MONROE COUNTY, INDIANA, CRIMINAL JUSTICE PROJECT

STRENGTHS ASSESSMENT & GAP ANALYSIS

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I. OVERVIEW OF THE PROJECT

The Monroe County, Indiana, Board of Commissioners has undertaken a Comprehensive Criminal Justice Review with the goal of exploring changes to consistently reduce the number of individuals in the Monroe County Corrections Center ("MCCC"). It seeks to work collaboratively with other County constituents to implement alternatives to incarceration, effective and cost-effective rehabilitation and treatment, and restorative justice principles. Kenneth Ray Justice Services ("RJS") and its partner, Justice Concepts Inc. ("JCI"), have reviewed, and made findings and recommendations regarding, improvements to Monroe County's diversion, pretrial release, court processing, and specialty court systems designed to reduce incarceration.

Building on the Comprehensive Review, Inclusivity Strategic Consulting, in consultation with RJS and JCI, and with assistance from the Bazelon Center for Mental Health Law, has reviewed Monroe County's mental health and addiction treatment and intervention resources; its law enforcement, jail, and court responses to individuals experiencing mental health and substance use crises and needing treatment; its resources for such people reentering their communities after incarceration; and its mechanisms for collaboration among its healthcare service system, its crisis intervention system, and its criminal justice system. In addition, Inclusivity has reviewed the general findings and recommendations of the Comprehensive Criminal Justice Review by RJS and JCI and assessed the impact of those recommendations on individuals with mental illness and substance use disorders.

The purpose of our review is to identify strengths and gaps in and between Monroe County's mental health and addiction, crisis, and criminal justice systems in their efforts to prevent, divert, treat, and facilitate successful reentry from criminal justice involvement of individuals with mental illness and substance use disorders ("SUD"). Based on the strengths and gaps identified, Inclusivity Strategic Consulting provides recommendations, priorities, and model policies to facilitate building on the identified strengths and filling the identified gaps in order to achieve the goals of the Comprehensive Criminal Justice Review.

A. Scope of Work

1. Interviews and Site Visits

Inclusivity Strategic Consulting conducted numerous telephone interviews with County leaders and project staff, County agencies, and service providers over the course of the summer and fall of 2019 and fall of 2020, using a survey instrument developed in coordination with the Bazelon Center for Mental Health Law. We conducted two multi-day site visits to Monroe County in August and September 2019. Over the course of the site visits, we met with the County Council, Commissioners, judiciary, Sheriff, Prosecutor, Public Defender, and other County leadership,

and with mental health and addiction service providers, deans and faculty of Indiana University, members of the bar and Chamber of Commerce, and members of the community. In addition, we led a community meeting and a session at the annual Opioid Summit.

Community representatives interviewed included:	
Amethyst House	IU Center for Collaborative Systems Change
Bloomington Housing Authority	IU Health
Bloomington Meadows Hospital	IU School of Social Work
CASA Team	Made Up Mind (M.U.M.)
Catholic Charities	Milestones Clinical and Health Resources
Centerstone	Monroe County United Ministries
Chamber of Commerce	NAMI Greater Bloomington
CleanSlate Centers	New Leaf New Life
Cook	Oxford House
Courage to Change	Shalom Community Center
Goodwill/New Beginnings	United Way of Monroe County
Groups Recover Together	Vocational Rehabilitation Services
Hoosier Initiative for ReEntry (HIRE)	Volunteers in Medicine (now HealthNet Bloomington)
Indiana Center for Recovery	Local Bar Association
Indiana Institute on Disability and Community	Various community members
Institute on Community and Disability	

2. *Research and Data Collection*

We researched promising and best practices from the evidence base and from initiatives in similar jurisdictions to identify models for community-based mental health and addiction services, Medicaid funding, crisis intervention, and other programs that have been shown to reduce incarceration without compromising public safety.

We relied on RJS and JCI to collect data regarding numbers of, charges against, case outcomes, lengths of stay, and services for individuals with mental health conditions and addiction in the criminal justice system. We also conducted research into Indiana's Medicaid system, including interviewing experts, analyzing limitations imposed by state Medicaid rules, and researching the demographic makeup and prevalence of

We attempted to gather data on numbers of individuals with mental health conditions and addiction entering emergency rooms, numbers of individuals hospitalized for mental health conditions and addiction, and numbers receiving service by community-based providers. We met with limited success, because there is no central repository of data and because these providers are not County-controlled.

mental illness and addiction of the County. Finally, we reviewed prior plans touching on the subjects of the review, including the Local Coordinating Committee's Community Comprehensive Plan for Monroe County.

3. Products

Inclusivity Strategic Consulting reviewed demographic data regarding Monroe County's population to inform the research. Appendix A. Inclusivity Strategic Consulting, along with the Bazelon Center for Mental Health Law, produced *Diversion to What? Essential Community Based Services*, setting out best practices for prevention of and diversion from criminal justice involvement for people with mental health disabilities and substance use disorders. Appendix B. The document describes the essential and effective evidence-based community-based services that should be part of communities' mental health and addiction services systems in order to decrease incarceration and institutionalization of individuals with mental illness and addiction. It also sets out the importance of collaborative planning and case management involving criminal justice, behavioral health, and service agencies.

The primary best practices for mental health services, as described in greater depth in the Best Practices document, include Assertive Community Treatment ("ACT"), Supported Housing, Mobile Crisis Services, Supported Employment, and Peer Support Services. The primary best practices for addiction services include Cognitive Behavioral Therapy, Contingency Management, and Medication-Assisted Treatment.[1]

4. Timing

Although the review was planned to be completed by early 2020, lack of access to data slowed completion. The COVID-19 pandemic and nationwide racial and political unrest then delayed progress for several months as both the County and the consultants responded to emergencies. The death of George Floyd at the hands of police officers, other prominent recent examples of police responses to people of color and people with mental disabilities, and data about incarceration rates and the effects of unnecessary incarceration on communities, however, bring even more urgency to Monroe County's efforts. This report seeks to assist the County to be responsive to its entire community, to ensure its criminal justice resources are used wisely and efficiently, and to ensure that other resources are available to people with needs that law enforcement is not designed to address.

[1] *See Diversion to What? Essential Community Based Services*, Appendix B.

II. BACKGROUND ON THE INTERSECTION OF MENTAL HEALTH, ADDICTION, AND CRIMINAL JUSTICE

> *"The penal code shall be founded on the principles of reformation, and not of vindictive justice."*
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> ~ Indiana Constitution, Article 1, Section 18.

Indiana's Constitution mandates that its criminal code should focus on reformation. This is a more than 200-year-old mandate that may have been forgotten by many Hoosiers, but that can and should be given meaning by Monroe County. The Indiana Constitution calls on authorities to carefully consider their responses to drug and alcohol use, addiction-motivated criminal offenses, and mental illness. It is widely recognized that incarceration of people with mental illness and addiction is counterproductive to recovery and that certain conditions of incarceration (e.g., segregation) for such individuals are inhumane, unethical, and illegal. The cost and ineffectiveness of incarceration also cry out for new approaches to prevent and treat, rather than punish, substance use and mental illness. Less expensive and more effective, long-lasting, and humane responses exist.

The Comprehensive Criminal Justice Review gives Monroe County an unprecedented opportunity to respond swiftly and boldly to the lessons of the past few years in criminal justice. Most calls to action regarding criminal justice reform have focused on communities of color and low-income communities. Closely related, and equally urgent, however, is the need to reform the response of criminal justice and healthcare systems to people with mental illness or addiction.

Monroe County's residents support the goals of the Comprehensive Criminal Justice Review. Participants in community meetings expressed concern that the jail has shifted costs to inmates for supplies, programming, medication, and treatment and that its limited resources disparately negatively affect inmates with mental illness and SUD. We heard that the jail does not effectively set people with mental illness and addiction on the road to recovery and community integration.

Participants identified that prejudice against, and assumptions about, individuals with SUD, as well as systemic racism, have led the public health and criminal justice systems to emphasize criminalization and fail to prioritize treatment. Participants were concerned that, despite the growing evidence that mental illness and SUD are treatable health conditions and not character flaws or serious threats to public safety, the justice system continues to focus on punitive responses to the conditions.

Many participants were disturbed by the conditions and overcrowding of the jail. Participants had varying opinions as to whether a new jail should be constructed or money invested, instead,

in community-based treatment and diversion. Participants consistently called for a "paradigm shift" from considering behaviors related to mental illness and addiction as crimes to treating them as illnesses requiring treatment. They also sought criminal justice reform based on principles of restorative justice and evidence-based practices.

In addition, participants expressed concern that the capacity and continuum of community mental health and SUD treatment options were inadequate, making it difficult to implement diversion programs. Because these services are even further limited for those returning from incarceration, we heard that they inhibited successful reentry and reintegration into the community. Participants also repeatedly pointed to structural barriers that particularly harm individuals who are most vulnerable, such high market rents, limited public transportation, and limited employment options.

Participants commended many in the criminal justice system for their efforts to reform responses mental illness/SUD and to give people a chance to avoid criminal justice involvement or recidivism. In considering possible solutions, participants identified improved, and consistent, data collection, sharing, and analysis, improved education for leadership and stakeholders in the criminal justice and public health systems, elimination of barriers to treatment before, during, and after incarceration, and greater community openness to housing, employing, and working together with individuals with mental illness/SUD and histories of incarceration.

A. Need for Change in Criminal Justice and Public Health Responses to Mental Illness and Substance Use Disorders

Many widely publicized incidents across the country have led communities to reexamine the effects of various aspects of their criminal justice systems. These include sentencing guidelines with disparate effects on communities of color; cash bail systems that make incarceration unavoidable for low-income communities; incarceration based on debt for fines and fees; law enforcement training, personnel practices, and immunities that make best practices difficult to implement effectively and consistently; and the long-term, even generational, effects of incarceration on individuals, families, and entire communities, in terms of employment, housing, family stability, and trauma.[2]

The COVID-19 pandemic has highlighted the potential risks of holding people in congregate settings such as jails, even while the pandemic's effects - economic losses, COVID illness and long-haul COVID, closure of in-person services, and limitations on in-person outreach - have exacerbated many of the service gaps that lead people to interaction with law enforcement. At

[2] U.S. Office of Disease Prevention and Health Promotion (ODPHP), Healthy People 2020, Social Determinants of Health, Social Determinants of Health, Incarceration, https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health/interventions-resources/incarceration.

the same time, responses to the pandemic – including increased use of telehealth, internet-based resources, and online coordination tools – have shown us some possible solutions to some of those gaps, at least for people with access to those tools.

Much of the national focus this past year has been on the disparate responses and devastating effects of criminal justice systems on people of color, and in particular Black people.[3] While this report focuses on criminal system responses to people with mental illness and SUD, we emphasize that the effects of unaddressed systemic racism in, and other barriers to, health care, employment, housing, and other systems are cumulative and contribute to the disparate involvement of people of color, including those with mental illness and SUD, in criminal systems in Monroe County and elsewhere.

Resources are becoming and may become more available from the new federal Administration to support states, counties, and localities to shift responses to mental health and substance use disorders from criminal interventions to treatment interventions.[4] In addition, efforts to address the overincarceration of people with mental illness and substance use disorders have been made nationwide, including by the MacArthur Safety and Justice Challenge[5] and the Council of State Governments Stepping Up Initiative, in which over 500 counties are participating.[6] This should help law enforcement, corrections, and courts to focus on their primary public safety missions. The Biden Administration has committed to pursuing a new grant program based on a Brennan Center proposal[7] that would call on states to reduce prison populations by 7% over three years by focusing on, among other things, drug and mental health treatment, alternatives to incarceration/diversion, alternative courts, re-entry services, and employment.[8] At the same time, the Administration has committed to tackling the drug addiction crisis by designating substance use disorder and mental health services as essential benefits that insurers must cover and by expanding Medicaid availability. It intends to invest $125 billion in a comprehensive public

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[3] Loftman & Aydt, Race and Criminal Justice in Monroe County, Indiana: A Long-Range Perspective, available at http://www.uubloomington.org/wp-content/uploads/2018/12/2018-RaceAndCriminalJusticeReport-online.pdf (2018).
[4] See Bazelon Center, An Alternative to the Police: New Funding is Available for Mental Health Mobile Crisis Teams, available at http://www.bazelon.org/ and Appendix D; See Bazelon Center, New Funding is Available for Community-Based Mental Health Services, available at Appendix E; Mental Health Justice Act, proposing creation of a grant program for training, technical assistance, and salary for mental health provider first responder units, available at https://www.congress.gov/bill/117th-congress/house-bill/1368/text; HCBS Infrastructure Improvement Act, https://www.govtrack.us/congress/bills/116/s3277/summary.
[5] https://www.safetyandjusticechallenge.org/.
[6] https://csgjusticecenter.org/2019/08/06/stepping-up-initiative-celebrates-500-counties-milestone/.
[7] Brennan Center for Justice, The Reverse Mass Incarceration Act, available at https://www.brennancenter.org/sites/default/files/publications/The_Reverse_Mass_Incarceration_Act%20.pdf.
[8] The Biden Plan for Strengthening America's Commitment to Justice, available at https://joebiden.com/justice/.

health approach to addiction, doubling funding to community mental health centers, expanding the supply of providers and workers, and reforming criminal justice so that drug use alone does not lead to incarceration.[9] Jurisdictions that do not take advantage of these opportunities to prevent unnecessary incarceration of people with mental illness and SUD do so at their peril. The Department of Justice appears poised to expand its enforcement of the constitutional and federal rights of these individuals, regarding both whether they should be incarcerated and the conditions of their incarceration. In April, 2021, the Department of Justice issued a letter of findings to the County of Alameda, California, concluding that

1) Alameda's mental health system is violating the Americans with Disabilities Act by failing to provide services to individuals with mental health disabilities in the community and unnecessarily institutionalizing them and forcing them into unnecessary encounters with law enforcement due to unmet mental health needs, and
2) Alameda's jail is violating the U.S. Constitution by failing to provide constitutionally adequate mental health care to prisoners, including those at risk of suicide, by denying adequate access to programs and activities because of their disabilities, and by putting them at risk of repeated or unnecessary psychiatric hospital stays upon release.[10]

Indiana appears supportive of efforts to reduce jail overcrowding. The state's Jail Overcrowding Task Force, with specific focus on mental health and drug and alcohol treatment services, educational programs, and other evidence-based programs designed to reduce recidivism, issued its report in December 2019, recommending:

- Amending the criteria for termination of Medicaid upon incarceration;
- Increasing jail efforts, such as through community corrections case managers, to enroll inmates in Medicaid and connect to services prior to reentry;
- Expanding mental health and addiction treatment services, including MAT and crisis centers, in communities and jails;
- Increasing partnerships among jails and community service providers;
- Reducing arrest warrants for nonviolent offenders by developing cite and release procedures, using release matrices, and implementing non-carceral methods of preventing failures to appear;
- Expanding prosecutor diversion programs and pilot programs focusing on treatment services;
- Implementing early mental health screenings to divert people with severe mental illness away from the criminal justice system;
- Expanding the state's pretrial reform initiative based on best practices and graduated incentives and sanctions focusing on therapeutic adjustments;
- Expanding availability of alternatives to incarceration (including problem-solving courts) and community-based treatment services;
- Considering more flexibility for local governments to use jail income tax, public safety tax, and other tax income for resources to address criminal justice system needs other than paying for correctional facilities.

The Task Force also recommended the state invest in these efforts by appropriating additional funding for the Recovery Works pilot project authorized by IC 12-23-1902(d), increasing community supervision staffing levels, and reviewing reimbursement levels for felons held in county jails. While the Task Force found that inadequate data collection was a major hurdle to targeting interventions, it nonetheless found that incarceration of people with mental illness and SUD was sufficiently documented and sufficiently critical to require immediate intervention.

B. National Data on Prevalence of Substance Use Disorders and Mental Illness in Police Interactions and Jail Populations

Recent incidents continue to highlight the need for law enforcement not to be the only available response to people in mental health or substance use crises. For example, police killings of people in mental health crises in Philadelphia and Rochester in just the last several months have sparked community concern.[11] Indiana has not been immune to tragic outcomes.[12] A *Washington Post* database of all reported police fatal shootings since 2015 shows that 23% of the individuals shot by police during the last five years had known mental illness.[13] This is a significant undercount, as it includes only fatal shootings and only of persons the police, themselves, identified as mentally ill. Even this percentage, however, reflects a tremendous disproportionate incidence, as only approximately 5% of the U.S. population has a serious mental illness.[14]

The Bureau of Justice Statistics ("BJS") reported in 2017 that, based on 2011 and 2012 surveys, approximately 26% of jail inmates had experienced serious mental illness within the previous 30 days.[15] Approximately 44% of jail inmates had a history of mental illness. Inmates with more than one arrest were more likely to have mental illness than those experiencing their first arrest.[16] Notably, the prevalence of mental illness did not vary significantly between those incarcerated for violent crimes and property crimes or across lengths of sentence.[17]

Nationally, approximately 44% of jail inmates had a history of mental illness. Approximately 63% of sentenced jail inmates met DSM-IV criteria for drug dependence or abuse, compared with approximately 5% of the general population.

In addition, according to a 2017 BJS report, based on

[11] https://www.nbcnews.com/news/us-news/family-says-walter-wallace-jr-killed-philadelphia-police-needed-mental-n1245166; https://www.nytimes.com/2020/10/09/nyregion/daniel-prude-rochester-police-mental-health.html.
[12] https://www.wthr.com/article/news/crime/police-investigating-fatal-shooting-air-force-veteran-during-mental-health-emergency/531-d245c6fd-bea2-42cb-be6d-7659439f3b61.
[13] https://www.washingtonpost.com/graphics/investigations/police-shootings-database/.
[14] U.S. Bureau of Justice Statistics (BJS), Indicators of Mental Health Problems Reported by Prisoners and Jail Inmates, 2011-12 (June 2017), https://www.bjs.gov/content/pub/pdf/imhprpji1112.pdf, 4.
[15] Id. at 1
[16] Id. at 7.
[17] Id. at 6.

2007–2009 data, approximately 63% of sentenced jail inmates met DSM-IV criteria for drug dependence or abuse, compared to approximately 5% of the general population.[18] Notably, these figures do not include alcohol dependence and abuse. Prevalence of drug dependence/abuse was higher among those incarcerated for property and drug offenses than for violent offenses, and jail inmates with drug dependence/abuse represented approximately 45% of those incarcerated for DWI/DUI and 51% for public order offenses.[19] Some 37% of jail inmates incarcerated for property offenses, 29% of those incarcerated for drug offenses, and 14% of those incarcerated for violent offenses reported that they committed the crime to obtain drugs or money for drugs.[20]

However, arrests tell only a small part of the story. A 2006 Canadian study found that, by far, most police interventions with people with mental illness were for Potential Offenses ("incidents stemming from crises, contentious situations that may degenerate into violence, and antisocial acts or situations that suggest a crime is about to be committed") (31%), Individuals in Distress (34%), and Noncriminal Incidents (27%).[21] Police were called to intervene with people with mental illness as Individuals in Distress and for Noncriminal Incidents disproportionally to such calls for individuals without disabilities, although those calls rarely resulted in arrest.[22]

C. Monroe County Data on Prevalence of Substance Use Disorders and Mental Illness in Police Interactions and Jail Populations

The evidence indicates the prevalence of mental illness and SUD in MCCC is far greater in Monroe County than nationally. This is concerning and should be both a red flag to Monroe County and a call to action. Individuals both within and outside the criminal justice system in Monroe County estimate that 75–80% of the individuals in MCCC at any given time have mental illness and/or SUD. However, self-report surveys such as those conducted for BJS have not been implemented in Monroe County. Nor are current MCCC intake screenings or other data designed to reliably collect or track this information. However, by all accounts, this is a crisis that the County has simply failed to count. Finally, although on the national level, criminal justice involvement increased the likelihood that an individual participated in a drug treatment program (8% participation without criminal justice involvement versus 35% participation by probation/parole population and 30% participation by those arrested),[23] MCCC is not currently equipped to guide people into treatment upon reentry. As a result, MCCC sees individuals with

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[18] BJS, Drug Use, Dependence, and Abuse Among State Prisoners and Jail Inmates, 2007-2009, https://www.bjs.gov/content/pub/pdf/dudaspji0709.pdf, 1.
[19] Id. at 3.
[20] Id. at 6.
[21] Charette, et al., PSYCHIATRIC SERVICES, Vol. 65, No. 4, *Police Encounters Involving Citizens with Mental Illness: Use of Resources and Outcomes*, Table 1 (2014).
[22] However, even in these types of calls, which rarely led to arrest in general, these interventions were twice as likely to lead to arrest when an individual with a mental illness was involved than when a person without a mental illness was involved. *Id*. at 514.
[23] BJS, Drug Use, Dependence, and Abuse Among State Prisoners and Jail Inmates, 2007-2009, at 14.

mental illness and SUD return and return and return.

MCCC had 4,869 bookings in 2019, a slight decrease from 2018. MCCC has 294 beds, including 2 holding beds, 4 segregation beds, and 1 padded cell bed.[24] Bookings resulted in an average daily inmate population in 2019 of 280, but monthly averages ranging from 239 to 301. If, as estimated, 75% of jail inmates have mental illness and/or SUD, some 3,650 bookings would involve someone with mental illness and/or SUD per year.

Despite the failure to specifically count inmates with mental illness or SUD, the charges for which people are booked demonstrate that these illnesses are significant causes of MCCC overcrowding. The MCCC 2019 Annual Report states that the top ten booking types in 2019 included Operating While Intoxicated (#1), Violation of Terms of Placement (#2), Failure to Appear Warrant (#3), Probation Violation (#4), Possession of Methamphetamine (#8), Public Intoxication (#9), and Possession of Paraphernalia (#10). The number of Public Intoxication bookings decreased substantially from a high of 1,156 in 2011 to a low of 171 in 2016, but rose (to 206) in 2018. Notably, the number and percentage of women booked for Public Intoxication has increased from a low of 35 (13%) in 2014 to 51 (25%) in 2018.[25]

In addition, the average length of stay at MCCC for Public Intoxication has dramatically increased from a low of 1.9 days in 2012 to a high of 20.3 days in 2018, when **Public Intoxication accounted for 4,173 MCCC days**.[26] **All possession crimes amounted to 11,214 days in MCCC in 2018**.[27] Other drug-, alcohol-, and mental health-associated bookings also resulted in substantial jail stays, according to 2018 data:

- Operating While Intoxicated – 7,421 days (340 bookings averaging 22 days);
- Minor Possessing Alcohol – 3,034 days (119 bookings averaging 26 days);
- Disorderly Conduct – 1,737 days (82 bookings averaging 21 days);
- Drug Court Violations – 899 days (55 bookings averaging 16 days).[28]

Individuals in the jail's Detox Unit detoxifying from drug or alcohol account for a significant number of daily beds in MCCC, especially on Fridays, Saturdays, and Sundays.[29] In 2018, an average of 9.5 inmates were detoxing in jail per day, with a maximum of 31 inmates detoxing on at least one day.[30] The Annual Report also reports 834 suicide observations in 2019, an increase

[24] 2019 Monroe County Correctional Center Annual Jail Report at 3.
[25] RJS Consulting, MCCC Public Intoxication Bookings - Gender 2003-2018; RJS Consulting LOS Charges 2003-2018.
[26] RJS Consulting, MCCC Public Intoxication Bookings Number of Days Length of Stay 2003-2018.
[27] Id.
[28] Id.
[29] RJS Consulting, MCCC Detox Unit Count 2012-2019.
[30] RJS Consulting, MCCC Number Inmates Per Day in Detox Unit.

of 73 over 2018 and an increase of 186 over 2017.[31]

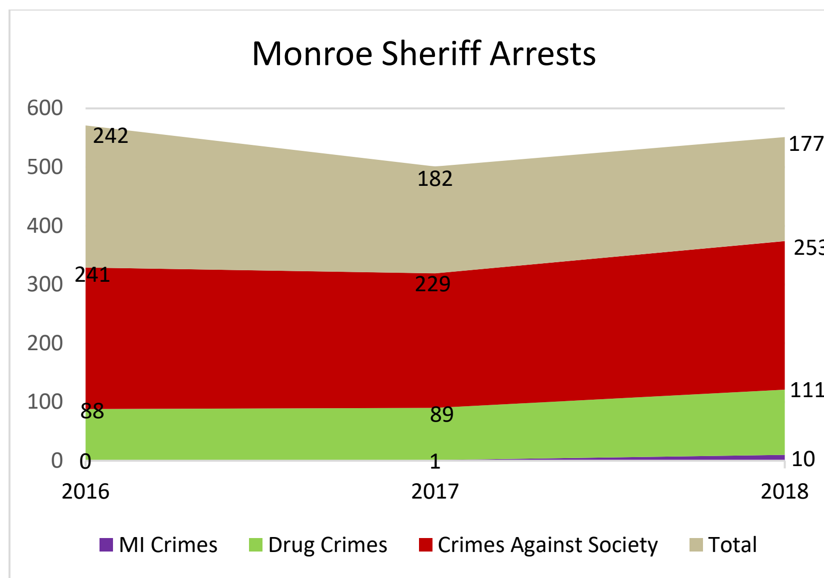
The FBI's database for 2019 did not show arrest data for the Monroe County Sherriff.[32] The Sheriff's arrest data for 2018[33] show 551 arrests, of which more than half were for crimes associated with drugs, alcohol, or mental illness:

- 153 arrests (28%) for Driving Under the Influence, the largest category;
- 111 arrests (20%) for Drug Abuse Violations, the second largest category (100 of which were for possession);
- 10 arrests (2%) for Disorderly Conduct, the seventh largest category;
- 9 arrests (2%) for Liquor Law violations, the eighth largest category;
- 5 (1%) arrests for Drunkenness.

Arrest data from Monroe County's three law enforcement agencies:

	2018	%	2019	%
MCS Drug/Alcohol Offenses	278	50%	*	*
MCS Mental Illness Offenses	10	2%	*	*
BPD Drug/Alcohol Offenses	594	27%	982	28%
BPD Mental Illness Offenses	111	5%	248	7%
IUPD Drug/Alcohol Offenses	510	75%	379	69%

* MCSD switched in March to NIBRS from UCR, as such Federal database does not reflect partial years



A review of Bloomington Police Department ("BPD") arrest data reported to the Federal Bureau

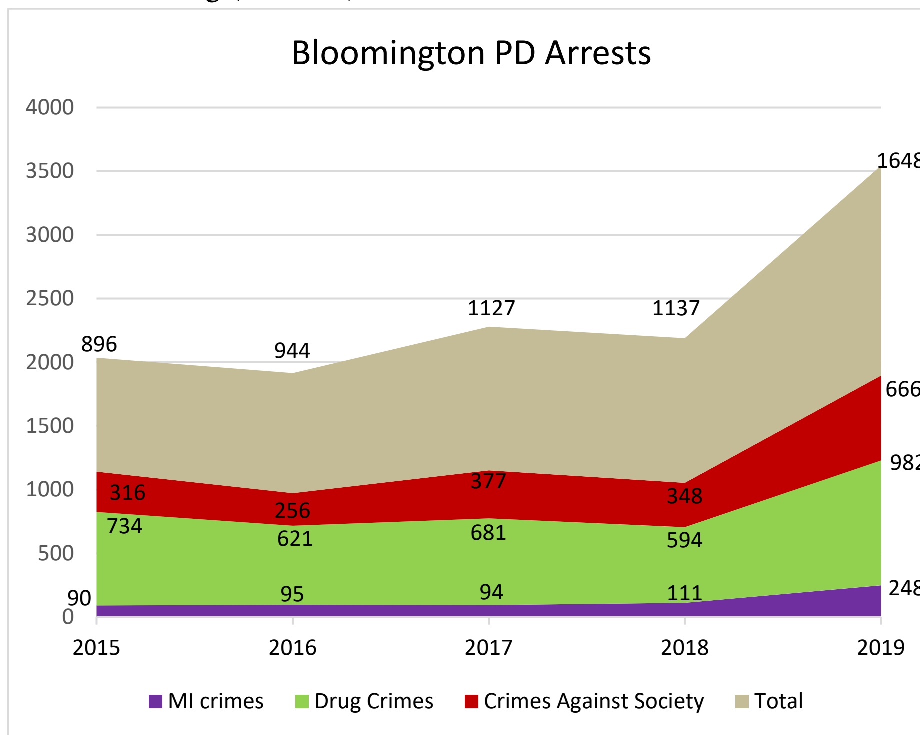
[31] 2019 Monroe County Correctional Center Annual Jail Report at 4.
[32] FBI Crime Data Explorer, https://crime-data-explorer.fr.cloud.gov/explorer/agency/IN0530000/arrest.
[33] FBI Crime Data Explorer, https://crime-data-explorer.fr.cloud.gov/explorer/agency/IN0530000/arrest.

of Investigation for 2019[34] shows 982 arrests for drug- and alcohol-related offenses (28% of all arrests):

- 458 arrests (13%) for Drug Abuse Violations – making it the second largest category of enumerated arrests (388 of these arrests were for possession);[35]
- Drunkenness, at 308 arrests (9%), was the fourth largest category;
- Driving Under the Influence (186 arrests, 5%) the seventh largest category;
- "Possession, Etc. Liquor Laws" (30 arrests. 1%) was the 14th largest category.

The BPD also reported 248 arrests in categories often associated with mental illness,[36] including:

- Disorderly Conduct (240 arrests, 7%) the fifth largest category;
- Vagrancy (6 arrests);
- Curfew and Loitering (2 arrests).

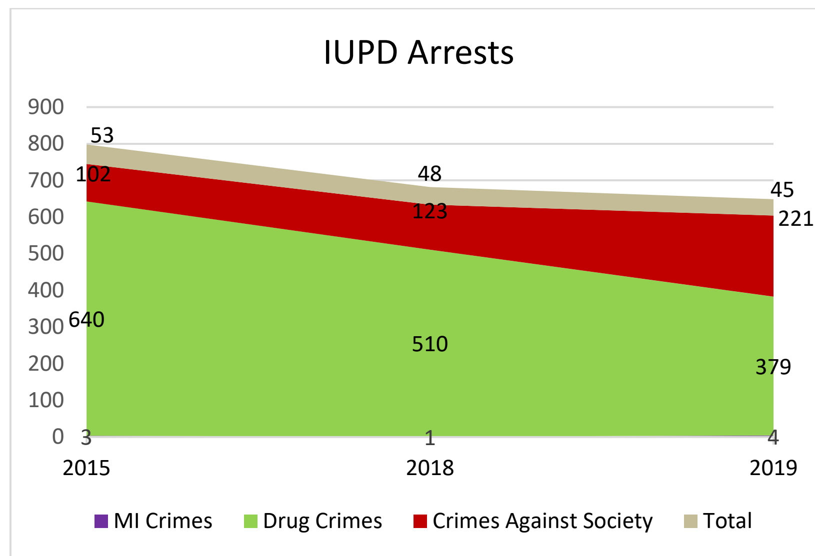


Although similar percentages were reported (27–36% drug- and alcohol-related) in 2015–2018. the total number of BPD arrests grew by 62%, or 1,354 arrests, in 2019 compared to 2018 and prior years. Therefore, the raw numbers of people arrested for substance-related offenses increased from 594 in 2018 to 982 in 2019, a 65% increase. The number of people arrested for

[34] FBI Crime Data Explorer, https://crime-data-explorer.fr.cloud.gov/explorer/state/indiana/arrest.
[35] FBI Crime Data Explorer, Bloomington Police Department, https://crime-data-explorer.fr.cloud.gov/explorer/agency/IN0530100/arrest. The catch-all category "All Other Offenses (Except Traffic)" accounted for the most arrests (610).
[36] Fisher, et al., PSYCHIATRIC SERVICES, *Patterns and Prevalence of Arrest in a Statewide Cohort of Mental Health Care Consumers*, Vol. 57, No. 11 (2006).

mental-illness-associated offenses more than doubled from 111 in 2018 to 248 in 2019.

The Indiana University: Bloomington Police Department ("IUPD") reported a total of 549 arrests in 2019. Of these, 379 (69%) were alcohol- or drug-related. Arrests for "Crimes Against Society" (including drug- and alcohol- offenses), as opposed to crimes against persons or property, were 92% of all IU arrests.[37] The highest category of arrests in 2019 was for violations of the liquor laws (152 arrests, 28%), such as underage possession and possession on IU's dry campus. By contrast, BPD arrests for liquor law violations constituted only 1% of arrests (30). Although the number and percentage of IUPD arrests for drug and alcohol offenses has been dropping in recent years, these figures indicate that IU and the Monroe County community have different priorities regarding criminalization of these activities. Yet, MCCC bears the burden of the arrests.



Of note are BPD arrest rates for "Drunkenness," or Public Intoxication, and Disorderly Conduct, which are Class B misdemeanors. Disorderly Conduct is defined as fighting or tumultuous conduct, making unreasonable noise, or disrupting a lawful assembly. Public Intoxication is only a criminal offense if the person is endangering someone's life, breaching the peace, or harassing another person. Notably, police have complete discretion not to arrest for this offense, as the IN Code provides that no one can maintain a legal action against an officer for failing to enforce it.

These arrest numbers indicate a substantial use of law enforcement and MCCC resources to respond to individuals with substance use (including alcohol) and mental illness needs, with all the predictable impacts on criminal justice budgets and on individuals' employment, family,

[37] FBI Crime Data Explorer, IU: Bloomington, https://crime-data-explorer.fr.cloud.gov/explorer/agency/IN0530100/arrest. IU did not report for 2016, and its 2017 report showed less than 40% of the number of arrests in past and subsequent years, indicating that reporting may not have been complete in 2017.

housing, and health. These numbers, however, substantially underestimate the impact of substance use/mental illness on local government. Many police interventions with people experiencing drug/alcohol use or mental illness issues – such as welfare checks, transporting individuals to treatment services or responding to drug overdoses – do not result in arrest. Bloomington Police data on service calls for 2017 show nearly 4,000 welfare checks, 800 calls for drugs, 650 involving alcohol, and 235 for mental health.[38] Annual overdose deaths in Monroe County have ranged from 25 to 28 consistently from 2016–2019, with 15 overdose deaths in the first half of 2020.[39] Those interventions divert law enforcement resources from responding to crimes, take additional time compared to interventions for people without SUD and mental illness, and are not the central mission, or skill set, of law enforcement.[40]

Substance use and mental health crises also impact other entities, such as hospitals. In 2017, IU Health Bloomington handled 3,591 drug/alcohol abuse-related Emergency Room visits, and 1,107 overdoses.[41]

In short, in order to reduce jail overcrowding and unnecessary incarceration of its residents, Monroe County must prioritize alternatives to incarceration (diversion) for violation of court-imposed requirements, for substance use violations, for detox, and for mental illness-related offenses. To the extent people cannot be diverted from criminal justice involvement, Monroe County must ensure that the jail operates as a pipeline into treatment, rather releasing people to the never-ending revolving door of crisis, relapse, and recidivism that destroys lives, families, communities, and County budgets.

D. Effects of Incarceration of Individuals with Mental Illness and Substance Use Disorders

Law enforcement interventions with individuals with mental illness and substance use disorders have long-lasting and serious negative effects on the affected individuals, their families, their communities, and law enforcement and jails. When a significant public safety need is not present, law enforcement interactions, arrests, and incarceration of individuals with mental illness and substance use disorders should be avoided in favor of alternatives.

The use of law enforcement personnel to respond to individuals with mental illness and

[38] Bloomington First Responders Dashboard, available at https://www.bloomingtonrevealed.com/first-responders.
[39] https://www.in.gov/isdh/27393.htm.
[40] Charette, *Police Encounters Involving Citizens with Mental Illness: Use of Resources and Outcomes*, supra note 11, at 514.
[41] Monroe County Comprehensive Community Plan, 2019 Update at 16. This represents over 18 per 100,000 people.

substance use disorders can have deleterious effects on law enforcement and criminal justice personnel and resources. Police do not want to kill or harm people with mental illness, people in crisis, or people experiencing drug addiction. It is often devastating to the officers who do so. Police are rightly dedicated to, and necessary for, protecting the safety of their communities. Similarly, corrections, prosecutors, and court staff do their best to respond to the needs of inmates with these conditions. They are hampered by the fact that law enforcement and corrections systems and facilities were not designed or funded to provide intensive mental health and substance use treatment. It is now clear that, in order to be most effective, treatments need to be provided in communities, not in institutions. Monroe County has an opportunity to consider how this can be done at the local level, using the local control, discretion, authority and funds that are available. There are executive and fiscal decisions that could be made by Monroe County, if the will exists, to re-shape how people are being treated and dollars are being spent.

1. Effects on Law Enforcement and Jails

The 2006 Canadian study discussed above found that law enforcement officers were disproportionally called to respond to non-criminal incidents involving people with mental illness, thus diverting them from responding to criminal activity. The study also found that police responses to people with mental illness took much more time than responses to people without mental illness. The study found that interventions involving individuals with a mental illness represented 4.4% of all police interventions, but they took twice as much police time as interventions involving a control sample.

After controlling for the occurrence of arrest and the severity of the intervention, the analysis showed that an intervention involving an individual with a mental illness still used nearly 90% more resources than interventions involving the control sample.[42]

An intervention involving an individual with a mental illness used nearly 90% more resources than interventions involving the control sample.

