information about an inmate's release • Cost-efficient option for supportive services, allowing mental health professionals more time to focus on providing licensed services • Most holistic method of providing wrap around services to this population	*See above*	*See above*
Peer Support Services	• Individual relationships can give PSS direct information regarding inmate's release • PSS are usually a cost-efficient option • PSS can engage more directly with clients than might be appropriate for a provider, allowing them to aid in home visits, transportation, etc.	*See above*	*See above*

Questions for Consideration

The following are suggested questions jurisdictions may consider in the context of the approaches used in individual communities. They are not meant to be exhaustive, but instead to begin the conversation about identification methods and the information included above.

What is our process for connecting inmates to services upon release from jail?

Is that process achieving our goals for promoting continuity of care?

What challenges are we facing using those methods?

Which approach(es) sound most promising to address those challenges?

What impediments would we face if we tried to implement these approaches?

What would need to happen to make those approaches possible?

SUMMARY

Addressing the issues that arise from housing inmates with mental illness in local confinement facilities is no small task. Areas across the state are tackling this daunting task by coming together with other stakeholders and developing strategies to accomplish common goals. Through community collaboration, areas are working to identify and define their mental health populations, to provide them with what services they can, and to connect them to services in the community upon their release. By bringing in partners with different perspectives and levels of expertise, localities are making progress on this complex issue. The Stepping Up Initiative confirms this approach as a national trend; it encourages a collaborative approach to problem solving because while all entities have a vested interest in the outcome, no one entity has sole ownership of these challenges.

This publication intends to facilitate discussion of these important and complicated issues. While questions, ideas, and information have been offered, at no point did the Commission contemplate that this would complete the work necessary to achieve positive outcomes for inmates and the communities that house them. It is the hope that this document serves as a starting point and resource for communities to begin or to reinvigorate their efforts. The Sentencing Commission staff remains available for any assistance it may be able to provide towards those goals.

APPENDIX A
SITE VISIT INFORMATION

NORTH CAROLINA SENTENCING AND POLICY ADVISORY COMMISSION
Research and Policy Study Group

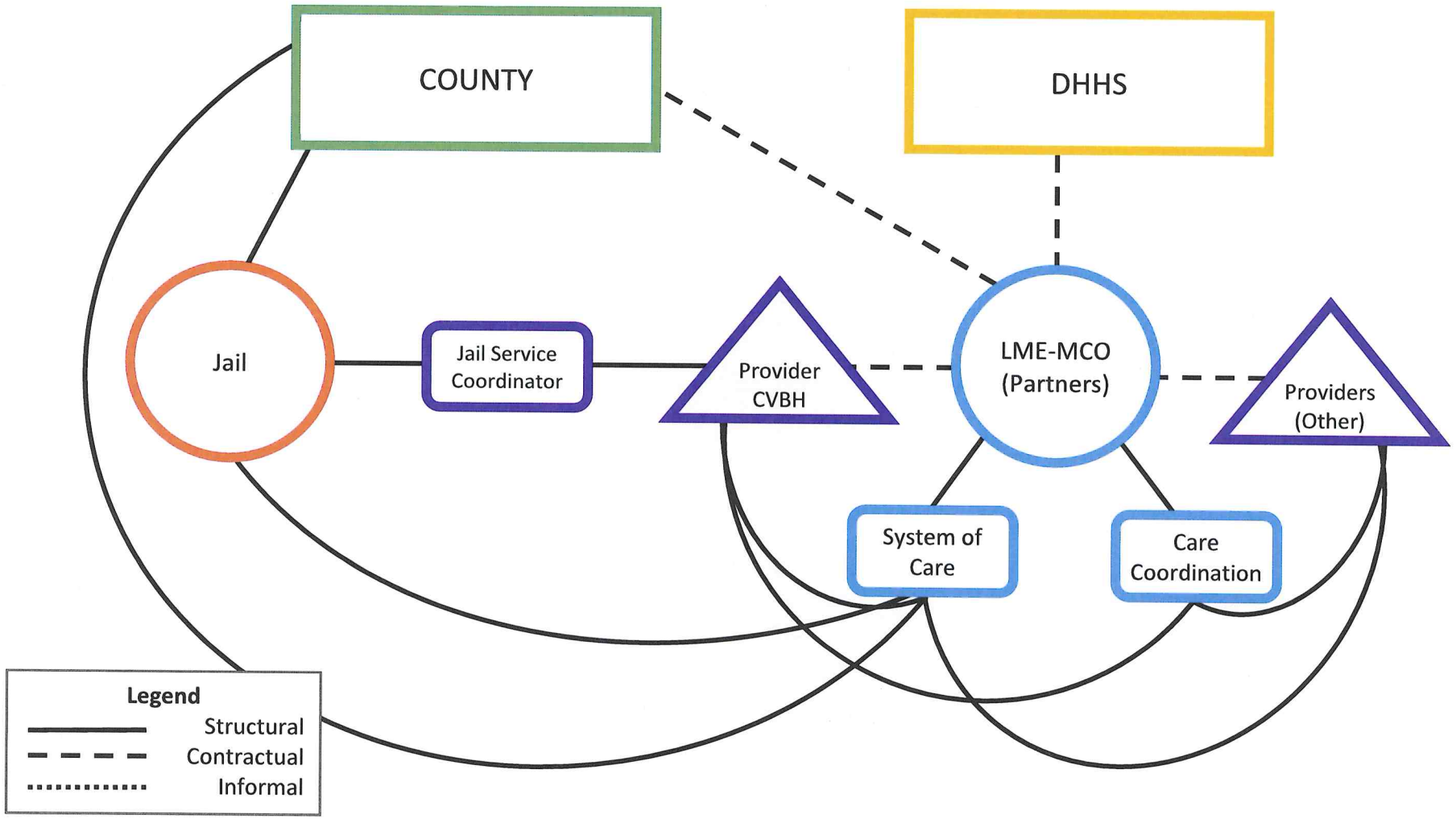
List of Stakeholders Interviewed

<u>Burke</u>	
LME/MCO:	Partners Behavioral Health Management
Provider:	Catawba Valley Behavioral Health (CVBH)
Sheriff:	Burke County Sheriff's Office, Burke-Catawba District Confinement Center Administration
County Commissioner:	Maynard Taylor, Chairman
<u>Durham</u>	
LME/MCO:	Alliance Behavioral Health
Provider:	Telecare Corporation
Sheriff:	Durham County Detention Facility Administration
Criminal Justice Services:	Durham County Criminal Justice Resource Center
County Commissioner:	Michael D. Page, Chairman
<u>Mecklenburg</u>	
LME/MCO:	Cardinal Innovations Healthcare Solutions
Provider:	Monarch
Sheriff:	Mecklenburg County Sheriff's Office, Charlotte Jail Central Administration
Criminal Justice Services:	Mecklenburg County Criminal Justice Services
County Commissioner:	Vilma Leake, District 2 Representative
<u>Richmond</u>	
LME/MCO:	Sandhills Center
Provider:	Daymark Recovery
Sheriff:	Richmond County Sheriff's Office, Jail Administration
County Commissioner:	Kenneth Robinette, Chairman

