When Political Will Is Not Enough: Jails, Communities and Persons with Mental Health Disorders

Prepared for John D. & Catherine T. MacArthur Foundation's Safety and Justice Challenge

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Background

The November, 2014 final report of the New York City Mayor's Task Force on Behavioral Health and the Criminal Justice System began by noting, "despite our success in reducing the overall jail population, the number of people with behavioral health issues has stayed largely constant, with individuals with behavioral health issues comprising a bigger and bigger percentage of the total number incarcerated." It went on to note, "at every point, the criminal justice system has become the default for addressing the problems presented by people with behavioral health issues, whether at arrest, arraignment, confinement or in the neighborhood. When appropriate, the criminal justice system has an important role to play, yet many people who cycle through the system could be better served – and public safety improved – if their underlying conditions were addressed effectively."

Frustration and outrage at the inappropriate use of jails for persons with serious mental illness (SMI) is not new. In the mid-1980s, The National Coalition for Jail Reform issued its pamphlet, "The New Mental Institution" observing "mentally ill people often end up in jail because there is no other place for them in our communities." In 1990, the National Coalition for the Mentally Ill in the Criminal Justice System convened a meeting on these issues and concluded that "in addition to a large number of people circulating through the jail, these people tend to be highly visible. Jails are locally based. Their detainees are picked up on nearby streets by law enforcement personnel who live in the same communities. These facilities are not distant prisons, staffed by strangers, which hold offenders for years at a time. Finally, the dollars that pay for jails come from county and municipal budgets. This means that increases in their costs become easily identifiable components of a property tax bill. Jails are not nebulous institutions. They are highly visible facilities whose problems have immediate local impacts" (1).

In our book, *The Mentally Ill in Jail: Planning for Essential Services* (2), we talked about "the jail under siege" as jail populations surged and how persons with SMI were contributing to this crisis by being inappropriately housed there.

Best estimates (3) are that of the approximately 12 million admissions to U.S. jails each year, about 17% (2 million) have active symptoms of SMI when booked into the jail. In addition, approximately 75%–80% of these detainees also have co-occurring substance use disorders. Another key issue fills out the "trifecta" for these justice-involved persons with SMI. Nearly all, both men and women, have lifetime histories of sexual and physical abuse.

Just as the outrage about the inappropriate use of jails is not new, the solutions about what to do are not new either. The issue is how to implement what we know and how to capitalize on emergent evidence-based practices for community-based alternative services that enhance both public health and public safety goals. Putting this knowledge into practice is the challenge.

One core principle has proven effective in guiding knowledge-to-practice transfers. In regard to justice-involved persons with mental illness that principle is: The jail is a community institution, and the mentally ill inmate is a community problem. Most detainees spend very short periods of time in jail. Further, except for the "megajails" in the major metropolitan areas, it is impractical given their mission and fiscal constraints to consider developing a comprehensive set of mental health services within jail. In other words, jails must form partnerships with other community agencies who also serve many of the same individuals when they are outside jail.

"To establish appropriate services for such persons requires that the jail be seen as but one agency in a continuum of county services. Indeed, some mental disturbance is a function of the incarceration experience itself, which can be quite frightening and depressing. However, the more common mental health problems are presented by persons whose existing problems are exacerbated by jail or whose current acute episodes have precipitated their arrest and incarceration. As such, the jail is attempting to perform its custodial function of safe pretrial detention while addressing the mental health problems of a community member whose access to services is often highly restricted. Obviously, an adequate response cannot be expected if the mental health service needs are defined simply as the jail's problem. The jail is a community institution, and the mentally disturbed inmate is a community problem" (2).

In the 25 years since that was written, some communities in the U.S. have taken this principle and operationalized it in the form of responsive service systems that have resulted in fewer persons with SMI entering jail and fewer returning to jail as often after release. The large majority of U.S. communities, however, are still wrestling with how to effectively do this while properly balancing individual rights, public protection, and constricting economies.