Police interactions with individuals with substance use disorders are more likely to result in arrests than similar interactions with individuals with mental illness, because the fact of possession of an illegal substance is, itself, a crime, regardless of whether any other crime is being committed. In addition, law enforcement often responds to overdose calls that are unlikely to result in arrest.[43]

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[42] Id. at 515.

[43] In Indiana, the drug overdose death rate in 2018 was 25.6 out of 100,000, 18th worst in the nation (2018 data showed a decrease from 2017, but 2020 provisional data shows an increase). Centers for Disease Control and Prevention, National Center for Health Statistics, Key Health Indicators, available at https://www.cdc.gov/nchs/pressroom/states/indiana/in.htm (2020); CDC, NCHS, Vital Statistics Rapid Release: Provision Drug Overdose Death Counts, available at https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm (2020). Monroe County's overdose death rate was 16.9 out of 100,000. Drug Overdose

These interactions take law enforcement away from mission-critical efforts to prevent and respond to violent and property crime and create additional stresses on law enforcement officers. According to a convening by the National Institute of Justice, the RAND Corporation, and the Police Executive Research Forum, "[b]ecause of their role in responding to the opioid crisis, law enforcement officers experience additional physical dangers, mental trauma, and stressors."[44]

Arrests of people with mental illness, substance use disorders, and alcoholism also increase burdens on corrections systems, including MCCC, prosecutors and public defenders, courts, and probation offices. These individuals have unique needs and jail facilities and staff, including those at MCCC, do not have adequate facilities, skills or treatment resources to address them.

In addition, these impacts on the justice system do not end when a person leaves (or avoids) jail. Monroe County's 2018 annual Probation Report shows that 700 people were under supervision for drug offenses (328 for felonies and 372 for misdemeanors). It is not clear how many of these probationers were under pre-conviction supervision. Based on Probation budget figures for 2018, Monroe County's cost of probation supervision averages $1,118 per individual, per year or, in total, $782,794 annually for supervised probation of individuals awaiting conviction or convicted of drug and alcohol offenses. In addition, when an individual does not succeed on probation, the burden on both the individual and the criminal justice system increases further.

2. Effects on Individuals, Families, and Communities

Involvement in the criminal justice system causes lasting harm to individuals, their families, and their communities. Even relatively short pretrial detention has been shown to have significant negative effects on people's ability to leave the criminal justice system, resulting in more convictions and guilty pleas, longer sentences, higher fees, and even more likely future criminal justice involvement.[45] Detention also has a devastating effect on individuals' ability to succeed, and therefore remain, outside the criminal justice system. Research into the National Longitudinal Survey of Youth in 2010 showed that serving time in prison was associated with a

Recent homelessness was 7.5 to 11.3 times more common among jail inmates than in the general population.

Epidemic in Indiana: Behind the Numbers, at 5, available at https://www.in.gov/isdh/files/85_Drug%20Overdose%20Data%20Brief_2019.pdf (2019)

[44] Priority Criminal Justice Needs Initiative, *Law Enforcement Efforts to Fight the Opioid Crisis*, at 2, available at https://www.rand.org/content/dam/rand/pubs/research_reports/RR3000/RR3064/RAND_RR3064.pdf (2019).

[45] Vera Institute, *Justice Denied: The Harmful and Lasting Effects of Pretrial Detention*, available at https://www.vera.org/downloads/publications/Justice-Denied-Evidence-Brief.pdf (April 2019); Heaton, Mayson & Stevenson, T*he Downstream Consequences of Misdemeanor Pretrial Detention*, 69 Stanford Law Review 711, available at https://perma.cc/8BB3-8BPY (March 2017).

40% reduction in earnings, as well as reduced job tenure, reduced wages, and higher unemployment.[46] Approximately 27% of formerly incarcerated people are unemployed.[47] Even short-term detention can harm economic outcomes, as not showing up for work even for a few days is likely to result in termination and loss of positive references and other benefits, all of which have domino effects on other areas of life, such as access to credit, housing, transportation, and healthcare. Homelessness and incarceration increase the risk of each other exponentially and in a vicious cycle, particularly for those with mental illness or SUD.[48]

These impacts do not end with the incarcerated person. Partners and children of incarcerated people lose the economic contributions of their family members, leading to eviction and housing instability, greater reliance on public benefits, crushing debt, and other long-term consequences. Partners, children, and extended family members also must often interrupt their own employment and education to address their family members' incarceration (*e.g.*, arranging bail, attending court, testifying, visiting during established hours) and to make up for their family members' contributions of time for non-employment matters, such as child care.[49]

Children of incarcerated parents are, on average, six times more likely to become incarcerated themselves.

In addition, "[h]aving a parent incarcerated is a stressful, traumatic experience of the same magnitude as abuse, domestic violence and divorce, with a potentially lasting negative impact on a child's well-being."[50] Based on 2011–2012 data, these effects are being felt by at least 11% (177,000) of Indiana children, the second highest percentage in the country, after Kentucky.[51]

[46] Western & Pettit, *Incarceration & Social Inequality*, Daedalus Journal of the Academy of Arts & Sciences, at 13, available at https://www.amacad.org/sites/default/files/daedalus/downloads/Su2010_On-Mass-Incarceration.pdf (Summer 2010). See also Brennan Center for Justice, *Conviction, Imprisonment, and Lost Earnings*, at 2, available at https://www.brennancenter.org/sites/default/files/2020-09/EconomicImpactReport_pdf.pdf (Sept. 2020) (2017 data showing average earnings loss of 16% for a misdemeanor conviction, 21.7% for a felony conviction without imprisonment, and 51.7% for imprisonment). Explanations for this employment effect include the negative attitudes of employers about criminal records, incarceration's interruption of work experience, and negative habits and behaviors that are needed in prison but poorly suited to the workplace.

[47] Couloute & Kopf, *Out of Prison & Out of Work: Unemployment among formerly incarcerated people*, Prison Policy Initiative, available at https://www.prisonpolicy.org/reports/outofwork.html (July 2018).

[48] Greenberg, et al., *Jail Incarceration, Homelessness, and Mental Health: A National Study*, 59 Psychiatric Services 2, at 175, available at https://homelesshub.ca/sites/default/files/Greenberg.pdf (Feb. 2008); Bailey et al., *No Access to Justice: Breaking the Cycle of Homelessness and Jail*, Vera Institute of Justice Evidence Brief, available at https://www.safetyandjusticechallenge.org/wp-content/uploads/2020/08/homelessness-brief-web.pdf (August 2020).

[49] Annie E. Casey Fdn., *A Shared Sentence: the devastating toll of parental incarceration on kids, families, and communities* at 4, available at https://www.aecf.org/m/resourcedoc/aecf-asharedsentence-2016.pdf#page=5 (April 2016).

[50] Id.

[51] Id. at 5. Notably, this percentage counts only children whose incarcerated parent lived with them at some point.

Children of incarcerated parents may be, on average, six times more likely to become incarcerated themselves and are more likely than their peers to experience reactive attachment disorder, academic setbacks, antisocial behaviors, and intergenerational incarceration.[52] Research indicates these effects are greatest among children whose mothers are incarcerated,[53] a great concern in light of the fact that 70% of women in prison are mothers. In addition, research suggests that parental incarceration significantly increases children's risk of developing mental illness in early adulthood.[54] Notably, Monroe County's CHINS cases have increased in recent years, possibly as a result of increase parental incarceration. These intergenerational effects of incarceration increase the long-term burdens on Monroe County's budgets and on the health and success of its children and its community.

Finally, incarceration harms communities. "In areas where a sizable portion of residents are behind bars, the effect is cumulative: The sheer number of absent people depletes available workers and providers while constraining the entire community's access to opportunity – including individuals who have never been incarcerated."[55] Formerly incarcerated individuals face severe employment barriers, particularly when their convictions involve substance use disorders or mental illness, thus depriving their families and communities of needed income.

E. Substance Use and Mental Health Treatment Needs in Monroe County

The high rates of arrests for drug- and alcohol-related offenses and mental-illness-related offenses in Monroe County should come as no surprise. The resources needed to prevent those diseases from leading to criminal justice involvement are lacking in the community. The 2018 IU University Health Bloomington Hospital Community Health Needs Assessment ("Assessment")[56] of Monroe, Lawrence, and Owen Counties identified drug and substance abuse and mental health treatment as some of the most significant needs in the communities. Monroe County was in the bottom quartile of Indiana Counties on several health indicators, including poor mental health days (#83 out of 94 counties), excessive drinking (#92 out of 94), percent uninsured (#72), and severe housing problems (#92), and in the bottom half on several others,

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[52] Bailey & Wakefield, Emotional, Psychological, and Behavioral Challenges of Children with Incarcerated Parents, available at https://digitalscholarship.unlv.edu/cgi/viewcontent.cgi?article=1052&context=mcnair_posters (2013); Martin, Hidden Consequences: The Impact of Incarceration on Dependent Children, National Institute of Justice Issue 278, at 2-4, available at https://www.ncjrs.gov/pdffiles1/nij/250349.pdf (May 2017).

[53] Hidden Consequences, at 2.

[54] Garris, et. al, Association of Childhood History of Parental Incarceration and Juvenile Justice Involvement with Mental Health in Early Adulthood, Journal of the American Medical Association, available at https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2749232?utm_campaign=articlePDF&utm_medium=articlePDFlink&utm_source=articlePDF&utm_content=jamanetworkopen.2019.10465 (2019).

[55] Id. at 4.

[56] IU Health Bloomington Hospital, Community Health Needs Assessment, available at https://cdn.iuhealth.org/resources/Bloomington-Hospital-CHNA_2018-compressed.pdf?mtime=20181219131956 (November 26, 2018).

such as unemployment (#57).[57] Suicide mortality rates were higher than average in Monroe County.[58] Survey participants reported on average 4.4 mentally unhealthy days reported in the past 30 days in Monroe County, higher than the state average and considerably higher than the national average. Nearly 21% of participants reported excessive drinking, exceeding state and national averages.[59]

A recent Community Need Index calculation based on barriers to health care access identified Monroe ZIP code 47404 as a "highest need" area, with 47403, 47406, and 47408 ranking as "high need."[60] In the face of these high needs, Monroe County was designated as a medically underserved area and a Health Professional Shortage Area for Mental Health.[61]

A significant number of Monroe County residents do not have access to the resources they need. Monroe County's poverty rate, at 25%, is above both the Indiana and U.S. averages. Poverty rates for residents of color is higher than the average for white residents. Monroe's unemployment rate is above the state average. This has a significant impact on access to healthcare, because most people receive health insurance benefits through their employers. The greatest uninsured rate in the county occurs in ZIP code 47403 and is above the state average.[62] Monroe County's uninsured rate is over 12% among individuals under age 65.[63]

2018 IU University Health Bloomington Hospital Community Health Needs Assessment

Although Monroe County has an abundance of resources, it is often difficult to get economically disadvantaged populations to affordable providers.

- There is a need for more mental health providers, particularly those that use medication-assisted treatment.
- Navigating the healthcare system in Monroe County is very difficult for many residents, especially those on fixed incomes or in high economic need.[1]

Monroe County's significant homeless population is both a result and an epicenter of these unmet needs. According to the annual Point In Time homelessness count, Monroe County homelessness has remained high in recent years and increased to 380 people in 2019.[64]

[57] Id, Ex. 23.
[58] Id. at 7-9.
[59] Id. Ex. 24. Monroe County residents also reported exceedingly high rates of death from chronic liver disease and cirrhosis. Id. Ex. 26.
[60] Id. App. 34.
[61] Id. at 9.
[62] Id. at 24.
[63] Id. App. 24.
[64] Indiana 2019 Region 10 Point In Time Homeless Count 1/23/19, on file with authors; Homelessness: Unpacking the Point in Time Count, available at https://www.monroeunitedway.org/WakeUp-

Chronically homeless individuals – defined as those with disabilities experiencing long-term homelessness – in Monroe County rose from 31 in 2018 to 46 in 2019, after dropping from 63 in 2017 when supported housing apartments became available.[65] According to self-reports, about 27% of homeless people have serious mental illness and 19% have a substance use disorder.[66]

Of persons who used meth, 57.7% reported mental illness, and 25% reported serious mental illness in the past year.

Arrest and bookings data, as well as reports from providers, indicates that major SUD issues in Monroe County are marijuana, alcohol and methamphetamine.[67] This is not to say that opioids and marijuana use are not contributing to incarceration and treatment needs. They are, but alcohol and methamphetamine appear to be the addictive drugs contributing to the greatest number of encounters between individuals and law enforcement, as well as the largest contributors to homelessness and other crises.

METHAMPHETAMINE & ADHD

Alcohol and methamphetamine addiction should challenge our traditional assumptions about addicts and effective responses to addiction. While traditional beliefs about people with SUD are incorrect for nearly every substance, the view that SUD is caused by character flaws or lifestyle choices is particularly erroneous in regard to alcohol and meth. People addicted to alcohol are introduced to it because it is inescapably available, legal, and perceived as harmless. People who become addicted to alcohol, thus, come from every walk of life.

While methamphetamine is not legal, it is closely related to legal drugs for attention-deficit hyperactivity disorder ("ADHD"). Approximately 23% of people with SUD meet the diagnostic criteria for ADHD,[1] compared to only 5% of the general population.[1] This suggests that individuals may be using meth as self-medication.

Mental illness is common among methamphetamine users, with 57.7% of persons who used methamphetamine reporting any mental illness and 25% reporting serious mental illness during the past year.[68] These are likely underestimates, as the research did not include unsheltered homeless people, incarcerated people, or people in hospitals or institutions. Methamphetamine may also contribute causally to mental illness. As a result, combinations of SUD and mental health treatment for co-occurring disorders is key to recovery. A gap in such treatment exists in many communities, including Monroe

ADHD is about 2–6 times more common in methamphetamine users than non-users.

PointInTimeCount; https://www.monroeunitedway.org/sites/monroeunitedway.org/files/uw_files/untitled%20folder4/Wake%20Up!%20Point%20in%20Time%20Count/PIT%20Trends%20in%20Homelessness%20-%20National%2C%20State%2C%20and%20Local.pdf.

[65] Indiana 2019 Region 10 Point In Time Homeless Count 1/23/19, on file with authors.

[66] Bloomington Social Services Dashboard, available at https://www.bloomingtonrevealed.com/social-services.

[67] Centerstone 2020 CMHC Report – Top 5 Substances Served – Marijuana/Hashish- 986; Alcohol – 931; Methamphetamin – 537; Opiates – 328; Heroin – 283.

[68] Jones, et al., Patterns and Characteristics of Methamphetamine Use Among Adults – United States, 2015-18, CDC Morbidity and Mortality Weekly Report, available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7725509/, (March 27, 2020).

County. The overlaps of mental illness and ADHD with SUD, and particularly with methamphetamine use, council for an increased focus on diagnosis and treatment, rather than punishment, for these individuals.

F. Funding Resources

Law enforcement, corrections, and criminal justice expenses are borne by the Monroe County budget. For 2021, expenses (not including special purpose and public safety funds), are expected to be approximately:

Jail	$6.7 million
Courts	$3.8 million
Probation	$4.8 million
Prosecutor	$3.7 million
Public Defender	$2.4 million
Sheriff	$6.4 million
Total	**$27.8 million**

Thus, it costs nearly $28 million, or over $5,700 a person, to primarily "serve" the 4,869 people booked into the MCCC.[69] Even excluding the costs of the Sheriff's office, the per inmate cost is approximately $4,400. By contrast, applying that amount to treatment and services could pay the Medicaid monthly payments plus one third to half of the average rent for two people to live in a two-bedroom apartment for a year.[70] This is consistent with research in Maryland showing that incarceration of a drug offender cost $20,000 while treatment cost $4,000. The Maryland data also showed that $1 of in-prison treatment yields a benefit of $1.91–$2.69 compared to failure to treat in prison. However, community treatment outside of prison yields $3.30 for every dollar spent, and drug courts yield $2.83 per dollar spent.[71] Thus, an investment of $4,000 for community-based mental health treatment could generate $13,200 in benefits and savings, while an investment of $4,000 in drug treatment could generate $11,320, compared to the same $4,000 in in-prison treatment generating $7,640-$10,760.

Moreover, mental health and substance use treatment services are covered by federal, state, and private funds. For individuals not eligible for Medicaid or Medicare, those services can be funded by private insurance. Treatment for Medicaid-eligible individuals is covered by state and federal Medicaid funding. The federal government reimburses nearly 66% of Indiana's Medicaid

[69] Some of these expenses are reimbursed by the state.
[70] Based on average rent Bloomington-wide of $1075 per month for a two-bedroom apartment and average rent of $650 for a two-bedroom apartment in particular areas of Bloomington. https://www.zumper.com/rent-research/bloomington-in.
[71] McVay et al., Treatment or Incarceration? National and State Findings on the Efficacy and Cost Savings of Drug Treatment Versus Imprisonment, Justice Policy Institute available at http://www.justicepolicy.org/research/2023 (2004).

costs.[72] Because of Monroe County's relatively high poverty rate (20.8% overall in 2019;[73] nearly twice that rate for Black residents and over twice that rate for Asian and Latino residents[74]) many residents are likely eligible for Medicaid. At the same time, Monroe's high (12.3%) uninsured rate among working age adults[75] indicates that individuals are not enrolling in Medicaid.[76]

IU's uninsured student population may be playing a role in these figures as well. While young, otherwise-healthy students often believe insurance to be unnecessary, the prevalence of arrests by IUPD for liquor law, drug abuse, and driving under the influence violations suggests access to treatment services is a need for this population. In addition, the extremely high uninsured rates for Asian and Latino residents indicates immigration status may be a barrier to some Monroe County residents, as undocumented immigrants are ineligible for federal and Indiana Medicaid, Medicare, the Children's Health Insurance Program, or the Affordable Care Act marketplaces. Most lawfully present noncitizen immigrants, such as Legal Permanent Residents and "green card" holders, must wait five years before enrolling in Medicaid.

In Indiana, individuals are eligible for Medicaid if they meet income limits (up to $17,829 annual income for an individual; up to $36,590 for a family of four). Generally, Indiana Medicaid requires members to contribute financially upon enrollment ($10) and monthly (up to 3% of income).[77] Employers and providers can make these contributions on individuals' behalf.

Indiana Medicaid's covered substance use disorder treatments include early intervention, outpatient, intensive outpatient, partial hospitalization, residential and inpatient treatment, withdrawal management, opioid treatment (including methadone, buprenorphine, naloxone, naltrexone), and addiction recovery management (including peer recovery coach) services.

In addition, Indiana's Adult Mental Health Habilitation program, under Social Security Act

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[72] Congressional Research Service, Medicaid's Federal Medical Assistance Percentage, available at https://fas.org/sgp/crs/misc/R43847.pdf (July 29, 2020). In addition, during the COVID19 pandemic, federal matching rates have been temporarily increased by 6.2%.
[73] StatsIndiana, Monroe County, available at https://www.stats.indiana.edu/profiles/profiles.asp?scope_choice=a&county_changer=18105.
[74] IU Health Bloomington Hospital, Community Health Needs Assessment at 22-23.
[75] Id. at Ex. 24.
[76] At the same time, Monroe County's unemployment rate is lower than the rest of the state, Bureau of Labor Statistics, Bloomington, IN Economy at a Glance, available at https://www.bls.gov/regions/midwest/in_bloomington_msa.htm. This suggests many low-income, uninsured individuals are working, which can pose a barrier, in terms of reduced available time and energy, to seeking public services, such as Medicaid coverage. IU's student population, who are not included in the unemployment rate, may also contribute to the high uninsured rate.
[77] Indiana also charges people who use tobacco products an increased contribution amount as a tobacco surcharge. Given that nearly 20% of Monroe County residents smoke, IU Health Bloomington Hospital, Community Health Needs Assessment at Ex. 24, this may discourage Medicaid enrollment.

section 1915(i) and a section 1115 demonstration project, funds intensive home and community-based services for adults with serious mental illness and serious emotional disturbance, with or without co-occurring substance use disorders.[78] These services include crisis intervention, therapy and behavioral support services, addiction counseling, care coordination, and medication support.

Indiana's Medicaid system has expanded coverage of telemedicine services for most healthcare services during the pandemic, including for medication assisted treatment prescriptions to treat opioid dependence and mental health services covered by the Home and Community-Based Services Waiver.[79] This program has been highly successful, and Indiana may consider continuing telemedicine coverage after the pandemic.

Medicaid reimbursement is not available to otherwise-eligible individuals who are incarcerated.[80] Therefore, treatment services provided in jail are not reimbursable by Medicaid. In fact, Medicaid is suspended for individuals on Medicaid who are incarcerated longer than 30 days. Jails are required to assist inmates who are incarcerated for more than 30 days to apply for or reinstate Medicaid and are allowed to act as the inmate's authorized representative for the application.[81] Upon release, the inmate must activate their enrollment or reinstatement. It is essential to begin the application/reinstatement process early, as processing can take 45–90 days.

H. Legal Requirements Affecting Public Health and Incarceration

The Americans with Disabilities Act ("ADA")[82] protects those with mental illness and substance use disorders from discrimination.[83] Criminal justice activities, as well as healthcare systems, are covered by the ADA and the Department of Justice ("DOJ") has issued guidance explaining the ADA's requirements and providing examples and resources to support compliance.[84]

1. Criminal Justice Interactions

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[78] Division of Mental Health and Addiction, Adult Mental Health Habilitation Services, available at https://y-tac.org/wp-content/uploads/2020/12/Essential-Guide-to-School-Transition-YTAC.pdf.
[79] http://provider.indianamedicaid.com/ihcp/Bulletins/BT202022.pdf.
[80] Presumptive Eligibility can be used for hospital inpatient treatment while incarcerated.
[81] Frequently Asked Questions Regarding Medicaid and Inmates, available at https://www.in.gov/medicaid/files/medicaid%20for%20inmates%20faqs.pdf.
[82] 42 U.S.C. 12132-34; 28 C.F.R. Part 35.
[83] 28 C.F.R. § 35.108(b).
[84] Examples and Resources to Support Criminal Justice Entities in Compliance with Title II of the ADA, available at https://www.ada.gov/cjta.pdf (DOJ Examples & Resources); Bazelon Center for Mental Health Law, "Diversion, Not Discrimination: How Implementing the Americans with Disabilities Act Can Help Reduce the Number of People with Mental Illness in Jails, available at https://secureservercdn.net/198.71.233.254/d25.2ac.myftpupload.com/wp-content/uploads/2018/07/MacArthur-White-Paper-re-Diversion-and-ADA.pdf (2017).

a. Arrests

Title II of the ADA prohibits state and local governments, including their law enforcement agencies, from discriminating against individuals with disabilities and requires them to reasonably modify their policies, practices, and procedures to accommodate disabilities.[85] The reasonable modification obligation applies whenever an agency's employee knows or reasonably should know that a person has a disability and needs a modification, even if the individual has not requested a modification, such as during a crisis, when the disability may interfere with the person's ability to articulate a request.[86]

When a law enforcement officer responds to a mental health crisis or overdose and fails to de-escalate the situation or insists on compliance with law enforcement demands, a danger of legal liability arises for unreasonable use of force and for violation of the ADA's requirement to reasonably modify policies and practices. DOJ's Examples & Resources guidance provides examples of how local law enforcement, corrections, and justice system leaders have facilitated compliance with this obligation, including:

- Training law enforcement officers that, when responding to a person in a mental health crisis who does not pose a significant safety threat, they should consider providing time and space to calm the situation.
- Training officers that, if available and appropriate, they should dispatch a crisis intervention team or officers trained in de-escalation techniques to the scene or involve mental health professionals.
- Requiring court staff to explore reasonable modifications to allow qualified individuals with these disabilities to participate in diversion and probation programs and specialty courts.
- Implementing policies that, in situations where a prisoner with these disabilities exhibits negative or disruptive behavior that does not pose a significant safety threat, encourage staff to seek assistance from prison-based crisis intervention teams and mental health professionals, involve officers trained in the use of de-escalation techniques, or forego discipline and provide treatment where it is apparent that a prisoner's behavior was related to a disability.[87]
- Training personnel on:
  - How non-medically trained criminal justice personnel can recognize common characteristics and behaviors associated with mental health disabilities or I/DD;
  - How to interact with people with these disabilities and when and how to make reasonable modifications for people with these disabilities;
  - What people with these disabilities may experience and how that may affect their interactions with others (*e.g.*, hearing voices);
  - How to take appropriate steps to ensure effective communication with people with mental health disabilities;

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[85] 28 C.F.R. § 35.130(b)(7).
[86] DOJ Examples & Resources at 3.
[87] Id.

    - How to avoid escalating interactions with people with these disabilities and how to use de-escalation or other alternative techniques to increase safety and avoid using force unnecessarily;
    - What local resources are available to provide treatment, services, or support for individuals with mental health disabilities and when and how to draw upon resources, such as crisis intervention teams, mobile crisis teams, assertive community treatment teams, or mental health providers.[88]
- Training dispatchers on how to recognize and handle calls involving people with mental health disabilities and on:
    - The availability of crisis intervention teams or other resources to respond to calls about individuals with mental health disabilities;
    - When to dispatch crisis intervention teams or officers with training in interacting with people with these disabilities;
    - When to consider dispatching a mental health provider rather than a police officer;
    - Information about, and contact information for, community-based service providers;
    - The importance of communicating information dispatchers receive about individuals' disabilities to responding officers or service providers.[89]
- Reviewing policies and data regarding individuals involved in the criminal justice system and outcomes to determine whether people with disabilities are subjected to bias or discrimination and taking corrective measures.[90]

DOJ found that the Baltimore Police Department was violating the ADA by frequently using force in the course of transporting people with mental illness for mental health evaluations and possible civil commitment.[91] It found that training law enforcement officers on how to interact with individuals with mental health disabilities, de-escalate crises, and involve mental health professionals or specially trained crisis intervention officers is a reasonable modification required by the ADA.[92] Although Baltimore had provided some specialized training to new officers, DOJ found it inadequate because it did not include all officers and Baltimore did not require an officer with the training or a mobile crisis team to be dispatched to crisis calls. As a result, DOJ found that Baltimore officers frequently failed to de-escalate encounters, resulting in handcuffing and detaining those in crisis and subjecting them to force unnecessarily.[93]

The DOJ settlement with Baltimore required the City to assess its behavioral health service system, make recommendations, and implement the recommendations to address gaps in behavioral health services, such as assertive community treatment, permanent supported housing, targeted case management, crisis services, and substance use disorder services, that lead to

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[88] Id. at 5-6.
[89] Id. at 6.
[90] Id.
[91] See DOJ Investigation of the Baltimore Police Department at 80, available at https://www.justice.gov/crt/file/883296/download (2016).
[92] Id. at 81.
[93] Id. at 80-85.

DOJ Baltimore Consent Decree
Required the Police Department to: • Establish a preference for the least police-involved response possible to respond to crisis calls, including diverting people to mental health service providers rather than jail or emergency rooms; • Implement a Crisis Intervention Team (CIT) Program; • Train enough CIT Officers with 40 hours of specialized training to ensure there are enough CIT Officers to cover all shifts and all districts, and ensure that at least one CIT Officer responds to all incidents where it is known or reasonably should be known that an individual with mental illness is involved; • Provide 8 hours CIT Training to all officers (and 16 hours for new recruits); • Provide CIT training to all dispatchers and revise its dispatch policies to limit police involvement in crises and, instead, dispatch mobile crisis teams and other services, and to send CIT Officers when police involvement is necessary; • Designate a Crisis Intervention Coordinator; • Develop and implement a Crisis Intervention Plan to ensure CIT Officers are available to respond to all incidents involving an individual in crisis; • Expand its Collaborative Planning and Implementation Committee to identify strategies to reduce unnecessary encounters with police by people with mental illness; • Collect, analyze, and report data on mental illness or crisis in police calls; • Ensure its use of force policy prioritizes de-escalation techniques and takes into consideration whether noncompliance may be due to a medical or mental health disability, behavioral health crisis, … or drug or alcohol use.[1]

preventable criminal justice involvement.[94]

b. Incarceration

The DOJ Examples and Resources guidance also provides examples of how corrections entities and courts have ensured they do not contribute to the unnecessary incarceration of individuals

[94] U.S. v. Police Department of Baltimore City, Consent Decree, at 34, available at https://www.justice.gov/crt/case-document/file/925036/download.

with disabilities, including:

- Training and supervising staff to conduct screening interviews of all prisoners upon admission to help identify prisoners with mental health disabilities or I/DD.
- Forbidding use of non-essential eligibility criteria in diversion or re-entry programs that courts or corrections operate, mandate, or contract with.[95]

The Constitution imposes requirements for mental health care for jail inmates, including:

- There must be a systematic program for screening and evaluating inmates in order to identify those needing mental health services.
- There must be a mental health treatment program that involves more than segregation and close supervision.
- There must be trained Mental Health Professionals in sufficient numbers to provide the identification and treatment services in an individualized manner to treatable inmates suffering a serious mental disorder.
- There must be maintenance of accurate, complete, confidential records.[96]

Applying both the Civil Rights of Institutionalized Persons Act ("CRIPA") and the ADA, DOJ has also focused its enforcement on ensuring that jails comply with constitutional standards and prevent unnecessary harm to inmates, including, specifically, inmates with mental illness. Segregation and mental health treatment of inmates with mental illness have been a particular focus of these enforcement efforts. Regarding mental health treatment, DOJ has found jails to be in violation of the constitution and federal law when they:

- Failed to provide constitutionally adequate mental health care to inmates, as evidenced by lack of proper screening for inmates with mental illness, lack of adequate treatment planning, lack of adequate administration of medications and psychotherapy, and inadequate treatment and supervision of suicidal inmates;
- Failed to identify and treat, at intake, inmates withdrawing from drugs or alcohol;
- Prolonged use of restrictive housing on inmates with serious mental illness, as evidenced by large numbers and percentages of inmates with mental illness in segregation, long stays in segregation, high rates of suicide threats and self-inflicted injuries among segregated inmates, and overlap between inmates in restrictive housing and inmates transferred to psychiatric hospitals;
- Placed inmates in restrictive housing because of their mental illnesses, without other disciplinary reason.[97]

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[95] DOJ Examples & Resources at 4-5.
[96] *See, e.g., Ruiz v. Estelle*, 503 F. Supp. 1265 (S.D. Tex. 1980).
[97] Investigation of the Hampton Roads Regional Jail (Portsmouth, Virginia), available at https://www.justice.gov/crt/case-document/file/1121176/download (2018); Investigation of the Miami-

To correct such violations, DOJ has demanded jurisdictions:

- Ensure adequate intake screening for mental illness is conducted by staff trained to identify mental health issues and is reviewed by mental health professionals, and that current medications are accurately reported;
- Conduct comprehensive mental health assessments within 14 days of arrival by a psychiatrist or registered nurse ("RN");
- Ensure timely access to mental health professionals when an inmate is presenting mental illness symptoms;
- Obtain mental health records from prior treatment providers;
- Develop appropriate, detailed treatment plans for inmates with mental health needs;
- Ensure all prisoners with serious mental health needs receive regular, consistent therapy and counseling;
- Increase psychiatry coverage and support staff;
- Ensure timely medication ordering and fulfillment, as well as timely psychiatrist follow-up for new or changed medications;
- Provide discharge planning for inmates needing further treatment upon reentry, including:
    - Arranging appointments with community mental health providers and ensuring inmates meet with the provider prior to, or at the time of, discharge to facilitate a warm hand-off;
    - Providing referrals for ongoing treatment post-release; and
    - Arranging with local pharmacies to have prescriptions renewed to ensure they have sufficient supply through their next appointment.
- Ensure psychiatric assessment and treatment of inmates in restrictive housing who show symptoms of decompensation;
- Prevent inmates with mental illness from being placed in segregation because of their illnesses or because of the lack of services for their illness.

Regarding segregation, DOJ has required jails to

- Presume that segregation is contraindicated for inmates with serious mental illness;
- Ensure mental health professionals conduct mental health rounds at least weekly to assess the effect of segregation on each inmate, *in addition to providing treatment*;
- Include the input of mental health professionals in decision-making when considering placing inmates with mental illness in segregation;
- Screen inmates on the mental health caseload within 24 hours of placement in segregation by a mental health professional;

Dade County Jail, available at https://www.justice.gov/sites/default/files/crt/legacy/2011/08/29/Miami-Dade_findlet_8-24-11.pdf (2011).

- Stop placement in segregation for any inmate determined by a mental health professional to have a serious mental illness or to exhibit acute mental health contraindications, in the absence of documented extraordinary circumstances; and
- Immediately refer any inmate in segregation who shows signs of decompensation or of serious mental illness to a mental health professional.[98]

2. *Treatment and Crisis Services*

The ADA also requires state and local governments to administer services in the most integrated setting appropriate to the needs of individuals with disabilities.[99] This requirement has been interpreted by the U.S. Supreme Court to require state and local governments that provide disability-related healthcare and habilitative services to do so in community-based, rather than institutional, settings.[100]

The ADA, as interpreted in the *Olmstead* decision, recognizes that segregation and institutions are not necessary to treat disabilities, but have been used for the convenience of service systems, rather than the needs of persons with disabilities. The *Olmstead* integration mandate requires the provision of community-based services for people with disabilities whenever (a) such services are appropriate; (b) the affected persons do not oppose community-based treatment; and (c) community-based services can be reasonably accommodated, taking into account the resources available to the entity and the needs of other persons with disabilities. The *Olmstead* requirement to provide community-based services applies both to people who are already in institutions and to people who are at risk of institutionalization.

Following the ADA and the *Olmstead* decision, state and local governments have been required to shift their services from institutions, such as nursing homes, psychiatric hospitals, adult homes, training centers, separate schools, and sheltered workshops, to individual homes, integrated classrooms, and integrated jobs, where persons with disabilities can receive the services they need while interacting regularly with people without disabilities. In addition, jurisdictions have been required to provide transition services to people with disabilities who have been unnecessarily institutionalized to assist them in moving to community settings.

Most relevant to Monroe County's Criminal Justice Project, DOJ has highlighted the connected obligations of healthcare services and criminal justice systems regarding incarceration and the ADA integration mandate. In its Examples and Resources guidance, DOJ provides:

> States, counties, and cities, which often administer both criminal justice and disability service systems, have obligations under the ADA to ensure people with mental health

[98] Settlement Agreement Between the United States of America and Hinds County, Mississippi Regarding the Hinds County Jail, available at https://www.justice.gov/crt/file/883861/download (2016).
[99] 28 C.F.R. 35.130(d).
[100] *Olmstead v. L.C.*, 527 U.S. 581 (1999).

disabilities or I/DD receive services in the most integrated setting appropriate to their needs. Services such as scattered-site supported housing, Assertive Community Treatment (ACT), crisis services, intensive case management, respite, personal care services, behavior support, nursing care, peer support, and supported employment services can support a jurisdiction's efforts to divert people with these disabilities from the criminal justice system and serve them in their communities.

State and local governments must prevent unnecessary institutionalization of people with disabilities. Governments have complied with this obligation by using community-based treatment services to keep people with disabilities out of the criminal justice system. These governments have recognized that the responsibility for effectively serving people with mental health disabilities or I/DD cannot fall to law enforcement alone. Therefore, they ensure that their disability service systems offer sufficient community-based services and support criminal justice entities to coordinate with, and divert to, community-based services.

Criminal justice entities have collaborated with their jurisdiction's mental health and disability services programs and with service providers on the following:

- Ensuring that law enforcement officers have contact information for relevant service providers and developing policies for when dispatchers or law enforcement officers should contact mental health service providers rather than engage in arrests.
- Helping individuals with these disabilities access community-based services. Federal resources may be available to help individuals connect with and participate in these services. When release conditions include finding housing and employment, agencies have prepared their staff to facilitate access to community-based supported housing and employment services or have modified such conditions when needed to avoid discrimination.
- Facilitating Medicaid or health insurance enrollment for prisoners with disabilities, identifying community-based service providers, and collaborating with providers to complete intake interviews and schedule initial appointments before release.
- Developing policies, procedures, and training on diversion, de-escalation, release planning, use of force, and discipline. [101]

DOJ has found jurisdictions to be violating the ADA *Olmstead* integration mandate when their community mental health service array did not provide sufficient community-based services to allow people to avoid emergency rooms, psychiatric hospitals, or other mental health institutions. DOJ has found violations when insufficient community-based mental health services, such as ACT, supported housing, mobile crisis, crisis stabilization, peer support services, case management, and supported employment puts people at risk of institutionalization.[102] In New

[101] DOJ Examples & Resources at 6-7.

[102] See DOJ Letter of Findings to Delaware, available at https://www.justice.gov/sites/default/files/crt/legacy/2010/12/15/DPC_findlet_11-09-10.pdf (2010); DOJ

Hampshire, the Justice Department specifically referenced the fact that a lack of sufficient community-based mental health services "contribute[s] to negative outcomes for persons with mental illness, such as the day-to-day harms associated with improperly treated and/or untreated mental health conditions, needless visits to local hospital emergency departments, needless admissions to institutional settings, … *and the serious incidents that prompt involvement with law enforcement, the correctional system, and the court system*." It found that "Community capacity in New Hampshire has declined in recent years and this has led to … a greater likelihood that some will end up in even less desirable settings not designed to provide mental health care, such as the state corrections system and the county jails."