NC Sentencing and Policy Advisory Commission
Research and Policy Study Group
October 23, 2015

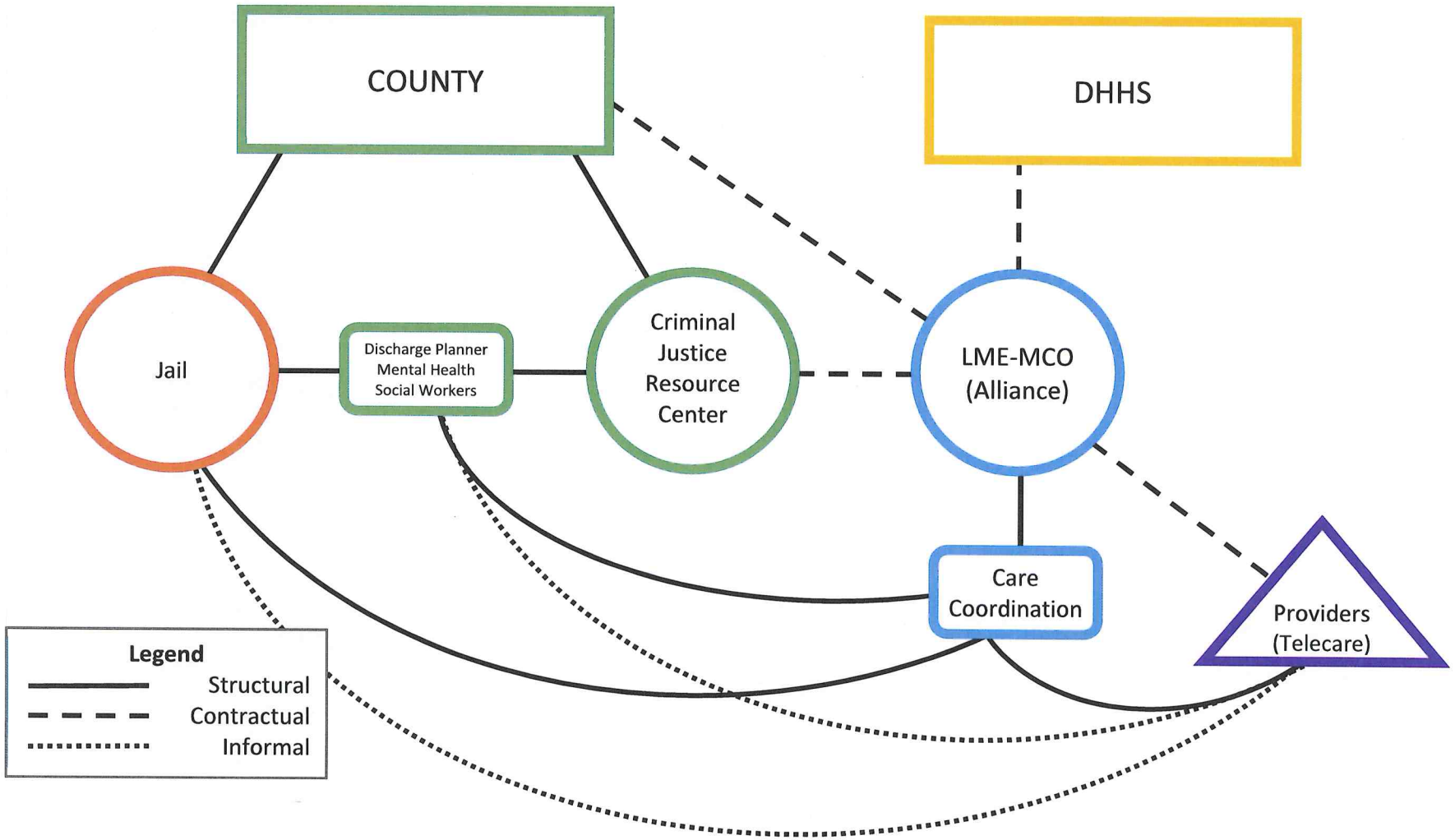
Relationship Diagram of Criminal Justice and Mental Health Treatment Systems

BURKE COUNTY



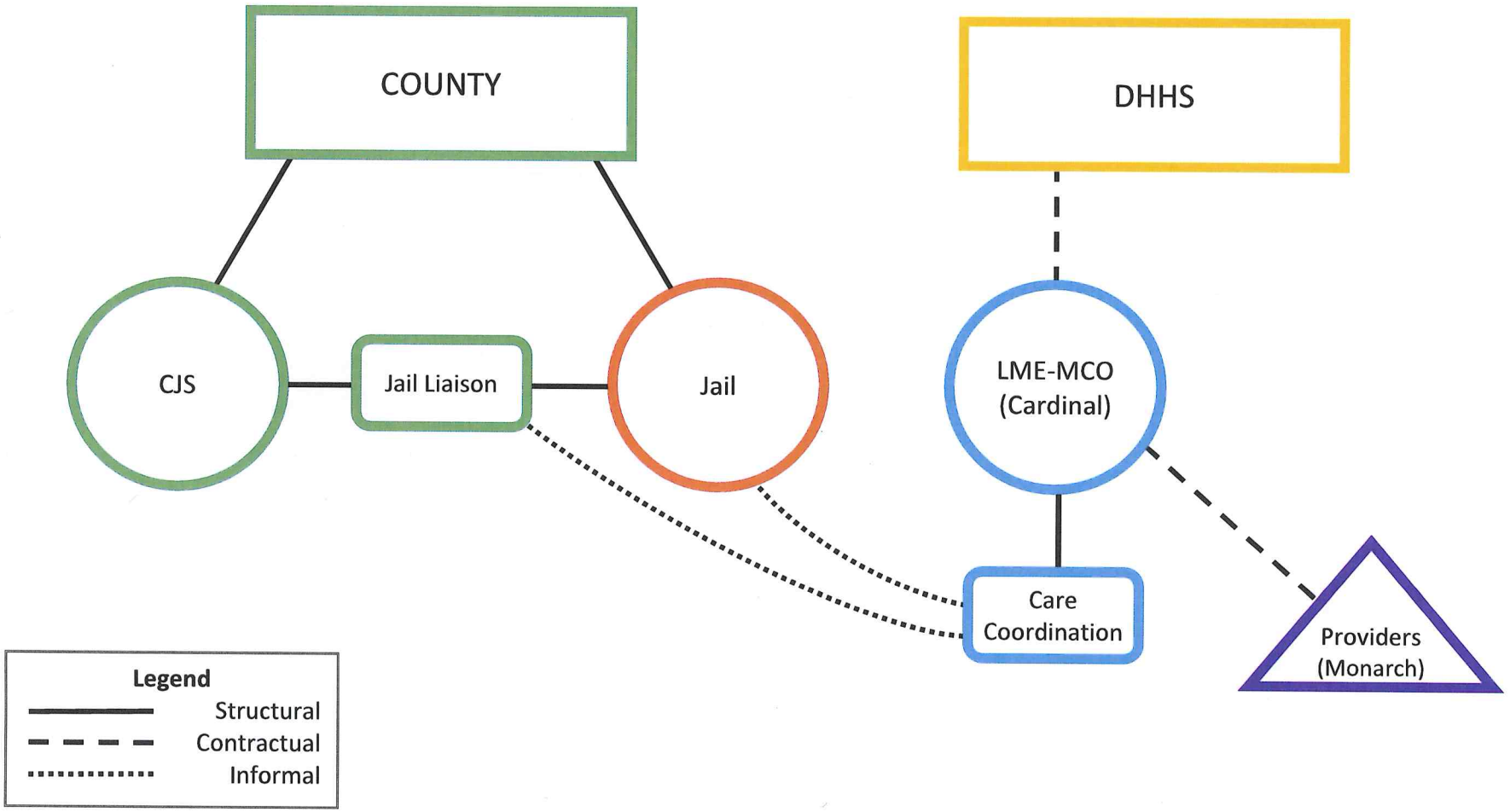
Relationship Diagram of Criminal Justice and Mental Health Treatment Systems