All of this is not to say that these issues have been ignored. At the federal-level, the Substance Abuse and Mental Health Services Administration (SAMHSA) has taken a lead role in funding community diversion initiatives. From 2002 to 2009 SAMHSA funded 37 localities under its Targeted Capacity Expansion (TCE) initiative to create jail diversion programs. From 2008 to 2015, 13 states under the Jail Diversion Trauma Recovery Priority to Veterans were funded to develop diversion options for veterans and other justice-involved persons with trauma histories. From 2011 to 2014, Adult

Treatment Court Collaboratives were funded in 11 jurisdictions to focus on coordination of arraignment, dispositional and treatment courts in innovative ways to divert persons with mental health disorders. Beginning in 2014, 17 communities are funded for four years in the Behavioral Health Treatment Court Collaboration. Currently (2013–2016) three jurisdictions have been funded to operate pre-booking diversion programs. SAMHSA's GAINS Center for Behavioral Health and Justice Transformation has provided technical assistance to all of these programs.

During this same period, the Mentally Ill Offender Treatment and Crime Reduction Act has funded 254 grants in 46 states, each ranging from $100,000–$250,000, under the Justice and Mental Health Coordination program for planning, implementation and expansion initiatives. Funded through the Bureau of Justice Assistance, these localities have been eligible for technical assistance from the Council of State Governments Justice Center.

A few of these initiatives have collected some evaluation data showing improvement on clinical factors and reductions in subsequent numbers of arrest and fewer jail days. Most of these initiatives were funded as federal 'seed-money' pilot projects that usually phased-out after grant dollars were expended. Some have successfully addressed sustainability by coming up with alternative funding streams for discrete projects. Only a handful have had a more macro-level impact that reshaped the way the community deals with justice-involved persons with SMI. The implication from these few success stories is that what's needed is a more macro focus on bringing a community to scale; not just sustaining or expanding a particular, successful program.

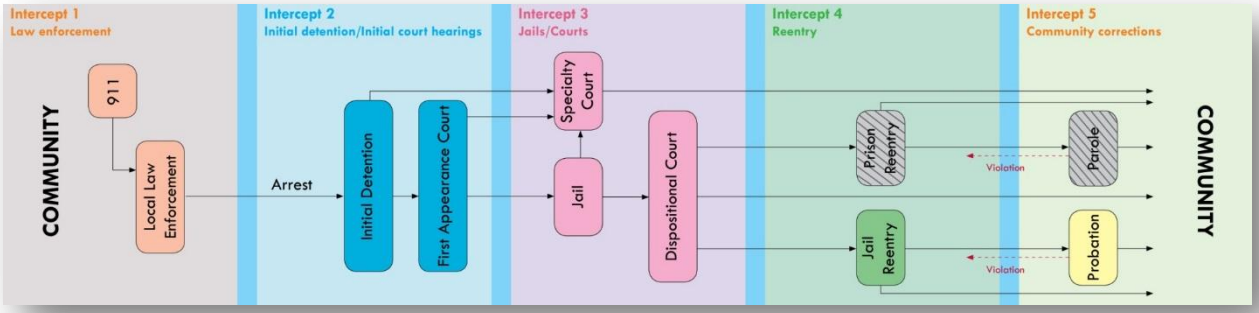
It is simply not enough for stakeholders interested in jail-mental health issues to want to do the right things. They need to know how to do things and how to continually refine their actions as new obstacles occur. This is especially true when responding to community needs around persons with mental health disorders who are involved with the criminal justice system. What is needed is a combination of willing collaborators, accurate facts, proven steps to achieve goals, and on-going assistance to achieve success.

The Sequential Intercept Model as a Planning Tool

It can be challenging in addressing the issues of detainees with SMI in the jail to avoid getting bogged down in the specifics of jail operations. Screening, classification, general population or specialized housing, administering medications and other routine jail mechanics can each absorb huge amounts of time in thinking about the issues of detainees with SMI. However, to begin to effectively analyze and discuss these issues it is essential to have a broader view of where the jail fits in the

processing and detention of citizens who are charged with or convicted of crimes. One tool that has been developed that facilitates a clearer, broader picture is the Sequential Intercept Model.

As seen below, the model is a schematic of the criminal justice system that is broken into five segments, or intercepts. The Sequential Intercept Model was first published by Munetz and Griffin (4) having been developed in conjunction with SAMHSA's GAINS Center staff. The intercepts are seen as



locations in which persons with mental illness can be identified, diverted, treated and returned to the community.