In developing solutions, DOJ's settlements with Delaware and New Hampshire explicitly targeted "individuals who have had criminal justice involvement as a result of their mental illness" as priorities for community-based services. DOJ thus recognized that criminal justice involvement of individuals with mental illness is evidence of the inadequacy of a mental health services system and that those individuals are at "high risk of unnecessary institutionalization."

The DOJ settlements in Delaware and New Hampshire laid out the main elements of an *Olmstead*-compliant crisis service system. Such a system should be available 24/7 and provide timely and accessible services and supports to individuals experiencing a crisis at the site of the crisis, stabilize individuals quickly, promptly assess them, and identify and connect them to the services and supports necessary to meet their needs in a timely manner, including;

- 24/7 Crisis Hotlines staffed by licensed clinical professionals to assess crises and provide information about and referrals to available resources;
- 24/7 Mobile Crisis teams able to respond within an hour, composed of clinicians and peer specialists and an on-call psychiatrist, that offer crisis de-escalation at the site of the crisis, as well as via telephone or video, and are able to work with law enforcement;
- 24/7 Crisis Walk-In Centers for psychiatric and counseling services during a crisis;
- Crisis Stabilization Services for short-term acute inpatient care up to 14 days;
- 24/7 Community Crisis Apartments where individuals can receive crisis services for up to 7 days;
- Assertive Community Treatment multi-disciplinary teams (including, at least, a psychiatrist, nurse, clinician, functional support worker, and peer specialist) available 24/7 offering customized individual services, supports, treatment, and rehabilitation including case management, assessments, psychiatric services, employment and housing assistance, family support and education, substance abuse services, and crisis services to up to 10 people at a time;
- Intensive Case Management teams composed of clinical mental health professionals and

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Letter of Findings to New Hampshire, available at https://www.justice.gov/sites/default/files/crt/legacy/2011/04/13/New_Hampshire_MH_findlet_04-07-11.pdf (2011).

case managers, to help people identify and access supports and services and coordinate treatment and support services;

- Case Managers to coordinate treatment and supports for no more than 35 individuals each;
- Supported Housing that is permanent, scattered-site single-occupancy or family housing with tenancy rights that are not conditioned on participation in treatment or program compliance and that provides flexible support services;
- Community Residences serving up to 4 individuals with complex needs by coordinating care, services, and treatment;
- Supported Employment services in accordance with the Dartmouth evidence-based model, providing individualized assistance in identifying, obtaining, and maintaining integrated, paid, competitive employment;
- Rehabilitation Services, including education, substance abuse treatment, volunteer work, and recreational activities to develop and enhance social, functional, and academic skills;
- Family Supports that teach families skills and strategies for supporting their family member's treatment and recovery;
- Peer Support Programs through which peers who have personal experience with mental illness and recovery deliver peer services and supports to help individuals develop skills in managing and coping with symptoms, self-advocacy, and using natural supports;
- Transition Planning services that identify the services and supports each individual needs to live in an integrated community setting, the providers to deliver the services, any barriers to community living and plans to overcome them, and regular monitoring.

Hinds County, Mississippi

DOJ has also required corrections entities to help lead efforts to divert persons with disabilities from criminal justice into treatment, including in Hinds County, Mississippi, where the jail agreed to "work toward the goal of population reduction in a manner that preserves public safety, prioritizes diversion for unnecessary criminal justice involvement, and reduces recidivism," particularly for individuals with mental health disabilities. Hinds County agreed to establish a criminal justice coordinating committee to enhance coordination between criminal justice and mental health agencies to prevent unnecessary arrest and detention and connect individuals with disabilities to mental health services, to screen inmates for mental illness as part of booking and provide treatment and therapeutic housing, to notify community mental health providers when releasing an inmate with mental illness, to arrange a warm hand-off to a mental health provider upon release, and to provide sufficient medications until the appointment.[1]

I. Essential Community Services for Diversion from Criminal Justice

Inclusivity, along with the Bazelon Center for Mental Health Law, researched the essential community-based services that need to be available in order to successfully divert people with mental illness and SUD from criminal justice involvement to treatment and to help avoid crises and prevent recidivism. In our report, "Diversion to What? Essential Community-Based Services," we identify the following mental health services as essential:

- Assertive Community Treatment
- Supported Housing
- Mobile Crisis Services
- Supported Employment
- Peer Support Services

We identify the following SUD services as essential:

- Cognitive Behavioral Therapy
- Contingency Management/Motivational Incentives
- Medication-Assisted Treatment

Importantly, jurisdictions that have implemented some or all of these essential services have seen remarkable drops in incarceration and institutionalization of people with mental illness and SUD. For example, in Delaware, according to a monitor overseeing the implementation of crisis services, peer supports, ACT, supported housing, and supported employment, the

> reforms to the state's mental health system have also helped reduce unnecessary arrests and incarceration of people with SPMI. For instance, Delaware created two statewide mobile crisis teams that typically divert 80 to 90 percent of people they encounter from hospitalization and criminal justice interaction. The state's crisis walk-in center in Sussex County diverts about 70 percent of people from further hospitalization or criminal justice interaction. This walk-in center reports that it takes law enforcement officers less than 10 minutes on average to drop-off an individual in a mental health crisis, which spares police officers an unnecessary and lengthy emergency room admission or jail booking process. Delaware also operates a peer program in the state's Mental Health Court that serves people with SPMI or co-occurring disorders. Mental Health Court Peers support individuals throughout the process and help defendants access community resources that are necessary to increased stability in the community, including housing and transportation.[103]

[103] Federal Court Terminates Agreement after Delaware Reforms Service System for People with Mental Illness, available at https://www.justice.gov/opa/pr/federal-court-terminates-agreement-after-delaware-reforms-service-system-people-mental.

In the first six months of health care professionals replacing police officers, no one they encountered was arrested

DPD Chief Pazen, who is fond of the STAR program, says it frees up officers to do their jobs: fight crime.

Chris Richardson and Carleigh Sailon with the Mental Health Center of Denver (left and right) an[d] Spencer Lee, a Denver Health paramedic, stand in front of the Support Team Assisted Response's ne[w] van. June 8, 2020. (Kevin J. Beaty/Denverite)

David Sachs

Feb. 02, 2021, 5:00 a.m

https://denverite.com/2021/02/02/in-the-first-six-months-of-health-care-professionals-replacing-police-officers-no-one-they-encountered-was-arrested/

Monroe County, itself, may have already seen some results of investing in community-based services for people with mental illness and SUD on the criminal justice system. In 2013–2014, when Shalom Center's first permanent supportive housing project opened, bookings for Public Intoxication dropped substantially. Again in 2016, when Centerstone's first major permanent supportive housing project opened, bookings for mental-illness- and addiction-related crimes, such as Public Intoxication, fell substantially.[104] Monroe County should watch for a similar drop following the upcoming opening of another supportive housing facility in 2021.

II. SEQUENTIAL INTERCEPT MODEL

The best practice in identifying key points where SUD and mental illness can be addressed in a

[104] RJS Consulting, MCCC Public Intoxication Bookings - Gender 2003-2018;

criminal justice system is Sequential Intercept Mapping (SIM). SIM helps communities identify resources and gaps in services at each intercept point and develop strategic action plans to address them.[105] SAMHSA offers mapping workshops through its GAINS Center to help communities plot their Sequential Intercept Maps, introduce best practices, identify available and missing services, build collaborative relationships, and develop shared action plans. An example of a map is below. The intercept points are:

Intercept 0) Community/Crisis Services – Opportunities to divert people into local treatment services, whether through 911 or other connections, without arrest or charge, such as mobile crisis and co-responders, emergency room diversion, and police-behavioral health collaborations;

Intercept 1) Law Enforcement – Diversion by law enforcement or other emergency service providers to treatment services without arrest or charge, including dispatcher training, specialized police response, affirmative interventions with frequent utilizers, and post-crisis follow up;

Intercept 2) Initial Detention/Initial Court Hearings – Diversion to community-based treatment by jail clinicians, social workers, or court officials during jail intake, booking, or initial hearing, including screening for mental illness and SUD, data-matching between jail and community-based treatment providers, and pretrial diversion and supervision;

Intercept 3) Jails/Courts – Diversion to community-based services through jail or court processes and programs after booking, including problem-solving courts, and services that prevent the worsening of a person's illness during jail stay, such as jail-based programming and health care services;

Intercept 4) Reentry – Supported reentry into the community after jail to link people in jail to treatment services and to reduce further justice involvement after release, such as transition planning by reentry coordinators, peer support staff, and/or community in-reach by providers, medication and prescription access upon release, and warm hand-offs from corrections to providers; and

Intercept 5) Community Corrections – Specialized community-based criminal justice supervision with added supports for people with mental illness and SUD to prevent violations or offenses.

SAMHSA provides a great deal of information on the SIM model[106] and offers grants,

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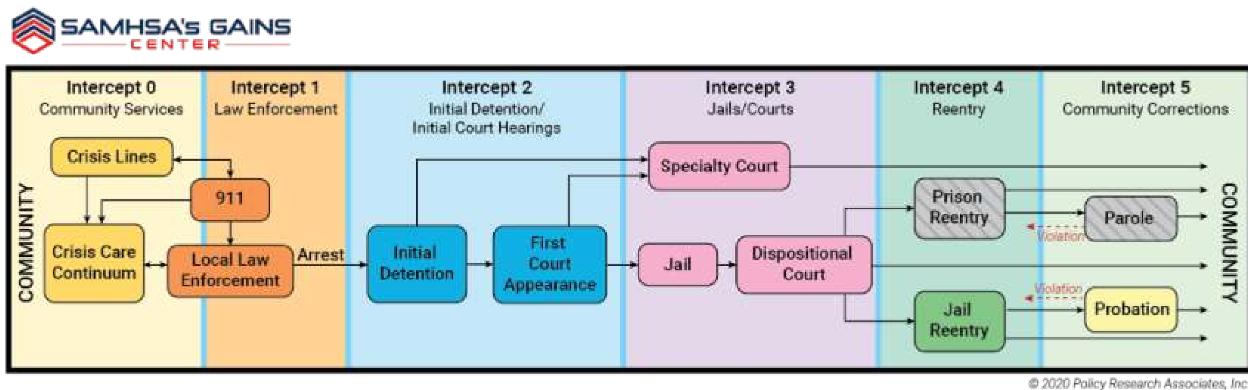
[105] SAMHSA, The Sequential Intercept Model, available at https://www.samhsa.gov/criminal-juvenile-justice/sim-overview; Council of State Governments Stepping Up Initiative, Conducting a Comprehensive Process Analysis, available at https://csgjusticecenter.org/wp-content/uploads/2020/02/JC_Stepping-Up-In-Focus_Conducting-a-Comprehensive-Process-Analysis.pdf.
[106] https://www.youtube.com/playlist?list=PLBXgZMI_zqfTZLFkwVAUAypnpsWWc_G9b.

workshops, webinars, virtual learning communities, and communities of practice to state and local governments.[107] Examples of Sequential Intercept Maps are widely available, including those in 31 Ohio counties,[108] Tulsa County, Oklahoma,[109] and Missoula County, Montana.[110]

In the SIM model, the focus should be on increasing effectiveness of services and diversion at Intercept 0, relying on the community services system, rather than the criminal justice system. The County should, therefore, focus on improving services at Intercept 0, while training and requiring stakeholders at Intercepts 1–5 to facilitate diversion of individuals who come into the criminal justice system back to Intercept 0.



This report follows a SIM framework, but expands it to add Intercept 6, addressing community-based SUD and mental illness treatment to prevent crisis and criminal interactions from happening in the first place. Improving these community-based services at Intercept 6 will prevent individuals with these disabilities from encountering the criminal justice system at all, thus reducing costs to the County and trauma and collateral consequences to the individuals. We acknowledge that not all of our recommendations are within the Monroe County government's sole power or authority. Certain recommendations may require involvement, or even leadership, by other entities. Building on this report, a SIM process could help generate the shared vision, goals, and commitment to allow all the needed stakeholders to play their important roles and to prioritize the stakeholders' implementation of this Report's recommendations.

III. MONROE COUNTY STRENGTHS AND GAPS REGARDING REDUCING INCARCERATION AND INCREASING TREATMENT OF PEOPLE WITH MENTAL HEALTH AND SUBSTANCE USE DISORDERS

A. Infrastructure - Leadership, Community Support, and Coordination

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[107] https://www.prainc.com/pra-authors/samhsas-gains-center/.
[108] https://www.neomed.edu/cjccoe/sequential-intercept-mapping/county-reports/.
[109] https://tulsacounty.org/TulsaCounty/SIM/Sequential%20Intercept%20Model%20Mapping%20Report.pdf
[110] https://www.missoulacounty.us/home/showdocument?id=72690.

Key elements of a successful effort to reduce incarceration of people with mental illness and SUD are strong leadership, community support, and coordination across responsible entities.[111] The MacArthur Foundation identified key roles counties play in reducing mental illness in jails:[112]

- Leadership and collaboration (identifying a champion; creating or engaging criminal justice planning groups);
- Resources (developing or identifying pre-arrest and pre-booking diversion alternatives; identifying diverse funding strategies; enrolling individuals into health coverage and connecting them with care);
- Data and information sharing (working with what you have; collecting date on multiple system touch points; agreeing on what can and should be shared).

A successful effort will usually involve a county-wide team, including people responsible for budget, key leaders from the justice system, and key leaders from the service provider system, with a clear mandate and commitment to making needed changes. Other jurisdictions that have undertaken concerted efforts to reduce incarceration of people with mental illness and SUD have identified six "pivotal factors:"

- Centralized Point of Coordination for Planning and Organization
- A Champion/Leader
- Information Sharing
- Cross-System Training
- Defining the Target Group
- Jail In-Reach

1. Strengths:

    a. The State's Jail Overcrowding Task Force has shown that there is some state-level commitment to addressing jail overcrowding and expanding alternatives.[113]

    b. Indiana law provides for special taxes for corrections and public safety. Monroe County has implemented these and used some of these funds to improve non-carceral efforts, such as electronic monitoring and problem-solving court staff.[114]

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[111] Haneberg, et al., *Reducing the Number of People with Mental Illnesses in Jail: Six Questions County Leaders Need to Ask*, https://stepuptogether.org/wp-content/uploads/2017/01/Reducing-the-Number-of-People-with-Mental-Illnesses-in-Jail_Six-Questions.pdf.
[112] County Roles and Opportunities in Reducing Mental Illness in Jails, available at https://www.naco.org/sites/default/files/documents/SJC-Mental%20Illness-Final.pdf.
[113] Indiana Jail Overcrowding Task Force Report, https://www.in.gov/judiciary/iocs/files/jail-overcrowding-report.pdf (2019).
[114] https://www.co.monroe.in.us/egov/documents/1606971557_80061.pdf.

c. Monroe County leadership has a strong commitment to criminal justice reform, reducing jail crowding, and ensuring all residents have access to appropriate treatment and services. County leaders have publicly committed to these goals, have invested in identifying means of achieving these goals, and have worked to be responsive to community concerns.

d. Service providers, nonprofits, employers, housing providers, and community members working on mental health, substance use, and other services and supports that can help reduce incarceration are willing and able to collaborate and work together without unnecessary disputes over turf or funding.

2. Gaps:

a. State law permits counties to assess taxes specifically for corrections, I.C. 6-3.6-6-2.7, and public safety, I.C. 6-3.6-6-8. Monroe County appears to have implemented these taxes and generates $3.16 million and $3.6 million in annual revenue respectively. However, under state law, revenue from these taxes is limited to supporting correctional and rehabilitation facilities in the county and only 20% of any revenue can be used for operations. Although the Indiana Jail Overcrowding Task Force has recommended increased flexibility for permissible uses of these funds, such as for alternatives to incarceration, or a greater percentage for operating funds for better reentry and treatment services, the laws have not been amended.

b. Monroe County has used only a small amount (3%) of its corrections and public safety tax revenues for efforts that explicitly support reductions of jail overcrowding, with the vast majority of revenue going to corrections officers, sheriff's deputies and dispatch interlocal emergency management.

c. Bloomington City leadership, BPD leadership, IUPD leadership, and IU in general are not fully engaged in, and coordinated with, the County government's efforts. In addition, in the aftermath of recent events and the growing divisions nationally, distrust may be developing among stakeholders in the community, County and local government officials, and law enforcement based on their expressed responses to the events. If stakeholders begin to refuse to work together, communicate, and participate in collaborative efforts, it could make achievement of shared goals much more difficult and waste resources and time that could be more effectively used.

d. There is no single county-wide cross-stakeholder leadership for coordination of planning and efforts to address the needs of people with mental illness and SUD. Collaboration mechanisms among providers have resulted in a plethora of

coordinating groups regarding various issues related to the incarceration and treatment of people with SUD and mental illness, from the perspectives of homelessness, mental illness, SUD, employment, housing, etc.. Many stakeholders are involved in many groups, which makes participation in all of them burdensome and duplicative. To some extent, different groups were created because traditionally SUD and mental health have been subject to different funding streams and different treatment within the public health systems and because the state provided support for different elements at different times.

e. Some members of County law enforcement and court leadership are perceived as having concerns about diverting people to certain treatment services, such as Medication Assisted Treatment, and may be hesitant to fully engage in diversion or alternatives to incarceration when a crime has been committed, even if treatment could provide a more effective means of preventing recidivism. In addition, law enforcement, corrections, and court staff may be hesitant to pursue new ways of working because of the risk that they will not have sufficient resources.

f. Inclusivity researchers had trouble getting data from MCCC and various providers about the numbers of people with mental illness and SUD in their services. For example, one important indicator that a health care system is failing to prevent SUD and mental health crises before they result in incarceration or institutionalization is data on mental illness- and SUD-related visits to emergency departments and psychiatric hospitals. However, neither the researchers nor the County staff were able to obtain that data. Because of the lack of data on frequent users of the criminal justice, emergency and inpatient behavioral health, and homelessness systems, it is currently not possible to identify the community-based service needs of frequent users and target those services to them to prevent crises and criminal justice interactions. This data would help Monroe County prioritize the development of the services recommended in Intercept 6 and target them to frequent users first.

3. Recommendations:

a. **Work with the state legislature to expand flexibility** of the corrections, I.C. 6-3.6-6-2.7, and public safety, I.C. 6-3.6-6-8, tax revenues to support reducing incarceration and implementing other recommendations of the Jail Overcrowding Task Force.

b. **Work with the state legislature and state Medicaid and mental health agencies** to secure statewide or local authority to pursue American Rescue Plan funding through which the federal government will pay 85% of the cost of mobile crisis teams for three years. **Work with the state Medicaid and mental health agencies** to take

advantage of the enhanced federal match rate for home and community-based mental health services under the American Rescue Plan, to expand capacity for case management, mental health rehabilitative, waiver, and other services.

c. **Explore the bounds of permissible uses of tax revenues** for corrections, I.C. 6-3.6-6-2.7, and public safety, I.C. 6-3.6-6-8, to support efforts to reduce incarceration by implementing non-law-enforcement crisis interventions, using alternatives to incarceration, and improving treatment and reentry preparation in MCCC.

d. **Engage leaders among Bloomington City, BPD, IU, and IUPD in the Criminal Justice Project efforts.**

e. **Convene stakeholders**, including community, provider, law enforcement, university, and local government leadership in a facilitated process to establish shared goals and trust. Work to address resource concerns for stakeholders who will be responsible for carrying out priority activities (*e.g.*, shift resources to new priorities, supplement resources temporarily, seek additional resources). Stakeholders may have different perspectives on the issue of people with mental illness/SUD in jail and at risk of jail, and a shared framework should be developed.

f. **Engage collaboratively in a Sequential Intercept Mapping process** through a SAMHSA workshop or independently with the Bazelon Center for Mental Health Law, Policy Research Associates, or another qualified facilitator. Beware allowing this process to duplicate the work of this Report by focusing on gathering data about existing resources. Focus, instead, on shared goals, stakeholder leadership and responsibility, and strategies and priorities for addressing the gaps that exist.

g. **Reduce the number, and increase the efficiency of collaboration efforts** by

- Appointing a Coordination Leader to conduct a network analysis of the coordinating groups that exist, identify gaps, overlap, and duplication, identify more efficient means of collaboration, develop the infrastructure for the group(s), and facilitate the group(s) to develop consensus on shared structure, goals, activities, responsibilities, reporting and troubleshooting mechanisms. The Coordination Leader should have access to, and support from, local government decisionmakers and resources, as well as strong connections to community stakeholders.

- Combining coordination groups to focus on the targeted group and reduce the number of meetings (especially combining SUD and mental illness groups).

- Focusing the group(s) on systemic changes needed to achieve the overarching goals of reducing incarceration and recidivism, increasing treatment, and preventing crises from SUD and mental illness.

- Establishing subcommittees within groups to address specific issues (*e.g.*, housing, employment, transportation) and report back to the full group.

- Ensuring the right people are included and committed to attendance and participation, including relevant County, Bloomington, and IU leadership.

- Identifying goals, agendas, research, and other activities to be conducted, parties responsible, timelines for completion, and reporting mechanisms.

h. **Increase education of stakeholders in courts and law enforcement** regarding the evidence base for needed solutions, including MAT and alternatives to incarceration, and regarding the budget and resource benefits of such solutions.

i. **Engage emergency departments, psychiatric hospitals, MCCC, and local law enforcement** regarding numbers and characteristics of emergency room patients, psychiatric hospital patients, arrestees and inmates, and the community-based services that could prevent such admissions. Implement integrated data systems between criminal justice and public health providers to cross-walk data between the two systems, making it possible to identify the needs of frequent users of public health and criminal justice systems and to target services to meet those needs.[115] This lack of data inhibits any effort to target needed services to frequent users of crisis and law enforcement services. These entities are justifiably concerned about revealing HIPAA-protected information unlawfully. The most effective mechanism for compliance is to seek individuals' consent to sharing their personally identifiable information with agencies they choose. Therefore, Monroe County should develop a consent form that seeks consent to share with identified agencies specific information of most use.[116]

4. Resources

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[115] Vera Institute, Closing the Gap: Using Criminal Justice and Public Health Data to Improve the Identification of Mental Illness, p. 21-24 and 32-35, available at https://www.vera.org/downloads/Publications/closing-the-gap-using-criminal-justice-and-public-health-data-to-improve-the-identification-of-mental-illness/legacy_downloads/closing-the-gap-report.pdf (2012).
[116] See https://www.hhs.gov/hipaa/for-professionals/faq/mental-health/index.html regarding ability to share information with and from law enforcement.

a. Council of State Governments Justice Center, Adults with Behavioral Health Needs Under Correctional Supervision: A Shared Framework for Reducing Recidivism and Promoting Recovery, available at https://csgjusticecenter.org/wp-content/uploads/2020/02/9-24-12_Behavioral-Health-Framework-final.pdf.
b. County Roles and Opportunities in Reducing Mental Illness in Jails, available at https://www.naco.org/sites/default/files/documents/SJC-Mental%20Illness-Final.pdf.
c. Haneberg, et al., *Reducing the Number of People with Mental Illnesses in Jail: Six Questions County Leaders Need to Ask*, https://stepuptogether.org/wp-content/uploads/2017/01/Reducing-the-Number-of-People-with-Mental-Illnesses-in-Jail_Six-Questions.pdf.
d. SAMHSA, The Sequential Intercept Model, available at https://www.samhsa.gov/criminal-juvenile-justice/sim-overview.
e. Council of State Governments Stepping Up Initiative, Conducting a Comprehensive Process Analysis, available at https://csgjusticecenter.org/wp-content/uploads/2020/02/JC_Stepping-Up-In-Focus_Conducting-a-Comprehensive-Process-Analysis.pdf.
f. Examples of Sequential Intercept Maps
    - Blueprint for Mental Health Reform: A Strategic New Approach Addressing the Intersection of Mental Health, Homelessness and Criminal Justice in San Diego County, available at https://www.sdcda.org/Content/Preventing/Blueprint%20for%20Mental%20Health%20Reform.pdf.
    - Tulsa, OK, Sequential Intercept Model Mapping Report, available at https://tulsacounty.org/TulsaCounty/SIM/Sequential%20Intercept%20Model%20Mapping%20Report.pdf
    - Sequential Intercept Model Mapping Report for Missoula County, MT, available at https://www.missoulacounty.us/home/showdocument?id=72690
    - Sequential Intercept Mapping Springfield, MA, available at https://www.mass.gov/doc/sequential-intercept-mapping-report-springfield/download
    - Sequential Intercept Mapping Report- Milwaukee County, WI, available at https://www.milwaukee.gov/CJC1/MilwaukeeCountyWISIMReport-FinalwithAppendices.pdf
g. Vera Institute, Closing the Gap: Using Criminal Justice and Public Health Data to Improve the Identification of Mental Illness, available at https://www.vera.org/downloads/Publications/closing-the-gap-using-criminal-justice-and-public-health-data-to-improve-the-identification-of-mental-illness/legacy_downloads/closing-the-gap-report.pdf (2012).

h. HHS, Health Information Privacy, https://www.hhs.gov/hipaa/for-professionals/faq/mental-health/index.html regarding ability to share information with and from law enforcement.

B. Preventing Crisis - Mental Health and SUD Treatment Services

This intercept is an addition to the traditional Sequential Intercept Model. This recognizes that preventing incarceration and reincarceration of people with mental illness/SUD requires the prevention of crisis. While the criminal justice system is rightly focused on responding to crises, we must look beyond the entry and exit points of the criminal justice system to identify the most effective, and cost-effective, ways of providing treatment and supports before a crisis begins. This intercept, therefore, looks to ways the County can support community-based non-crisis-driven interventions that will avoid interactions between people with mental illness/SUD and the criminal justice system. Not only will focusing on strengthening the community-based mental health/SUD system reduce the burdens on the criminal justice system and avoid collateral harms to individuals from encountering that system, but focusing resources on community-based treatment will help shift costs from Monroe County to the state and federal governments.

1. Strengths:

a. Most of the types of community-based services Monroe County needs to support people with SUD and mental illness exist in the County. Monroe County providers are experienced, qualified, and deeply committed to serving people with SUD and mental illness and to making Monroe County a safe and healthy community.

b. Indiana Medicaid and DMHA provide coverage (at state and federal cost) for the vast majority of services needed for SUD and mental illness treatment in Monroe County. Monroe County has a Community Mental Health Center (Centerstone) that can provide the more restricted services, as well as a few providers, including Centerstone and the local hospitals, that can authorize presumptive eligibility to overcome some application delays. Additional providers are working at becoming certified to provide Medicaid services and DMHA SUD services.

c. In an effort to attract more physicians to accept Medicaid patients, the Affordable Care Act initially mandated a Medicaid reimbursement rate “fee bump” to increase the Medicare-to-Medicaid rate ratios for 2013–2014. The federal government initially paid the entire cost of the increase. The fee bump appears to have had some success, and Indiana has continued the increased rates after federal funding stopped.[117]

[117] https://khn.org/news/15-states-extend-health-laws-higher-medicaid-payments-to-doctors/.

d. Leading employer Peter Yonkman at Cook Medical has become an ambassador for employment of people leaving incarceration, including those with SUD and mental illness, and is helping to lead other employers.

2. Gaps:

a. **Essential treatment services for mental illness and SUD**. A number of essential services for preventing crises and diverting people with SUD and mental illness from criminal justice involvement are not available in sufficient quantity or with sufficient timeliness. Having sufficient, timely, and easy access to services is essential to helping people with SUD and mental illness. The nature of these diseases often interferes with people's ability to seek, and succeed in, treatment. Therefore, availability, timeliness, and ease of access are essential in order to take advantage of people's ability to seek treatment at the time they seek it. Most stakeholders agreed that the following necessary services are unavailable or not available in sufficient quantity to meet the need in Monroe County:

- **SUD treatment services, in particular Medication Assisted Treatment and residential treatment**, are insufficient to meet the need. CleanSlate and Groups Recover Together offer MAT; Centerstone recently received a grant to begin MAT; Amethyst House offers residential SUD treatment and has a long waitlist for services, indicating that demand substantially exceeds current capacity.

- **Assertive Community Treatment (ACT)** – Centerstone has one ACT team of 12 staff serving over 80 people. No specialized Forensic Assertive Community Treatment is available in Monroe County.

- **Peer Support Services** – Centerstone and several SUD service providers provide peer support services. However, paid peer specialists are not available in sufficient numbers at every intercept point. Because of the importance of shared life experience in treating individuals with mental illness and SUD, particularly those with history of incarceration, peer support should be an available element of all service and treatment at all intercept points. Training and work as a peer support provider also provides meaningful employment opportunities to individuals who face a number of employment barriers.[118]

[118] SAMHSA, Peer Support Roles in Criminal Justice Settings, available at https://ndcrc.org/wp-content/uploads/2020/08/Peer_Support_Roles_in_Criminal_Justice_Settings.pdf (August 2017).

- **Permanent supportive housing** using a Housing First model[119] –

    - Stable, affordable housing supported by flexible treatment and other services is often the key to sustained recovery for people with serious mental illness and SUD. Centerstone offers permanent supportive housing to approximately 100 people with mental illness and 20 people with SUD, including some families. Shalom Center offers approximately 100 permanent supportive housing units, including some family units. Indiana Center for Recovery also offers permanent supportive housing to its clients. All the available permanent supportive housing programs in Monroe show tremendous success for those who are able to participate. Estimated need is for 50–100 more PSH units.[120]

    - Most SUD and mental health services and supports in Monroe County are site-based, rather than available in homes in the community or on the streets. Overreliance on site-based treatment services can make it difficult for some people to keep appointments because of transportation, cognitive, technological, and other barriers. Single-site housing and employment also tend to be more expensive,[121] take longer to develop/build than scattered-site services, and often face opposition from neighbors if they are located (as they need to be) in residential neighborhoods. They also may be less effective, at least for people with mental illness, because they tend to segregate individuals from the broader community and to stigmatize receiving services, which discourages individuals from seeking treatment and may hinder successful integration into the community. Finally, overreliance on segregated site-based settings risks violation of the ADA/*Olmstead* integration mandate.[122] As a result, best practices call for scattered-site services, particularly for permanent supportive housing and supported employment, and for mobile service

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[119] https://files.hudexchange.info/resources/documents/Housing-First-Permanent-Supportive-Housing-Brief.pdf; https://www.prainc.com/gains-survival-recovery-housing-promotes-success/.
[120] Indiana Housing and Community Development Authority, Supportive Housing Initiative, available at https://www.in.gov/ihcda/4091.htm.
[121] National Academies Press, "Permanent Supportive Housing: Evaluating the Evidence for Improving Health Outcomes Among People Experiencing Chronic Homelessness," Chapter 5, at 87 (2018) at 87, available at https://www.nap.edu/read/25133/chapter/7#87 ("With respect to costs, a report by the General Accounting Office (GAO) estimated that the average total 30-year costs for one-bedroom units in the same general location are 8–19 percent higher for programs that produce housing (such as the construction of a single-site supportive housing building) compared to housing vouchers (which are used in scattered-site supportive housing programs) (GAO, 2002)")
[122] See Settlement Agreement, U.S. v. New York, https://www.ada.gov/olmstead/olmstead_cases_list2.htm#ny.

availability of crisis services and homeless services. In Monroe County, Centerstone and Shalom provide a limited amount of scattered-site permanent supportive housing, but landlord unwillingness to offer affordable rents or to rent to people with serious mental illness or SUD remains a barrier.

- **Job placement and supported employment** – Jobs are foundational to helping people with SUD and mental illness succeed in recovery and achieve housing, self-sufficiency and stability.[123] In short, for many, jobs are treatment. Yet many employers are reluctant to hire former jail inmates or people with criminal convictions, SUD, or mental illness, especially felons and people on MAT. Goodwill/New Beginnings employs approximately 20 clients per week in its own facility for a 6-month program. Centerstone has hired over 87 homeless residents with SUD and/or mental illness to work seasonally for the Bloomington City Parks Department over the past 5 years and is expanding to serve the Department of Public Works year-round. These workers are supervised and supported by people who are in long term recovery, who provide important peer supports. Made Up Minds offers supported employment by employing 4–8 people at a time and contracting them out to community employers, then helping them move through the ABC (A Job – Better Job – Career) Kickstart model. In part because of employer resistance, too many of these programs are site-based or provider-based, rather than supporting people in regular community employment. As a result of this limitation, and community employer hesitance to hiring these individuals, these programs cannot meet the current demand for their services.

- **Psychiatrist Services**, including individual psychiatry, street psychiatry, and remote (telephone/video) psychiatry services are limited. Many stakeholders noted a lack of psychiatrists available to serve Medicaid patients, uninsured patients, and underinsured patients. It takes 4–5 months to get into mental health treatment and 8–10 months to get a psychiatrist. This is a nationwide problem, as just 62% of psychiatrists nationwide accept any insurance and only 35% will accept new Medicaid patients.[124] The 2019 Indiana Access Monitoring Review Plan confirms this deficit, in the availability of psychiatry services for Medicaid patients with both mental illness and SUD.[125]

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[123] IPS Employment Center, What is IPS?, available at https://ipsworks.org/index.php/what-is-ips/; https://www.samhsa.gov/homelessness-programs-resources/hpr-resources/employment; https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5846108/.

[124] Health Payer Intelligence, PCPs, Psychiatrists Much Less Likely to Accept Medicaid (2019), available at https://healthpayerintelligence.com/news/pcps-psychiatrists-much-less-likely-to-accept-medicaid.

[125] 2019 Indiana Access Monitoring Review Plan at 44-45, 48-49, 52, available at https://www.in.gov/fssa/ompp/files/Indiana-Access-Monitoring-Review-Plan-2019-Update.pdf.

- It is widely believed that state-controlled Medicaid rates are insufficient to encourage psychiatrists to provide services to Monroe's target population when more lucrative private practices are available. In addition, psychiatrists who do serve these individuals experience high levels of stress, frustration, and income loss due to individuals' high needs, missed appointments, insurance loss, and failure to follow through on treatment. As a result, many psychiatrists who begin serving this community do not stay long-term.

- A key factor for ensuring an adequate supply of psychiatrists and other medical providers for Medicaid patients is the Medicare-to-Medicaid reimbursement rates ratio. For "other services" (including psychiatry), Indiana's rate is .75. Indiana states that its ratio for behavioral health services is .8, meaning Medicaid providers receive 80% of what they would receive from Medicare. This is below the national average of .82.

- Telepsychiatry and mobile psychiatry services are effective at reducing transportation and work barriers, delays in care, and stigma, as well as facilitating continuity of care and treatment compliance.[126] Making telepsychiatry more available could increase the numbers of psychiatrists willing to serve target communities and increase the number of high-needs patients willing to engage in treatment. Indiana Medicaid currently covers telepsychiatry services.[127]

b. **Medicaid barriers**: While Indiana Medicaid covers most of the services needed in Monroe County, its coverage is neither generous nor easy to access. It is widely recognized that Medicaid enrollment is a complicated and difficult process, particularly for individuals with mental illness, SUD, homelessness, lack of access to technology, transportation, and other barriers.

- Individuals who are over the federal poverty limit must make regular monthly contributions. If they do not, they are disenrolled and "locked out" of enrollment for six months.[128] Individuals who are below the federal poverty level (up to $12,760 annual income for an individual; up to $26,200 for a family of four) and

[126] American Psychiatric Association, What is Telepsychiatry, available at https://www.psychiatry.org/patients-families/what-is-telepsychiatry.
[127] Center for Connected Health Policy, State Telehealth Laws and Reimbursement Policies, https://www.cchpca.org/sites/default/files/2020-05/CCHP_%2050_STATE_REPORT_SPRING_2020_FINAL.pdf (Spring 2020).
[128] Indiana is also authorized to lock out people who do not timely complete enrollment renewals, but is not currently exercising that authority.

do not make a contribution are eligible for a reduced-benefit package subject to copays for services, but only after 60 days.

- As discussed above, enrollment processing takes 45–90 days. While generally Medicaid eligibility is retroactive to three months prior to application, Indiana has eliminated retroactive eligibility. (That elimination has been stayed pending ongoing litigation.) Any denial of retroactivity will create coverage gaps that result in people being unable to access treatment. A few providers (hospitals and CMHCs) can address this to some extent by temporarily approving patients for Medicaid pending a completed application, relying on "presumptive eligibility."

- Beginning in 2019, Indiana added a work requirement to its Medicaid program, requiring any member to either 1) work at least 20 hours per week, 2) complete qualified activities, such as job search, education, job training, or volunteer work, for eight out of the 12 calendar months, or 3) be subject to an exemption, such as homelessness, age 60 or older, recently incarcerated or institutionalized, or participating in substance use disorder treatment. The work requirement is currently the subject of ongoing litigation and is not yet being enforced.

- These current and impending barriers to initial and continued Medicaid coverage contribute to and threaten to further increase Monroe County's uninsured rate, likely leading more people to forego treatment of mental illness and substance use disorders, with likely further increased criminal justice effects.