DURHAM COUNTY



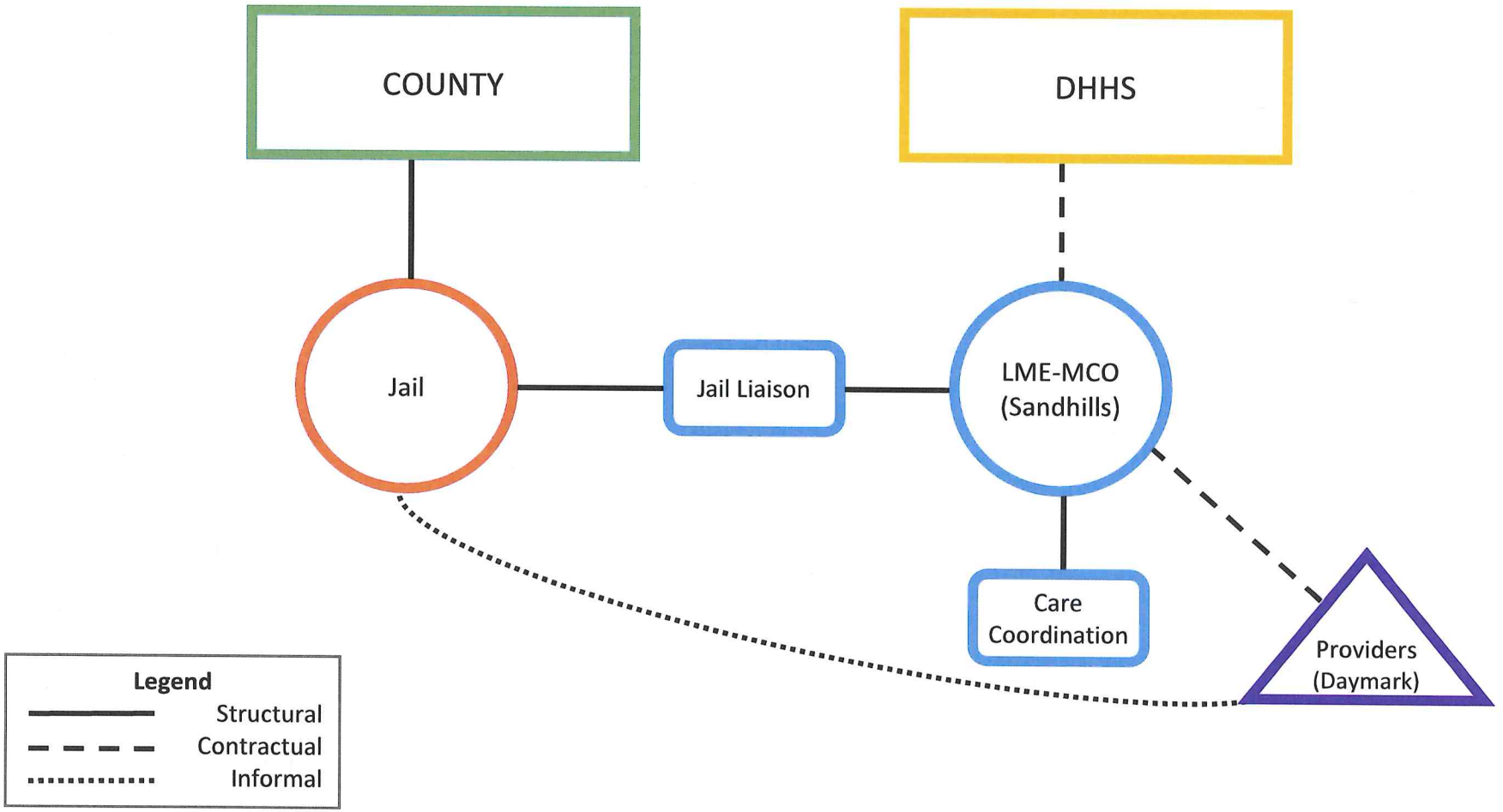
Relationship Diagram of Criminal Justice and Mental Health Treatment Systems

MECKLENBURG COUNTY



Relationship Diagram of Criminal Justice and Mental Health Treatment Systems

RICHMOND COUNTY



APPENDIX B
SENTENCING AND POLICY ADVISORY COMMISSION'S POLICY PROPOSALS

NORTH CAROLINA SENTENCING AND POLICY ADVISORY COMMISSION
SUMMARY OF PROPOSALS FOR THE CONSIDERATION OF THE NORTH CAROLINA SHERIFFS ASSOCIATION AND THE NORTH CAROLINA JAIL ADMINISTRATORS ASSOCIATION

Introduction

As part of its mandate, the Sentencing Commission is required to study issues relating to the recidivism of adult offenders on an ongoing basis. In 2014, the Commission formed the Research and Policy Study Group to explore existing criminal justice research findings that could lend themselves to policy recommendations that would ultimately reduce recidivism. One of the issues the Study Group identified related to offenders with mental illness, as these offenders tend to recidivate at higher levels than offenders without a mental illness. Jails are usually the first place offenders with mental illness come into contact with the criminal justice system and, as such, the jails face unique challenges in handling this population. Inmates with mental illness require more resources and many jails are often not well equipped to handle the needs of this specific population. To that end, the Study Group focused on policies that would balance providing appropriate care for these offenders and the many other responsibilities of the jail.

The Study Group worked for eighteen months studying the intersections of the mental health and criminal justice systems. To understand existing practices in the field, staff to the Study Group conducted site visits to four counties in the state. The proposals described below are based on the observations of those site visits, supplemental research collected on best-practices, and the discussions of the Study Group over the course of numerous meetings and with other stakeholders. The Commission adopted the proposals at its meeting on June 17, 2016 and recommended that they be submitted to the North Carolina Sheriffs' Association and the North Carolina Jail Administrator's Association for consideration. The set of proposals and the commentary are detailed below.