As a planning tool, the Sequential Intercept Model rests on two core principles:

1. Minimize the inappropriate penetration of persons with mental illness into the criminal justice system
2. The unit of analysis to successfully address criminal justice–mental health problems is the community

In looking across the five intercepts at the community it is apparent that the jail is at a critical juncture, Intercept 3. It is central, but moderately deep into the criminal justice system. It is clear to everyone who has analyzed the CJ-MH issues that it is in everyone's best interest to avoid penetration as far as the jail, if appropriate. The person with SMI, criminal justice professionals, taxpayers, and family members are all better off if alternatives at Intercepts 1 and 2 are available to link the person with SMI to community-based services. If planning moves "upstream," fewer people with SMI will be arrested and more people who are charged can be diverted after 24-28 hours incarcerated via first appearance court and linkage to community based services after charges are dismissed or while awaiting disposition.

Putting the jail into a community context shifts the focus to what needs to be done. In doing so, it is important to keep what is needed from being unnecessarily complicated.

The goals for any community vis-à-vis the jail really come down to three:

1. Keep people out of the criminal justice system who do not need to be there
2. Provide constitutionally adequate services when people are incarcerated
3. Link people to services at the "backdoor" of the jail to prevent them from returning

The Sequential Intercept Model is a tool to help think through how to accomplish these three fundamental goals. It works both as a roadmap and as a flow chart that can be used to map all of the community mental health programs that are and can be linked to the components of the criminal justice system overall and to the jail in this particular context.

Bringing the Community to Scale

A concept often heard when a pilot program has been successfully implemented and has some evaluation outcome data to support its effectiveness is "bring the program to scale," i.e. extend it to the entire population that could benefit from it.

We would suggest that this is the wrong core concept for solving the jail SMI problem. Looking at the Sequential Intercept Model, bringing any one program at any intercept to scale will not effectively address the full array of issues to accomplish the three fundamental community goals discussed above. Filling one intercept with a proven program could help, but the ultimate goal is to "bring the community to scale", i.e. have programs at all five intercepts that minimize inappropriate penetration into the criminal justice system, facilitate constitutionally adequate services in the jail, and link detainees leaving the jail to community-based services. All five intercepts need to operate in synch being linked not only to the programs within each intercept, but also linking all the intercepts to one another.

It is our perspective that the absence of this concept of "bringing the community to scale" has compromised the successful solutions to CJ-MH issues even when pilot programs with both federal and state dollars have produced positive public safety and public health outcomes. Rarely do we see communities recognize that having one or two proven programs alone will not solve the problems. With the community as the basic unit of analysis and with the Sequential Intercept Model as a schematic to see where gaps are and where priorities can be set to cover all intercepts over time there is reason for optimism. These problems are not intractable.

It is important to recognize that in almost every jurisdiction that has made significant progress in bringing their communities to scale, a core element has been the development of a task force or core committee. These groups are highly diverse, often with judicial leadership, that include law enforcement,

correctional administrators, mental health service providers, probation, housing specialists, entitlement specialists, family members, consumers, faith community representatives, among various other stakeholders. This group meets regularly from the planning phase through program implementation and program operations. Often membership expands as other key partners get identified as important and as a more comprehensive approach to the issues of SMI in the jail takes shape.

Diversion

In the context of justice-involved persons with SMI, diversion means avoiding or radically reducing jail time by referring a person to community-based services. Such programs may or may not also include continuing supervision. On the Sequential Intercept Model intercepts, diversion is primarily happening at Intercepts 1 and 2. However, problem-solving dispositional courts are in Intercept 3 and diverting probationers with SMI from being reincarcerated for technical violation would be in Intercept 5. To achieve our Core Principle 1, minimizing inappropriate penetration into the criminal justice system requires programs at all of these diversion points.

Recognizing that the jail cannot stand alone in the provision of services to members of the community who have mental disabilities and come into contact with the criminal justice system is fundamental to developing effective programs.

Constructive use of available mental health resources can be accomplished both through in-jail mental health services and through diversion. Clearly the best method for ensuring that services are delivered is to combine diversion of mentally ill detainees with appropriate provision of in-jail mental health services. Alone, neither is as effective as when both are appropriately structured and integrated with one another. In other words, effective mental health treatment depends upon components both within the jail and in the community.