- In addition to the barriers to individual enrollment in Medicaid, providers report that they face difficulty and delays in getting approved to provide Medicaid-funded and DMHA-approved services, and that Medicaid rates are inadequate to recruit and retain staff for some services, *e.g.*, psychiatry.

c. **Structural Barriers to Treatment**: External barriers interfere with individuals accessing some services before a crisis. Individuals with these disabilities are often experiencing life stressors (parenting, housing instability, work instability, financial difficulties) in addition to and/or as a result of their illnesses. As a result, even seemingly small difficulties or delays in access can defeat people from receiving treatment until a crisis occurs. External barriers to treatment in Monroe County include:

    - Public transportation has limited routes, schedules, and hours of operation, with even more limited service on Saturdays and no service on Sundays, which makes getting to appointments difficult, efficiently, logistically, and cognitively.

Transportation is reported to be the biggest reason people miss appointments, which has domino effects in terms of providers' ability to get paid for their time and their level of frustration with serving lower-income clients. It also impacts clients' ability to achieve and maintain consistency and stability, to maintain employment, and to comply with diversion, probation/parole, and court requirements. In addition, lack of affordable, readily available transportation likely contributes to the high numbers of **Driving Under the Influence (340 arrests per year) arrests** contributing to MCCC overcrowding.

- **Fair market rents are beyond reach for individuals working minimum wage jobs or on Social Security Income, and affordable housing in Monroe County is very limited.** While more affordable options may be available outside Bloomington, those do not provide the connections to treatment, services, and peer support that people with mental illness and SUD need, may disconnect them from family, and offer little affordable transportation. High rents are also a barrier to scattered-site supportive housing and sober living, resulting in providers of these services having to charge rents or initial fees that are out of reach for individuals who would benefit. Monroe County lacks sufficient affordable housing to support the need for permanent supportive housing. Twenty-four percent of homeowners and 64% of renters (including 47% of non-student households) spend more than 30% of their income on housing.[129] A renter would need to earn $16.90 per hour to afford a 2-bedroom apartment in the County, yet the mean renter wage is only $10.86 per hour.[130] Minimum-wage workers can afford only $377 per month in rent, and individuals relying on Social Security Income can only afford $235 per month, while fair market rent for a studio apartment is $646 per month.[131]

- **Public and subsidized housing is limited.** Federal Section 8 vouchers, which pay rent exceeding 30% of a person's income, are in short supply and subject to a long waitlist. Bloomington's Public Housing Authority has approximately 1,300 housing vouchers and a waitlist of 1,000 people who are expected to wait 6–12 months before securing housing. The waitlist is not first-come, first-served, but ranks people based on factors such as whether they are the head of a household, whether any member of the household has a disability, is a victim of domestic violence or is a veteran, and whether the individual is working full or part time.

[129] Monroe County Affordable Housing Advisory Commission, Housing is a Human Right, March 2019.
[130] National Low Income Housing Coalition, *Out of Reach 2020: Indiana*, available at https://reports.nlihc.org/oor/indiana.
[131] Id.

Individuals seeking public or subsidized housing are often excluded if they have a criminal record.

- **Access to jobs** is often key to recovery, both for SUD and mental illness, and to avoiding criminal justice involvement and homelessness.[132] However, in Monroe County, many employers resist hiring people with known mental illness, drug use, or criminal records (particularly felonies). Employer engagement efforts have been attempted in Monroe County, with some success.

3. Recommendations:

a. Essential Services – A **Frequent Users Program (FUSE),** if data were available to identify such users (see above), would allow Monroe County to identify those most in need of the recommended service array and roll services out on a pilot basis to frequent users before extending them more broadly.

- **SUD treatment**
  - Assist qualified providers to become approved for Medicaid- and/or DMHA-funded MAT and residential SUD treatment.
  - Seek (through grants or other funding mechanisms) or provide funding for MAT, residential treatment and detox for uninsured individuals.
  - Provide non-jail detox services to those not eligible for hospital detox, perhaps through collaboration with the STRIDE Center.[133]

- **Telepsychiatry**
  - Work with the State to ensure continuation and expansion of telepsychiatry reimbursement after the pandemic, ensure telepsychiatry is reimbursed at the same rates as in-person visits, and ensure prescribing can be accomplished via telehealth.
  - Work with Centerstone to seek or provide funding for equipment and secure software for video psychiatry and street psychiatry services to make psychiatry services accessible for patient where they live and when they are available, ease overhead burdens on psychiatrists, and reach people who are unhoused.

- **ACT Services**

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[132] https://www.samhsa.gov/homelessness-programs-resources/hpr-resources/employment.
[133] Harris County, TX Sobering Center, https://houstonrecoverycenter.org/harris-county-substance-abuse-sobering-center-tours/.

- Evaluate the Centerstone ACT team to ensure it is serving everyone who would benefit (the .06% of adult population figure is based on cost-effectiveness of ACT versus hospitalization, not on everyone who would benefit from ACT). Consider expanding ACT to those with fewer hospitalizations (especially if they also have incarceration(s)) as appropriate.
- Because of the importance of employment to recovery, support increased capacity of the ACT team to provide supported employment services in community employment.
- Work with Centerstone to develop a Forensic ACT Team to serve individuals with mental illness and history of incarceration.

- **Peer Support Services** – Provide training toward any necessary certifications for Peer Support Specialists with lived experience of mental illness, SUD, and incarceration. Hire qualified Peer Support Specialists to provide services at all intercept points, including crisis diversion, jail programming, court diversion, reentry, and community-based services. There are a few peer-run organizations among Monroe County's recovery community organizations who can assist in identifying existing peer support services. In addition
  - Identify desired practice standards and core competencies, and develop training, certification, and continuing education opportunities, and job qualifications;
  - Provide training, certification, and continuing education opportunities at low or no cost;
  - Prioritize lived experience, including experience in incarceration, and address how to overcome hiring barriers based on criminal background checks;
  - Ensure compensation and reimbursement rates for peer staff are adequate and reflects the value of their contribution.

- **Scattered Site Permanent Supportive Housing (PSH)**[134] – Estimated need for permanent supportive housing is approximately an additional 50–100 scattered-site units, including units for reentering citizens and homeless individuals with mental illness and/or SUD. Supportive housing treatment services are reimbursable by Medicaid, but room and board supports must be covered through separate funding. Monroe County's high market rents make providing scattered-site permanent supportive housing challenging.
  - Partner with housing developers, the Housing Authority, and community service providers to set aside a percentage of new and existing housing to be designated as scattered-site PSH. Indianapolis launched an Integrated

[134] SAMHSA, Permanent Supportive Housing: Building Your Program, available at https://www.ncceh.org/media/files/files/3f79fb85/samhsa-key-elements-of-psh.pdf.

Supportive Housing Initiative in 2017 to create approximately 500 rental units, 25% of which would be designated as PSH. Use low-income housing tax credits, community-based development organization funds, and bonds to assist with financing and Section 8 housing vouchers to subsidize rent payments.[135]

- Lease or sell County-owned property to developers at reduced cost on the condition that it provide a mix of affordable and PSH housing.
- Explore purchasing scattered-site condominium units or houses to lease as PSH to low-income residents.
- Encourage landlords to rent to residents participating in PSH (and relax their screening criteria regarding credit, past evictions, and criminal justice involvement) by
  - Educating landlords about the need and benefits and challenging their assumptions about risk.[136]
  - Connecting landlords with County or service provider teams that will provide services and supports and respond quickly to concerns.[137]
  - Creating a Risk Reduction Fund for landlords who participate in PSH. This is a pooled fund participating landlords can access to cover damage, nonpayment/ abandonment, disruption, and eviction.[138]
  - Loaning PSH participants security deposits, allowing repayment in monthly installments with low interest, or paying for security deposit insurance for participating landlords and/or tenants.[139] Cincinnati recently passed a law requiring landlords to accept security deposit insurance, monthly installments, or capped up-front deposits (no more than ½ of a month's rent).[140]
  - Subsidizing rent (short-term or long-term) for targeted individuals in scattered-site PSH, using state and/or County funds.

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[135] IHCDA Request for Qualifications for Development Teams, available at https://www.in.gov/ihcda/files/IISHI-%20RFQ%20for%20Developers%20(00028682-2xD2C80).pdf.

[136] Rural Supportive Housing Initiative, Engaging Landlords to Serve Vulnerable Populations, available at https://www.cibhs.org/sites/main/files/file-attachments/ca_lle_ppt_9.24.18.pdf?1538760945; U.S. Interagency Council on Homelessness, Landlord Engagement, available at https://www.usich.gov/solutions/housing/landlord-engagement/.

[137] See Arlington County, VA Landlord Partnership, available at https://publicassistance.arlingtonva.us/arlington-landlord-partnership/.

[138] Descriptions and information about such funds in Denver, Orlando, Portland, and Seattle are available at https://www.usich.gov/tools-for-action/engaging-landlords-risk-mitigation-funds-community-profiles/. See also District of Columbia program, https://dhs.dc.gov/release/mayor-bowser-announces-landlord-partnership-fund.

[139] https://www.localhousingsolutions.org/act/housing-policy-library/security-deposit-and-or-first-and-last-months-rent-assistance-overview/security-deposit-and-or-first-and-last-months-rent-assistance/.

[140] https://www.washingtonpost.com/realestate/clearing-a-housing-access-hurdle-options-for-a-security-deposit/2020/05/20/4508d4e6-5263-11ea-b119-4faabac6674f_story.html.

- **Supported Employment (aka Individual Placement and Support)**[141] – Supported community engagement services, such as supported employment, are reimbursable for recipients of Adult Mental Health Habilitation services through Community Mental Health Centers such as Centerstone and through Vocational Rehabilitation. The biggest obstacle to supported employment of individuals with mental illness/SUD is employer reluctance to hiring.
    - Working with community-based employment services providers serving those with mental illness/SUD, those who are homeless, and those returning after incarceration (e.g., MUM ABC Kickstart program and HIRE), develop a robust supported employment program for the target population, without relying on facility-based or provider-based employment. Fully utilize all available reimbursement systems for services for those eligible and identify any needed unreimbursed services or ineligible members of the target populations and identify funds to cover those services and target groups.[142]
    - Appoint or fund centralized staff responsible for developing and supporting supported employment services, including educating employers
    - Work with Vocational Rehabilitation and supported employment providers to engage employers to hire individuals participating in supported employment services.
        - Employer engagement programs are available through Dave's Killer Bread Foundation (they also make great everything bagels);[143] the U.S. Department of Labor Office of Disability Employment Policy;[144] and DisabilityIN,[145] among others.
        - Explore employer incentives, such as subsidized paid apprenticeships or internships guaranteeing successful apprentices/interns will retain permanent employment, providing insurance against problems/absences, and County procurement preferences for employers who participate in supported employment programs.

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[141] Bazelon Center for Mental Health Law, Getting to Work: Promoting Employment of People with Mental Illness, available at http://www.bazelon.org/wp-content/uploads/2017/01/Getting-to-Work.pdf; Bazelon Center for Mental Health Law, Advances in Employment Policy for Individuals with Serious Mental Illness, available at http://www.bazelon.org/wp-content/uploads/2018/10/Supported-Employment-Report_Oct-2018.pdf (describing successful initiatives in Delaware, Illinois, and New Jersey).

[142] SAMHSA, Supported Employment: Building Your Program, available at file:///C:/Users/Eve/AppData/Local/Temp/buildingyourprogram-se_0-1.pdf.

[143] https://dkbfoundation.org/

[144] https://www.dol.gov/agencies/odep/program-areas/mental-health

[145] https://diabilityin.org/resources/

b. **Make the practice of psychiatry for the most at-risk members of the community more attractive**.
  - Work with the state to increase Medicaid rates for psychiatry services.
  - In the meantime, subsidize Medicaid rates and provide other supports to psychiatrists.
  - Work with IU School of Medicine to explore offering a psychiatry residency program at IU Bloomington. Currently IU psychiatry residencies are offered only in Indianapolis. Such residency programs could include a public service component and/or scholarships that require or incentivize remaining in Monroe County and serving uninsured and Medicaid-eligible communities.
  - Explore paid community service fellowships, full- or part-time, for qualified psychiatrists willing to serve uninsured and Medicaid-eligible Monroe County residents.
  - Psychiatry practice for people with high needs who miss appointments is frustrating to providers, who already struggle with low reimbursement rates and have higher-paying private practice options. Consider combatting these frustrations by subsidizing reminders and transportation for clients (particularly those leaving incarceration and those at high risk of incarceration) and/or guaranteeing payment for missed appointments for high-risk individuals.

c. **Subsidize nonemergency medical transportation** for target populations. Currently, limited Medicaid coverage means people can only access health providers who are located on the limited bus route. This limits availability of providers and makes it very hard to schedule an appointment during off-work hours and make it to the appointment on time on the bus. Explore partnering with insurance companies/Medicaid MCOs to cover some of the cost of transportation to treatment.[146]
  - Subsidize on-demand (*e.g.*, Uber/Lyft) or volunteer transportation for targeted individuals employed in shift work or weekend work or at sites not on public transportation routes, as well as for court appearances, supervision, etc. Both Uber (Uber Central and Uber Health) and Lyft offer the option of an entity (business or health care) creating a restricted account for the use of

[146] https://www.cnbc.com/2018/03/14/blue-cross-lyft-walgreens-and-cvs-partner-to-help-patients-get-their-scripts.html?keyword=uber%20employee&matchtype=b&network=g&device=c&adgroup=uber-employee&gclid=CjwKCAiAu8SABhAxEiwAsodSZJZg0KPjAanfOsntFsaxKm8IFdrFDSWusi6-6tPrb20p8iareMUk2xoCtfAQAvD_BwE&utm_source=google&utm_medium=cpc&utm_content=SS&utm_campaign=Search-Prospecting-Competitor-Uber-Broad; https://money.cnn.com/2018/03/05/technology/lyft-concierge-health-care/index.html?keyword=uber%20employee&matchtype=b&network=g&device=c&adgroup=uber-employee&gclid=CjwKCAiAu8SABhAxEiwAsodSZJZg0KPjAanfOsntFsaxKm8IFdrFDSWusi6-6tPrb20p8iareMUk2xoCtfAQAvD_BwE&utm_source=google&utm_medium=cpc&utm_content=SS&utm_campaign=Search-Prospecting-Competitor-Uber-Broad.

employees/patients/customers that is direct-billed to the entity.[147] These entities have also partnered with insurance companies and governments.

d. **Increase Medicaid enrollment/insurance coverage and fill Medicaid gaps**.

- Fund monthly Medicaid contributions and copays to prevent targeted individuals from being disenrolled and locked out for 6 months.
- When targeted individuals are disenrolled and locked out, subsidize continued treatment.
- If/when the state eliminates retroactive Medicaid coverage, subsidize providers for part of what Medicaid would have paid for that period for targeted individuals, particularly if it affects services needed during the 60-day wait period for HIP Basic.
- Partner with IU to ensure students have coverage for mental health and SUD treatment (through IU insurance, campus mental health providers, and/or partnerships with community providers).
- Educate mixed-immigration-status families about their eligibility for Medicaid and about clinical programs that serve undocumented immigrants.
- Prepare for implementation of the Medicaid employment requirement by implementing a robust employment services program, including employer engagement, to prevent individuals from losing Medicaid coverage.

e. **Address Structural Barriers to Treatment.**

- Limited public Transportation is a barrier to treatment, as discussed above, as well as a barrier to employment and a contributor to criminal justice involvement of people with SUD. While driving while intoxicated is inexcusable, providing targeted populations relatively easy options to avoid the need to drive could substantially limit arrests and incarceration, as well as better serve individuals in reentry or recovery attempting to succeed in treatment and employment while restricted in driving.
  - Explore expanded late-night and weekend access to public transportation (for shift work and avoiding intoxicated driving). Smaller buses are an option for this.
  - Explore alternative transportation programs for people who are intoxicated to call on demand (especially Friday/Saturday night).[148]
- Limited affordable housing not only makes it more difficult to succeed in reentry or treatment after a crisis but contributes to crises, homelessness, and

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[147] See https://help.uber.com/business/article/accessing-uber-health-or-uber-central?nodeId=07f4a003-346a-478a-91eb-692bd6443a42.

[148] See https://www.ems.gov/pdf/811188.pdf.

incarceration. Expand on the landlord engagement programs discussed above to increase affordable housing.

4. Resources
    a. Detox – Harris County has a new model program for detox, description and tour information available at https://houstonrecoverycenter.org/harris-county-substance-abuse-sobering-center-tours/.
    b. Corporation for Supportive Housing, FUSE Introduction, Resources, and Tutorial, available at https://www.csh.org/fuse/; National Association of Counties, Supportive Housing for Justice-Involved Frequent Users of County Public Systems, available at https://www.naco.org/sites/default/files/documents/Supportive_Housing_2013.pdf; Urban Institute, Frequent Users of Jail and Shelter Systems in the District of Columbia, available at https://www.urban.org/sites/default/files/publication/25101/412504-frequent-users-of-jail-and-shelter-systems-in-the-district-of-columbia-an-overview-of-the-potential-for-supportive-housing.pdf; FUSE: Frequent User Systems Engagement, Lane County, OR, available at https://www.sheltercare.org/fuse-frequent-user-systems-engagement/;
    c. Indiana Continuum of Care Permanent Supportive Housing Administration Manual, available at https://www.in.gov/ihcda/files/CoC%20PSH%20Administration%20Manual.pdf; SAMHSA, Permanent Supportive Housing: Building Your Program, available at https://www.ncceh.org/media/files/files/3f79fb85/samhsa-key-elements-of-psh.pdf.
    d. Rural Supportive Housing Initiative, Engaging Landlords to Serve Vulnerable Populations, available at https://www.cibhs.org/sites/main/files/file-attachments/ca_lle_ppt_9.24.18.pdf?1538760945; U.S. Interagency Council on Homelessness, Landlord Engagement, available at https://www.usich.gov/solutions/housing/landlord-engagement/; Arlington County, VA Landlord Partnership, available at https://publicassistance.arlingtonva.us/arlington-landlord-partnership/.
    e. Descriptions of Risk Reduction Funds are available at https://www.usich.gov/tools-for-action/engaging-landlords-risk-mitigation-funds-community-profiles/. See also District of Columbia program, https://dhs.dc.gov/release/mayor-bowser-announces-landlord-partnership-fund.
    f. Bazelon Center for Mental Health Law, Getting to Work: Promoting Employment of People with Mental Illness, available at http://www.bazelon.org/wp-content/uploads/2017/01/Getting-to-Work.pdf; Bazelon Center for Mental Health Law, Advances in Employment Policy for Individuals with Serious Mental Illness, available at http://www.bazelon.org/wp-content/uploads/2018/10/Supported-

Employment-Report_Oct-2018.pdf (describing successful initiatives in Delaware, Illinois, and New Jersey).

g. SAMHSA, Supported Employment: Building Your Program, available at file:///C:/Users/Eve/AppData/Local/Temp/buildingyourprogram-se_0-1.pdf.

C. Intercept 0 – Community Crisis Services

Intercept 0 focuses on opportunities to divert people into local treatment services without arrest or charge, such as mobile crisis and co-responders, emergency room diversion, and police-behavioral health. **The goal of law enforcement, prosecutors, jails, and courts at Intercepts 1–5 should be to divert individuals with mental illness and SUD to Intercept 0**. Such diversion can reduce the need for, and cost of, every other intercept point. Because those intercept points are much more costly per offender for counties than community crisis services, the leveraging effect of such diversions can help "right-size" county criminal justice budgets.

1. Strengths

a. Service providers in Monroe County understand and are capable of serving people in crisis. Many of the crisis response services needed in Monroe County exist in some respect, including Centerstone's Telephone Crisis Line, Wheeler Mission's (140 low-barrier beds), and Shalom Center's (40 safe and sober beds) emergency shelters.

b. Monroe County service providers have made efforts to develop and maintain coordinated service information through Findhelp.org (formerly Aunt Bertha).

c. The new STRIDE Center is an excellent addition to Monroe County's crisis service array and is already achieving success in diverting individuals with mental illness and SUD from jail to treatment. STRIDE is a 24/7, low-barrier, voluntary crisis diversion center providing individualized trauma-informed approaches, service referrals and coordination, and laundry and shower facilities. STRIDE offers professional therapist, peer recovery specialist, recovery coaching, and LPN services. Guests are allowed to stay up to 23 hours and may make return visits. In what could be a model for further activities to reduce incarceration of this population, STRIDE is supported by the City of Bloomington, Monroe County, the Cook Group, Bloomington Health, the Community Foundation of Bloomington and Monroe County, IU Health, and the Division of Mental Health and Addiction ("DMHA"), as well as providers Centerstone, Amethyst House, IU Bloomington Hospital, Meadows Hospital, Wheeler Mission, Friend's Place, and Shalom Community Center, and both BPD and the Monroe County Sheriff.

Since opening on August 24, 2020, through December 11, 2020, STRIDE served 142 unique individuals (averaging just over 5 new visitors per week), many of whom returned for additional services, for 520 total visits (nearly 19 per week). By far the most referrals have been from BPD. STRIDE has largely met its goal of getting law enforcement officers in and out in less than 5 minutes. While many people arrive at STRIDE because law enforcement brings them, many return subsequently without law enforcement.

2. Gaps

a. Some crisis services are unavailable or too limited, such as crisis phone lines, mobile crisis services, detox, Overdose Rapid Response teams, residential addiction treatment, intensive case management, and non-religious, low-barrier emergency shelter.

- **Non-law-enforcement options to seek help** in a crisis are essential to avoiding law enforcement involvement in non-criminal incidents. A non-law-enforcement crisis phone line is theoretically available through Centerstone, but it is not well known (most community members were not aware of its existence). More work clearly is necessary to ensure non-law-enforcement options are really available and known, both without calling 911 and when 911 makes decisions about dispatch.
- **Mobile crisis services**, which meet a person in crisis where they are, are also essential for helping people avoid law enforcement as the default response to crisis.[149] Particularly in an area such as Monroe County, where public transportation resources are limited, requiring individuals in crisis to go to a particular location for services is likely to be unsuccessful. Although Centerstone offered mobile crisis service for a limited time under a DMHA grant, there is currently no mobile crisis service in Monroe County. Because dispatch generally sent law enforcement to respond to calls, law enforcement was reportedly resistant to calling mobile crisis services because officers had to wait for crisis services to arrive. This could be addressed by dispatching mobile crisis instead of, or at the same time as, law enforcement.
- **The lack of residential SUD treatment and detox** has been well documented by the Monroe County CARES Board in the County's Comprehensive Community Plan for the Governor's Commission for a Drug Free Indiana since at least 2015[150] and is confirmed by the high, and rising, number of people detoxing in

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[149] *In the first six months of health care professionals replacing police officers, no one they encountered was arrested*, https://denverite.com/2021/02/02/in-the-first-six-months-of-health-care-professionals-replacing-police-officers-no-one-they-encountered-was-arrested/.

[150] Monroe County Comprehensive Community Plan, 2019 Update.

jail. **Jail-based detox with current medical staffing, particularly on weekends when the need is greatest, is dangerous and a potential liability risk for MCCC.** Bloomington Meadows offers some detox beds for complex detox, but many sources report these are difficult to access. Indiana Center for Recovery is planning to offer detox and residential treatment.

- **Overdose Rapid Response Teams** are being rolled out across the country to respond to overdoses in a way that helps overdose victims get into immediate treatment. Rapid (or "Quick") Response Teams are teams of law enforcement, emergency services, and treatment professionals that follow up with overdose victims within 24–72 hours of overdose to connect people with treatment options.[151] Emergency Response ("CERT") is available in Southeastern Indiana through Choices,[152] but it is not currently in place in Monroe County.
- **Limited availability of urgent walk-in services and peer supports.** Walk-in clinics able to serve individuals in mental health crises without involving an emergency room or psychiatric hospital are essential to encourage people to seek treatment without the stigma often associated with mental illness. In addition, ensuring trained (and paid) Peer Specialists with lived experience with mental illness/SUD are available at walk-in clinics further reduces stigma and encourages engagement in treatment. Centerstone offers one walk-in clinic at its main office, but its hours are Monday to Friday 8:00 AM to 5:00 PM. The STRIDE Center is currently not open to self-referrals who have not previously been referred by law enforcement. The only 24/7 option is the emergency department.

b. **Gaps Exist in the Continuum of Housing Options.** One result of SUD and mental illness is often homelessness, especially in areas such as Monroe County, where affordable housing is limited. Homelessness, particularly when combined with illegal drug use or mental illness, is also a substantial contributor to interactions with law enforcement, as homeless people often have no acceptable place to be during the day (leading to trespassing), have no access to toilet and bathing facilities (leading to indecent exposure), and have no resources for food or other necessities (leading to panhandling and petty theft).[153] The United Way of Monroe County and Monroe

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[151] See, e.g., Maine, https://www.ems1.com/opioids/articles/maine-to-launch-rapid-response-team-to-combat-opioid-crisis-GCkL21q7qrlPTHu7/; Huntington, WVa, https://www.opioidlibrary.org/wp-content/uploads/2019/08/QRT_Brochure.pdf; Kentucky and Ohio, https://www.interactforhealth.org/qrt-directory/.

[152] https://www.choicesccs.org/uploads/articles/Choices_CERT_Brochure_PRINT.pdf.

[153] Bailey, et al., *No Access to Justice, Breaking the Cycle of Homelessness and Jail*, Vera Institute Evidence Brief, at 4 (August 2020); Greenberg, et al., *Jail Incarceration, Homelessness, and Mental Health: A National Study*, 59 Psychiatric Services 2, at 175-76, available at https://homelesshub.ca/sites/default/files/Greenberg.pdf (Feb. 2008).Metraux, et al., *Incarceration and Homelessness, 2007 National Symposium on Homelessness Research*, Chapter 9 at 6-8 and 11, available at https://aspe.hhs.gov/system/files/pdf/174201/report.pdf#page=337 (2007).

County Community Foundation are leading a multi-stakeholder effort to coordinate effective anti-homelessness strategies and may provide key partnerships or models for efforts in this area. A range of long-term affordable and supportive housing options (Intercept 6) is, of course, the answer to avoiding criminal implications of such "survival behaviors." However, short-term housing options can reduce incarceration of people with SUD and mental illness who are homeless at Intercept 0. In Monroe County, there are short-term housing options, but they are primarily either faith-based (Wheeler Mission) and, therefore, of limited use to those who are unwilling or unable to participate in the religious faith, or require sobriety (Shalom Center's Friend's Place) before eligibility, which poses a barrier to those unable or unwilling to get sober immediately. In addition, the limited hours (nights only) of emergency shelters in Monroe County leave homeless individuals nowhere to legitimately be during the day and make employment difficult, particularly for people who do shift work and need to sleep during the day.

c. **Shared up-to-date real-time data** about available services, slots, beds, and providers, as well as up-to-date eligibility, contact, and payment information, is important for crisis avoidance and response, case management, service coordination, diversion, and reentry. Government, community, and service provider stakeholders need just-in-time, up-to-date access to available human services information, particularly when seeking services for someone in crisis. Such shared data can break down silos, avoid over-stressing some providers when others have available capacity, increase the efficiency of service referrals for law enforcement, crisis responders, social workers, and case managers, among others, identify gaps in service availability, and track progress. The community's providers are currently using the national online tool, Findhelp.org (formerly Aunt Bertha), as a means of publishing information about available services, locations, and hours. However, this relies on individual providers to regularly update information, does not provide precise information about service slots currently available (*e.g.*, providers report all the services that they provide and then indicate whether services are "available" without indicating which services have slots available and which have waitlists), and does not allow other providers to know whether a client they are serving is also receiving services from another provider.

d. Use of the **STRIDE Center** has been lower than expected, resulting in only approximately 5 new entries per week. STRIDE Center only has three years of funding.

3. Recommendations

a. Expand non-law-enforcement crisis options.
   - Work with Centerstone to **enhance the crisis telephone line** and increase community knowledge of the line and the services it can access.

   - Work with Centerstone and the IU School or Social Work to **offer mobile crisis services** and increase community knowledge of the availability of, and eligibility for, the services. Social work students at IU are in need of practical experience and could support and learn from licensed providers in this practice. Particularly since the COVID-19 pandemic, video-based mental health services are more and more an option, which could supplement and improve the reach of non-law-enforcement mobile crisis services.

   - **Train 911 dispatchers** about the crisis telephone line and mobile crisis services for response to non-criminal and non-dangerous service calls and train them to ask about mental illness and SUD history before making dispatch decisions. Train and require 911 dispatchers and law enforcement to call mobile crisis services in appropriate cases. **Facilitate direct connection** from 911 to crisis line so callers do not have to re-dial and law-enforcement dispatch as back-up when 911 refers to mobile crisis services.

   - Work with SUD service providers, medical detox providers, and Indiana Medicaid, DMHA, and insurance providers to **establish Medicaid, insurance, and other funding for a detox service** to manage and minimize the physical harm of detoxification, acute intoxication, and withdrawal symptoms, and that includes evaluation, stabilization, and facilitating readiness for, and entry into, treatment.[154] Detox should include SUD counseling and other non-medical services, should be evaluated, in part, by how successfully it prepares people for, and encourages them to enter, treatment, and should be bundled, for payment purposes, with SUD treatment when appropriate.[155] The detox service should offer warm, direct hand-offs to a range of SUD and mental health treatment and wrap-around services, but not require the patient to commit to becoming an ongoing client of the detox provider.[156] While some facility- or hospital-based detox may be necessary for individuals with complex medical needs or those who are homeless, services need to be provided in the settings that least interfere with

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[154] According to SAMHSA, only about 1/5 of people discharged from acute care hospitals for detoxification receive SUD treatment during the hospitalization, and only 15% of those admitted through an emergency room for detox receive SUD treatment after discharge. Detoxification and Substance Abuse Treatment, A Treatment Improvement Protocol (TIP 45), at 8, available at https://store.samhsa.gov/sites/default/files/d7/priv/sma15-4131.pdf.
[155] Id. at 8-9.
[156] Id. at 41-45.

their civil rights and community integration. Therefore, detox services should be offered in a variety of settings, including all five levels of Adult Detoxification levels of care (outpatient without extended onsite monitoring, outpatient with extended onsite monitoring, clinically managed residential, medically managed inpatient, and medically managed intensive inpatient).[157]

- **Implement an Overdose Rapid Response Team**, through a partnership among law enforcement, emergency responders, and treatment providers to follow up with individuals experiencing overdose quickly and facilitate entry into treatment, rather than criminal justice engagement. While law enforcement will be involved, to maintain the option of criminal involvement and allow investigation of crimes related to the overdose, the goal of the Team should be to help the individual access treatment quickly at a crucial time when they may be particularly ready to seek it. This will require agreements among the agencies to share information as appropriate and permitted by law, to train personnel, and to make team members available in a timely manner.

b. **Expand emergency housing options.** Support the availability (through providing space and/or funding) of increased emergency shelter options for those who need low-barrier shelter but cannot access the Wheeler Mission because of its religious principles (e.g., non-Christian individuals and LGBTQ+ individuals).

c. **Improve sharing of up-to-date information among providers** about what's available, where, and to whom, and facilitate rapid direct warm referrals to reduce bureaucratic hurdles. In addition, improve data-sharing regarding clients served by multiple agencies to allow providers to identify overlap, inconsistency, and gaps without relying on repeated self-reporting by clients. Other more customizable tools are available, such as
   - Benetech's Service Net system, https://benetech.org/about/resources/benetech-service-net/; https://openreferral.org/release-announcement-benetech-service-net-upgrade/, as well as tools that allow providers to know when clients are getting services from other providers, in order to facilitate collaboration.
   - My Resource Connection, which is hosted by counties and can collaborate with their local 211, United Way, and community providers. See https://www.naco.org/sites/default/files/documents/SAMHSA%20Case%20Study%20-%20Johnson%20County%20Kan_FINAL.pdf.

d. In addition to increasing law enforcement's use of the STRIDE Center (see below), it is important to **expand availability of STRIDE Center services** to individuals

[157] Id. at 13.

referred by local hospital emergency departments and psychiatric units, detox providers, homeless shelters, and other providers who encounter crises. Such expansion was not planned to take place until after the first year after opening, but the STRIDE Center is a key resource for responding to crises and should be used to its fullest. The STRIDE Center is already reaching out to hospitals to educate them about the services the Center offers. **Secure the STRIDE Center's long-term stability** beyond the initial three-year funding period. Working with Medicaid managed care organizations, insurance providers, and DMHA to make STRIDE services a billable service may be an option for sustainable funding. In addition, cost savings to the County from getting people to treatment services (paid for by insurance and the state and federal governments) instead of incarceration (paid for by the County General Fund) may justify increased County funding of the STRIDE Center.

e. **Support opening of 24/7 walk-in crisis centers in locations beyond Centerstone's main office** that do not require law enforcement or hospital referral. Monroe needs crisis walk-in centers where individuals or their families can seek crisis services without the fear of incarceration or hospitalization outside of normal business hours.

4. Resources

a. Police Mental Health Collaboration Toolkit, Delivering Behavioral Health (discussing mental health guidance for 911 dispatchers, co-location of mental health professionals in 911 dispatch centers, and behavioral health hotlines), available at https://bja.ojp.gov/program/pmhc/behavioral-health#gcov4e ; https://bja.ojp.gov/program/pmhc/learning/essential-elements-pmhc-programs/4-call-taker-and-dispatcher-protocols.

D. Intercept 1 – Law Enforcement

Intercept 1 focuses on diversion by law enforcement or other emergency service providers to treatment services without arrest or charge, including through dispatch, specialized police response, affirmative interventions with frequent utilizers, and post-crisis follow up.

1. Strengths

a. The new STRIDE Center is an excellent addition to Monroe County's crisis service array and is a tremendous resource for law enforcement to divert individuals with mental illness and SUD from jail to treatment.

b. Bloomington Police Department has shown a strong commitment to addressing community concerns about the need for diversion, but other law enforcement officers have not been as receptive so far. BPD provides six specially trained Downtown Resource Officers ("DROs") engaging in diversion efforts among homeless

communities, as well as a Police Social Worker to address root causes of police involvement and two non-sworn Neighborhood Resource Specialists to assist with welfare checks and dispute resolution. DROs responded to over 3,734 calls for service in 2017 and made referrals to social services, medical care, mental health treatment, and housing services.

c. BPD has engaged in Crisis Intervention ("CIT"), de-escalation skills, and Mental Health First Aid training for officers and has joined the One Mind Challenge led by the International Association of Chiefs of Police to respond to people with mental illness. It has committed to 20% of officers being certified in CIT and 100% of officers and dispatchers are trained in Mental Health First Aid.

d. BPD has experience with diversion programs, including the special diversion program used for the IU Little 500 Bicycle Race.

2. Gaps

a. Law enforcement use of the STRIDE Center has been less than should be expected. BPD's DROs use the Center, although they were limited during the pandemic by restrictions on transporting people. The Monroe County Sheriff and IUPD have barely used the Center at all. Based on the numbers of annual arrests per year for drug/alcohol/mental illness-related offenses, law enforcement are using STRIDE in only about 6% to 16% of drug/alcohol/mental illness-related incidents. IUPD, whose uniquely high numbers of arrests for alcohol offenses are burdening the MCCC, is barely using the STRIDE Center at all. Given the extraordinarily high percentage of inmates in MCCC estimated to have mental illness and the nearly 5,700 annual BPD calls for service for welfare checks, drugs, alcohol, and mental health, law enforcement use of this resource is strikingly low.

Entity	Annual Drug/ Alcohol/MI Arrests	Avg. Arrests per Month	Avg. Referrals to STRIDE per Month (Aug–Dec 2020)
Sheriff (2018)	288	24	4 (16%)
BPD (2019)	1,230	103	15 (15%)
IUPD (2019)	379	32	2 (6%)

BPD DROs are the primary users of the STRIDE Center, which makes sense. However, the lack of use by other law enforcement officers, as well as the anecdotal stories of individuals who have been brought to the Center, suggest that law enforcement is using the Center primarily to respond to their social work calls – for individuals who are not perceived as having committed any crime at all but simply needing social services help. In order for a diversion program to work effectively, it

must be available both for individuals in crisis who are not accused of a crime and for those who are accused of a crime but where discretion is available to use alternatives to arrest.

In Monroe County, disorderly conduct, public intoxication/drunkenness, underage liquor possession, and minor drug possession offenses account for large numbers of arrests, many of which should be directed to the STRIDE Center. Even referring just 20% of such arrests to the STRIDE Center has the potential to cut some 4,000 jail bed days from MCCC.

b. BPD's DROs are a model program and, by all accounts, effective. However, their geographic reach is limited. The Monroe County Sheriff and IUPD, as well as other BPD officers, could benefit from learning from, and collaborating with, the DROs, so that their skills and resources can benefit individuals throughout the community.

c. While BPD has implemented CIT training and Mental Health First Aid, it is unclear that either the Sheriff's office or IUPD has done the same. In addition, it is not clear whether 20% of BPD officers receiving the training is sufficient to ensure CIT officers are available to meet the need for all shifts. It is also not clear whether they receive the full 40-hour CIT training.

d. It is unclear whether 911 dispatchers have been fully trained on alternatives to police responses to crises, whether they have been trained on the STRIDE Center or how and when to dispatch CIT-trained officers, the BPD DROs and social worker, or when to connect callers to non-law-enforcement crisis services. Monroe County should make sure that this becomes a priority for their combined dispatch center.