Proposals

1. The Commission proposes that a validated screening instrument be used upon admission to jail or as early as possible for the purpose of early identification of inmates with potential mental health issues.

Commentary: Identification of the mentally ill population is a critical component to maintaining a safe environment in the jail, both for the inmates and for staff. An early and improved identification process could assist in determining a prevalence rate. Establishing the prevalence of mental illness within a local facility helps the county assess its use of criminal justice resources and understand ongoing needs for this population. This evaluation can help stakeholders develop targeted strategies to improve the connection to care for this population, which could lead to a reduction in their recidivism.

All areas visited during the Study Group's site visits reported difficulty grasping the breadth of the mental health population in their facility. This is not unique to North Carolina, as confirmed by Stepping Up: A National Initiative to Reduce the Number of People with

Mental Illnesses in Jails, an initiative sponsored by the National Association of Counties, the American Psychiatric Association Foundation, and The Council of State Governments Justice Center.[1] To tackle this problem, counties across the state are engaging in various methods to identify the mentally ill population in their jails. A common method used is a screening tool given upon admission to the jail, usually during the booking process. The screening instrument asks a series of questions to determine whether someone has potential mental health issues and, depending on the answers, refers the inmate for a more comprehensive follow up to assess mental health needs. The use of a mental health screening tool as part of the screening process was required in 2007; however, because the requirement was a session law, it sunset at the end of the biennium.

The Commission discussed the benefits of using a screening instrument as a method of identifying the mentally ill population in jails. The use of a screening instrument is widely promoted as a best practice among experts in the field.[2] Using a screening tool upon admission helps to identify inmates who may not be presenting mental health issues upon intake, but could exhibit symptoms after more time in custody. Additionally, while there are other methods used to flag inmates for follow-up that have been in mental health services before (see below), using a screening instrument is one of the few methods that can identify inmates that may be new to the mental health system. As such, the Commission wanted to ensure that the use of a screening instrument continues to be a consistent practice throughout the state. To preserve local flexibility, the Commission decided not to recommend the use of a uniform screening instrument due to localities reporting preferences for certain instruments over others.

2. The Commission proposes that county sheriffs and/or their designee make the daily jail booking log available to the designee of the local management entity – managed care organization.

Commentary: Another common method used to identify the mentally ill in jails is for the local management entity – managed care organization (LME-MCO) and/or providers to review the local jail population for current and former patients. Stakeholders interviewed during the site visits reported issues with the screening tool capturing all the mentally ill in their facility; the review of the jail logs for current and past clients helped identify additional inmates that the screener might not otherwise catch. Review by the LME-MCO or its designee also proved to be an effective way of addressing the possible gap in identification that occurs when current consumers are taken into custody. The LME-MCO knows whether the inmate has a provider in the community and, if so, can make a connection with that provider to ensure all relevant and available information about the inmate is communicated to the jail medical providers. This also offered the opportunity for the providers to help the inmate prepare for their release back into the community.

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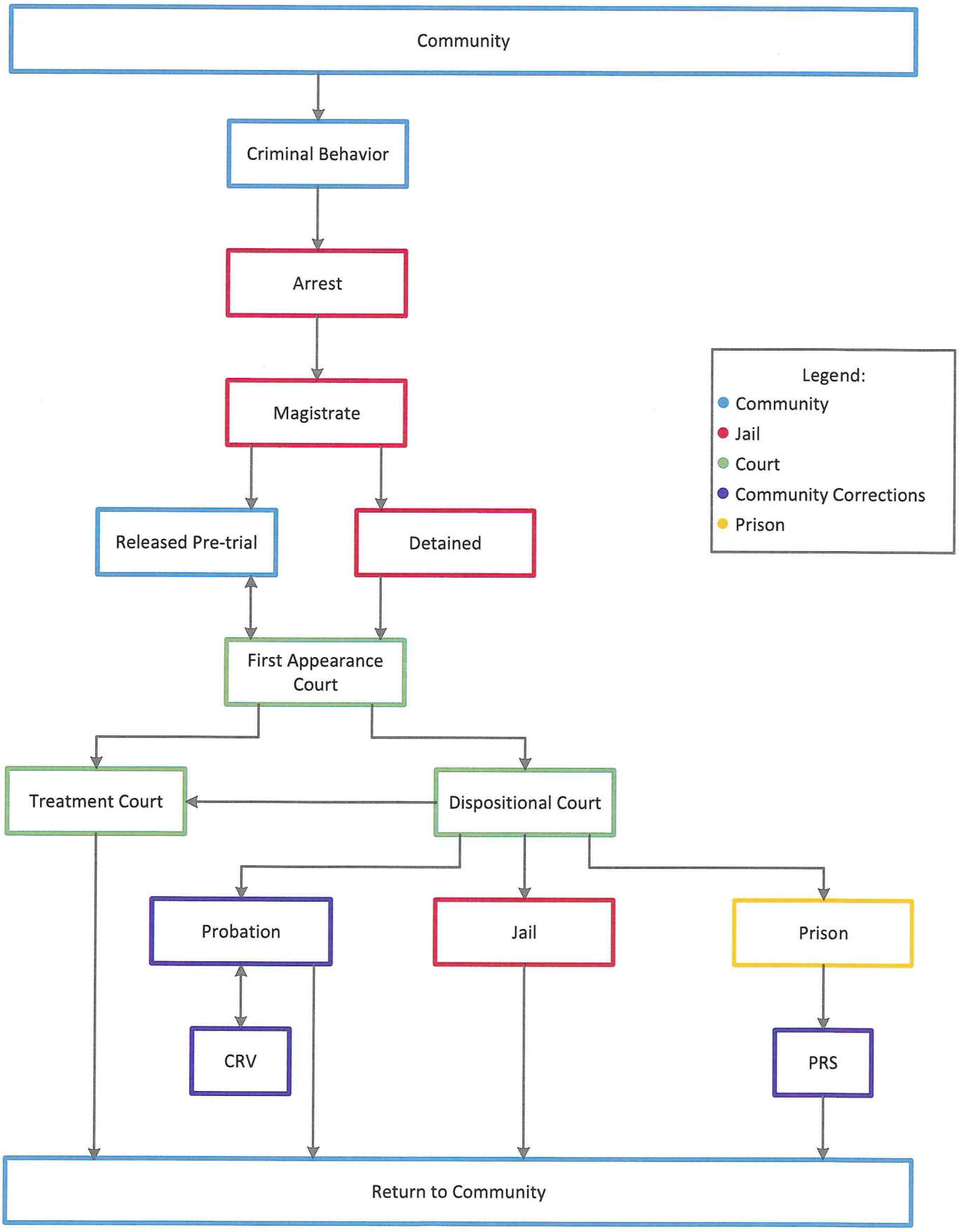
[1] For more information on The Stepping Up Initiative, visit stepuptogether.org.