Limits of Jail Responsibility

Earlier, I noted that the second of the three goals for every community in regard to persons with SMI in jail was to provide constitutionally adequate services. This goal is actually a legal requirement. Estelle v. Gamble (429 U.S. 97, 103 (1976)) established the requirement for adequate medical care under the Eight Amendment's prohibition of cruel and unusual punishment. If a jail administrator exhibits "deliberate indifference to serious medical needs" they can be liable for tort damages.

Exactly what standards are necessary to prove "deliberate indifference" is addressed in other case law (e.g. Farmer v. Brennan, 511 U.S. 825 (1994)), but for our purposes the key question is what is

"adequate medical care" for detainees with SMI. The American Psychiatric Association's report, "Psychiatric Services in Jail and Prisons" proposes that jails should have universal screening for mental illness at intake, treatment, and discharge planning. If the treatment section of this report is read carefully the emphasis is really on keeping the detainee safe while incarcerated to get their charges resolved or their sentences completed. The focus is not on comprehensive treatment targeting long term benefit for the detainees when they return to the community. That responsibility is emphasized in the "back door" activities of the jail in the form of reentry planning and linking to community-based programs. It is interesting to note, that a national survey of jails (5) found jails did little reentry linkage, mostly offering referrals.

It may be setting an impossible standard for jails to attempt long term treatment impacts with rapid turnover (approximately 750,000 jail detainees on any given day, but 12,000,000 bookings per year), strained budgets, and a workforce whose primary goal is security. This reality suggests that not only should we be committed to working on diversion of persons with SMI earlier in the criminal justice system, but also we should expect less in the way of comprehensive treatment in the jail. Meeting constitutional standards is achieved if detainees with SMI are held safely and have no harm imposed upon them because of their disorders. This is not to say that to provide a safe environment does not require some programming. It is to say that practically such programming cannot be too ambitious and its outcomes should target in-jail functioning rather than longer term behavioral changes in the community after release.

The Changing Landscape

As we look towards solutions to reducing the number of persons with mental health disorders in U.S. jails, there is nothing more important than the January 1, 2014 full implementation of the Affordable Care Act (ACA). The best estimates are that in the 25 Medicaid expansion states and the District of Columbia roughly 25-30% of persons released from jails could enroll in Medicaid and in non-expansion states 20% could enroll in Marketplace health plans (6). In some states the estimates are even higher. Washington officials estimate that approximately 160,000 people released annually from Washington jails will be eligible for Medicaid in 2014. Previously only 20% were Medicaid eligible and around 112,000 had no state funded health care coverage (7).

Another way of looking at the impact of ACA on jail populations is to see that about 27% of the 13 million U.S. citizens newly eligible for health insurance—or some 3.5 million persons--will be justice involved (8).

What all of these statistics mean is that large numbers of justice-involved persons with mental health disorders who could not previously pay for services could now have insurance. Further, with the federal Parity law requiring equal benefit coverage for mental health and physical illnesses, there could be access to a whole new array of behavioral health services. This means that if eligible and enrolled, whether they are diverted from jail or released from jail post-disposition, they will be desirable clients who can pay for community-based services; services that will not be reimbursable if they remain in jail.

An example of services that may evolve influenced by ACA coverage is the Houston, TX Jail Inreach Project operated by the Houston Health Care for the Homeless (9). They frame that program in the context of Patient-Centered Medical Homes. Other states, particularly New York, are framing this concept as Health Homes as envisioned by Accountable Care Organizations. Regardless of the label, the concept is that there will be targeted integrated behavioral and physical health programs with care coordination specifically for justice involved persons covered under ACA.

It is a time of opportunity. Criminal justice professionals need to be at the table as the sequela of the ACA get played out. The specific needs and system issues of the justice involved population need to be front and center, not just in conversations about jail management, but also in the broad community discussions of implementing ACA.

Pivotal Factors

From the material above it should be clear that we know much about how to bring a community to scale around these SMI issues in the local jail. In fact, a number of locales around the U.S. have been quite successful in creating comprehensive, integrated responses. One way to move forward towards broader implementation is to look at how these locales have achieved these goals. What produced successful programming in these locales when so many other jurisdictions, with the same information available, have either failed in their efforts or have yet to try? What were the pivotal factors in communities that have made significant strides in addressing these issues?