3. Recommendations

a. Increase appropriate use of diversion options by law enforcement officers, including:

- **Train IUPD on STRIDE** and encourage IUPD leadership to use it (as well as its own code of conduct for student-involved incidents) in all appropriate cases. Make clear the wide range of appropriate cases for which STRIDE is an appropriate alternative, including disorderly conduct, public intoxication/drunkenness, underage liquor possession, minor drug possession offenses, and others in which arrest and booking is also an available option. Consider entering into or updating an MOU with IUPD regarding County expectations that IUPD will explore alternatives to incarceration prior to bringing people to MCCC.

- **Train Monroe County Sheriff's Officers on STRIDE** and require its use in all appropriate cases, including disorderly conduct, public intoxication/drunkenness, underage liquor possession, minor drug possession offenses, and others when arrest and booking is also an available option.

- **Increase BPD use of STRIDE** by emphasizing the broad range of calls for which STRIDE Center is an appropriate alternative, including disorderly conduct, public intoxication/drunkenness, underage liquor possession, minor drug possession offenses, and others in which arrest and booking is also an available option.

- **Expand diversion techniques** used for the Little 500 to other events and types of offenses. Reduce the fees charged to alleged offenders for participation in the diversion program.

b. **Implement DRO cross-training of Sheriff's officers and IUPD** officers (as well as BPD officers) on the skills, resources, and activities of BPD DROs and its social worker. Provide mechanisms (such as DRO and social worker contact information) for other officers to seek recommendations from DROs when encountering individuals who can be assisted to avoid incarceration.

c. **Provide 40-hour CIT training** to Sheriff's officers and IUPD officers (and BPD officers if not already trained) sufficient to ensure CIT officers are available to meet the need 24/7 for all shifts and geographic areas.[158] In addition, provide Mental Health First Aid training to all Sheriff's officers and IUPD officers.

d. **Train 911 dispatchers in CIT and Mental Health First Aid** and to recognize service calls that may be appropriate for non-law-enforcement response or responses in which mobile crisis or other treatment provider is primary responder and law enforcement is backup. Again, because this is a combined dispatch center, Monroe County should insist this training becomes a priority.

4. Resources
   a. Police-Mental Health Collaboration Programs: Checklist for Law Enforcement Leaders, available at https://bja.ojp.gov/sites/g/files/xyckuh186/files/media/document/Checklist_LawEnforcementLeaders_final.pdf.

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[158] The Major County Sheriffs of America recommends all sheriff's deputies receive CIT training. *Sheriffs Addressing the Mental Health Crisis in the Community and in the Jails* at 56, available at https://cops.usdoj.gov/RIC/Publications/cops-w0869-pub.pdf.

b. Training for Police-Mental Health Collaboration Programs, available at https://bja.ojp.gov/program/pmhc/training.
c. Managing Police-Mental Health Collaborations, available at https://bja.ojp.gov/program/pmhc/managing.
d. Council of State Governments Justice Center, Police-Mental Health Collaboration (providing checklists, self assessment tools, resources, and models), available at https://csgjusticecenter.org/projects/police-mental-health-collaboration-pmhc/.
e. CIT Training – CIT International, https://www.citinternational.org/Learn-About-CIT; SolutionPoint+, https://solutionpointplus.com/.
f. Council of State Governments Justice Center, Conducting Follow-up After a Crisis Encounter (providing information on information-sharing models and post-crisis response), available at https://csgjusticecenter.org/projects/police-mental-health-collaboration-pmhc/sharing-behavioral-health-information/developing-policies-and-procedures-to-guide-information-sharing/.

E. Intercept 2) - Initial Detention/Initial Court Hearings

Intercept 2 focuses on situations in which arrest has occurred but opportunities exist for diversion to community-based treatment by jail or court officials during jail intake, booking, or initial hearing, including screening for mental illness and SUD, data-matching between jail and community-based treatment providers, and pretrial diversion and supervision;

1. Strengths

a. An initial mental health/behavioral health screening is done by deputies at intake. If the inmate reports he or she is on a prescription, the record is place in a box for the medical team to address, typically the same or next day. Deputies are trained to call medical if a special need is detected.

b. MCCC has a full-time Licensed Clinical Social Worker and an experienced Psychiatric Nurse Practitioner who can prescribe psychiatric medications and is on-site 1 day per week and on-call by telephone 24/7. Both these mental health professionals appear well qualified, experienced, and committed to doing their best for their patients. The jail is in the process of hiring a part-time (20 hours/week) social worker. The jail also has medical nurses in service 7 days a week, for 12 hours per day, but they do not appear to focus on mental health and SUD treatment.

c. MCCC houses up to 7 inmates accepted into the problem-solving courts in a separate (K) block that provides them greater access to tools to assist with transition to the community.

2. Gaps

a. **MCCC does not use a validated mental health or SUD screening tool** for its initial screenings and does not use qualified staff to administer its screenings. Initial screening for mental illness is essential to an effective diversion program.[159] The DOJ has found other jails to be unconstitutionally placing inmates with mental illness at substantial risk of harm because their screening tools relied on self-reporting by inmates, were administered by deputies, or even by a nurse, without training in identifying symptoms of mental illness, and were not systematically reviewed by supervisors for accuracy. As a result, individuals with mental illness were under-identified and denied care or delayed in receiving care they needed.[160] Yet, MCCC relies on uniformed officers to conduct screening. It is not clear to what extent those officers are trained or supervised for accuracy.

   Perhaps as a result of this gap, when RJS Consulting conducted a site visit, the inmate count was 227 and 193 inmates were under medical care. However, only 35 were receiving mental health prescriptions. This is a red flag, considering that this represents only 15.4% of the population. By contrast, national studies indicate 30-60% of a jail's population are diagnosed or diagnosable with a mental health disorder and staff believe it is more likely that 75–80% of MCCC's population has a mental health condition and/or SUD. It is likely that inmates are reluctant to share mental health and substance use information at booking to a uniformed deputy, in a non-private setting, and in response to a self-designed screening tool.

   Relatedly, **MCCC did not provide data on mental illness and SUD among the inmate population.** Data collection on these populations is important to ensure staffing and services are available to meet their needs, to assess the success of interventions and programs designed to provide treatment and reduce their incarceration and recidivism, and to help identify gaps in community-based services

[159] Council of State Governments Stepping Up Initiative, Implementing Mental Health Screening and Assessment, available at https://stepuptogether.org/wp-content/uploads/In-Focus-MH-Screening-Assessment-7.31.18-FINAL.pdf; Council of State Governments Justice Center, Guidelines for the Successful Transition of People with Behavioral Health Disorders from Jail and Prison, available at https://csgjusticecenter.org/wp-content/uploads/2020/02/Guidelines-for-sucessful-transition-summary.pdf; Validation of the Brief Jail Mental Health Screen, available at https://ps.psychiatryonline.org/doi/10.1176/appi.ps.56.7.816.
[160] Investigation of Mobile, AL County Metro Jail, at 18, available at https://www.justice.gov/sites/default/files/crt/legacy/2010/12/15/MCMJ_findlet_01-15-09.pdf (2009); Investigation of Cook County Jail, at 60-61, available at https://www.justice.gov/sites/default/files/crt/legacy/2011/04/13/CookCountyJail_findingsletter_7-11-08.pdf (2008); Investigation of the Hampton Roads Regional Jail (Portsmouth, Virginia), available at https://www.justice.gov/crt/case-document/file/1121176/download (2018).

that are leading to their incarceration. It is not clear whether MCCC has any data on the numbers, criminal offenses, diagnoses, treatment, and outcomes for these populations. DOJ has identified such data gaps as relevant to violations of federal law.[161]

b. With some 250–320 inmates on any given day, and 75–80% of those having some form of mental illness and/or SUD, **MCCC is understaffed with mental health professionals**. As cited by DOJ, the American Psychiatric Association recommends one FTE psychiatrist for every 75–100 inmates with serious mental illness.[162] The limited mental health staff available are forced to focus on addressing crises rather than diagnosis and treatment. This may contribute to the delays in identifying inmates as candidates for the mental health and drug courts, referrals to which, as noted in JCI's report, are taking over 30 days. Currently, there is no availability of video-based treatment. Mental health consultations must happen either in-person or by phone. Telephone interactions obviously limit a treating professional's ability to assess a patient's body language and affect and even to interact with the patient directly (as most calls are placed by an on-site nurse). Relying exclusively on in-person consultation results in limited availability of staff, limited hours, and logistical difficulties.

   Lack of mental health staffing on weekends, when arrests related to SUD and mental illness are highest, delays diagnosis and treatment for those who do not have pre-existing diagnoses and disrupts treatment for those who already have diagnoses and treatment regimens. We encountered an inmate who was arrested on a Friday, reported their mental health diagnosis and their regular psychiatric medication, and did not receive the medication until Tuesday, when they appeared in court. A three-day break in medication may not only cause mental health symptoms to return, but may create additional, often severe, symptoms from withdrawal and can seriously set back individuals undergoing treatment. Mental health staff also reported delays in filling prescriptions after they are ordered, even during weekdays, suggesting a break in the fulfillment chain. These delays can cause devastating problems, not only for the individual inmates in terms of symptoms, but also inhibiting their ability to follow jail rules, avoid segregation, and demonstrate behavior appropriate for diversion or reduced sentences. For the corrections and court systems, these delays in treatment can lead to delays due to loss of, and restoration to, competency, or inability to appear at court, and miscarriages of justice when inmates are unable to demonstrate their true

[161] Investigation of Mobile, AL County Metro Jail, at 19, available at https://www.justice.gov/sites/default/files/crt/legacy/2010/12/15/MCMJ_findlet_01-15-09.pdf (2009)
[162] Investigation of the Hampton Roads Regional Jail (Portsmouth, Virginia), available at https://www.justice.gov/crt/case-document/file/1121176/download (2018).

character and eligibility for diversion. The DOJ has found other jails to be in violation of the Constitution and federal law for similar delays in providing medication to inmates with mental illness and for similarly limited hours of mental health staff.[163]

c. **Lack of veteran-specific mental health and SUD interventions.** Staff report that many veterans are being seen in MCCC. Many veterans are reluctant to admit to trauma, mental illness, or SUD and require targeted approaches to diagnosis and treatment. Many jails nationwide have developed veteran-specific housing pods, allowing veteran inmates access to targeted services, veteran-specific benefits (such as connections to VA health and housing assistance upon reentry) and, importantly, peer supports.[164] These programs have had significant success in reducing recidivism.[165]

3. Recommendations

a. **Adopt validated screening tools**, such as the Brief Jail Mental Health Screen and Texas Christian University Drug Screen-V.[166] When these tools identify mental health, SUD, or co-occurring disorders, follow up with timely comprehensive assessment and diagnosis by mental health professionals. When screening reveals prior mental health or SUD treatment, MCCC should have processes to timely seek a release from the inmate and request records from prior providers. **Utilize the results of the screening tools to track** numbers, criminal offenses, diagnoses, treatment, and outcomes for these populations in order to inform decisions about staffing and programming capacity, gaps within MCCC and in the community, and successful interventions.

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[163] Id (citing psychotropic medication delays as violations; citing mental health staffing of over 7 FTE mental health staff, with no mental health professional present on weekends, as inadequate for 500 prisoners with mental illness); Update to Letter of Findings, US' Civil Rights Investigation of the Orleans Parish Prison System, at 13-16, available at https://www.justice.gov/sites/default/files/crt/legacy/2012/04/23/parish_update_4-23-12.pdf; Investigation of Mobile, AL County Metro Jail, at 21-23 and 26, available at https://www.justice.gov/sites/default/files/crt/legacy/2010/12/15/MCMJ_findlet_01-15-09.pdf (2009).
[164] U.S. Dept. of Justice Nat'l. Inst. of Corrections, Barracks Behind Bars: In Veteran-Specific Housing Units, Veterans Help Veterans Help Themselves, available at https://info.nicic.gov/jiv/sites/info.nicic.gov.jiv/files/Barracks-Behind-Bars-508.pdf (2018).
[165] Legal Help for Veterans, Jail Programs Help Veteran Inmates Work Through Problems and Reintegrate Into Society, available at https://www.legalhelpforveterans.com/2018/02/28/jail-programs-help-veteran-inmates-work-through-problems-and-reintegrate-into-society/ (reporting that an Albany, NY jail veterans pod program reduced recidivism to 6%, compared to 40% of the general population); https://wesoldieron.org/albany-county-house-corrections/; https://veterans.ny.gov/content/incarcerated-veterans-program.
[166] SAMHSA, Screening and Assessment of Co-Occurring Disorders in the Justice System, Fig. 8 and p. 58-61, available at file:///C:/Users/Eve/AppData/Local/Temp/pep19-screen-codjs.pdf (2019).

b. **Increase the number and hours of qualified mental health staff** at MCCC to ensure adequate coverage on weekends and nights and to ensure staffing is adequate to make timely assessments, diagnoses, and treatment plans. APA recommended ratios would suggest, conservatively, 2.5–3.5 FTE mental health professionals are needed for MCCC's population. Explore using video consultations to allow psychiatrists and other treatment professionals more flexibility to consult with patients in a timely and regular manner. **Speed up diagnosis, prescription fulfillment, and referral to problem solving courts, as well as assignment to K block or the mental health unit** for those believed to be eligible (see below).

c. **Adopt a veteran-specific program** in jail, including a veteran housing pod and peer-to-peer services, which would support and complement the County's Veterans' Court.

5. Resources
   a. Mental Health Screening - Policy Research Associates, Brief Jail Mental Health Screen, available at https://www.prainc.com/?product=brief-jail-mental-health-screen. SAMHSA, Screening and Assessment of Co-Occurring Disorders in the Justice System, Fig. 8 and p. 58-61 (2019), available at file:///C:/Users/Eve/AppData/Local/Temp/pep19-screen-codjs.pdf; Council of State Governments Stepping Up Initiative, Implementing Mental Health Screening and Assessment, available at https://stepuptogether.org/wp-content/uploads/In-Focus-MH-Screening-Assessment-7.31.18-FINAL.pdf; The Brief Jail Mental Health Screen, available at https://dbhds.virginia.gov/library/forensics/ofo%20-%20brief%20jail%20mental%20health%20screen%20part%203.pdf;
   b. Council of State Governments Justice Center, Guidelines for the Successful Transition of People with Behavioral Health Disorders from Jail and Prison, available at https://csgjusticecenter.org/wp-content/uploads/2020/02/Guidelines-for-sucessful-transition-summary.pdf.
   c. U.S. Dept. of Justice Nat'l. Inst. of Corrections, Barracks Behind Bars: In Veteran-Specific Housing Units, Veterans Help Veterans Help Themselves, available at https://info.nicic.gov/jiv/sites/info.nicic.gov.jiv/files/Barracks-Behind-Bars-508.pdf (2018).

F. Intercept 3) - Jails/Courts

Intercept 3 focuses on diversion to community-based services through jail or court processes and programs after booking, including problem-solving courts, and services that prevent the worsening of a person's illness during jail stay, such as jail-based programming and health care services.

Jails have constitutional and legal mandates to provide adequate mental health and SUD treatment. They should not, however, be considered part of the treatment continuum of care. People with these illnesses should be diverted from jail to treatment and community whenever possible. Jails should play a role, along with courts, in ensuring that diversion happens. In order to play that role, jail mental health systems must:[167]

- Identify people with mental illness entering the criminal justice system: An effective system utilizes evidence-based mechanisms to identify, manage, and divert people to treatment as quickly as possible. Training of corrections staff on the signs and symptoms of mental illness and SUD is an important supplement to professional mental health staff in this effort. Coordination with prior treatment providers is also important to inform jail treatment.

- Stabilize and treat mental illness and SUD in ways that avoid harm and prepare inmates for diversion or reentry: An adequate mental health system includes licensed and unlicensed care providers, support staff, and custody staff. Staffing levels should be determined by levels of need and required care activities (intake, assessment and diagnosis, treatment and discharge planning, treatment, medication management, and records keeping). In addition, inmates must have ready access to care, including individualized treatment plans, specialized interventions when needed, and care outside of normal business hours. While medication is important, it should not be the primary method of care, when individual and group therapy may be more effective, less expensive, and cause fewer side effects. Beyond treatment, programming to help inmates maintain stability, engage in activities of daily living, and care for themselves is important.

- Provide adequate physical resources: A jail system must provide adequate housing and treatment capacity for this population. Areas for individual and group treatment should exist and allow for adequate levels of privacy and confidentiality. Housing options should allow for different levels of care and security based on needs and risk.

- Maintain adequate health records: Good health records are the cornerstone to effective care and to the legal requirement of continuity of care. They are instrumental in evidencing care quality of assurance and to ensuring continuity of treatment upon reentry. Records must be complete, thorough, and accurately represent care activities. Electronic health records and management information systems are important tools in this effort, as they support continuous quality improvement, tracking, and coordination with post-incarceration treatment providers.

- Engage in continuous quality assurance and analysis of data and outcomes: An ongoing internal survey, evaluation, and feed-back system accompanied by a statutory, evidentiary privilege to safeguard such studies from disruptive discovery demands should be part of any system. Along with such feedback mechanisms, data

[167] National Commission of Correctional Health Care, Jail Health Care Policies and Procedures.

tracking and analysis by multidisciplinary teams will enable adoption of or changes to policies, procedures, programs, and services to continuously improve outcomes.

- Discharge planning: Structures and processes should exist to prepare inmates with mental illness/SUD for release. This should include assisting them to reactivate financial and community resources to meet basic needs and treatment needs. All inmates with a serious mental illness should be released with a complete and clear release plan that is shared among appropriate criminal justice components, community, and personal supports.

1. Strengths

a. As discussed above, in recent years, MCCC has expanded mental health staff and started a new K block for inmates considered eligible for the problem-solving courts.

b. Monroe County has implemented four problem-solving courts: Mental Health Court, Drug Court, Veterans Court, and Reentry Court to handle felony charges of eligible individuals. Such courts can, if well executed and utilized, help to break the cycle of mental illness and criminal behavior that stems from failures of community mental health systems and may be aggravated by inadequate jail treatment systems, and provide effective treatment options rather than the usual criminal sanctions for offenders with mental illness.[168] In 2019, the Drug Court reduced average number of days in jail to 49 per participant, compared to a comparison group serving 69 days per participant on average.[169]

c. The Monroe County Prosecutor offers a Mental Health Review Team diversion program for misdemeanor charges against individuals with diagnosed mental illness. The Mental Health Review Team is a multi-disciplinary team of representatives of the Prosecutor, Public Defender, Probation Department, Jail Diversion Coordinator, and Centerstone. This program relies on the Prosecutor's discretion to dismiss charges if an offender agrees to, and does, comply with a written diversion agreement. In the case of a breach of the agreement, the court may sanction the breach or reactivate the original charge. Alternatively, the terms of a diversion agreement may be incorporated into a plea agreement and failure to comply will be treated as a probation violation.

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[168] Bazelon Center for Mental Health Law, "The Role of Mental Health Courts in System Reform," available at https://secureservercdn.net/198.71.233.254/d25.2ac.myftpupload.com/wp-content/uploads/2018/03/Role-of-Mental-Health-Courts.pdf.

[169] IU School of Social Work, Program Evaluation of the Monroe County (Indiana) Drug Court, available at https://www.co.monroe.in.us/egov/documents/1554129975_86798.pdf.

d. Since 2017, MCCC has partnered with New Beginnings to offer programming to inmates preparing for reentry, including a Vivitrol injection within one week of release. Although the number of inmates who have been able to participate is not clear from MCCC reports, participants have been successful, with a nearly 70% no-recidivism rate over 3 years and reduced anxiety, depression, and criminal thinking among participants. In 2019, the DMHA reduced the program from 15 hours of programming per week to 8 hours and from 90 days of jail programming plus 90 days of community programming to 60 days of jail programming and 120 days of community programming. MCCC is working to increase the programming hours and duration of the program and seeks funding to do so. New Leaf New Life has also offered some programming at MCCC, including support groups, re-entry workshops, writing workshops, meditation and recreational programs, but it is not clear to what extent these programs have continued during the pandemic.

e. MCCC partnered with ASPIN Health Navigators to begin the Medicaid enrollment process for specified inmates. This partnership continued in 2019 with 500 inmates given the opportunity to begin the enrollment process to obtain healthcare.[170]

2. Gaps

a. **Mental health staffing and housing are insufficient** to meet the need. As a result, individual treatment plans are lacking. **The new K block is too small** (7 beds) to meet the need. Most inmates with mental illness and SUD are in general population, except when they are in segregation for a crisis. Being in general population makes it harder for inmates to focus on treatment, exposes them to abuse and extortion (for their medications), and makes them less likely to demonstrate the behaviors necessary to make them appear to be good candidates for shorter sentences, community supervision, or early release. The DOJ has found jails to be in violation of the law for failing to have adequate capacity in its mental health units. In addition, lack of adequate **screening, medical records, data collection, and tracking** makes visibility into the outcomes and quality improvement difficult.

b. **Delays in treatment for inmates with mental illness result in vicious cycles** where inmates become incompetent and wait for months, reportedly, for admission to inpatient treatment, which delays court processes until competency is restored. But once an inmate is restored and returns to jail, court processes do not timely resume. Without access to robust treatment in the jail, the inmate decompensates, and the cycle begins again.

[170] 2019 Monroe County Correctional Center Annual Jail Report at 9.

c. **MCCC offers very little programming** to assist inmates with mental illness and SUD to engage in recovery or prepare for reentry. The New Beginnings reentry program, while apparently successful, is small and is not targeted to inmates with these diseases. In addition, recent changes in that program threaten its efficacy.

d. **Inmates with serious mental illness are often kept in segregation cells.** Because of the limited number of beds and services for inmates with mental illness and/or SUD, individuals with these conditions are too often in crisis and in segregation units, which are not therapeutic, are resource-draining for MCCC, and, in a vicious cycle, require mental health staff to run from crisis to crisis, rather than addressing root causes. Segregation is presumptively contraindicated for, and dangerous to, inmates with serious mental illness, and if inmates with mental illness are being placed in segregation because of their illnesses and the lack of safe housing for them, that is discriminatory in violation of the ADA. Segregation is well documented to be counterproductive to most mental health treatment, both because it exacerbates symptoms and because it limits availability of treatment.[171] Mental health staff at MCCC make segregation rounds once a week, limiting their ability to provide treatment to those most in need. It is not clear whether MCCC screens inmates for mental health conditions that would contraindicate segregation before placing inmates in segregation.[172] **Segregation of inmates with mental illness raises potential serious constitutional and legal liability concerns.**

e. **MCCC's medical provider charges copays** for mental health and addiction treatment. Staff report that some inmates refuse treatment and medication because of cost. For inmates, who lose both their employment and their benefits while incarcerated, any financial barrier to health care, even if it appears small, likely significantly discourages them from seeking treatment.

f. It is unclear whether MCCC's **Medicaid enrollment effort** is sufficiently staffed to meet the need. In 2019, MCCC reports it offered the opportunity to 500 inmates (10%) out of the nearly 5,000 bookings that year. It is also not clear how successful

[171] National Commission on Correctional Health Care, Position Statement on Solitary Confinement (Isolation), available at https://www.ncchc.org/solitary-confinement (2016) ("Juveniles, mentally ill individuals, and pregnant women should be excluded from solitary confinement of any duration."); Andrade, Mental Health Units as Alternatives to Segregation: It Can Be Done, Vera Institute Think Justice Blog/Addressing the Overuse of Segregation in U.S. Prisons and Jails, available at https://www.vera.org/blog/addressing-the-overuse-of-segregation-in-u-s-prisons-and-jails/mental-health-units-as-alternatives-to-segregation-it-can-be-done (2020).

[172] Kapoor, et al., Mental Health Effects of Restrictive Housing, in U.S. Dept. of Justice Nat'l. Inst. of Justice, Restrictive Housing in the U.S.: Issues, Challenges, and Future Directions, Ch. 6, at 218-20, available at https://www.ncjrs.gov/pdffiles1/nij/250321.pdf (2016).

the program is. Because of the 45- to 90-day processing time, it is crucial to start the enrollment process early. For example, according to recent research,

> New Mexico initiates enrollment efforts when individuals first enter incarceration, which helps the state connect with individuals even if they have short stays. The other states begin their enrollment efforts about 90–120 days prior to release. . . . The states educate individuals about Medicaid coverage and assist in completing and submitting an application as well as selecting a Managed Care Organization (MCO). Individuals either leave with their Medicaid card or it is mailed to their home. These efforts are primarily conducted by corrections staff who are trained as presumptive eligibility determiners; Ohio also has trained some inmates to serve as peer navigators.[173]

g. **Problem-solving courts in Monroe County appear to be underutilized.** Despite the high numbers of drug-, alcohol-, and mental illness-related arrests, in 2017, the Drug Court supervised only 77 people and the Mental Health Court supervised only 9.[174] Similarly, as of May 2019, the Drug Court had 71 people under supervision and the Mental Health Court had only 9. It was estimated that the Drug Court could handle 49 more offenders and the Mental Health Court could handle 11 more offenders, with current staffing.

   Several barriers-to-entry seem to be limiting the role of the problem-solving courts. As discussed in JCI's report, inmates often wait over 30 days to reach the problem-solving courts. A 2019 evaluation of the Drug Court found participants waited an average of 48 days for admission to drug court. This is a significant barrier for all courts, as any inmate who has served 30 days already is likely to prefer to take the chance of a guilty plea in hopes of receiving time served, probation, or minimal additional time, rather than engage in the problem-solving court, which requires him/her to acknowledge a mental illness or addiction, enter a guilty plea, pay a participation fee, a monthly fee ($25), drug testing fees ($10–$25 per test), and treatment fees, and subject himself/herself to supervision, random drug tests, weekly court appointments, and an employment requirement. Moreover, his/her conviction will only be eliminated if he/she succeeds in the entire program for two years. The prospect of possibly, in two years, having the conviction withdrawn, is unlikely a sufficient "carrot" at this point in the process, particularly when balanced against the possibility of failing in the program while having given up the right to a trial.

[173] Wachino, et al., How Connecting Justice-Involved Individuals to Medicaid Can Help Address the Opioid Epidemic, Kaiser Family Foundation Issue Brief, at 4, available at https://www.kff.org/medicaid/issue-brief/how-connecting-justice-involved-individuals-to-medicaid-can-help-address-the-opioid-epidemic/ (June 2019).

[174] Monroe County Courts & Related Offices Data Response (May 6, 2019).

Delays are particularly problematic for Mental Health and Drug Courts, as mental health and addiction symptoms and needs will have changed significantly over the course of 30 days since the incident leading to arrest. The individual's crisis occurred at the time of arrest and their openness to treatment may also be heightened at that time. Because of the inadequate mental health screening done upon booking, Prosecutors and Public Defenders often do not have sufficient information early enough to identify appropriate candidates for Mental Health or Drug Court and must invest additional time and resources in investigating offenders' mental health and drug history. Offenders' defense attorneys may delay referrals to problem-solving courts in order to get offenders treatment in jail because an offender with less mental illness or addiction symptoms may be a better candidate for a reduced or dropped charge or reduced or suspended sentence. Such a result counts as a success based on traditional criminal justice measures but does not necessarily help offenders connect successfully to community-based treatment the way a problem-solving court could. As discussed above, because participation in problem-solving courts requires a guilty plea, there is little incentive for defense attorneys or their clients to choose those courts.

Success in the problem-solving courts is not guaranteed. A 2019 evaluation found the drug court achieved a 66% graduation rate and an 18% recidivism rate.[175] One requirement of the courts (and an important element of success for participants)[176] is employment. However, participation in Drug or Mental Health Court requires the person to plead guilty to a felony and admit to a mental illness or SUD. Employers are reluctant to employ people with mental illness or SUD and are particularly concerned about (and in some cases prohibited from) employing felons. Thus, each participant begins with a strike against success. In addition, the participant must take time off work for weekly court appearances (Drug Court is at 7:30AM Wednesdays, and Mental Health Court is a 1:00PM on Tuesdays), probation officer meetings, site visits, and random drug tests 2–3 days/week (announced by phone at 6AM the day of the test). The average user fees and drug-test costs are estimated to be $150/month for over a year of the Drug Court program.[177] A survey of participants in the Drug Court noted that the frequent and random drug testing system was too expensive and time-consuming and kept them from graduating from the program and attaining the benefit

[175] IU School of Social Work, Program Evaluation of the Monroe County (Indiana) Drug Court, available at https://www.co.monroe.in.us/egov/documents/1554129975_86798.pdf.
[176] Id.
[177] Monroe County Drug Treatment Court Program Participant Handbook and Program Information, available at https://www.co.monroe.in.us/egov/documents/1580306758_38504.pdf (2020); Monroe County Mental Health Court Program Participant Handbook and Program Information, available at https://www.co.monroe.in.us/egov/documents/1580333164_78068.pdf (2020).

of having their plea withdrawn. The evaluators recommended providing financial and other alternative incentives for abstinence.

3. Recommendations

a. It is essential to use MCCC as a mechanism for diverting individuals to other services as quickly as possible. MCCC should **speed up diagnosis, prescription fulfillment, and referral to diversion and problem-solving courts, as well as assignment to K block or the mental health unit** for those believed to be eligible. Speed up admissions to inpatient treatment for those deemed incompetent, and, when individuals are restored to competency, ensure their court date is soon after their return to jail.

b. **Maximize use, and timeliness, of the Prosecutor's Mental Health Review Team and reduce barriers to participation in and graduation from problem-solving Courts**.

- Ensure the Mental Health Review Team, together with defense attorneys, has early access to individuals in MCCC and the resources to make timely decisions about diversion and to provide access to community-based treatment and services for individuals identified as eligible for diversion.

- Indiana law requires participants in problem-solving courts to plead guilty to the offenses with which they are charged. Particularly for mental health courts, this is not a best practice, as it requires the individual to give up their constitutional right to a trial in which their mental health – the very reason they are eligible for the court – may be a defense.[178] This requirement is likely a disincentive to eligible individuals participating and to their attorneys recommending participation, This requirement is likely a disincentive to eligible individuals participating and to their attorneys recommending participation, as well as making it more difficult for them to achieve housing and employment, both of which are required for problem-solving court graduation. **Work with the Indiana legislature to implement flexibility for the Mental Health and Drug Courts to accept individuals into the program without an up-front guilty plea.**

- Indiana law also requires drug testing to participate in the problem-solving courts. However, the law does not specify the frequency of drug testing or require problem-solving courts to charge participants for drug testing. Nor does Indiana

[178] Bazelon Center for Mental Health Law, Mental Health Courts, http://www.bazelon.org/our-work/criminal-justice-2/mental-health-courts/.

law require the assessment of a participation fee. Given the cost savings of community-based treatment versus incarceration and recidivism, Monroe County should share the goal of participation, success, and graduation with participants. We agree with the IU evaluators of the Drug Court in 2019 that frequent random drug testing is likely most effective in the early phases of the program and less necessary as the program progresses. **We would propose focusing drug testing in the first few weeks after release and not assessing fees for drug tests that are negative. As the participant progresses, drug tests can be less frequent and, again, without cost when tests negative.** At the end of a successful program, therefore, a participant could graduate without debt to the County. Similarly, **participation fees should be eliminated or restructured** to avoid disincentivizing participation. If any participation fees are charged, they should be charged only upon a violation of the Drug/Mental Health Court agreement, thus disincentivizing *violations*, rather than *participation*.

- While participants in Drug Court found their interactions with program staff and judges very helpful, the frequency and timing of those requirements interfere with a central requirement of the program – employment. The need to comply with drug testing, court appearances, and supervision visits makes it even more difficult for participants to obtain meaningful employment (which is already limited by mental illness/SUD diagnosis, criminal record, and treatment needs). While the Drug Court endeavors to hold court hearings in the early morning, the Mental Health Court is currently scheduled in the middle of a weekday. Monroe County should **explore evening hours for Mental Health Court and evening and weekend hours for regular supervision meetings and even drug testing**.

c. While the best way to prevent individuals with mental illness and SUD from receiving inadequate care while incarcerated is to prevent and divert from incarceration as early and as often as possible, to the extent that is not accomplished immediately, Monroe County should **increase mental health staffing at MCCC** to ensure adequate coverage on weekends and nights and to ensure staffing is adequate to make timely assessments, diagnoses, and treatment plans. APA recommended ratios would suggest, conservatively, 2.5–3.5 FTE mental health professionals are needed for MCCC's population. Explore using video consultations to allow psychiatrists and other treatment professionals more flexibility to consult with patients in a timely and regular manner. When screening identifies mental health, SUD, or co-occurring disorders, follow up with timely comprehensive assessment and diagnosis by mental health professionals. Use screening data and medical records to evaluate outcomes and engage in continuous quality improvement.

d. Again, jail is never going to be an effective mental health treatment provider and should not be relied upon as such. However, to the extent individuals with mental illness remain at MCCC, Monroe County should **expand the K block and create a mental health unit** (and/or behavior management unit)[179] to protect inmates with mental illness/SUD from potential predators and provide them greater structure and programming to prepare them for early diversion and problem-solving courts, as well as to allow professional staff to provide better treatment interventions and oversight to prevent abuse. Mental health unit beds, along with substantial treatment and programming, should be available for every inmate with a serious mental illness.

e. **Increase mental health and SUD programming** and treatment options at MCCC. The current New Beginnings program at MCCC is effective but is available to far too few inmates to meet the need. As a result, many inmates who could benefit from its therapeutic programming, Vivitrol treatment, and coordination with Centerstone are not able to participate.

f. **Stop the use of segregation/solitary confinement for inmates with mental illness** and focus on providing therapeutic interventions, preventing crises, and facilitating diversion to treatment. Unless and until adequate mental health staffing and programming are provided in MCCC, segregation of inmates with known mental illnesses should be strictly avoided. Screening of inmates should be conducted before putting them in segregation to identify any indications of serious mental illness that would contraindicate segregation. In addition, mental health staff should be consulted before placement of any inmate that might have mental illness in segregation. When an inmate is in segregation, mental health professionals should regularly screen for new or exacerbated mental health symptoms.

g. To encourage inmates with mental illness/SUD to access treatment, **waive or subsidize mental health/SUD treatments and medications**. While co-pays may seem a small inconvenience, if, as is reported, they are inhibiting individuals with mental illness/SUD from seeking treatment, they should be reduced or eliminated. The jail has an important role to play in getting inmates with these illnesses stabilized, connected to community treatment, and able to avoid recidivism. It cannot

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[179] A mental health unit serves those with "traditional" mental illnesses (*e.g.*, schizophrenia, bipolar disorder, etc.), while a behavior management unit is for those with psychopathy or severe personality disorder. Each offers different interventions, including therapy, medication and insight in the mental health unit, and behavior management, incentives and consequences in the behavior management unit. Andrade, Mental Health Units as Alternatives to Segregation: It Can Be Done, Vera Institute Think Justice Blog/Addressing the Overuse of Segregation in U.S. Prisons and Jails, available at https://www.vera.org/blog/addressing-the-overuse-of-segregation-in-u-s-prisons-and-jails/mental-health-units-as-alternatives-to-segregation-it-can-be-done (2020).

do so effectively if people with mental illness/SUD face barriers to participation. In addition, inmates foregoing treatment because of financial concerns likely increases crises in jail, leading to greater security needs.

h. MCCC should **screen all inmates for Medicaid eligibility soon after booking and begin the Medicaid enrollment process as early as possible (shortly after booking or at least 120 days before release)**, recognizing the 45–90 day processing time for the state and the need to gather the necessary documents to complete the application. If additional benefits navigators are needed, this is a worthwhile investment to improve treatment compliance upon reentry and reduce recidivism.

4. Resources

a. Wachino, et al., How Connecting Justice-Involved Individuals to Medicaid Can Help Address the Opioid Epidemic, Kaiser Family Foundation Issue Brief, at 4, available at https://www.kff.org/medicaid/issue-brief/how-connecting-justice-involved-individuals-to-medicaid-can-help-address-the-opioid-epidemic/ (June 2019).
b. SAMHSA, Use of Medication-Assisted Treatment for Opioid Use Disorder in Criminal Justice Settings, available at https://store.samhsa.gov/product/Use-of-Medication-Assisted-Treatment-for-Opioid-Use-Disorder-in-Criminal-Justice-Settings/PEP19-MATUSECJS.

G. Intercept 4) - Reentry

This intercept point addresses supported reentry into the community after jail to link people in jail to treatment services and to reduce further justice involvement after release. It includes transition planning by reentry coordinators, peer support staff, and/or community in-reach by providers, medication and prescription access upon release, and warm hand-offs from corrections to providers.