[2] *See* International Association for Correctional and Forensic Psychology, *Standards for Psychology Services in Jails, Prisons, Correctional Facilities, and Agencies,* (Vol. 37, No. 7, July 2010). *See also* The Stepping Initiative, *Six Key Questions Counties Should Ask Themselves to #StepUp4MentalHealth,* April 2016, available as csgjusticecenter.org (which identifies screening as an important component to reducing the mentally ill in jails).

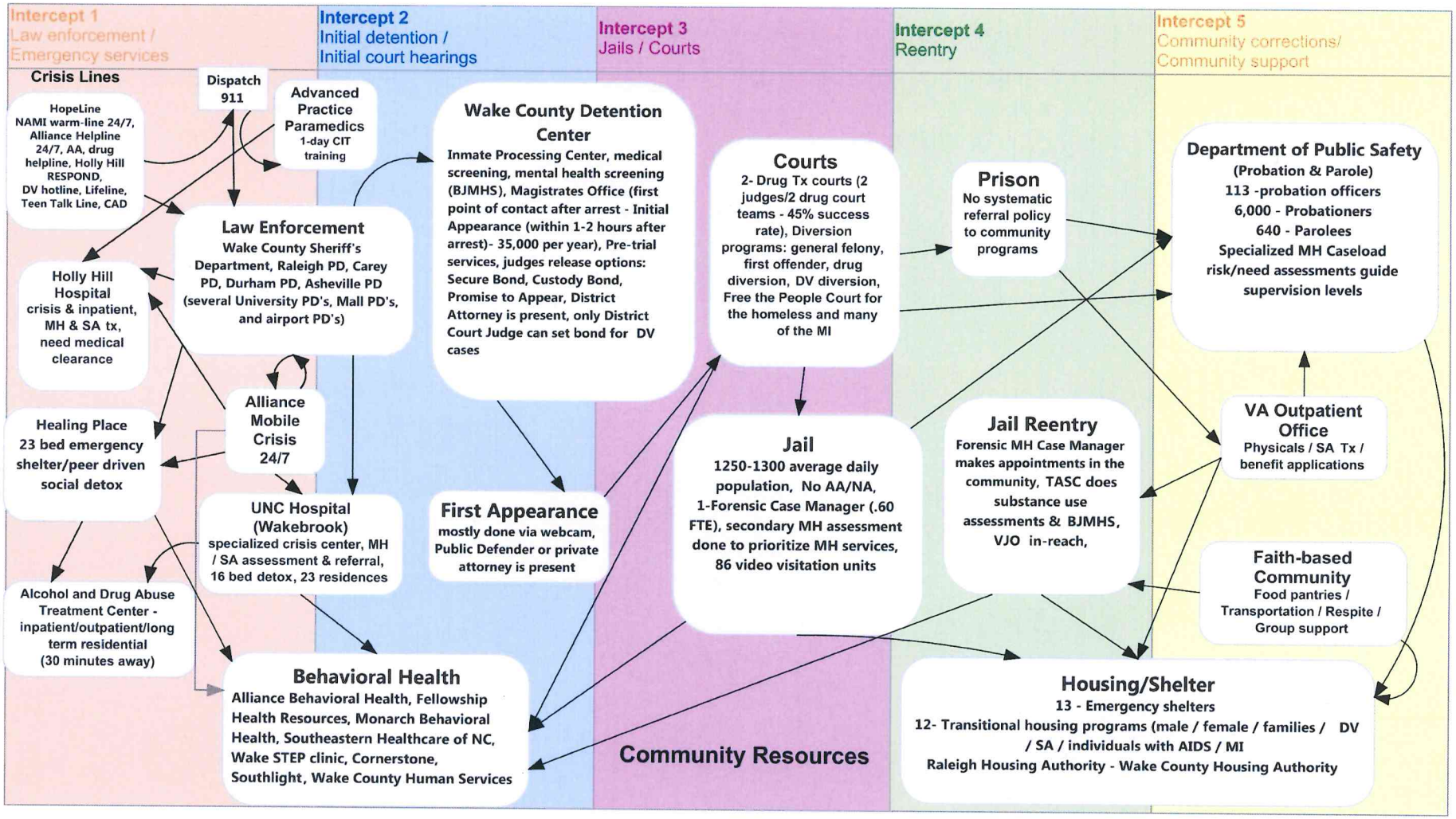
Counties visited during the site visits had different methods of record-keeping regarding their jail population, due to different levels of resources and technologies available. The accessibility of records also varied, ranging from areas that provided little or no access to the jail records to areas that facilitated direct provision of the records via email. The Commission weighed the benefits of allowing the LME-MCOs access to review the records with the demand on resources from asking the jails to allow such access. Because the jail logs are considered public records, the Commission decided that jail records should be made available to the LME-MCO or their designee. However, because of the different record-keeping practices, the Commission did not want to recommend any specific manner of how to make the jail logs available. Instead, it decided the stakeholders in each area could best determine how the LME-MCO could access this information in a way that could benefit both the jail and the inmates.

APPENDIX C
OPPORTUNITIES FOR MENTAL HEALTH INTERVENTIONS AND THE SEQUENTIAL INTERCEPT MODEL

Opportunities for Mental Health Intervention: A Criminal Justice Perspective



Wake County, NC Sequential Intercept Mapping



APPENDIX D
INSTRUMENTS FOR SCREENING MENTAL HEALTH DISORDERS IN THE CRIMINAL JUSTICE SYSTEM

NORTH CAROLINA SENTENCING AND POLICY ADVISORY COMMISSION
RESEARCH AND POLICY STUDY GROUP

Instruments for Screening Mental Health Disorders in the Criminal Justice System

During discussion at a Research and Policy Study Group meeting on January 17, 2016, the Study Group requested examples of screeners used to identify inmates with possible mental health issues. This packet includes four validated screening instruments, three of which are recommended by the Substance Abuse and Mental Health Services Administration (SAMHSA) in their study, "Screening and Assessment of Co-Occurring Disorders in the Justice System" (SAMHSA Study). Those screeners are:

- The Brief Jail Mental Health Screen (BJMHS), widely used in North Carolina;
- The Correctional Mental Health Screen (Male/Female) (CMHS-M; CMHS-F); and
- The Mental Health Screening Form-III (MHSF-III).

Per the SAMHSA Study, "the criteria utilized for the recommendations were based on a critical review of literature and research of each area of screening and comparing the efficacy of each of them. Some factors in recommending specific instruments include empirical evidence supporting the reliability and validity of the instrument, relative cost of the instrument, ease of administration, and previous use in the justice system" (pg.86).

The fourth screener included is the Gain Short Screener (GAIN-SS) that Durham County, a site studied as part of this project, has experimented with.