To examine these questions in October, 2014 eight jurisdictions were invited to send two person teams to a two-day meeting to identify the pivotal factors for success with a community-wide response to SMI and local jails. From their presentations on their baseline status, their situation today, and their assessment of what were the pivotal factors that got them there, a number of factors emerged as consistently part of their success. The eight jurisdictions were: Johnson County, Iowa; Miami, Florida; Montgomery County, Maryland; Multnomah County, Oregon; Monroe County, New York; Bexar County, Texas; and King County, Washington. These jurisdictions were selected based on their histories

of developing a wide range of responses to justice-involved persons with behavioral health issues in their communities. Some of programs were jail based, while many others were jail diversion and reentry programs. Only Johnson County, IA was the only somewhat rural locale as formal jail diversion programs are infrequent in rural communities in the U.S. Their deliberations identified six pivotal factors and three areas of special focus.

Pivotal Factor 1 – Centralized Point of Coordination for Planning & Operation

In all eight jurisdictions at the meeting, very early in the process, a single group was created whether called a workgroup, task force, planning committee or whatever that brought together all the key stakeholders and gave a highly visible locus for relevant conversations. They had a charge. In many instances they created the charge. They forged visibility of themselves and their issues. They had frontline knowledge to make potential changes involving policies, procedures and practices. When missing stakeholders were recognized the groups reached out to engage them. The membership evolved as new ideas emerged.

Pivotal Factor 2 – A Champion/Leader

These planning groups ultimately were as good as their leadership. In a number of instances, the champion was on the scene first, publicizing the problems and initiating action. The tool that inevitably emerged was the centralized point of coordinated action. The champions came from various positions, e.g. judges, jail administrators, county correctional health directors and jail alternatives coordinators. Often the champion created his/her role; not worrying about any official designation. Regardless of who they are, champions are an essential element to reform.

Pivotal Factor 3 – Information Sharing

Inevitably, a core problem that was identified was a lack of sharing of relevant information across the behavioral health and criminal justice systems. The information issues were in both directions. At police encounter, booking, and arraignment, the criminal justice system was often looking for behavioral health information to inform arrest, classification and bail decisions. Reciprocally, the behavioral health system wanted to access information on incarceration, discharge planning and release decisions to enhance continuity of care. In every one of the eight jurisdictions involved in our meeting, the centralized planning group had addressed these issues and created options for information sharing across systems that protected individual confidentiality while sharing information that assisted both systems meeting their respective responsibilities.

Pivotal Factor 4 – Cross-System Training

At the outset of these communities' reform efforts, it quickly became apparent that the professionals in both systems had critical gaps in knowledge of the other system; not only factual knowledge, but also an understanding of the respective values and cultures. The training that was developed was inevitably truly cross-training, i.e. both systems trained the other. It was not just behavioral health training criminal justice staff on the signs and symptoms of mental illness. It was as much about how correctional security and community supervision really work and why they are legitimate responsibilities. Likewise, for example, behavioral health trainings of both their own staff and the criminal justice staff on the central role of trauma in understanding the legal and illegal behaviors of justice-involved persons were invaluable.

Pivotal Factor 5 – Defining the Target Group

As one meeting participant noted, "this means knowing who's in your jail." What became apparent to these communities in the early stages of their planning was that the population in question was really very heterogeneous. On a few dimensions they were homogeneous such as poverty, marginal housing and poor physical health. However, on dimensions relevant to creating diversion options and jail treatment options such as diagnosis, acuity, and offending patterns they are quite diverse. At the early stages of planning for reform it usually became apparent that there was not really a clear picture of who these people were and how to define the target groups for various interventions. Resolving this issue involved both developing relevant data and then going through the process of defining who the target groups would be now knowing how many people would be included depending on the criteria selected for inclusion in a target group.

Pivotal Factor 6 – Jail In-Reach

Going hand in hand with the centralized point of coordination and information sharing, a common factor in all participating jurisdictions was bringing community treatment providers into planning groups and literally into the jail. A major emphasis of jail involvement was for effective discharge planning. By having community-based providers actually have staff come into the jail to contact inmates and develop treatment plans for when they are released, treatment gaps were minimized. A secondary development of this in-reach tended to be increased information sharing upon jail admission. Providers became willing to connect with detainees when admitted to the jail both to facilitate diversion and to insure continuity of medication they may have been taking in the community.