1. Strengths

a. Some community-based service providers specifically serve individuals reentering the community after incarceration. Most others are willing, and do, serve such individuals, although they are not their primary client targets.

b. MCCC offers the reduced New Beginnings program to approximately 17 inmates in a special dorm. The New Beginnings program has a strong success rate measured in terms of recidivism, as well as reducing anxiety, depression, and criminal thinking.[180]

[180] MCCC 2019 Annual Report.

c. New Leaf New Life offers some programming in the jail, including reentry workshops.[181]

2. Gaps

a. Insufficient reentry planning, case management, and programming is available in MCCC to meet the need.

b. Very little opportunity is available in MCCC for inmates to connect with community-based mental health/SUD treatment and service providers while still in jail. As a result, individuals with mental illness/SUD leave jail having received some treatment, but without connections to community-based treatment and services. This leads to a cycle of relapse and recidivism.

c. Complex disparate funding mechanisms for MCCC versus community-based treatment make transition from one system to the other difficult.

d. Lack of family engagement in preparation for reentry of individuals with mental illness and SUD. Families can provide important supportive roles during reentry. However, families are also stressed by the reentry of a formerly incarcerated person and often do not have the tools they need to provide support in preventing recidivism.[182]

e. Monroe County lacks adequate housing to help returning individuals with mental illness and SUD reestablish themselves in the community while avoiding triggers of the behavior that led to incarceration.

f. Finding and keeping employment is a major element of success upon reentry, particularly for those with mental illness and SUD, but remains particularly difficult.

g. Although Centerstone offers an Assertive Community Treatment team of 12 staff serving approximately 83 people, Monroe County does not have an ACT team focusing on individuals with severe mental illness who have been incarcerated (commonly referred to as Forensic Assertive Community Treatment or "FACT"). ACT and FACT teams use similar approaches, but whereas ACT is focused on preventing hospitalization, FACT is focused on preventing reincarceration.

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[181] Id.
[182] Engaging Offenders' Families in Reentry, Coaching Packet, available at https://cepp.com/wp-content/uploads/2015/12/Engaging-Offenders-Families-in-Reentry.pdf.

3. Recommendations

a. Recognizing that virtually every inmate will leave the jail and reenter the community, the Council of State Governments ("CSG") Justice Center recommends that transition planning begin at the same time as treatment planning for individuals with mental illness/SUD.[183] CSG recommends jails develop collaborative responses between behavioral health and criminal justice systems and arrange for appropriate interventions to be available immediately upon release. **MCCC should include reentry planning, case management, and reentry programming in its treatment plans for inmates with mental illness/SUD and engage community service providers in both in-jail treatment and transition planning.**[184]

b. Warm hand-offs to, and coordination with, treatment and services providers upon reentry are essential to avoid gaps in care that lead to relapse and recidivism for individuals with mental illness and/or SUD.[185] **Monroe County should invest in case management at the jail to work with jail and community treatment providers, with supervision providers, and with inmates preparing for reentry** to 1) assess each individual's needs upon reentry, 2) identify appropriate treatment and service providers, 3) introduce individuals to those treatment providers and establish eligibility and other requirements for services upon reentry, and 4) share jail assessment and treatment information with community treatment providers to ensure smooth transition.[186] A method of doing this is via the Assess, Plan, Identify, and Coordinate ("APIC") Model,[187] which calls for jails to conduct transition planning that addresses short- and long-term needs (*e.g.*, family, housing, treatment, services, income, and transportation), identify and contract with specific community providers

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[183] Council of State Governments Justice Center, Guidelines for the Successful Transition of People with Behavioral Health Disorders from Jail and Prison, Guideline 3, available at https://csgjusticecenter.org/wp-content/uploads/2020/02/Guidelines-for-sucessful-transition-summary.pdf; SAMHSA, Guidelines for Successful Transition of People with Mental or Substance Use Disorders from Jail and Prison: Implementation Guide, available at https://store.samhsa.gov/product/Guidelines-for-Successful-Transition-of-People-with-Mental-or-Substance-Use-Disorders-from-Jail-and-Prison-Implementation-Guide/SMA16-4998; The Assess, Plan, Identify, and Coordinate (APIC) Model, at 4 (recommending assessment and planning begin within 48 hours of booking), available at https://www.eenet.ca/sites/default/files/wp-content/uploads/2014/04/APIC-summary-addendum_March2014.pdf.
[184] The Assess, Plan, Identify, and Coordinate (APIC) Model, available at https://www.eenet.ca/sites/default/files/wp-content/uploads/2014/04/APIC-summary-addendum_March2014.pdf.
[185] Id., Guideline 6.
[186] Id., Guidelines 4-8.
[187] Osher, et al., A Best Practice Approach to Community Re-entry from Jails for Inmates with Co-occurring Disorders: The APIC Model, available at https://www.addictioncounselorce.com/articles/101286/apic.pdf (2002).

that can meet those needs, provide a complete discharge summary to community providers upon release, and provide case management to facilitate transition and avoid gaps in care (including in-reach by community providers, introductions of inmates to service providers prior to release, and tracking of missed appointments after release).[188]

c. **Engage and support families** and peers in preparing for inmates' reentry, including by offering training on coping mechanisms and supporting inmates to prevent relapse and recidivism.

d. Housing stability is instrumental in helping released individuals achieve positive outcomes, such as maintaining employment and avoiding future incarceration.[189] Securing housing is perhaps the most immediate challenge facing prisoners upon their release. While many returning prisoners have plans to stay with family, those who do not confront limited housing options. The process of obtaining housing is often complicated by a host of factors: the scarcity of affordable and available housing, legal barriers and regulations, prejudices that restrict tenancy for this population, and strict eligibility requirements for federally subsidized housing.[190] **Permanent Supportive Housing** – stable, affordable housing supported by flexible treatment and other services – is often the key to sustained recovery for people with serious mental illness and SUD. As discussed below, Monroe County needs additional permanent supportive housing, some of which should be dedicated to returning citizens with mental illness/SUD.

> **Released prisoners who do not have stable housing arrangements are more likely to return to prison, suggesting that the obstacles to securing both temporary and permanent housing warrant**

e. As discussed below, Monroe County needs additional **supported employment services** for people with mental illness/SUD, some of which should be dedicated to returning citizens.

f. **Implement a Forensic Assertive Community Treatment team.** While we did not receive data on the numbers of people with severe mental illness in MCCC or the

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[188] Id at 8-16.

[189] Bradley, K. H., R. B. Oliver, N. C. Richardson, and E.M. Slayter. (2001). No Place Like Home: Housing and the Ex-Prisoner. Issue brief. Boston, MA: Community Resources for Justice.Graffam, J., A. Shinkfield, and W. McPherson. (2004). Variables Affecting Successful Reintegration as Perceived by Offenders and Professionals. Journal of Offender Rehabilitation 40: 147–71.

[190] Urban Institute, Understanding the Challenges of Prisoner Reentry: Research Findings from the Urban Institute's Prisoner Reentry Portfolio, at 8, available at https://www.urban.org/sites/default/files/publication/42981/411289-Understanding-the-Challenges-of-Prisoner-Reentry.PDF (2006).

number of those incarcerated more than twice in a year, a rule of thumb is that FACT services should be sufficient to serve approximately .05% of a community's adult population.[191] Applied to Monroe County, that would call for at least one FACT team able to serve approximately 63 people.[192]

4. Resources
   a. Council of State Governments Justice Center, Guidelines for the Successful Transition of People with Behavioral Health Disorders from Jail and Prison, Guideline 3, available at https://csgjusticecenter.org/wp-content/uploads/2020/02/Guidelines-for-sucessful-transition-summary.pdf.
   b. SAMHSA, Guidelines for Successful Transition of People with Mental or Substance Use Disorders from Jail and Prison: Implementation Guide, available at https://store.samhsa.gov/product/Guidelines-for-Successful-Transition-of-People-with-Mental-or-Substance-Use-Disorders-from-Jail-and-Prison-Implementation-Guide/SMA16-4998.
   c. The Assess, Plan, Identify, and Coordinate (APIC) Model, at 4 (recommending assessment and planning begin within 48 hours of booking), available at https://www.eenet.ca/sites/default/files/wp-content/uploads/2014/04/APIC-summary-addendum_March2014.pdf.
   d. Vera Institute, Bridging the Gap: Improving the Health of Justice-Involved People through Information Technology, available at https://www.vera.org/publications/bridging-the-gap-improving-the-health-of-justice-involved-people-through-information-technology.
   e. Osher, et al., A Best Practice Approach to Community Re-entry from Jails for Inmates with Co-occurring Disorders: The APIC Model, available at https://www.addictioncounselorce.com/articles/101286/apic.pdf (2002).
   f. Engaging Offenders' Families in Reentry (provides tools and examples for involving families in assessment, planning, and implementation of reentry), available at https://cepp.com/wp-content/uploads/2015/12/Engaging-Offenders-Families-in-Reentry.pdf.
   g. Vera Institute, The Front Line: Building Programs that Recognize Families' Role in Reentry, available at https://www.prisonpolicy.org/scans/vera/249_476.pdf.

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[191] Cuddelback, et al., How Many Forensic Assertive Community Treatment Teams Do We Need?, available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2712922/ (2008).

[192] Note that this rule of thumb is based on cost-effectiveness of FACT versus jail, rather than treatment effectiveness or need for assertive treatment. Therefore, it focuses only individuals with severe mental illness experiencing incarceration more than two times in a year. Once a FACT team is in place, that team should work closely with local hospitals and MCCC to identify individuals who experience combinations of hospitalization and incarceration more than two times per year, whether FACT (or ACT) services are needed for individuals with two or fewer hospitalizations/incarcerations in a year, and whether FACT (or ACT) services are needed for individuals with less severe mental illness.

h. Forensic Assertive Community Treatment (FACT): A Service Delivery Model for Individuals With Serious Mental Illness Involved With the Criminal Justice System, available at https://store.samhsa.gov/product/Forensic-Assertive-Community-Treatment-FACT-A-Service-Delivery-Model-for-Individuals-With-Serious-Mental-Illness-Involved-With-the-Criminal-Justice-System/PEP19-FACT-BR.
i. Rochester Forensic Assertive Community Treatment model, available at https://www.blueprintsprograms.org/programs/1452999999/rochester-forensic-assertive-community-treatment-r-fact/print/.
j. Bazelon Center for Mental Health Law, Building Bridges: An Act to Reduce Recidivism by Improving Access to Benefits for Individuals with Psychiatric Disabilities upon Release from Incarceration, available at http://www.pacenterofexcellence.pitt.edu/documents/BuildingBridges.pdf.

H. Intercept 5) - Community Corrections

This intercept focuses on specialized community-based criminal justice supervision with added supports for people with mental illness and SUD to prevent violations or offenses. CJI reviewed Monroe County's probation services. They are therefore beyond the scope of this Report. However, the number of bookings to MCCC for probation violations (4th largest category in 2019) suggests work could be done here to tailor probation requirements to behaviors associated with the offense at issue and to expand use of alternatives to arrest for probation violations. IU and the Monroe County Probation department joined the Reducing Revocations Challenge to better understand the drivers behind probation revocations and the report on that Challenge is expected in March, 2021.

Prior assessment of the Justice Center considered whether MCCC should build a new work-release center. Monroe County has long been without a work-release center. Other counties that have built work-release facilities have not been able to fully utilize them. While such a facility may be an alternative to building a completely new jail, it would likely do little to reduce incarceration and recidivism of individuals with mental illness/SUD. While these individuals may benefit from meaningful work preparation and experiences to the extent they must remain in jail, they are more likely to benefit from treatment, support services, and employment experiences in the community.

Appendices

A. Monroe County Preliminary Demographic Research
B. Diversion to What? Essential Community-Based Services
C. Indiana Jail Overcrowding Task Force 2019 Report
D. Bazelon Center, An Alternative to the Police: New Funding is Available for Mental Health Mobile Crisis Teams
E. Bazelon Center, New Funding is Available for Community-Based Mental Health Services

Monroe County, Indiana: Consultation on Criminal Justice Reform

Preliminary Demographic Research Document

July 2019

I. Basic Demographics:

Monroe County is home to approximately 146,000 people, nearly 92% of whom were born here.

A. Poverty:

Monroe County's income and resource profile indicate heightened levels of need as compared to other counties in Indiana. Most notably, Monroe County reported the highest poverty rate in the state as compared to other counties in Indiana[i].

- **21.6% of residents** lived below the poverty line in 2017, exceeding the state average by approximately 80% percent.
- The county median household income in the same year ranked 62nd in the state as the 50th percentile of households **earned $49,180**.
- **17.2% of children** under the age of 18 lived below the poverty line, which earned Monroe County a state ranking of 46th across all other Indiana counties:

Income and Poverty	Number	Rank in State	Percent of State	India
Per Capita Personal Income (annual) in 2017	$39,880	49	88.3%	45,1
Median Household Income in 2017	49,180	62	90.8%	$54,1
Poverty Rate in 2017	21.6%	1	162.4%	13.3
Poverty Rate among Children under 18	17.2%	46	96.6%	17.8
Welfare (TANF) Monthly Average Families in 2018	55	22	0.9%	6,0
Food Stamp Recipients in 2018	7,612	18	1.3%	605,8
Free and Reduced Fee Lunch Recipients in 2018/2019	5,300	22	1.0%	514,9

Sources: U.S. Bureau of Economic Analysis; U.S. Census Bureau; Indiana Family Social Services Administration; Indiana Department of Education

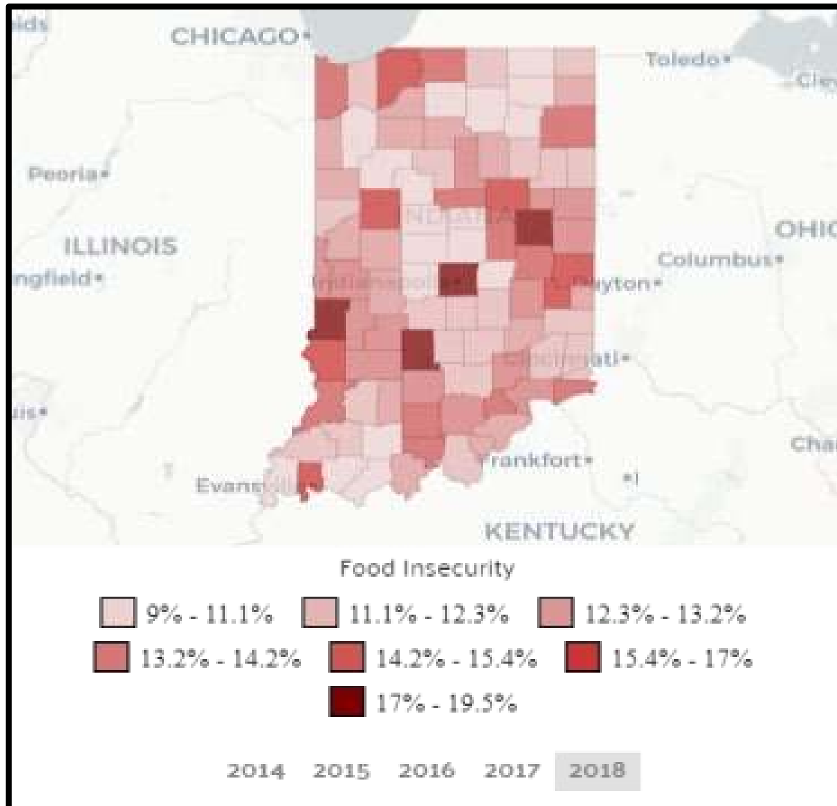
An average of 55 families per month benefitted from TANF assistance in 2018, while over 7,500 families benefitted from Food Stamp services[ii].

- Over a 10-year interval, this figure marks a decrease of approximately 80% in the number of eligible families benefitting from TANF services. Food Stamp recipients totaled 7,612 in 2018, marking a continuation of longitudinal trends across a 10-year period. Monroe County ranks 18th

in the state for Food Stamp recipients, and this 2018 metric marks a slight decline of 4.4% over this same interval.

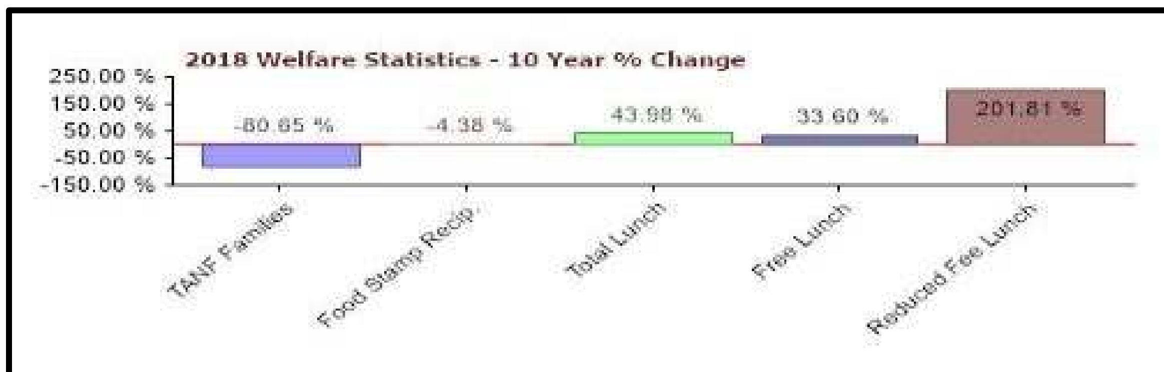
- Food Stamp benefits, therefore, report a higher level of stability as compared to TANF benefits, possibly because TANF's means-tested structure and administrative burden are discouraging eligible families from applying or continuing to receive benefits.

Monroe County reports the second-highest prevalence of food insecurity in Indiana[iii]:



In the above map, Monroe County is one of the four most darkly shaded counties. Compared to neighboring counties, its food insecurity conditions are notably worse.

- Free and reduced lunch recipients in Monroe County totaled 5,300 in 2018, ranking 22nd in the state among other counties.



- Over a ten-year interval, free lunch recipients increased by 33.6%; the population benefitting from reduced lunch services increased by over 200 percent in 2018, corroborating that food insecurity in Monroe County is a significant element of its poverty conditions[iv]

There are also significant racial strata dividing those living below the poverty line in Monroe County. In 2017, white families were far less likely than families in almost all other racial groups to live below the poverty line.[v]

- White households comprise 86.4% of the Monroe County population, while only 9.7% live below the poverty line.[vi]
- Comparatively, Black or African American households represent 3.6% of the county population, of which 48.9% live below the poverty line. This trend is present across American Indian, Asian, and Hispanic/Latino households.

B. Educational Attainment:

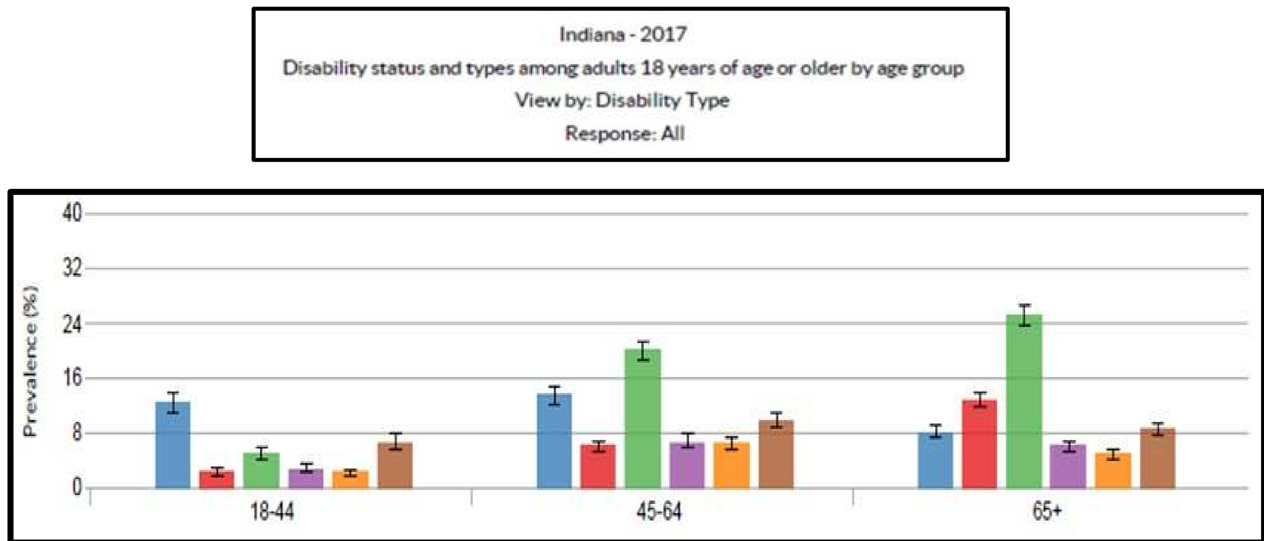
The 2015-2018 Monroe County Community Health Assessment and Improvement highlights that "Monroe County falls in the top 10th percentile of all U.S. counties regarding the high level of education of its residents, with a high school graduation rate of 94% and 77% of adults with at least some college education."[vii]

- Of the population over the age of 25, 21.8% have earned a high school diploma or equivalency;
- 6.8% hold an associate degree or partial college education, and
- 45.8% hold a bachelor's or graduate degree.
- 8.1% of the county population has not earned a high school diploma. There were 21 high school dropouts in Monroe County in 2018, marking a net change of -47.5% from 2017.[viii]
- The state of Indiana reported a net change of -8.2% in high school dropouts, indicating that Monroe County is achieving progress in that it is following statewide trends.

C. Disability Rates:

- 8.5% of those under 65 in Monroe County have a disability.[ix] Other estimates surmise that 9.7% of Monroe County Residents have a disability.[x]

- Statewide distributions of disability types:[xi]



Percentage Breakdowns (Among entire Indiana population 18 years and older):[xii]

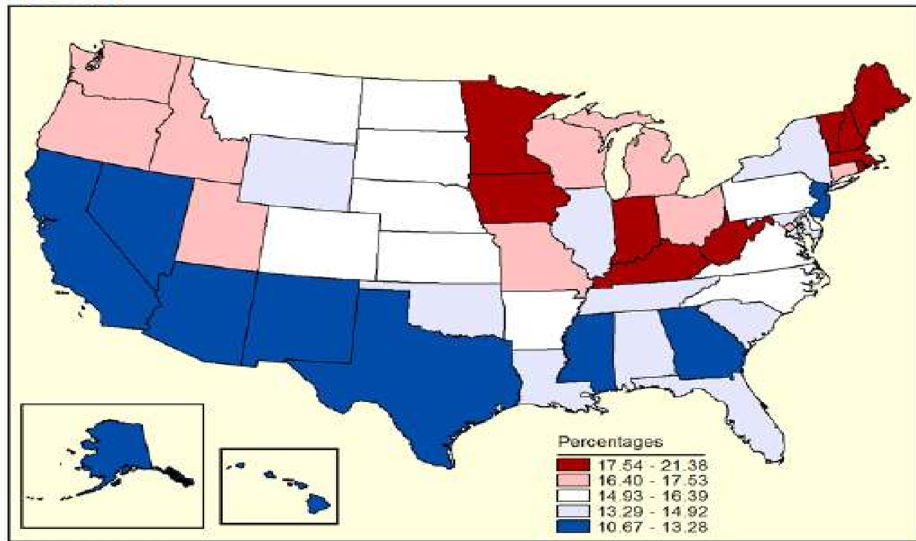
Cognitive Disability	12%
Hearing Disability	5.2%
Mobility Disability	12.9%
Vision Disability	4.5%
Self-Care Disability	3.9%
Independent Living Disability	7.9%

Note: Mental illness may be included in either Cognitive Disability or Independent Living Disability and mental illness is likely undercounted.

Mental Illness Rates:

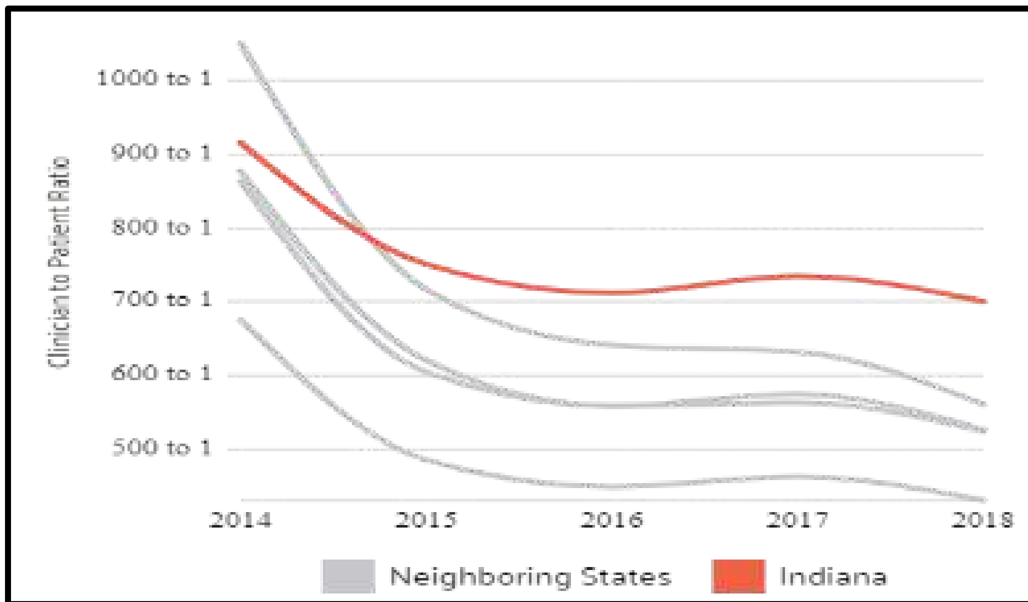
- In 2016, 7.69% of Indiana adults had a major depressive episode.[xiii] 7.69% of Monroe County's adult population is approximately 11,300 people.
- In the same year, the state reported that 4.93% of adults had a serious mental illness. 4.93% of Monroe County's adult population is approximately 7,240 people.
- 41.6% of adults in Indiana with mental illnesses report having used a mental health service (2015).[xiv]
- The United Health Foundation reported that 14.7% of adults in Indiana reported "frequent mental distress" in 2018, which ranks 42nd in the U.S. (only 8 states have a higher prevalence).[xv]
- However, national survey data show between 20 and 25% of Indiana (adult and juvenile) residents reported having a mental illness (of any kind), making it one of nine states to have the highest prevalence of this variable. 20% of Monroe County's population is about 29,300 people.
- Between 17.5% and 21% of residents in Indiana reported having received treatment for a mental illness, making it one of 11 states to report this level of prevalence.

Figure 29a ***Received Mental Health Services in the Past Year among Adults Aged 18 or Older*, by State: Percentages, Annual Averages Based on 2016 and 2017 NSDUHs**



Source: SAMHSA, Center for Behavioral Health Statistics and Quality, NSDUH, 2016 and 2017.

- Monroe County is one of three in Indiana to be designated as a Mental Health Care Health Professional Shortage Area by IU Health Bloomington Hospital.[xvi]

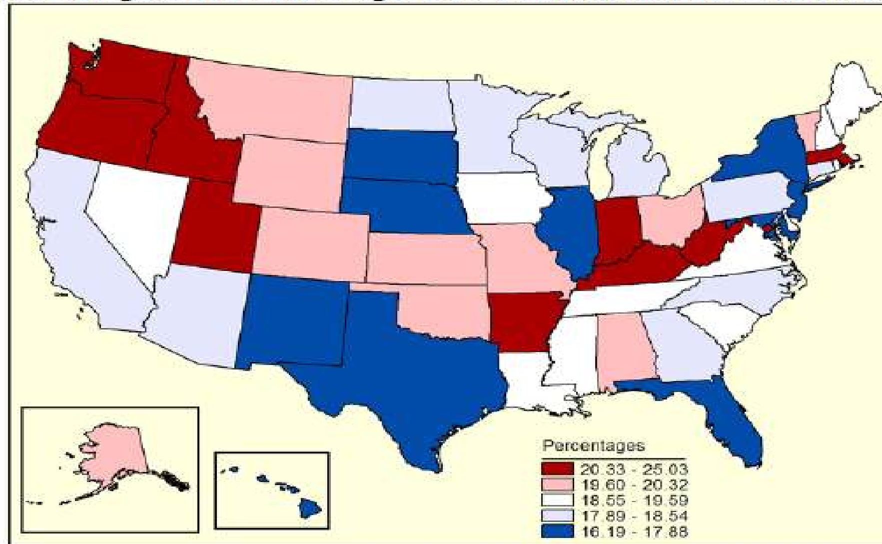


- Mental Health providers in Monroe County see an average of 444 patients per year, as of 2018.[xvii] This marks a 6.33% decrease from 2017. It reflects a continuation of the overall 4-year trend of improving patient to clinician ratios at the state level:
- *However, it is notable that the* ***shift in patient to clinician ratio has been driven as well by the ultimate decline in the total number of providers****, from 916 providers in 2014 to 701 in 2018. So*

it may be that the decline in the number of providers ***has discouraged Indiana residents from seeking help*** *for mental illness.*

- *National Survey on Drug Use and Health (2016-17)[xviii]:*

Figure 28a ***Any Mental Illness in the Past Year among Adults Aged 18 or Older,*** **by State: Percentages, Annual Averages Based on 2016 and 2017 NSDUHs**



Source: SAMHSA, Center for Behavioral Health Statistics and Quality, NSDUH, 2016 and 2017.

Substance Use Disorder Rates:

- In 2016, Indiana reported 7.12% of people age 12+ had Substance Use Disorder.[xix]
- In the same year, the state reported a Drug Overdose Death rate of 24 people per 100,000. In 2017, this number increased to 29.4 people per 100,000.[xx]
- State Opioid Overdose Death Rate: 13 deaths per 100,000. This statistic specifies opioid overdose-related deaths, as compared to all drug overdoses. **Opioids are therefore responsible for approximately half of overdose-related deaths in Indiana.**
- In Indiana as a whole, drugs were responsible for **9 out of 10 poisoning deaths in 2017**. Of this total, 90% were unintentional. **The rate for males was 1.9 times higher than that of females**, and people **ages 25-34 had the highest overdose death** rate among all ages. [xxi]

- (See map) Indiana reported that between 6.78% and 7.44% of its residents aged 12 and older were diagnosed with a substance use disorder.[xxii]

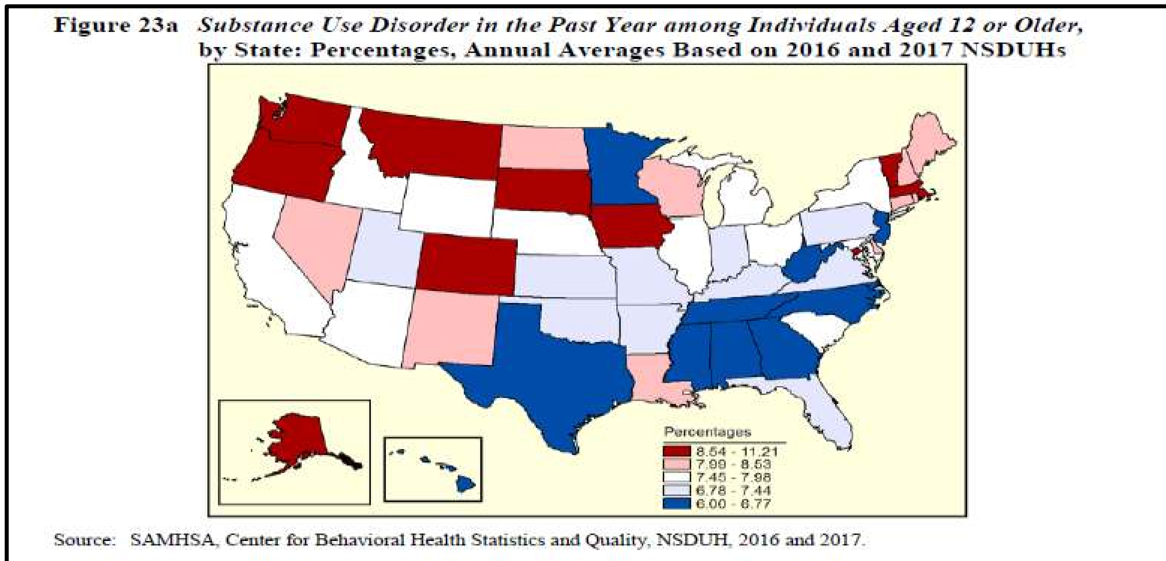


Figure 23a ***Substance Use Disorder in the Past Year among Individuals Aged 12 or Older,*** **by State: Percentages, Annual Averages Based on 2016 and 2017 NSDUHs**

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, NSDUH, 2016 and 2017.

Indiana Injury Prevention Resource Guide:

- "In January 2015, the prescription drug abuse epidemic in Indiana gained national prominence for its link to an epidemic of acute HIV infection in a rural city resulting from sharing syringes while injecting oral oxymorphone (OPANA®). As of June 2015, 169 people have been diagnosed with HIV; approximately 88% of those are coinfected with hepatitis C. The affected county, **[Scott County]**[xxiii], ranks second in the state for average age-adjusted prescription drug overdose mortality rates (33.48 for years 2002-2013)."[xxiv]
    - Scott County is in southeastern Indiana, in roughly the same region as Monroe County though they do not share a border.
- Of the 1,288 total deaths in Monroe County in 2016, 22 were reported to be drug-related.[xxv]
- There were 30 total suicide deaths in Monroe County in 2016.
- There were 78 confirmed cases of Hepatitis C (acute and chronic) in Monroe County in 2016, as well as 6 new cases of HIV.[xxvi]
- "*The* [State Epidemiological Outcome Work Group (SEOW)] *created the priority scores tool to be able to* ***measure and compare the severity of substance abuse among Indiana counties****. By looking at the severity of consumption and consequences of alcohol and other drugs (measured by the rate and the frequency of occurrence),* ***counties received a priority score based on their need for intervention****. Each category was made up of different indicators that all could be found in county level data. The overall substance abuse priority score was developed to* ***assess severity of consumption and consequences of alcohol and other drugs*** *within each county."*

- "Monroe [County] ranked in the top 25% for priority scores for methamphetamine use. According to the Indiana State Police, 35 meth labs were seized in Monroe County in 2015. The most labs, 245, were seized in Delaware County." (p.29)
    - SEOW rankings for Monroe county on the state level: Marijuana priority: 6 (tied); Cocaine/heroin: 8 (tied); Prescription Drugs: 3; Overall Substance abuse: 5. (p.30)
- Monroe County ranks 1st in the state for alcoholic beverage expenditure (p.30)
- *"Monroe County was among the top 10% of all Indiana Counties in five categories of drug/alcohol use in 2013, 2014 and 2016 and 4 categories in 2015…"*[xxvii]

Priority Ranking for Substance Abuse in Indiana								
Rank Top 10% Indiana Counties	2013 Priority #/ Score		2014 Priority #/ Score		2015 Priority #/ Score		2016 Priority #/ Score	
Alcohol	2	240	2	230	2	220	2	230
Marijuana	4	217	4	233	3 (tied)	217	6 (tied)	167
Cocaine=Heroin	7	213	7	200	in top 25%	188	8 (tied)	175
Prescription Drugs	6	200	4	213	3 (tied)	213	3*	200
Overall Substance Abuse	3	199	2	203	2	192	5	174
* four counties tied for 2nd								

fig. 17 Priority Rankings for Substance Abuse in Indiana
Indiana State Epidemiological Outcome Work Group, 2013-16

- Nationwide, **Whites and Native Americans had similar rates of alcohol use disorders and both rates were higher than those for other racial/ethnic groups**. The rate of drug use disorders was estimated to be similar for Non-Hispanic Whites, Non-Hispanic Blacks, and Native Americans and all were significantly higher than rates of drug use disorders among Asian/Pacific Islanders and Hispanics.[xxviii] In spite of similar prevalence of alcohol and drug use disorders among Whites and Blacks, incarceration rates for alcohol- and drug-related offenses are significantly higher among Blacks.

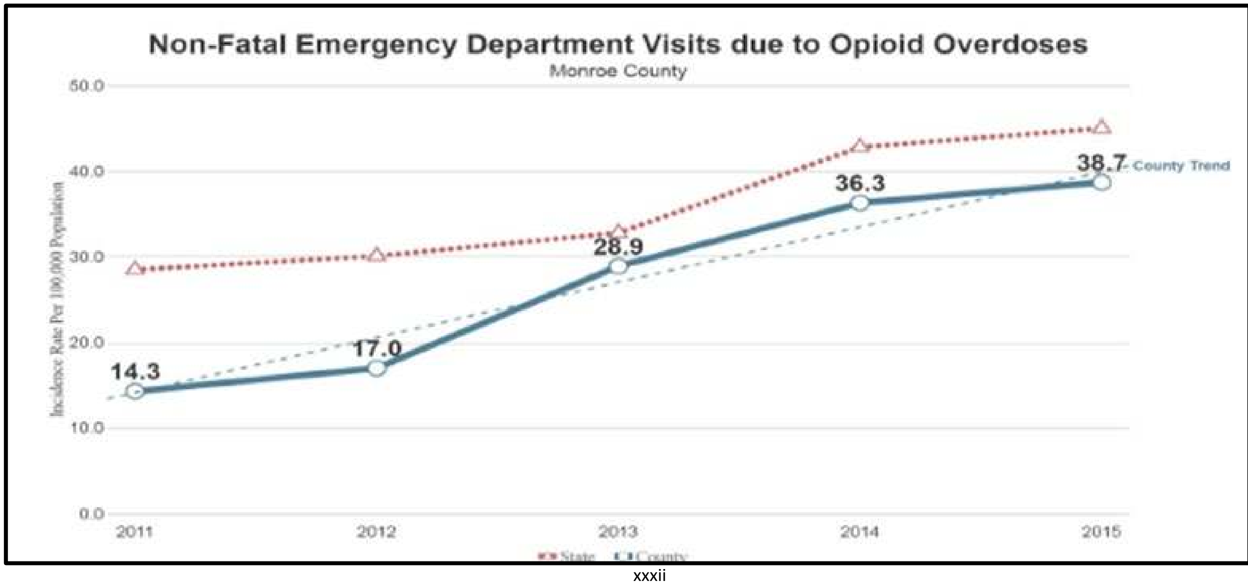
D. Homelessness Rates:

- Statewide estimate of chronically homeless individuals: 486 in the year 2017[xxix]
- Statewide homelessness resource metrics:[xxx]
    - Nighttime residence unsheltered: 249
    - Nighttime residence in shelters: 2,476
    - Nighttime residence in hotels/motels: 1,266
    - Veterans experiencing homelessness: 539
    - Persons experiencing chronic homelessness: 449

- Unaccompanied Young Adults experiencing homelessness: 268
- Total family households experiencing homelessness: 481

II. Addiction and Mental Health Services:

- In 2016, **60.5 people per 100,000** in Monroe County visited the Emergency Department for an opioid-related reason. The Indiana average is 104.5 per 100,000.[xxxi]
- In the same year, 34.4 people per 100,000 visited the ER for heroin-related reasons. The Indiana average is 70.7.