More information on this study can be found at:
http://store.samhsa.gov/shin/content/SMA15-4930/SMA15-4930.pdf

Brief Jail Mental Health Screen

Section 1

Name: _____ (First MI Last)	Detainee #: _____	Date: __/__/____	Time: _____ AM PM

Section 2

Questions	No	Yes	General Comments
1. Do you *currently* believe that someone can control your mind by putting thoughts into your head or taking thoughts out of your head?			
2. Do you *currently* feel that other people know your thoughts and can read your mind?			
3. Have you *currently* lost or gained as much as two pounds a week for several weeks without even trying?			
4. Have you or your family or friends noticed that you are *currently* much more active than you usually are?			
5. Do you *currently* feel like you have to talk or move more slowly than you usually do?			
6. Have there *currently* been a few weeks when you felt like you were useless or sinful?			
7. Are you *currently* taking any medication prescribed for you by a physician for any emotional or mental health problems?			
8. Have you <u>ever</u> been in a hospital for emotional or mental health problems?			

Section 3 (Optional)

Officer's Comments/Impressions (check *all* that apply):

☐ Language barrier ☐ Under the influence of drugs/alcohol ☐ Non-cooperative

☐ Difficulty understanding questions ☐ Other, specify: _____

Referral Instructions: This detainee should be referred for further mental health evaluation if he/she answered:

- **YES to item 7; OR**
- **YES to item 8; OR**
- **YES to at least 2 of items 1 through 6; OR**
- **If you feel it is necessary for any other reason**

☐ Not Referred

☐ Referred on __/__/____ to _____

Person completing screen _____

INSTRUCTIONS ON REVERSE

©2005 Policy Reseach Associates, Inc.

INSTRUCTIONS FOR COMPLETING THE BRIEF JAIL MENTAL HEALTH SCREEN

GENERAL INFORMATION:

This Brief Jail Mental Health Screen (BJMHS) was developed by Policy Research Associates, Inc., with a grant from the National Institute of Justice. The BJMHS is an efficient mental health screen that will aid in the early identification of severe mental illnesses and other acute psychiatric problems during the intake process.

This screen should be administered by Correctional Officers during the jail's intake/booking process.

INSTRUCTIONS FOR SECTION 1:

NAME:	Enter detainees name — first, middle initial, and last
DETAINEE#:	Enter detainee number.
DATE:	Enter today's month, day, and year.
TIME:	Enter the current time and circle AM or PM.

INSTRUCTIONS FOR SECTION 2:

ITEMS 1-6:

Place a check mark in the appropriate column (for "NO" or "YES" response).

If the detainee REFUSES to answer the question or says that he/she DOES NOT KNOW the answer to the question, do not check "NO" or "YES." Instead, in the General Comments section, indicate REFUSED or DON'T KNOW and include information explaining why the detainee did not answer the question.

ITEMS 7-8:

ITEM 7: This refers to any *prescribed* medication for any emotional or mental health problems.

ITEM 8: Include any stay of one night or longer. Do NOT include contact with an Emergency Room if it did not lead to an admission to the hospital

If the detainee REFUSES to answer the question or says that he/she DOES NOT KNOW the answer to the question, do not check "NO" or "YES." Instead, in the General Comments section, indicate REFUSED or DON'T KNOW and include information explaining why the detainee did not answer the question.

General Comments Column:

As indicated above, if the detainee REFUSES to answer the question or says that he/she DOES NOT KNOW the answer to the question, do not check "NO" or "YES." Instead, in the General Comments section, indicate REFUSED or DON'T KNOW and include information explaining why the detainee did not answer the question.

All "YES" responses require a note in the General Comments section to document:

(1) Information about the detainee that the officer feels relevant and important
(2) Information specifically requested in question

If at any point during administration of the BJMHS the detainee experiences distress, he/she should follow the jails procedure for referral services.

INSTRUCTIONS FOR SECTION 3:

OFFICER'S COMMENTS: Check any one or more of the four problems listed if applicable to this screening. If any other problem(s) occurred, please check OTHER, and note what it was.

REFERRAL INSTRUCTIONS:

Any detainee answering YES to Item 7 or YES to Item 8 or YES to at least two of Items 1-6 should be referred for further mental health evaluation. If there is any other information or reason why the officer feels it is necessary for the detainee to have a mental health evaluation, the detainee should be referred. Please indicate whether or not the detainee was referred.

Appendix A*

Correctional Mental Health Screen for Women (CMHS-W)

Name Last, First, MI	**Detainee #**	**Date** mm/dd/year	**Time**

Questions	No	Yes	Comments
1. Do you get annoyed when friends and family complain about their problems? Or do people complain you are not sympathetic to their problems?			
2. Have you ever tried to avoid reminders of, or to not think about, something terrible that you experienced or witnessed?			
3. Some people find their mood changes frequently-as if they spend everyday on an emotional rollercoaster. For example, switching from feeling angry to depressed to anxious many times a day. Does this sound like you?			
4. Have there ever been a few weeks when you felt you were useless, sinful, or guilty?			
5. Has there ever been a time when you felt depressed most of the day for at least 2 weeks?			
6. Do you find that most people will take advantage of you if you let them know too much about you?			
7. Have you been troubled by repeated thoughts, feelings, or nightmares about something terrible that you experienced or witnessed?			
8. Have you ever been in the hospital for non-medical reasons, such as a psychiatric hospital? (Do NOT include going to an Emergency Room if you were not hospitalized.)			

TOTAL # YES: _____	**General Comments:**

Refer for further Mental Health Evaluation if the Detainee answered ***Yes*** to **5** or more items ***OR*** If you are concerned for any other reason

- o **URGENT Referral** on _ _/ _ _/ _ _ _ _ to _____
- o **ROUTINE Referral** on _ _/ _ _/ _ _ _ _ to _____
- o **Not Referred**

Person Completing Screen: _____

* The forms in appendixes A and B are shown exactly as they are provided to correctional institutions.

INSTRUCTIONS FOR COMPLETING THE CMHS-W

General Information:

The CMHS is a tool designed to assist in the early detection of psychiatric illness during the jail intake process. The Research Team under the direction of Drs. Julian D. Ford and Robert L. Trestman at the University of Connecticut Health Center developed this Correctional Mental Health Screen for Women (CMHS-W), with a grant funded by the National Institute of Justice.

Instructions for administration of the CMHS-W:

Correctional Officers may administer this mental health screen during intake.

Name:	Detainee's name- Last, first and middle initial
Detainee#:	Detainee's facility identification number
Date:	Today's month, date, year
Time:	Current time (24hr or AM/PM)

Questions #1-8 may be administered as best suits the facility's policies and procedures and the reading level, language abilities, and motivation of the detainee who is completing the screen. The method chosen should be used consistently. Two recommended methods:

- Staff reads the questions out loud and fills in the detainee's answers to the questions on the form
- Staff reads the questions out loud, while the detainee reads them on a separate sheet and fills in her answers

Each question should be carefully read, and a check mark placed in the appropriate column (for "NO" or "YES" response).

The staff person should add a note in the **Comments** Section to document any information that is relevant and significant for any question that the detainee has answered "YES."