Areas of Special Focus

These were the major factors meeting participants identified. In addition to these, their deliberations also suggested three broad areas that were crucial in achieving reform: (1) redesigning financial incentives; (2) integrating state and local requirements and opportunities; and (3) creating a skilled and adequately sized workforce.

a. Complicated Financial Incentives

Many Medicaid termination (vs. suspension) states have providers that are becoming overwhelmed as inmates with behavioral health disorders are discharged from the criminal justice system. Since it takes many months for Medicaid to be reinstated (if they are fortunate to not have to go through an appeal) many behavioral health providers are left to serve the person on a pro bono basis or to tap into already scarce state behavioral health dollars that often times come through block grant funding from SAMHSA. When one of the authors (Travis Parker) was at the Community Mental Health Center, he noted that we would often times have exhausted our state behavioral health dollars 7-8 months into the designated fiscal year, leaving us to serve these persons on a pro bono basis until the next fiscal year started. This was especially true of persons we were not able to divert in our jail diversion program who would just come to the Mental Health Center after their incarceration seeking services. This was one argument we made to the court system as a criteria for potential diversion, especially if the person had existing Medicaid funding and was already involved in behavioral health services. We did not want them to lose this funding and then have to go to scarce behavioral health dollars to continue their services post incarceration.

A very real and unfortunate frustration for persons with behavioral health disorders who have discharged from the criminal justice system, for judges/attorneys and for behavioral health providers is the tug of war that often occurs between the court system and the Medicaid/Managed Care system. It is a very common occurrence to have a judge order someone to treatment (i.e. residential substance use disorder treatment), only to have State Medicaid or a Managed Care entity come back to deny that level of care citing that the person does not meet the Medical Necessity Criteria (MNC) for it. There are many instances where the judge/court system then decides to leave someone incarcerated (if they have only been in jail for a short period of time and have not had their Medicaid benefits terminated yet) or to sentence someone to incarceration because they cannot get into the level of treatment the judge is wanting. Often times, the conflict here is that the judge and prosecuting attorney want to know where this person is going to physically reside and lay their head down on a pillow at night in addition to the

treatment they will receive. The Medicaid/Managed Care system by CMS regulations are not paying for or worried about the "placement" issue for adults or children, they are only interested and paying for the treatment component. The judicial system and Medicaid/Managed Care system are often incompatible and many times at odds with one another when it comes to this "treatment" vs. "placement" issue, particularly when it comes to a residential level of care.

This issue is also applicable to mental health boards seeking to place someone on an inpatient, residential or outpatient commitment to services. If the Medicaid/Managed Care entity says the person does not meet the MNC for the level of care the mental health board wants the person to go to, it leaves the mental health board with difficult decisions regarding how to resolve the issue. It is not uncommon to have persons with behavioral health disorders returned to their communities with not enough treatment and support in place because Medicaid will not pay for a higher level of care and inpatient facilities are feeling the pressure to get people out the door, especially if Medicaid/Managed Care will not continue to pay for the person's stay beyond 3-5 days on average. Some of these people then end up having contact with law enforcement because they do not have the right treatment, supports, medications, etc. in place.

b. Integrating State and Local Efforts

Other comments at the Miami meeting suggested that by stressing community solutions to jail-SMI problems we cannot ignore root causes of the overuse of jails for people with SMI. This point was made with the upstream-downstream metaphor from the public health approach to prevention (10). The metaphor refers to a turbulent river where several people have drowned. Rescue workers have struggled to pull them out, but come to realize that regardless of hard they try they cannot resuscitate all the victims. They discuss how to raise funds to hire more staff, and how to develop better resuscitation and transport techniques. By contrast, the public health approach looks upstream to identify why people are falling or jumping into the river in the first place and then figuring out what can be done to prevent them from doing that in the future.

Upstream-downstream thinking has great relevance for jail-SMI interventions. Much of current jail diversion efforts focus on post-booking interventions such as mental health courts, mandated treatment, and mental health probation. All of these represent downstream interventions trying to rescue people who have already flowed into the criminal justice system. Although necessary, such efforts alone are not sufficient. We also need to be looking for upstream prevention strategies that can help to intercept and divert the flow of persons with SMI into local jails.