[xxxii]

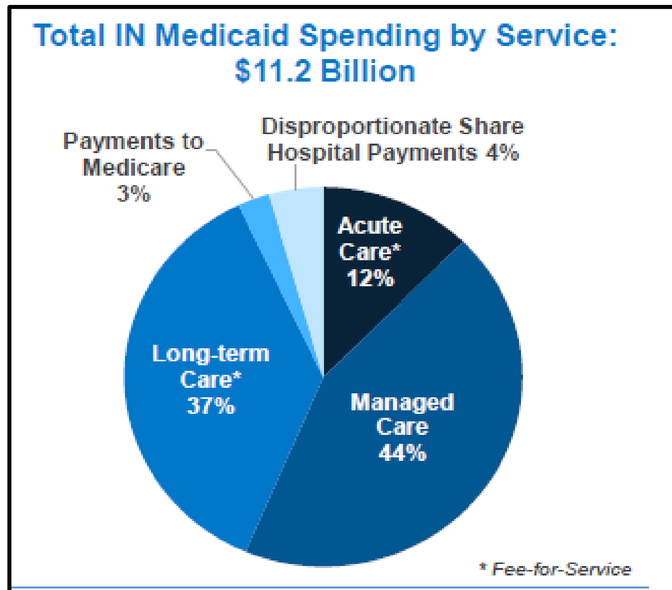
Substance abuse treatment systems in Indiana and elsewhere "have traditionally used an acute-care approach to address SUDs. The new paradigm proposed by the Substance Abuse and Mental Health Services Administration (SAMHSA) is a continuing-care model. It acknowledges the long-term nature of SUDs and emphasizes the need for ongoing access to services built around the concept of recovery. Recovery-oriented systems of care (ROSC) require agencies and providers to develop a full continuum of SUD services. This continuum of services should include … nontraditional services, such as recovery maintenance, peer services, and community-based recovery support services."[xxxiii]

A. Number of People Accessing Non-Crisis Addiction Services:

- In 2013, there were approximately 26,000 admissions to substance abuse treatment programs in the state of Indiana.[xxxiv] Most of these admissions (93.1%) were to outpatient treatment centers, with only 10.5% and 12.0% going to residential or hospital inpatient care, respectively.

B. Mental Health and Substance Abuse Capacity

State Spending and Budgets for Mental Health/Substance Abuse Services[xxxv]:



III. Monroe County Budget

A. Monroe County Budget 2017; Relevant Expenditures:[xxxvi]

- **Total Expenditures: $15.5 million**
  - Health: $1.19 million
  - Health Maintenance: $72,672
  - Public Safety LOIT: $1.17 million
  - County Offender transportation: $3,000
  - Juvenile Facility COIT: $2.58 million
  - Probation User fees, Adult: $309,313
  - Diversion User Fees: $413,382
  - Court Alcohol/Drug Services Fees: $350,848
  - County Corrections/Misdemeanant: $80,518
  - Alternative Dispute Resolution: $21,000

B. **Monroe County 2018 Budget (relevant Expenditures):**[xxxvii]

- **Total: $13.08 million**
  - Health: $1.27 million
  - Local Health maintenance: $72,672
  - User Fees, Adult Probation: $317,351
  - User Fees, Juvenile Probation: $18,883
  - County Offender transportation: $3,000
  - User Fees- Diversion Programs: $317,080
  - User Fees, Drug/Alcohol Court: $291,709
  - User Fees: Project Income/Job: $687,781
  - For Context:
    - Civic Center: $2.04 million

C. **Monroe County 2019 Adopted Budgets ():**[xxxviii]

- **Total: $16.5 million**
  - Health: $1.3 million
  - Local Health Maintenance: $72,672
  - User Fees for Adult Probation: $320,520
  - County Offender transportation: $3,000
  - Use Fees, Drug/Alcohol Court: $155,595
  - User Fees, Diversion Programs: $232,825
  - User Fees: Project Income/Job: $578,285
  - Misdemeanant/County Corrections: $117,450
  - For Context: (Same budget):
    - Home Rule for Monroe County (Public Safety): $1.89 million
    - Convention and Visitors Bureau: $2.13 million

D. **Three-Year Budget Trends:**

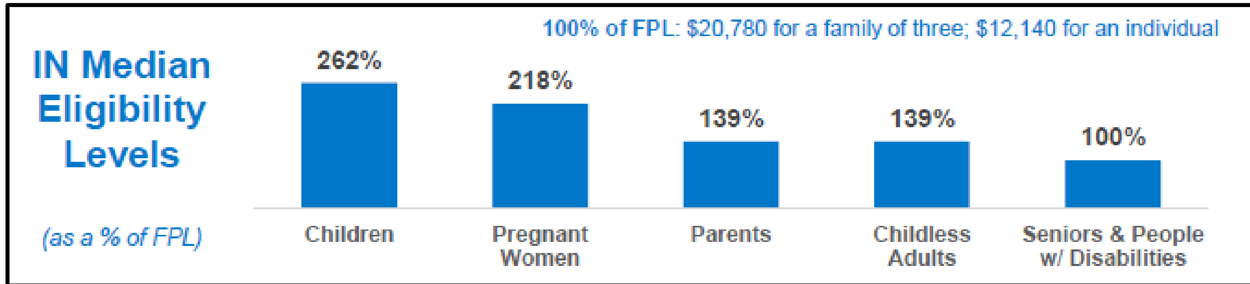
- **Health Spending** net change 2017-19: +$110,000, approximately a 10% increase from 2017 spending.
- **Public Safety** spending net change: +$720,000, approx. 62% increase from 2017 spending.

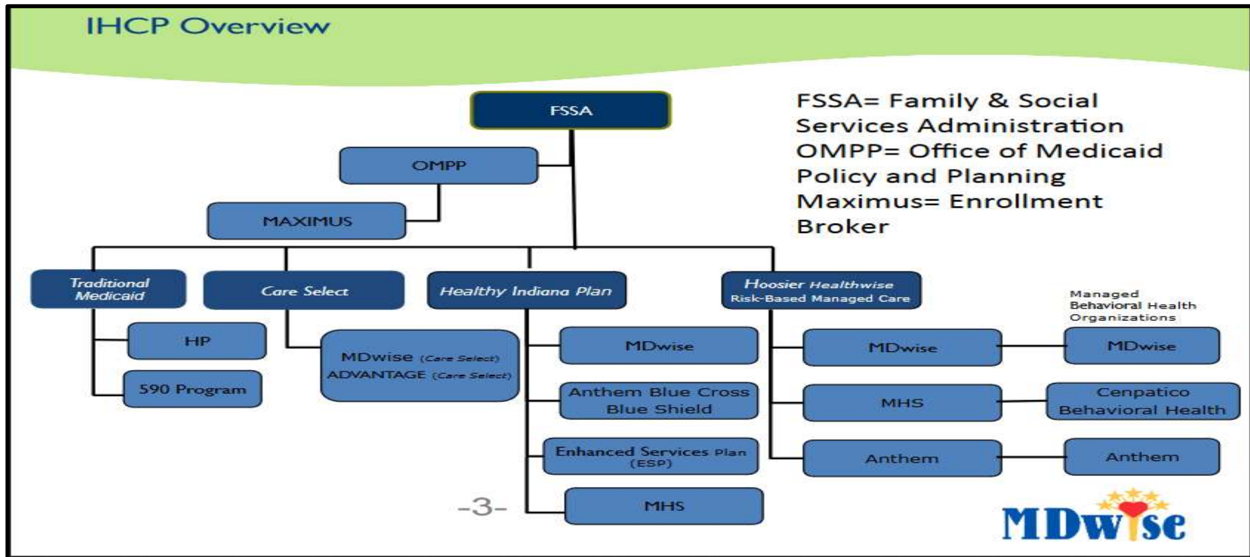
        - **Adult Probation** fees: +$11,207, approx. 4% increase from 2017 spending.
        - **Diversion Programs**: net change -$180,557, approx. 44% decrease since 2017.
        - **Drug/Alcohol Court User Fees**: net change -$195,253, approx. 55% decrease since 2017.
- **2017 Major takeaway**: The county spent more on a Juvenile facility ($2.58 million) than on Diversion Programs, Drug/Alcohol Court fees, and Probation user fees **combined ($1.07 million)**. The sum of these services is also less than Public Safety expenditures. (The Juvenile COIT fee appears to be a construction expenditure, given that it does not appear in the 2018 budget or the 2019 adopted budgets.)
- **2018 spending** shows the same trend as the year before; MC spent more on the Civic Center ($2.04 million) than those same three items (Diversion, D/A Court, and Probation fees) combined ($926,140).
- **The 2019 budget** suggests the same thing. Spending on the same three items totaled $708,940 compared to $1.89 million spent on Home Rule for Monroe County (Public Safety). This total spending for Diversion/Drug and alcohol Court fees/Probation fees marks a 34% decrease in spending in these areas since 2017.

IV. Indiana Medicaid Information

- Federal and state contribution to Medicaid in Indiana:
    - FY 2017: Federal contribution totaled 72.2%, while state contribution totaled 27.8%.[xxxix]
        - FY2020 Federal match covers 65.84% of Medicaid coverage.[xl]
- In Indiana, Medicaid covers[xli]:
    - 1 in 6 adults ages 19-64
    - 1 in 3 children
    - **3 in 7 individuals with disabilities**
    - 51% of children with special health care needs
- Number of people served (specifically the number of clients with a mental illness or substance use disorder): [xlii]
    - **5,820** individuals with disabilities received Hoosier Care Connect benefits in April 2019.[xliii]
        - **1,101** individuals in Monroe County received Hoosier Care Connect Benefits in April 2019.
    - **769** individuals categorized as “Working Disabled MEDWORKS” or “Working Disabled MEDWORKS Improved” received Hoosier Care Connect benefits in April 2019.

- Waiting List: there are 1,368 Indiana residents who qualify as having an Intellectual/Development Disability on the waiting list for Medicaid section 1915(c) Home and Community Based Services Waivers





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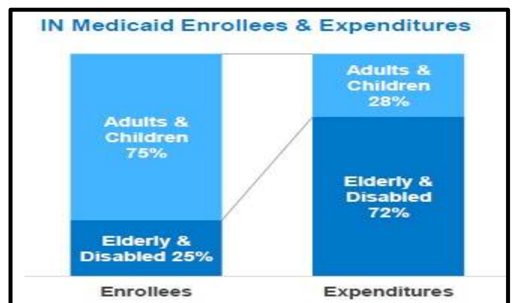
- The available programs include:
  - Traditional Medicaid
    - For disabled applicants to qualify for benefits, the individual's disability must meet the definition of the Social Security Administration.
    - Disability qualification is determined by the Medical Review Team through the applicant's medical records and may request procedures in order to collect the necessary information.
    - The Division of Family Resources "is responsible for determining initial and continuing eligibility for Medicaid disability." In order to qualify, "a person must have a significant impairment that is expected to last a minimum of 12 months. The **MRT** makes this decision and notifies the **DFR**.
      - "An individual receiving Supplemental Security Income (SSI) or Social Security Disability Income (SSDI) for his or her own disability

automatically meets the State's disability requirement without requiring a separate disability determination by MRT."[xlvii]

- Income limit for disabled individuals: $1,040 per month as compared to an Adult (family of 1) benefit which has an income limit of $1,454 per month.[xlviii]
- Home and Community Based Services (Programs and Waivers): Options are meant for individuals with special "medical or developmental needs to live in the least restrictive setting" while receiving the care they need.
    - Options include: Adult Mental Health and Habilitation, Aged and Disabled Waiver, Behavioral and Primary Healthcare Coordination, Child Mental Health Wraparound, and other waivers which provide options for family and community needs.[xlix]

- Managed Care Programs: Healthy Indiana, Hoosier Care Connect, Hoosier Healthwise.

[l]



[li]

V. Insurance Profile of Monroe County:[lii]

- 91.6% of county population has health coverage; 55% on employee plans, 10.7% on Medicaid, 9% on Medicare, 15% on non-group plans, 1.39% on military/VA plans.
- As of 2017, 8.36% of Monroe County residents are uninsured. Between 2016 and 2017, the percent of uninsured citizens declined from 9.8% to 8.36%. Medicaid enrollment appears to have increased from 2015 to 2017.
    - State Uninsured Level in 2017 for those under 64: 8%[liii]
    - National Uninsured Level in 2017 for those under 64: 10%
    - State Uninsured Level for those 19-64, 2017: **11%**[liv]

- National Uninsured Level for those 19-64, 2017: **12%**

- Per capita personal health care spending was $8,300 in 2014[lv], which matched the state average spending per capita ($8,300) and slightly exceeded the national average of $8,045.[lvi]
  - National per capita Health care spending: $10,739 in 2017.[lvii]
- Within 100 miles of Bloomington, IN there are 45,051 medical professionals that are in-network for Hoosier Care Connect plan members (elderly, blind/disabled who do not qualify for Medicaid).[lviii]

VI. Need versus Capacity Assessment

A. Need:

- Indiana ranked 41st out of 51 (all 50 states and D.C.) for Prevalence of Mental Illness, which is composed of six variables related to mental health issues.[lix]
- This ranking correlates with higher prevalence of mental health issues and substance abuse programs and suggests a significant area of need. This is especially true considering the results of the NSDUH survey which reported between 17-21% of the Indiana population as having received care.
- In the Access to Care assessment, Indiana ranked 33rd out of 51. There were nine measures used to calculate this ranking related to unmet need, insurance status, consistency of treatment, and workforce support availability.[lx]
  - This corroborates the NSDUH survey (below), which showed a significant portion of Indiana residents, almost 14% between the ages of 18 and 25, as needing care but not receiving it.

B. Capacity:

- Within Adult Evidence-Based Practices, Indiana is below the national average in providing almost every measure of care availability except for Supported Housing:[lxi]

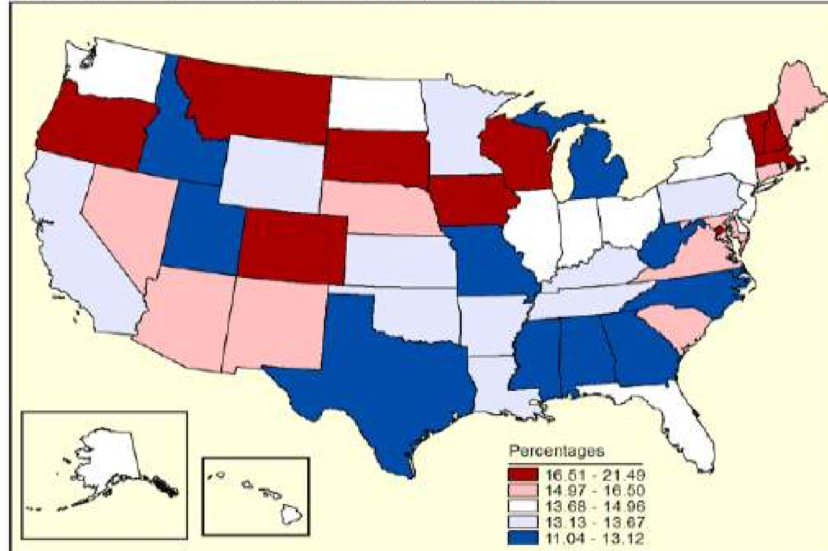
Adult Evidence-Based Practices	State Number	State Rate	U.S.	U.S. Rate
Assertive Community Treatment	879	1.1%	74,032	2.1%
Supported Housing	4,800	5.8%	89,414	3.0%
Supported Employment	1,203	1.5%	62,596	2.0%
Family Psychoeducation	-	-	35,658	2.8%
Integrated Dual Diagnosis Treatment	3,540	4.3%	237,513	11.7%
Illness Self-Management and Recovery	6,870	8.4%	318,831	20.0%
Medications Management	-	-	554,087	34.6%

- According to the same report, Indiana is behind on three Outcome measures as well:

Outcome	State Number	State Rate	U.S.	U.S. Rate
Adult Criminal Justice Contacts	1,639	2.8%	27,291	3.9%
Juvenile Justice Contacts	418	1.1%	6,885	3.1%
School Attendance (Improved)	-	-	14,973	33.4%

- 2016-17 data from the NSDUH Survey, show state-level gaps between those who needed treatment and those who got it. It is notable that these data likely underreport this population; it is also unclear if it includes those who are incarcerated.[lxii]
    - Among Indiana residents age 18-25, 13.68% needed but did not receive treatment for substance use in the past year. This indicates the possibility of an affordability or capacity issue in Indiana health care.
    - Among Indiana residents age 26 or older, the proportion of persons fitting the same description is notably smaller, only about 5.72%. Compared to the proportion of those aged 18-25, it appears that younger Indiana residents in need of treatment for substance use are generally less likely to receive treatment.
    - This is also true for those who needed but did not receive treatment for illicit drug use; 5.51% among those 18-25, 1.58% for those 26 or older.
    - Approximately 17.82% of all respondents aged 18-25 received mental health treatment.
        - **17.62%** of individuals 26 or older received mental health treatment.
        - In comparison to other items in this survey, we can note that while 17.8% of individuals in this sample received mental health treatment, approx. 13.8% of respondents also needed treatment but did not get it.
    - However**, a higher proportion of those 18-25 years old (7.85%) reported having a serious mental illness as compared to 4.72% of those 26 and older.** Residents age 18-25 were generally more likely to have a mental illness, serious or otherwise.

Figure 26c *Needing But Not Receiving Treatment at a Specialty Facility for Substance Use in the Past Year among Adults Aged 18 to 25,* **by State: Percentages, Annual Averages Based on 2016 and 2017 NSDUHs**



Source: SAMHSA, Center for Behavioral Health Statistics and Quality, NSDUH, 2016 and 2017.

INDIANA

Table 40 Selected Drug Use, Perceptions of Great Risk, Past Year Substance Use Disorder and Treatment, and Past Year Mental Health Measures in *Indiana*, by Age Group: Percentages, Annual Averages Based on 2016-2017 NSDUHs

Measure	12+	12-17	18-25	26+	18+
PAST YEAR SUBSTANCE USE DISORDER AND TREATMENT					
Illicit Drug Use Disorder[1,2,8]	2.48	2.52	6.22	1.82	2.47
Pain Reliever Use Disorder[2,8]	0.74	0.49	1.23	0.69	0.77
Alcohol Use Disorder[8]	5.24	1.58	10.69	4.75	5.63
Substance Use Disorder[1,2,8]	7.14	3.29	14.61	6.33	7.56
Needing But Not Receiving Treatment for Illicit Drug Use[1,2,9]	2.18	2.31	5.51	1.58	2.17
Needing But Not Receiving Treatment for Alcohol Use[9]	4.94	1.56	9.84	4.52	5.31
Needing But Not Receiving Treatment for Substance Use[1,2,9]	6.54	3.16	13.68	5.72	6.90
PAST YEAR MENTAL HEALTH ISSUES					
Serious Mental Illness[4,10]	--	--	7.85	4.72	5.19
Any Mental Illness[4,10]	--	--	27.45	19.75	20.90
Received Mental Health Services[11]	--	--	17.82	17.62	17.64
Had Serious Thoughts of Suicide[12]	--	--	11.05	3.99	5.04
Major Depressive Episode[4,13]	--	13.77	13.52	7.02	7.98

Conclusions

- **Basic demographics** show markers of inadequate health care, increasing prevalence of substance abuse disorders, and indicators of socioeconomic instability.
    - Monroe County had the **highest poverty rate** in the state in 2017, as well as one of the highest rates of food insecurity in the state.
    - The county ranks **among the highest in the state in terms of need for drug use intervention, as well as for prevalence of mental illness/shortage of aid scores**.
- Coverage of mental health counseling and substance use treatment are limited **below APA recommended annual quantities. Coverage in this respect is insufficient.**
    - There is a significant treatment gap for Indiana residents with respect to mental illness and substance use disorder treatment. **More than half of adults who need treatment do not get it.**

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[i] StatsIndiana, Indiana Public Utility Data. Accessed 04 June 2019. Monroe County Poverty rate in 2017: 21.6%; The state average was 13.3%. http://www.stats.indiana.edu/profiles/profiles.asp?scope_choice=a&county_changer=18105. This is corroborated by data from SAIPE, which is based in census data findings. United States Census Bureau, Small Area Income and Property Estimates. https://www.census.gov/data-tools/demo/saipe/#/?map_geoSelector=aa_c&s_county=18105.

[ii] TANF average families benefitting from services shows a decline of over 200 families across a 10-year period, reporting an average of 55 families in 2018. Food Stamp benefits reported 7,612 total beneficiaries with a slight decline of 349 families over a ten-year period. Free and reduced lunch services reported an increase in beneficiaries by 33.6% and 201.8%, respectively. Source: StatsIndiana, Indiana Public Utility Data and the United States Census Bureau. (see footnote [1]).

[iii] Data USA: Monroe, Indiana. "Health/Social Needs". Data provided by the County. Monroe County reports a 17.8% prevalence of food insecurity, which ranks second in Indiana among all counties. https://datausa.io/profile/geo/monroe-county-in/#health

[iv] STATSIndiana, Indiana Public Utility Data, "Welfare Statistics in 2018". http://www.stats.indiana.edu/dms4/new_dpage.asp?profile_id=314&output_mode=1

[v] U.S. Census Bureau sourced from American FactFinder, year 2017. https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_17_5YR_S1702&prodType=table. 9.7% of white families live below the poverty line, compared to 48.9% of Black or African American households, 20.8% of American Indian households, 32.1% of Asian households, and 8.6% of Latino or Hispanic Households. This racial disparity is increasingly stark among female-led households with no husband present: 31.8% among whites, 83.2% among Black or African American households, 0% of American Indian households, 65.3% of Asian households, and 21.3% of Latino or Hispanic households.

[vi] County racial demographics: StatsIndiana, Public Utility Data. https://www.stats.indiana.edu/profiles/profiles.asp?scope_choice=a&county_changer=18105&button1=Get+Profile&id=2&page_path=Area+Profiles&path_id=11&menu_level=smenu1&panel_number=1

[vii] Monroe County Community Health Assessment and Improvement Plan, 2017. Monroe County Health Department. https://www.co.monroe.in.us/egov/documents/1532305275_35693.pdf Corroborated by StatsIndiana and U.S. Census Bureau Data (2016 and 2017). http://www.stats.indiana.edu/dms4/new_dpage.asp?profile_id=302&output_mode=1

[viii]StatsIndiana, Public Utility Data. There were 21 high school dropouts in Monroe County in 2018, marking a -47.5% over-the-year change from 40 dropouts in 2017. http://www.stats.indiana.edu/dms4/new_dpage.asp?profile_id=326&output_mode=1

[ix] United States Census Bureau. “Quickfacts; Monroe County, Indiana”. 2013-2017. https://www.census.gov/quickfacts/fact/table/monroecountyindiana#

[x] “U.S. Disability Statistics by State, County and Age”, Disabled World, 2015, https://www.disabled-world.com/disability/statistics/scc.php#county

[xi] “Disability and Health Data System”, Centers for Disease Control and Prevention. https://www.cdc.gov/ncbddd/disabilityandhealth/dhds/data-guide/status-and-types.html

[xii] “Disability and Data Health System”, Centers for Disease Control and Prevention. https://dhds.cdc.gov/SP?LocationId=18&CategoryId=DISEST&ShowFootnotes=true&showMode=&IndicatorIds=STATTYPE,AGEIND,SEXIND,RACEIND,VETIND&pnl0=Chart,false,YR2,CAT1,BO1,,,,AGEADJPREV&pnl1=Chart,false,YR2,DISTYPE,,,,,PREV&pnl2=Chart,false,YR2,DISSTAT,,,,,AGEADJPREV&pnl3=Chart,false,YR2,DISSTAT,,,,,AGEADJPREV&pnl4=Chart,false,YR2,DISSTAT,,,,,AGEADJPREV

[xiii] Data USA: Monroe County, Indiana. “Behavioral Health Conditions”, 2016. https://datausa.io/profile/geo/monroe-county-in/#health

[xiv] Data U.S.A.: Monroe County, Indiana. “Health/Access and Quality.” https://datausa.io/profile/geo/monroe-county-in/#health

[xv] “Indiana Summary 2018” America’s Health Rankings, United Health Foundation 2018. https://www.americashealthrankings.org/explore/annual/measure/PH_funding/state/IN

[xvi] “Community Health Needs Assessment”, Indiana University Bloomington Hospital, 26 November 2019. https://cdn.iuhealth.org/resources/Bloomington-Hospital-CHNA_2018-compressed.pdf?mtime=20181219131956

[xvii] Data U.S.A.: Monroe County, Indiana. “Health/Patient to Clinician Ratios.” https://datausa.io/profile/geo/monroe-county-in/#health

[xviii] “2016-2017 National Survey on Drug Use and Health National Maps of Prevalence Estimates, by State”, Substance Abuse and Mental Health Services Administration 2018. See annual reports for more State and Sub-state level data. https://www.samhsa.gov/data/data-we-collect/nsduh-national-survey-drug-use-and-health

[xix] Data USA: Monroe County, Indiana. “Health/Behavioral Health Conditions”, 2016. https://datausa.io/profile/geo/monroe-county-in/#health

[xx] “Drug Overdose Death Rates in Indiana and the United States 2013-2017”, Indiana State Department of Health, last updated 20 December 2018. https://www.in.gov/isdh/27392.htm

[xxi] Indiana Special Emphasis Report: Drug Overdose Deaths”, State of Indiana Health Department, 2017. https://www.in.gov/isdh/files/2017%20SER.pdf

[xxii] “2016-2017 National Survey on Drug Use and Health National Maps of Prevalence Estimates, by State”, Substance Abuse and Mental Health Services Administration 2018. See annual reports for more State and Sub-state level data. https://www.samhsa.gov/data/data-we-collect/nsduh-national-survey-drug-use-and-health

[xxiii] “HIV Infection Linked to Injection Use of Oxymorphone in Indiana,” National Center for Biotechnology Information, National Institute of Health, 21 July 2016. https://www.ncbi.nlm.nih.gov/pubmed/27468059

[xxiv] Shultz, J. Indiana State Department of Health Resource Guide, “Indiana Injury Prevention Resource Guide”, 2015. https://www.in.gov/isdh/files/Preventing_Injuries_in_Indiana.pdf

[xxv] Monroe County Health Department. “Monroe County Community Health Assessment and Improvement Plan”, 2015-2018. https://www.co.monroe.in.us/egov/documents/1532305275_35693.pdf

[xxvi] Monroe County Health Department. “Monroe County Community Health Assessment and Improvement Plan”, 2015-2018. https://www.co.monroe.in.us/egov/documents/1532305275_35693.pdf

[xxvii] Monroe County Health Department. "Monroe County Community Health Assessment and Improvement Plan", 2015-2018. https://www.co.monroe.in.us/egov/documents/1532305275_35693.pdf

[xxviii] "Treatment and Recovery for Substance Use Disorders in Indiana," Center for Health Policy, October 2016. Indiana University. https://www.in.gov/bitterpill/files/Treatment%20and%20Recovery%20Report.pdf

[xxix] Data U.S.A.: Monroe County, Indiana. "Health/Social Needs." https://datausa.io/profile/geo/monroe-county-in/#health

[xxx]United States Interagency Council on Homelessness. "Indiana Homelessness Statistics," January 2018. https://www.usich.gov/homelessness-statistics/in/

[xxxi] "Overdose Response Monroe County", Indiana State Department of Health 2019. https://www.in.gov/isdh/27876.htm

[xxxii] "County Profiles of Opioid Use and Related Outcomes", Indiana State Department of Health 2017. https://www.in.gov/fssa/

[xxxiii] Id.

[xxxiv] "Treatment and Recovery for Substance Use Disorders in Indiana", Center for Health Policy, October 2016. Indiana University. https://www.in.gov/bitterpill/files/Treatment%20and%20Recovery%20Report.pdf

[xxxv] [xxxv] Henry J. Kaiser Family Foundation, "Medicaid in Indiana", November 2018. http://files.kff.org/attachment/fact-sheet-medicaid-state-IN

[xxxvi] "Monroe County 2017 Budget", Monroe County Government, generated 30 November 2017. https://www.co.monroe.in.us/egov/documents/1530641464_85123.pdf

[xxxvii] "Monroe County 2018 Budget," Indiana State Government 2019. https://www.co.monroe.in.us/egov/documents/1530640030_65364.pdf

[xxxviii] "Monroe County Adopted Budget 2019", Indiana State Government 2019. https://www.co.monroe.in.us/egov/documents/1542129035_96913.pdf

[xxxix] "Federal and State Share of Medicaid Spending," Kaiser Family Foundation 2019. https://www.kff.org/medicaid/state-indicator/federalstate-share-of-spending/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[xl] "Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier" Kaiser Family Foundation 2019. https://www.kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/?currentTimeframe=0&selectedRows=%7B%22states%22:%7B%22indiana%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[xli] Henry J. Kaiser Family Foundation, "Medicaid in Indiana", November 2018. http://files.kff.org/attachment/fact-sheet-medicaid-state-IN

[xlii] "Medicaid Monthly Enrollment Reports", Indiana State Government, Family and Social Services Administration 2019. https://www.in.gov/fssa/ompp/4881.htm

[xliii] "Hoosier Care Connect is a health care program for individuals who are aged 65 years or older, blind, or disabled and who are also not eligible for Medicare." Indiana State Government, Family and Social Services Administration, 2019. https://www.in.gov/medicaid/members/26.htm

[xliv] "Waiting List for Medicaid section 1915(c) Home and Community Based Services Waivers", Kaiser Family Foundation 2017. https://www.kff.org/health-reform/state-indicator/waiting-lists-for-hcbs-waivers/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[xlv] Henry J. Kaiser Family Foundation, "Medicaid in Indiana", November 2018. http://files.kff.org/attachment/fact-sheet-medicaid-state-IN

[xlvi] "MDWise 101: ICHP Overview", MDWise 2013 Annual ICHP Seminar. https://www.mdwise.org/MediaLibraries/MDwise/Files/For%20Providers/Continuing%20Education/MDwise_101.pdf

[xlvii] "Member Eligibility and Benefit Coverage", Indiana Health Coverage Programs, Indiana Family and Social Services Administration 2018, p.52. https://www.in.gov/medicaid/providers/630.htm

[xlviii] "Medicaid Eligibility Factors", Indiana State Government, 2019. https://www.in.gov/medicaid/members/59.htm

[xlix] "Medicaid Eligibility Factors", Indiana State Government, 2019. https://www.in.gov/medicaid/members/59.htm

[l] Henry J. Kaiser Family Foundation, "Medicaid in Indiana", November 2018. http://files.kff.org/attachment/fact-sheet-medicaid-state-IN

[li] Henry J. Kaiser Family Foundation, "Medicaid in Indiana", November 2018. http://files.kff.org/attachment/fact-sheet-medicaid-state-IN

[lii] Data U.S.A: Monroe County, Indiana. "Health", 2018. https://datausa.io/profile/geo/monroe-county-in/#health

[liii] "Health Insurance Coverage of Nonelderly 0-64" Kaiser Family Foundation 2017. https://www.kff.org/other/state-indicator/nonelderly-0-64/?currentTimeframe=0&selectedRows=%7B%22wrapups%22:%7B%22united-states%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[liv] "Health Insurance Coverage of Adults 19-64" Kaiser Family Foundation 2017. https://www.kff.org/other/state-indicator/adults-19-64/?currentTimeframe=0&selectedRows=%7B%22wrapups%22:%7B%22united-states%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[lv] Data U.S.A: Monroe County, Indiana. "Health", 2018. https://datausa.io/profile/geo/monroe-county-in/#health

[lvi] "Health Care Expenditures per capita by State of Residence", Henry J. Kaiser Family Foundation 2014. https://www.kff.org/other/state-indicator/health-spending-per-capita/

[lvii] "National Health Expenditures 2017 Highlights", Centers for Medicare and Medicaid Services 2017. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/downloads/highlights.pdf

[lviii] "Provider Directory", Indiana State Government Indiana Medicaid for Members 2019. https://www.in.gov/medicaid/members/114.htm

[lix] "Prevalence of Mental Illness", Mental Health America 2019. http://www.mentalhealthamerica.net/issues/ranking-states. *Mental Health Prevalence* was calculated using the following variables: Adults with Any Mental Illness, Adults with Substance Abuse disorders in the Past Year, Adults with Serious Thoughts of Suicide, Youth with at least one Major Depressive Episode in the Past Year, Youth with Substance use disorder in the Past Year, and Youth with Severe MDE.

[lx] (see [90]) *Access to Care* was calculated using the following variables: Adults with AMI who did not Receive Treatment, Adults with AMI reporting unmet need, Adults with AMI who are uninsured, Adults with Disability Who Could Not See a Doctor due to Costs, Youth with MDE who did not receive MH services, Youth with Severe MDE who received Consistent Treatment, Children with Private Insurance that did Not Cover Mental or Emotional Problems, Students identified with Emotional Disturbance for an Individualized Education Program, and Mental Health Workforce Availability.

[lxi] "Indiana 2017 Mental Health National Outcome Measures (NOMS): SAMSHA Uniform Reporting System, SAMSHA 2017. https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/Indiana-2017.pdf

[lxii] "2016-2017 National Survey on Drug Use and Health National Maps of Prevalence Estimates, by State," Substance Abuse and Mental Health Services Administration 2018. Accessed 06 June 2019. See annual reports for more State and Sub-state level data. https://www.samhsa.gov/data/data-we-collect/nsduh-national-survey-drug-use-and-health

JUDGE DAVID L. BAZELON CENTER FOR MENTAL HEALTH LAW

INCLUSIVITY STRATEGIC CONSULTING

DIVERSION TO *WHAT*?

ESSENTIAL COMMUNITY-BASED SERVICES

Many criminal justice systems are exploring ways to divert people with mental health disabilities and substance use disorders from their jails and courts to reduce overcrowding of jails and prisons, to avoid the damaging consequences of criminal justice involvement on communities, and to address root causes of criminal behavior and recidivism. These efforts often face the question, "Diversion to what?"

Investing in community-based mental health and addiction treatment services provides numerous benefits, including reductions in law enforcement intervention and incarceration and reductions in recidivism. These services also promote the integration of people with disabilities into their communities, allowing them to have opportunities to work, a place to call home, and support throughout the day.

This paper describes essential and effective community services that should be part of every community's mental health and addiction system. It also describes the evidence that these services decrease the incarceration and institutionalization of individuals with mental health and substance use disabilities. When communities provide these services in sufficient amounts and ensure that there is ongoing coordination between the criminal and treatment systems, they will dramatically reduce the damaging and costly cycling of people with disabilities in and out of jails, emergency rooms, hospitals, and shelters.

The effectiveness of investment in community-based services can be significantly leveraged by implementing collaborative case planning and case management services involving criminal justice, behavioral health, and social service agencies working together with the individual to identify priority needs and available services to address those needs, develop a plan, and confer regularly during plan implementation.[1] In addition, for those in custody, facilitating in-reach from community-based treatment staff before re-entry can ensure immediate access to treatment and avoid many recidivism risks.

[1] Council of State Governments Justice Initiative, Addressing Criminogenic Risk and Behavioral Health Needs, https://csgjusticecenter.org/nrrc/collaborative-comprehensive-case-plans/.

JUDGE DAVID L. BAZELON CENTER FOR MENTAL HEALTH LAW

INCLUSIVITY STRATEGIC CONSULTING

Evidence-Based Mental Health Services That Prevent Unnecessary Incarceration

Assertive Community Treatment (ACT)

What is ACT?

- ACT is an individualized package of services and supports effective in meeting the day-to-day needs of people with serious mental illness and substance use disorders living in the community. ACT is designed to meet the needs of individuals with the most significant conditions and greatest needs.
- ACT teams help people with serious mental illness navigate the day-to-day demands of community living, including staying in treatment, maintaining stable housing, securing and maintaining employment, and engaging in community activities. It helps individuals build skills, manage their illness, and recover.
- An ACT team is composed of a multi-disciplinary group of professionals, including a psychiatrist, a nurse, an employment specialist, a housing specialist, a substance use disorder specialist, a peer support specialist, and often a housing specialist and a social worker. As needed, the team may include a physical therapist or an occupational therapist. Among the services ACT teams provide are case management, assessments, psychiatric services, substance use disorder services, housing assistance, and supported employment.
- The team is on call 24 hours a day to address the individual's needs and any crises that may arise.