If the detainee declines to answer a question or says she does not know the answer to a question, do NOT check "YES" or "NO." Instead, record DECLINED or DON'T KNOW in the **Comments** box.

Total # YES: total number of YES responses

General Comments: Staff may include information here to describe overall concerns about the responses (for example: intoxicated, impaired, or uncooperative)

Referral Instructions:

Urgent Referral: A referral for **urgent** mental health evaluation may be made by the staff person if there is any behavioral or other evidence that a detainee is unable to cope emotionally or mentally or is a suicide risk.

Routine Referral: A detainee answering **"YES" to 5 or more items** should be referred for **routine** mental health evaluation. A referral also may be made if the staff person has any concerns about the detainee's mental state or ability to cope emotionally or behaviorally.

** If at any point during administration of the CMHS-W the detainee experiences *more than mild and temporary emotional distress* (such as severe anxiety, grief, anger or disorientation) she should be referred for immediate mental health evaluation.

Referral: Check the appropriate box for whether a detainee was referred. If referred, check URGENT or ROUTINE, enter the date of the referral and the mental health staff person or mental health clinic to whom the referral was given.

Person completing screen: Enter the staff member's name

Correctional Mental Health Screen for Men (CMHS-M)

Name Last, First, MI	Detainee #	Date mm/dd/year	Time
_____	_____	__/__/____	__:__

QUESTIONS	NO	YES	COMMENTS
1. Have you ever had worries that you just can't get rid of?			
2. Some people find their mood changes frequently – as if they spend everyday on an emotional roller coaster. Does this sound like you?			
3. Do you get annoyed when friends or family complain about their problems? Or do people complain that you're not sympathetic to their problems?			
4. Have you ever felt like you didn't have any feelings, or felt distant or cut off from other people or from your surroundings?			
5. Has there ever been a time when you felt so irritable that you found yourself shouting at people or starting fights or arguments?			
6. Do you often get in trouble at work or with friends because you act excited at first but then lose interest in projects and don't follow through?			
7. Do you tend to hold grudges or give people the silent treatment for days at a time?			
8. Have you ever tried to avoid reminders, or to not think about, something terrible that you experienced or witnessed?			
9. Has there ever been a time when you felt depressed most of the day for at least 2 weeks?			
10. Have you ever been troubled by repeated thoughts, feelings, or nightmares about something you experienced or witnessed?			
11. Have you ever been in a hospital for non-medical reasons such as in a psychiatric hospital? (Do NOT include going to an Emergency Room if you were not hospitalized.)			
12. Have you ever felt constantly on guard or watchful even when you didn't need to, or felt jumpy and easily startled?			

TOTAL # YES: _____	**General Comments:**

Refer for further Mental Health Evaluation if the Detainee answered ***Yes*** to **6** or more items ***OR*** If you are concerned for any other reason

- o **URGENT Referral** on __/__/____ to _____
- o **ROUTINE Referral** on __/__/____ to _____
- o **Not Referred**

Person Completing Screen: _____

INSTRUCTIONS FOR COMPLETING THE CMHS-M

General Information:

The CMHS is a tool designed to assist in the early detection of psychiatric illness during the jail intake process. The Research Team under the direction of Drs. Julian D. Ford and Robert L. Trestman at the University of Connecticut Health Center developed this Correctional Mental Health Screen for Men (CMHS-M) with a grant funded by the National Institute of Justice.

Instructions for administration of the CMHS-M:

Correctional Officers may administer this mental health screen during intake.

Name:	Detainee's name- Last, first and middle initial
Detainee#:	Detainee's facility identification number
Date:	Today's month, date, year
Time:	Current time (24hr or AM/PM)

Questions #1-12 may be administered as best suits the facility's policies and procedures and the reading level, language abilities, and motivation of the detainee who is completing the screen. The method chosen should be used consistently. Two recommended methods:

- Staff reads the questions out loud and fills in the detainee's answers to the questions on the form
- Staff reads the questions out loud, while the detainee reads them on a separate sheet and fills in his answers

Each question should be carefully read, and a check mark placed in the appropriate column (for "NO" or "YES" response).

The staff person should add a note in the **Comments** Section to document any information that is relevant and significant for any question that the detainee has answered "YES."

If the detainee declines to answer a question or says he does not know the answer to a question, do NOT check "YES" or "NO." Instead, record DECLINED or DON'T KNOW in the **Comments** box.

Total # YES: total number of YES responses

General Comments: Staff may include information here to describe overall concerns about the responses (for example: intoxicated, impaired, or uncooperative)

Referral Instructions:

Urgent Referral: A referral for **urgent** mental health evaluation may be made by the staff person if there is any behavioral or other evidence that a detainee is unable to cope emotionally or mentally or is a suicide risk.

Routine Referral: A detainee answering **"YES" to 6 or more items** should be referred for **routine** mental health evaluation. A referral also may be made if the staff person has any concerns about the detainee's mental state or ability to cope emotionally or behaviorally.

** If at any point during administration of the CMHS-M the detainee experiences *more than mild and temporary emotional distress* (such as severe anxiety, grief, anger or disorientation) he should be referred for immediate mental health evaluation.

Referral: Check the appropriate box for whether a detainee was referred. If referred, check URGENT or ROUTINE, enter the date of the referral and the mental health staff person or mental health clinic to whom the referral was given.

Person completing screen: Enter the staff member's name

Mental Health Screening Form–III (MHSF–III)

Instructions: In this program, we help people with *all* their problems, not just their addictions. This commitment includes helping people with emotional problems. Our staff is ready to help you to deal with any emotional problems you may have, but we can do this only if we are aware of the problems. Any information you provide to us on this form will be kept in strict confidence. It will not be released to any outside person or agency *without your permission.* If you do not know how to answer these questions, ask the staff member giving you this form for guidance. Please note, each item refers to your *entire life history, not* just your current situation. This is why each question begins, "Have you ever . . . "

Please circle "yes" or "no" for each question.