Many of these upstream factors can be found at the Federal and state levels. For example, Federal policies that stipulate restrictive eligibility and retention criteria for entitlement programs such as Medicaid, Supplemental Security Income, and HUD housing vouchers all play a role in shaping the health and welfare of persons with SMI who are poor, disproportionately persons of color, uninsured, often homeless, have co-occurring substance abuse disorders, with many continually recycling through the mental health, substance abuse, and criminal justice systems (11). So affordable and safe housing and jobs are key upstream considerations. Other factors relate to state statutes concerning mandatory sentences for non-violent felony drug offenses, for example, and prosecution of misdemeanors which are among the leading causes for arrest and detention of persons with SMI.

But there are opportunities for upstream thinking at the local community-level as well. Crisis Intervention Teams are an example of police-based pre-booking interventions that seek to screen-out nonviolent defendants with mental illness before arraignment by diverting them to treatments centers. Other upstream interventions can be pursued in concert with judges and prosecutors. Working with judges at arraignment to reduce their use of bail as a condition of release for mentally ill defendants who have a low risk of flight if enrolled in a treatment program is one example. Getting prosecutors to plead down low level drug possession and property crimes to misdemeanors and avoiding jail time for such offenses is another.

The take-away messages here are twofold. The first is that not all of the reasons for over-use of jails for people with SMI are determined locally. As a result, achieving fundamental changes in incarceration rates requires an agenda that reaches beyond local communities to changes in state sentencing laws and policies. The second is that downstream interventions on behalf of people with SMI who have already penetrated the local criminal justice system must be paired with upstream efforts to stem the flow of their ever coming in contact with criminal processing.

c. Workforce Issues

A third area that greatly concerned participants was initially again identified by one of the authors (Travis Parker). He noted that there is already a significant workforce shortage of behavioral health providers across many parts of the country. Medicaid expansion has been terrific from the standpoint of providing insurance coverage for more people who are in need of physical, behavioral, and integrated care. Nebraska, where he resides, is still not a Medicaid expansion state, but through monthly calls he would have with persons who were his colleagues in different parts of the country while he was

with Magellan Health, one of the commonly expressed concerns was that the existing behavioral health workforce, which was already spread desperately thin, was now being spread even thinner with new people seeking behavioral health services now that they had Medicaid coverage to pay for these services. In addition to behavioral health providers citing their growing capacity concerns, there were also behavioral health providers who were already upset with the poor reimbursement rate they received from Medicaid/Managed Care for the behavioral health services they rendered. Some of these providers have decided, once Medicaid expansion hit their area, to no longer provide behavioral health services to Medicaid recipients because now they were being asked to expand their capacity to serve this population at the same lousy reimbursement rate. One provider in another state cite during a call stated that they were deciding to get out of the Medicaid business because they were being asked "to do more with less and there is no end in sight."

Another workforce issue identified was the need for boundary spanners (12). As one participant noted, "they are the face of diversion." These positions are necessary because behavioral health staff rarely come into their roles being "criminal justice competent." They do not know how to navigate the criminal justice system to the advantage of their clients. To be effective they need credibility in both the behavioral health and criminal justice systems. These positions need not only to be funded, but also need people who understand both systems and are capable of doing cross-system formal and informal training for both sets of staff.

Achievable Reform

We know what to do. The eight jurisdictions involved in our meeting are at various stages of accomplishing real reform. The pivotal factors are clear. So why are so many communities left with so much to do for justice-involved persons with mental illness? We have argued here that there are two major reasons.

First, the jail is seen as an isolated facility operating within a secure perimeter safely separate from the community rather than, as one participant said, "as part of a continuum of care" or, as we said earlier, as a community institution.

Second, even with this reconceptualization of the jails, communities need support, technical assistance to support their champions and leaders and to help them put the pieces together across all the community criminal justice intercepts. As another participant observed, "the jail will always be a primary point of contact for certain people." Given that, the jail will always have a central place in a continuum of care. However, the jail should not be used as a "crutch," as one participant characterized it.

An entire array of alternatives are possible to the benefit of the justice-involved persons with mental illness, the community at large, and the jail itself. We know what to do. As the Nike ad says, "Just Do It."

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