1. Have you *ever* talked to a psychiatrist, psychologist, therapist, social worker, or counselor about an emotional problem? ..... Yes No
2. Have you *ever* felt you needed help with your emotional problems, or have you had people tell you that you should get help for your emotional problems? ..... Yes No
3. Have you *ever* been advised to take medication for anxiety, depression, hearing voices, or for any other emotional problem? ..... Yes No
4. Have you *ever* been seen in a psychiatric emergency room or been hospitalized for psychiatric reasons? ..... Yes No
5. Have you *ever* heard voices no one else could hear or seen objects or things which others could not see? ..... Yes No
6. (a) Have you *ever* been depressed for weeks at a time, lost interest or pleasure in most activities, had trouble concentrating and making decisions, or thought about killing yourself? ..... Yes No
   (b) Did you ever attempt to kill yourself? ..... Yes No
7. Have you *ever* had nightmares or flashbacks as a result of being involved in some traumatic/terrible event? For example, warfare, gang fights, fire, domestic violence, rape, incest, car accident, being shot or stabbed? ..... Yes No
8. Have you *ever* experienced any strong fears? For example, of heights, insects, animals, dirt, attending social events, being in a crowd, being alone, being in places where it may be hard to escape or get help? ..... Yes No
9. Have you *ever* given in to an aggressive urge or impulse, on more than one occasion, that resulted in serious harm to others or led to the destruction of property? ..... Yes No
10. Have you *ever* felt that people had something against you, without them necessarily saying so, or that someone or some group may be trying to influence your thoughts or behavior? ..... Yes No
11. Have you *ever* experienced any emotional problems associated with your sexual interests, your sexual activities, or your choice of sexual partner? ..... Yes No
12. Was there *ever* a period in your life when you spent a lot of time thinking and worrying about gaining weight, becoming fat, or controlling your eating? For example, by repeatedly dieting or fasting, engaging in much exercise to compensate for binge eating, taking enemas, or forcing yourself to throw up? ..... Yes No

continued on other side

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13. Have you *ever* had a period of time when you were so full of energy and your ideas came very rapidly, when you talked nearly nonstop, when you moved quickly from one activity to another, when you needed little sleep, and when you believed you could do almost anything? .... Yes No

14. Have you *ever* had spells or attacks when you suddenly felt anxious, frightened, or uneasy to the extent that you began sweating, your heart began to beat rapidly, you were shaking or trembling, your stomach was upset, or you felt dizzy or unsteady, as if you would faint? ..... Yes No

15. Have you *ever* had a persistent, lasting thought or impulse to do something over and over that caused you considerable distress and interfered with normal routines, work, or social relations? Examples would include repeatedly counting things, checking and rechecking on things you had done, washing and rewashing your hands, praying, or maintaining a very rigid schedule of daily activities from which you could not deviate. ..... Yes No

16. Have you *ever* lost considerable sums of money through gambling or had problems at work, in school, or with your family and friends as a result of your gambling? ..... Yes No

17. Have you *ever* been told by teachers, guidance counselors, or others that you have a special learning problem? ..... Yes No

---

Print client's name: _____

Program to which client will be assigned: _____

Name of admissions counselor: _____ Date: _____

Reviewer's comments: _____

_____

_____

_____

_____

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Chestnut Health Systems

GAIN Coordinating Center

GAIN Short Screener (GAIN-SS)

Version [GVER]: GAIN-SS ver. 3.0

What is your name? a._____ b. ____ c. _____
(First name) (M.I.) (Last name)

What is today's date? (MM/DD/YYYY) |__|__| / |__|__| / 20 |__|__|

The following questions are about common psychological, behavioral, and personal problems. These problems are considered **significant** when you have them for two or more weeks, when they keep coming back, when they keep you from meeting your responsibilities, or when they make you feel like you can't go on. After each of the following questions, please tell us the last time, if ever, you had the problem by answering whether it was in the past month, 2 to 3 months ago, 4 to 12 months ago, 1 or more years ago, or never.	Past month	2 to 3 months ago	4 to 12 months ago	1+ years ago	Never
	4	3	2	1	0

IDScr 1. **When was the last time** that you had **significant** problems with…

a. feeling very trapped, lonely, sad, blue, depressed, or hopeless about the future? 4 3 2 1 0

b. sleep trouble, such as bad dreams, sleeping restlessly, or falling asleep during the day? 4 3 2 1 0

c. feeling very anxious, nervous, tense, scared, panicked, or like something bad was going to happen? 4 3 2 1 0

d. becoming very distressed and upset when something reminded you of the past? 4 3 2 1 0

e. thinking about ending your life or committing suicide? 4 3 2 1 0

f. seeing or hearing things that no one else could see or hear or feeling that someone else could read or control your thoughts? 4 3 2 1 0

EDScr 2. **When was the last time** that you did the following things **two or more times**?

a. Lied or conned to get things you wanted or to avoid having to do something 4 3 2 1 0

b. Had a hard time paying attention at school, work, or home. 4 3 2 1 0

c. Had a hard time listening to instructions at school, work, or home. 4 3 2 1 0

d. Had a hard time waiting for your turn. 4 3 2 1 0

e. Were a bully or threatened other people 4 3 2 1 0

f. Started physical fights with other people 4 3 2 1 0

g. Tried to win back your gambling losses by going back another day. 4 3 2 1 0

SDScr 3. **When was the last time** that…

a. you used alcohol or other drugs weekly or more often? 4 3 2 1 0

b. you spent a lot of time either getting alcohol or other drugs, using alcohol or other drugs, or recovering from the effects of alcohol or other drugs (e.g., feeling sick)? 4 3 2 1 0

c. you kept using alcohol or other drugs even though it was causing social problems, leading to fights, or getting you into trouble with other people? 4 3 2 1 0

d. your use of alcohol or other drugs caused you to give up or reduce your involvement in activities at work, school, home, or social events? 4 3 2 1 0

e. you had withdrawal problems from alcohol or other drugs like shaky hands, throwing up, having trouble sitting still or sleeping, or you used any alcohol or other drugs to stop being sick or avoid withdrawal problems? 4 3 2 1 0

Review Only

(Continued) After each of the following questions, please tell us the last time, if ever, you had the problem by answering whether it was in the past month, 2 to 3 months ago, 4 to 12 months ago, 1 or more years ago, or never.	Past month	2 to 3 months ago	4 to 12 months ago	1+ years ago	Never
	4	3	2	1	0

CVScr 4. **When was the last time** that you…

a.	had a disagreement in which you pushed, grabbed, or shoved someone?	4	3	2	1	0
b.	took something from a store without paying for it?	4	3	2	1	0
c.	sold, distributed, or helped to make illegal drugs?	4	3	2	1	0
d.	drove a vehicle while under the influence of alcohol or illegal drugs?	4	3	2	1	0
e.	purposely damaged or destroyed property that did not belong to you?	4	3	2	1	0

5. Do you have other **significant** psychological, behavioral, or personal problems that you want treatment for or help with? (**Please describe**) ..... Yes 1 No 0

v1. _____

_____

6. What is your gender? (If other, please describe below) 1 - Male 2 - Female 99 - Other

v1. _____

7. How old are you today? |__|__| Age

7a. How many minutes did it take you to complete this survey? |__|__|__| Minutes

Staff Use Only

8. Site ID: _____ Site name v. _____

9. Staff ID: _____ Staff name v. _____

10. Client ID: _____ Comment v. _____

11. Mode: 1 - Administered by staff 2 - Administered by other 3 - Self-administered

13. Referral: MH ____ SA ____ ANG ____ Other ____ 14. Referral codes: _____

15. Referral comments: v1. _____

Scoring

Screener	Items	Past month (4)	Past 90 days (4, 3)	Past year (4, 3, 2)	Ever (4, 3, 2, 1)
IDScr	1a – 1f				
EDScr	2a – 2g				
SDScr	3a – 3e				
CVScr	4a – 4e				
TDScr	1a – 4e				

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Preview Only