ACT helps prevent unnecessary incarceration.

- ACT has proven extremely effective in reducing criminal involvement and hospitalization for individuals with mental health disabilities. For example:
  - A 2017 study examining forensic ACT (FACT), which is specifically designed to serve people involved with the criminal justice system, found that participants receiving FACT over the course of a year spent significantly fewer days in jail than similar participants not receiving FACT (21.5 vs 43.5) and were less likely to incur new convictions.[2]
  - An Illinois study found an 83% decrease in jail days over the course of a year for participants in Thresholds' Jail Linkage ACT program, which reduced jail costs by $157,000.[3] That same community also saw an 85% reduction in the number of inpatient hospital days, which reduced hospital costs by $917,000 that year.[4]
  - A California study found that over 12 months, jail bookings for individuals enrolled in

[2] J. Steven Lamberti et al., *Forensic Assertive Community Treatment: Preventing Incarceration of Adults with Severe Mental Illness*, 55 PSYCHIATRIC SERVICES 11, 1285–93, 1289 (2004).
[3] *Helping Mentally Ill People Break the Cycle of Jail and Homelessness: The Thresholds, State, County Collaborative Jail Linkage Project, Chicago*, 52 PSYCHIATRIC SERVICES 1380 (2001).
[4] *Id.*

ACT were 36% lower than those for similarly situated individuals not enrolled in ACT, and the group not enrolled in ACT spent 48% more days in jail.[5]
- A New York study found that over the course of one year, individuals enrolled in ACT had fewer arrests and spent approximately half the number of days in jail as individuals in a control group receiving enhanced "treatment as usual."[6]
- Individuals who received ACT for the first time in Oklahoma in 2007 spent 65% fewer days in jail and 71% fewer days in inpatient hospitals than they had during the prior year.[7]

Learn more:

- SAMHSA Evidence-Based Practices KIT, *Assertive Community Treatment* (2008)
- SAMHSA Evidence-Based Practices KIT, *The Evidence: Assertive Community Treatment* (2008)
- Case Western Reserve Center for Evidence-Based Practices, *Assertive Community Treatment*
- University of Rochester Medical Center, *Keeping Mentally Ill Out of Jail and in Treatment: Rochester Model Works in Breakthrough Study* (June 1, 2017)

Supported Housing

What is Supported Housing?

- Supported housing is a comprehensive set of services including a housing subsidy and social support for being a successful tenant. It allows people with serious mental illness to live in their own apartments and homes within their community. Tenancy rights should not be conditioned on participation in treatment or compliance with any other criteria.
- In addition to a housing subsidy and help with securing and maintaining housing of a person's choice, individuals in supported housing have access to a flexible and comprehensive package of services designed to address each person's individual needs. These services may include case management, independent living skills training, medication management, substance use disorder treatment, help securing and maintaining employment, help maintaining housing, and home health aide services. Supported housing recipients can also receive ACT, mobile crisis, or other team-based services if they need them.
- Supported housing units are typically scattered in buildings throughout the community—a practice that promotes greater integration than housing in developments exclusively or primarily

[5] Karen J. Cusack et al., *Criminal Justice Involvement, Behavioral Health Service Use, and Costs of Forensic Assertive Community Treatment: A Randomized Trial*, 46 COMMUNITY MENTAL HEALTH JOURNAL 356 (2010).
[6] J. Steven Lamberti et al., *A Randomized Controlled Trial of the Rochester Forensic Assertive Community Treatment Model*, 68 PSYCHIATRIC SERVICES 1016 (2017).
[7] Oklahoma Department of Mental Health and Substance Abuse Services, *Program of Assertive Community Treatment (PACT), One Year Pre- and Post Admission Comparison* (last modified June 16, 2010), https://www.ok.gov/odmhsas/documents/one%20year%20pre%20and%20post%20admission%20comparison.pdf.

designated for individuals with disabilities.[8]

Supported Housing helps prevent unnecessary incarceration.

- Supported housing "leads to more housing stability, improvement in mental health symptoms, reduced hospitalization and increased satisfaction with quality of life, including for participants with significant impairments, when compared to other types of housing for people with mental illnesses."[9]
- Supported housing reduces rates of incarceration. A large study in New York City of homeless individuals with serious mental illness receiving supported housing demonstrated that these individuals experienced significant reductions in shelter use, hospitalizations, duration of hospital stays, and incarceration.[10]
- A Philadelphia pilot involving Pathways to Housing, which provides supported housing to formerly homeless individuals with serious mental illness and substance use disorders, found that participants' incarceration rates fell by 50 percent.[11]
- An Ohio study found that individuals in supported housing who had been incarcerated were 40% less likely to be re-arrested and 61% less likely to be re-incarcerated.[12]

Learn more:

- Bazelon Center, *A Place of My Own* (2014)
- Bazelon Center, *Supported Housing: The Most Effective and Integrated Housing for People with Mental Disabilities*
- National Council on Disability, *Home and Community-Based Services: Creating Systems for Success at Home, at Work and in the Community, Appendix A, Supported Housing for People*

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[8] *See* Substance Abuse and Mental Health Service Administration, *Permanent Supportive Housing Evidence-Based Practices (EBP) KIT* (2010), https://store.samhsa.gov/system/files/sma10-4510-02-howtouseebpkits-psh.pdf; Press Release, Department of Justice, Justice Department Obtains Comprehensive Agreement to Ensure New York City Adult Home Residents with Mental Illness Are Afforded Opportunities to Live in the Community (July 23, 2013), http://www.justice.gov/opa/pr/2013/July/13-crt-830.html; Settlement Agreement, *United States v. North Carolina*, No. 5:12-cv-00557-F (E.D.N.C. Aug. 23, 2012), https://www.ada.gov/olmstead/documents/nc-settlement-olmstead.pdf.

[9] Bazelon Center for Mental Health Law, *A Place of My Own: How the ADA Is Creating Integrated Housing Opportunities for People with Mental Illnesses* 6 (2014), http://www.bazelon.org/wp-content/uploads/2017/01/A-Place-of-my-Own.pdf.

[10] Dennis P. Culhane et al., *The Impact of Supportive Housing for Homeless People with Severe Mental Illness on the Utilization of the Public Health, Corrections, and Emergency Shelter Systems: The New York, New York Initiative*, HOUSING POLICY DEBATE 13.1, at 137–38 (2002).

[11] Fairmount Ventures Inc., *Evaluation of Pathways to Housing PA* 3 (2011), https://centercityphila.org/uploads/attachments/cit0g2r8x0029f6qdpgp9b8ja-pathways-to-housing.pdf.

[12] Matthew Makarios et al., *Examining the Predictors of Recidivism Among Men and Women Released from Prison in Ohio*, CRIMINAL JUSTICE AND BEHAVIOR 37:12 (2010); Jocelyn Fontaine et al., Urban Institute, *Supportive Housing for Returning Prisoners: Outcomes and Impacts of the Returning Home-Ohio Pilot Project* (Aug. 2012), https://www.urban.org/sites/default/files/publication/25716/412632-Supportive-Housing-for-Returning-Prisoners-Outcomes-and-Impacts-of-the-Returning-Home-Ohio-Pilot-Project.PDF.

with Psychiatric Disabilities (2015)
- National Council on Disability, *Inclusive Liveable Communities for People with Psychiatric Disabilities* (2008)
- Anne O'Hara, *Housing for People with Mental Illness: Update to a Report to the President's New Freedom Commission* (July 1, 2007)
- Deborah K. Padgett et al., *Housing First Services for People Who are Homeless with Co-occurring Serious Mental Illness and Substance Abuse* (2006)

Mobile Crisis Services

What are Mobile Crisis Services?

- Mobile crisis services are typically provided by teams of mental health professionals trained to de-escalate individuals in mental health crises. Mobile crisis teams should include at least one peer specialist and one on-call psychiatrist.
- In some communities, these teams make arrangements with police departments or dispatchers to respond to particular emergency situations. In others, these teams are hired by police departments to assist law enforcement officers or include both police and mental health professionals.[13]
- Mobile crisis teams respond as quickly as possible to individuals in crisis, assess them, and utilize a variety of techniques to de-escalate the situation.
- By providing timely intervention directly to a person in crisis, teams can help divert individuals from hospitalization or arrest and incarceration.
- Teams should be available 24 hours per day, 7 days per week to respond to individuals needing crisis services. The team should provide services until the crisis subsides and up to a week following the onset of the crisis if needed to connect the individual with ongoing services.
- Mobile crisis teams should have access to community crisis apartments where individuals can stay for a short period as an alternative to hospitalization, incarceration, or stays in costly and hospital-like crisis facilities. Crisis apartments should be operated with sufficient clinical support and peer staffing.

Mobile Crisis Services help prevent unnecessary incarceration.

- Mobile crisis teams prevent needless incarceration because they can resolve emergency situations involving individuals with mental disabilities without intervention by law enforcement. Mobile crisis teams have been shown to be effective in diverting individuals from the criminal justice system.[14]

[13] H. Richard Lamb et al., *The Police and Mental Health*, 53 PSYCHIATRIC SERVICES 1266, 1268 (2002), https://ps.psychiatryonline.org/doi/pdf/10.1176/appi.ps.53.10.1266.
[14] *Id*.

- Studies have found that mobile crisis teams resulted in arrest rates ranging from 2% to 13% of clients, with an average of less than 7%, in contrast to an arrest rate of 21% for typical contacts between police officers and individuals with psychiatric disabilities.[15]
- A new mobile crisis team in Verde Valley, Arizona, stabilized crises in the community in 55% of the calls it received from first responders. Without the intervention of the mobile crisis team, 90 of the 109 calls received would have resulted in arrest or an emergency department visit.[16]
- Mobile crisis services also decrease hospitalization rates. One study found that mobile crisis team intervention led to an 8% decrease in hospital admissions and that people hospitalized as a result of a crisis were 51% more likely to be hospitalized within 30 days of the crisis than those who used mobile crisis services.[17]
- In DeKalb County, Georgia, mobile crisis services were found to have prevented hospitalization 55% of the time compared to only 28% for regular police intervention.[18]
- Both consumers and law enforcement prefer mobile crisis teams to police involvement and find them to be more effective.[19]

Learn more:

- SAMHSA, *Crisis Services: Effectiveness, Cost-Effectiveness, and Funding Strategies* (2014)
- Eddy D. Broadway and David W. Covington, National Association of State Mental Health Program Directors, *A Comprehensive Crisis System: Ending Unnecessary Emergency Room Admissions and Jail Bookings Associated with Mental Illness* (Aug. 2018)
- Jeffrey J. Vanderploeg et al., Children and Youth Services Review, *Mobile crisis services for children and families: Advancing a community-based model in Connecticut* (Dec. 2016)

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[15] *Id.*
[16] Cheri Frost, *Spectrum Healthcare's Mobile Crisis Team Partnership Program*, Verde Independent (Sept. 12, 2016), https://www.crisisnetwork.org/wp-content/uploads/2016/09/The-Verde-Independent-_-Spectrums-MobileTeam-Partnership.pdf.
[17] Shenyang Guo et al., *Assessing the Impact of Community-Based Mobile Crisis Services on Preventing Hospitalization*, 52 PSYCHIATRIC SERVICES 2, 223–28 (2001).
[18] Roger Scott, *Evaluation of a Mobile Crisis Program: Effectiveness, Efficiency, and Consumer Satisfaction*, 51 PSYCHIATRIC SERVICES 9, 1153–56 (2000).
[19] *Id.*

Supported Employment

What is Supported Employment?

- Supported employment is a package of services and supports aimed at helping people with serious mental illness get and keep a job in the mainstream workforce. Supports are not time limited and are focused on the individual's vocational goals and preferences.
- Employment is widely viewed as an essential part of mental health recovery.
- Individual Placement and Support (IPS) is the most successful model of supported employment for individuals with serious mental illness.[20] IPS has a proven track record of helping individuals with serious mental illness secure employment and of ensuring that employment is sustained over a period of time.[21]
- IPS uses a rapid job search approach to help individuals obtain jobs rather than focusing on lengthy assessments, training, and counseling. Individuals are not excluded from IPS on the basis of readiness, diagnoses, symptoms, substance use history, psychiatric hospitalizations, homelessness, level of disability, or involvement with the criminal justice system.[22]

Supported Employment helps prevent unnecessary incarceration.

- Supported employment prevents needless institutionalization and incarceration by promoting mental health recovery and keeping people with mental health disabilities successfully employed in their communities.
- IPS has consistently impressive outcomes in employment for people with mental illness,[23] with some studies showing 60% of individuals receiving IPS becoming employed, compared to 23% for traditional vocational services, and high employment rates 10 years after receiving IPS services.[24]

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[20] IPS Employment Center, *What is IPS?*, https://ipsworks.org/index.php/what-is-ips/.

[21] *See* Bazelon Center for Mental Health Law, *Getting to Work: Promoting Employment of People with Mental Illness* 5–6 (2014), http://www.bazelon.org/wp-content/uploads/2017/01/Getting-to-Work.pdf (citing Gary R. Bond et al., *An Update on Randomized Controlled Trials of Evidence-Based Supported Employment*, 31 PSYCHIATRIC REHABILITATION JOURNAL 280, 284 (2008), and Michelle P. Salyers et al., *A Ten-Year Follow-Up of a Supported Employment Program*, 55 PSYCHIATRIC SERVICES 302, 305 (2004)); *see also* David Salkever, U.S. Department of Health and Human Services, Assistant Secretary for Planning and Evaluation Office of Disability, Aging, and Long-Term Care Policy, *Toward a Social Cost-Effectiveness of Programs to Expand Supported Employment Services: An Interpretive Review of the Literature* (2010), http://aspe.hhs.gov/daltcp/reports/2010/supempLR.pdf.

[22] IPS Employment Center, *What is IPS?*, https://ipsworks.org/index.php/what-is-ips/.

[23] David Salkever, Westat, *Toward a Social Cost-Effectiveness Analysis of Programs to Expand Supported Employment Services: An Interpretive Review of the Literature* 27–28 (2010), http://aspe.hhs.gov/daltcp/reports/2010/supempLR.pdf..

[24] Gary R. Bond et al., *An Update on Randomized Controlled Trials of Evidence-Based Supported Employment*, 31 PSYCHIATRIC REHABILITATION JOURNAL 280, 284 (2008); Michelle P. Salyers et al., *A Ten-Year Follow-Up of a Supported Employment Program*, 55 PSYCHIATRIC SERVICES 302, 305 (2004).

- In one study, individuals receiving IPS decreased their use of mental health services by 41% over one year, with fewer inpatient hospitalizations and emergency room visits.[25]
- A Washington State study found that individuals with serious mental illness receiving supported employment had lower arrest rates than similarly situated individuals not receiving it.[26]
- Securing employment is particularly challenging for individuals with criminal justice involvement. Two controlled trials found significantly better competitive employment rates for individuals with criminal justice involvement receiving IPS than for individuals receiving traditional vocational services.[27]

Learn more:

- SAMHSA Evidence-Based Practices KIT, *The Evidence: Supported Employment* (2009)
- Case Western Reserve University, Center for Evidence-Based Practices, Supported Employment/Individual Placement & Support
- Bazelon Center, *Advances in Employment Policy for Individuals with Serious Mental Illness* (Oct. 2018)
- Bazelon Center, *Getting to Work: Promoting Employment of People with Mental Illness* (Sept. 2014)

Peer Support Services

What are Peer Support Services?

- The term "peer support services" includes a number of services designed to support people with mental illness and addiction. Peer support services are provided by trained specialists with "lived experience" in the mental health service system, who use that experience to build relationships of trust with people and provide needed support.
- Peer specialists may perform a variety of tasks, including helping individuals transition from a corrections or other institutional setting to the community, stay connected to treatment providers, build confidence, maintain or develop social relationships, and participate in community activities. Peer specialists may also staff crisis apartments or other crisis centers or serve on ACT, mobile crisis, or supported employment teams.

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[25] Sally Rogers, et al., *A Benefit-Cost Analysis of Supported Employment Model of Persons with Psychiatric Disabilities*, 18 EVALUATION AND PROGRAM PLANNING 2, 105-115, 113 (1995).
[26] Z. Joyce Fan et al., *Improving Employment Outcomes For People with Mental Health Disorders in Washington State* (June 2016), https://www.dshs.wa.gov/sites/default/files/SESA/rda/documents/research-11-230.pdf. The supported employment services studied were not required to be IPS.
[27] *Work for People with Justice Involvement*, EMPLOYMENT WORKS! (IPS Employment Center), Spring 2019, at 3, https://ipsworks.org/wp-content/uploads/2019/04/newsletter_spring2019-final.pdf.

- Some peer support programs are specifically designed for individuals with mental illness or addiction who have been in the criminal justice system, with peers who themselves have also had criminal justice system involvement.

Peer Support Services help prevent unnecessary incarceration.

- Peer support services prevent needless institutionalization and incarceration by assisting individuals to make decisions that promote their recovery. Individuals receiving peer support services report increased problem-solving capabilities, social connectedness, and ability to address stressors and crises.[28]
- Early participants in a New York "peer bridger" program for individuals being discharged from psychiatric hospitals experienced 41% fewer re-hospitalizations over a two-year period. Ten years later, the program continued to help keep participants from being re-hospitalized 71% of the time.[29]
- Pierce County, Washington, helped reduce involuntary psychiatric hospitalizations for individuals in emotional crisis by 32% using peer support services.[30]
- 24% of participants receiving peer support from a peer-run 23-hour crisis program in Louisville, Kentucky, (using a "Living Room" model) were diverted from hospitalization and 37% were diverted from jail in the first several months of the program.[31]

Learn more:

- SAMHSA Evidence-Based Practices KIT, *The Evidence: Consumer-Operated Services* (2011)
- SAMHSA, *What Are Peer Recovery Support Services?* (2009)
- Mental Health America, *Evidence for Peer Support* (Feb. 2017)
- Kevin Cleare, Policy Research Associates, *Spotlight on Peers Working in Criminal Justice Settings: Reintegration, Family, and Peer Support* (Sept. 17, 2018)
- Maureen Richey, Council of State Governments Justice Center, *For the Formerly Incarcerated, Peer Mentoring can Offer a Chance to 'Give Back'* (Aug. 14, 2015)

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[28] Phyllis Solomon, *Peer Support/Peer Provided Services Underlying Processes, Benefits, and Critical Ingredients*, 27 PSYCHIATRIC REHABILITATION JOURNAL 4, 392–401 (2004).
[29] New York Association of Psychiatric Rehabilitation Services, Inc., *Peer Bridger Project*, http://www.nyaprs.org/peer-services/peer-bridger/ (last accessed Ocotb, 2019).
[30] Sue Bergeson, Optum Health, *Cost Effectiveness of Using Peers as Providers* at 11 (2011), http://www.fredla.org/wp-content/uploads/2016/01/Cost_Effectiveness_of_Using_Peers_as_Providers.pdf.
[31] National Association of Counties, *Supporting People with Mental Illnesses in the Community* (2018), https://www.naco.org/sites/default/files/documents/SAMHSA%20Case%20Study%20Louisville-Jefferson%20Final.pdf.

Substance Use Disorder Treatment Services That Support Diversion and Reentry

Substance Use Disorder Services

The services addressed above are shown to be effective for people with mental health disabilities co-occurring with addiction. Early screening for both addiction (including the substance to which the individual is addicted) and mental health disabilities is essential in order to identify the most appropriate services. For individuals with substance use disorders in the absence of mental health disabilities, somewhat different treatment services may be appropriate. Although not all substance use treatment programs have been subjected to research to determine their impact on incarceration, research demonstrates that treatment can work for offenders with substance use disorders and failure to receive needed services often leads to relapse and re-arrest, usually during the first 12 months after release.[32] Several studies have shown that both correctional or supervised treatment and community-based substance use programs serve to increase diversion from incarceration and reduce recidivism risk upon reentry.[33]

The full range of substance use treatment services should be available in amounts sufficient to meet the needs of the particular community without delay, and treatment services should be combined as needed to serve each individual. In general, drug treatment should address issues of motivation, problem solving, and skill-building for resisting drug use and criminal behavior.[34]

Comprehensive drug addiction treatment consists of several key program models: Cognitive Behavioral Therapy, Motivational Incentives, Community Reinforcement Approach Plus Vouchers, Motivational Enhancement Therapy, Family Behavior Therapy, Medication Assisted Therapy, the Matrix Model, and 12-Step Facilitation.[35] Twelve-Step Facilitation, an abstinence-based approach, has been effective for some individuals but does not work for everyone. At the core, treatment should include an individualized assessment according to the American Society of Addiction Medicine criteria, client-centered treatment planning, monitoring, pharmacotherapy, behavioral health services, peer support, case management, coordinated access to medical services, and continued care.[36]

[32] National Institutes of Health, *Addiction and the Criminal Justice System,* https://report.nih.gov/NIHfactsheets/ViewFactsheet.aspx?csid=22.

[33] U.S. Dept. of Health and Human Services, National Institutes of Health, National Institute on Drug Abuse, *Principles of Drug Abuse Treatment for Criminal Justice Populations: A Research-Based Guide,* (2014), 17, https://d14rmgtrwzf5a.cloudfront.net/sites/default/files/txcriminaljustice_0.pdf.

[34] *Id.* at 2.

[35] National Institutes of Health, National Institute of Drug Abuse, *Principles of Drug Addiction Treatment: A Research-Based Guide* (3d ed. 2018), https://www.drugabuse.gov/publications/principles-drug-addiction-treatment/evidence-based-approaches-to-drug-addiction-treatment/behavioral-therapies.

[36] ATTC Network, *Exploring Models for the Implementation of Medication-Assisted Treatment for Opioid Use Disorder: Knowledge and Application* 9 (2019), https://attcnetwork.org/sites/default/files/2019-09/WhitePaper_MATforOUD.pdf.

In addition to treatment services, supportive housing using a housing-first model, discussed above, has been shown to improve outcomes, prevent homelessness, and reduce incarceration for people with substance use disorders.[37]

The National Institute on Drug Abuse (NIDA) focuses on three central treatment programs that have been shown to be effective in treating offenders with addiction and to reduce incarceration and recidivism - Cognitive Behavioral Therapy, Motivational Incentives, and Medication Assisted Treatment – and emphasizes the need for coordination between treatment providers and criminal justice personnel.[38]

What types of Substance Use Disorder Services should be available?

Cognitive Behavioral Therapy

- Cognitive-Behavioral Therapy (CBT) strategies are based on the theory that in the development of maladaptive behavioral patterns like substance use disorders, learning processes play a critical role.
- Individuals in CBT learn to identify and correct problematic behaviors by applying a range of different skills that can be used to address substance use disorders and to address a range of other problems that often co-occur with them.
- A central element of CBT is anticipating likely problems and enhancing patients' self-control by helping them develop effective coping strategies. Specific techniques include exploring the positive and negative consequences of continued drug use, self-monitoring to recognize cravings early and identify situations that might put one at risk for use, and developing strategies for coping with cravings and avoiding those high-risk situations.
- Research indicates that the skills individuals learn through cognitive-behavioral approaches remain after the completion of treatment.[39]

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[37] CSH, *Literature Review of Supportive Housing: Justice Outcomes*, https://d155kunxf1aozz.cloudfront.net/wp-content/uploads/2019/10/CSH-Lit-Review-Justice-Outcomes.pdf; CSH, *Literature Review of Supportive Housing: Mental Health and Substance Use*, https://d155kunxf1aozz.cloudfront.net/wp-content/uploads/2018/07/CSH-Lit-Review-MH-Outcomes.pdf. Individuals who move away from their former neighborhoods are more successful in refraining from future criminal activity, perhaps because these moves assist individuals in distancing themselves from their former criminogenic environments and networks. Fontaine, J., *The Role of Supportive Housing in Successful Reentry Outcomes for Disabled Prisoners,* 15 Cityscape: A Journal of Policy Development and Research 3 (2013) U.S. Department of Housing and Urban Development Office of Policy Development and Research.

[38] U.S. Dept. of Health and Human Services, National Institutes of Health, National Institute on Drug Abuse, *Principles of Drug Abuse Treatment for Criminal Justice Populations: A Research-Based Guide,* (2014), 18, https://d14rmgtrwzf5a.cloudfront.net/sites/default/files/txcriminaljustice_0.pdf.

[39] National Institutes of Health, National Institute of Drug Abuse, *Principles of Drug Addiction Treatment: A Research-Based Guide* (3d ed. 2018), https://www.drugabuse.gov/publications/principles-drug-addiction-treatment/evidence-based-approaches-to-drug-addiction-treatment/behavioral-therapies.

- CBT has been shown to significantly reduce recidivism among moderate- and high-risk adult offenders, including those with addictions.[40]

Contingency Management/Motivational Incentives

- Studies conducted using contingency management (CM) principles, which involve giving patients tangible rewards to reinforce positive behaviors such as abstinence, show that incentive-based interventions are highly effective in increasing treatment retention and promoting abstinence from drugs.
- Incentives may include vouchers or chances to win prizes.[41]
- Incentives have been shown to increase consistency and continuation of participation in treatment, which decreases recidivism.[42]

Medication-Assisted Treatment

- Medication-Assisted Treatment (MAT) involves using one of three medications—methadone, buprenorphine, or naltrexone—in combination with psychosocial support to treat a substance use disorder. MAT is the most effective means of supporting people with opioid addiction in recovery.
- In addition to increasing treatment retention and reducing illicit substance use, MAT provides important population-level benefits. For example, methadone and buprenorphine treatment can reduce overdose death rates. MAT has also been shown to reduce criminal justice system involvement and increase employment rates.
- At 12 months post-release, offenders who had received methadone treatment in prison and continued it in the community were significantly more likely to enter and stay in treatment and less likely to test positive for opioid and cocaine use than participants who received counseling

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[40] Aos, S, and Drake, E.. *Prison, Police, and Programs: Evidence-Based Options that Reduce Crime and Save Money*. Olympia, Wash.: Washington State Institute for Public Policy (2013). http://www.wsipp.wa.gov/ReportFile/1396/Wsipp_Prison-Police-and-Programs-Evidence-Based-Options-that-Reduce-Crime-and-Save-Money_Full-Report.pdf; Council of State Governments Justice Center, *In Brief: Using a Cognitive-behavioral Approach in Programs to Reduce Recidivism,* https://csgjusticecenter.org/jr/in-brief-using-a-cognitive-behavioral-approach-in-programs-to-reduce-recidivism/; McMurran M., *What works in substance misuse treatments for offenders?* Criminal Behaviour and Mental Health. 2007;17(4):225–33, https://onlinelibrary.wiley.com/doi/abs/10.1002/cbm.662; Quinn TP, Quinn EL., *The effect of cognitive-behavioral therapy on driving while intoxicated recidivism.* Journal of Drug Issues. 2015;45(4):431-446, https://journals.sagepub.com/doi/abs/10.1177/0022042615603390.

[41] *Id.*; *see also* ATTC Network, *Motivational Incentives: A Proven Approach to Treatment* (2018), https://attcnetwork.org/centers/global-attc/motivational-incentives-proven-approach-treatment.

[42] Prendergast, M. and Hall, E., *A Treatment Manual for Implementing Contingency Management: Using Incentives to Improve Parolee Enrollment and Attendance in Community Treatment* (UCLA, 2011), *http://www.uclaisap.org/assets/documents/Manual%20for%20Implementing%20Contingency%20Management_11-8-2011%20clean.pdf*; U.S. Dept. of Health and Human Services, National Institutes of Health, National Institute on Drug Abuse, *Principles of Drug Abuse Treatment for Criminal Justice Populations: A Research-Based Guide,* (2014), 18, 21-22 https://d14rmgtrwzf5a.cloudfront.net/sites/default/files/txcriminaljustice_0.pdf.

and referral to methadone, or those who received counseling with transfer to methadone maintenance upon release.[43]

- Although some jurisdictions have found ways to successfully implement medication therapy, addiction medications are underused in the treatment of individuals with substance use disorders within the criminal justice system, despite evidence of their effectiveness.[44]
- MAT medications may be prescribed or dispensed in a variety of treatment settings. By law, methadone used to treat an Opioid Use Disorder (OUD) can be dispensed only by a SAMHSA-certified opioid treatment program. Buprenorphine and naltrexone are available at a wide range of treatment settings. Practitioners must complete buprenorphine-waiver training to prescribe buprenorphine. Any individual who is licensed to prescribe medication can prescribe extend-release injectable naltrexone.[45]
- Important innovations in MAT include:
    - Use of designated nonphysician staff to perform the key integration/coordination role
    - Tiered care models with centralized intake and stabilization of patients with ongoing management in community settings
    - Screening and induction performed in emergency department, inpatient, or prenatal settings with subsequent referral to community settings
    - Community-based stakeholder engagement to develop practice standards and improve quality of care
    - Use of Internet-based learning networks in rural settings
- Several models of MAT are evidence-based:
    - The Hub and Spoke model is characterized by two levels of care delivered by selected, specialized, regional opioid treatment providers working in close collaboration with general medical practices. Specializing in the treatment of complex addiction, regional centers (Hubs) provide intensive treatment to patients and consultation support to medical providers (Spokes) treating patients in general medical practices. After receiving initial treatment, patients whose conditions stabilize or have lower acuity (lower risk and complexity) are transitioned from Hubs to Spokes for ongoing care.
        - Indiana's MAT-PDOA program (Indiana Medication-Assisted Treatment Project) uses a regionally modified version of the Hub and Spoke model to treat rural populations at its two provider locations. Indiana's model encompasses six service domains to meet the needs of patients engaged in MAT. The program targets two populations: (1) rural residents in several northwestern Indiana

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[43] U.S. Dept. of Health and Human Services, National Institutes of Health, National Institute on Drug Abuse, *Principles of Drug Abuse Treatment for Criminal Justice Populations: A Research-Based Guide,* (2014), 23, https://d14rmgtrwzf5a.cloudfront.net/sites/default/files/txcriminaljustice_0.pdf.

[44] *Id.*

[45] ATTC Network, Exploring Models for the Implementation of Medication-Assisted Treatment for Opioid Use Disorder: Knowledge and Application 9 (2019), available at https://attcnetwork.org/sites/default/files/2019-09/WhitePaper_MATforOUD.pdf.

counties who fall below the poverty line and (2) residents of Scott County in southeastern Indiana who are at risk for HIV, hepatitis C, or other infectious diseases because of injection drug use.

- Indiana has adopted the Integrating Dialectical Behavior Therapy (DBT) with Twelve-Step Facilitation (TSF) created by the Hazelden Betty Ford Foundation for its MAT implementation. DBT is a cognitive behavioral therapy (CBT) approach that was developed for clients with dual diagnoses and persistent and severe problems.
- Staffing Needs: One nurse and one licensed clinician case manager for every 100 MAT patients at Spokes.
- Payment Mechanisms: separate methodologies and payment streams for Hubs (large proportion of government funds to support services) and Spokes (heavy reliance on insurers and private payers).[46]

- The COR-12 Program includes the integration of evidence-based psychosocial services (i.e., TSF, MET, and CBT) along with medications that have proved effective for OUD across multiple levels of care. It partners with patients, families, and third-party stakeholders in long-term engagement, actively involving them in making decisions about the patient's care.
  - Patients follow one of three pathways: treatment with buprenorphine/naloxone, treatment with extended-release injectable naltrexone, or treatment with no medications. Buprenorphine/naloxone is used because of the ease of access in most healthcare settings compared with methadone, which is also an effective medication for treating OUD. Patients are on medications for an extended period—12 months at a minimum—before they can consider discontinuation.
  - COR-12 can serve as a bridge for organizations that are adopting MAT while making the most of existing effective frameworks (e.g., 12-step support, mutual aid programs).
  - Staffing Needs: Prescribing practitioner, coordinator, and counselor.
  - Payment Mechanisms: Medicaid, private insurers, and private payers.[47]
- Office-Based Opioid Treatment (OBOT) is a flexible model that combines MAT with behavioral health therapies and integrates primary care to better serve individuals who have chronic co-occurring physical and behavioral health conditions. The model deploys an interdisciplinary treatment team that is led by an addictions nurse care manager who serves as the point of contact for clients, develops a treatment plan in collaboration with a waivered physician, and coordinates all services.
  - Benefits of OBOT include retention in care, decreased emergency department visits and hospital events, and improved outcomes.

[46] *Id.* at 10–12.
[47] *Id.* at 13.

- Staffing Needs: One nurse case manager and one medical assistant per 125 patients.
- Payment Mechanisms: Initial grant that expands the budget for NCM salary followed by Medicaid reimbursement for OUD care management; traditional reimbursement mechanisms for the physician and medication.[48]

- One-Stop Shops bring physical and behavioral health services as well as support services together under one roof. Systems are streamlined, services are integrated, and necessary referrals are provided. This model simplifies otherwise complicated eligibility criteria based on status, housing status, gender, and other requirements. A selected set of services and care is assembled so that a person's behavioral and physical health needs can be met at one location. The goal is to maximize retention, improve cost-effectiveness, increase access to specialty services, and enhance overall well-being.
  - MAT services can be rolled into the array of services that patients are already accessing, making a One-Stop Shop model a form of "in-reach," in which an organization focuses internally to identify MAT candidates, rather than outreach, where candidates are identified outside the agency.
  - Scott County, Indiana, is currently implementing a One-Stop Shop model.[49]

[48] *Id*. at 15.
[49] *Id*. at 20–21.

Jail Overcrowding Task Force

2019 Report

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Executive Summary

The Jail Overcrowding Task Force was charged with studying why some Indiana jails are overcrowded and what can be done to ease or eliminate jail overcrowding. Also, the Task Force was asked to provide Indiana's Sheriffs and their communities with recommended solutions to address the jail overcrowding factors and increase the use of evidence-based programs to reduce recidivism for the jail population. To accomplish this mission, the Task Force held three regional meetings where it received informative presentations from a myriad of different stakeholders as well as public testimony. The regional meeting webcasts and PowerPoint presentations are archived on the Task Force's web page. In addition, the Task Force solicited written public comments on the Task Force's website, which was available 24 hours a day.

The information gathered throughout the last 148 days underscored the challenges that our Indiana Sheriffs face every day, some unique to their particular counties and others common to every county in Indiana. Indiana Sheriffs are charged with ensuring secure jails and holding inmates who are both awaiting trial and who are serving their sentences. In addition, they face ongoing challenges with and an increasing number of inmates with severe mental health issues and substance use disorders. In addition, many sheriffs have, with community support, implemented numerous programs for inmates, both those in jail pretrial and post sentence, to increase the likelihood that the inmate does not return to the criminal justice system. Many of these programs are successful but are often unique to a particular county.

The Task Force concludes that real solutions to jail overcrowding and successful jail programming will most often be specific to each county and that there is no "quick fix".

Nonetheless, reducing jail overcrowding while promoting, supporting and enhancing programs within Indiana's jails in a manner that does not diminish public safety must involve strong partnerships with Indiana Sheriffs and their counties through a combination of state and local funding, identification of best practices and promising programs, use of real time data and interfaces among criminal justice stakeholders and other risk reducing initiatives.

Achieving success will require intentional collaboration and coordination at both the state and local level along with subsequent study, data analysis, and process review. These recommendations provide a framework to implement sound strategies targeted to address the jail population concerns and expand access to evidence-based programs and services to reduce recidivism.

Every Task Force member has been grateful to serve, and each looks forward to collaborating on the next steps. Hoosiers are indeed different. Together we can do better and together we can do more.

The Task Force acknowledges the contributions of those listed below for their assistance with regional meetings and providing staff support throughout this process:

- Location hosts: Association of Indiana Counties – French Lick; Professor Nicole Doctor and Ivy Tech Community College – Valparaiso; President John S. Pistole, Lisa Ragsdale and Anderson University – Anderson; and
- Staff support and meeting logistics: Office of Judicial Administration staff – Mary Kay Hudson, Michelle Goodman, Jenny Kidwell, Jenny Bauer, and Lindsey Borschel; Indiana Supreme Court Sheriffs and Indiana State Police.

Jail Overcrowding Task Force Members

Hon. Steven H. David, *Chair*
Indiana Supreme Court
(Chief Justice's Designee)

Rep. Greg Steuerwald
Indiana House District 40

Rep. Ragen Hatcher
Indiana House District 3

Sen. Mike Gaskill
Indiana Senate District 26

Sen. J.D. Ford
Indiana Senate District 29

Tracy A. Brown
Tippecanoe County Commissioner
Appointee of Association of Indiana Counties

Douglas Huntsinger
Office of the Governor

Ralph Watson
Indiana Association of Community Corrections Act Counties

Commissioner Robert Carter
Indiana Department of Correction

David Powell
Indiana Prosecuting Attorneys Council

Bernice Corley
Indiana Public Defender Council

Sheriff Brett Clark
Hendricks County
Appointee of Indiana Sheriffs' Association

Superintendent Doug Carter
Indiana State Police

Hon. Christopher Goff [1]
Indiana Supreme Court

[1] Justice Goff regularly participated in the Task Force meetings.

Overview of Statutory Charge

House Enrolled Act 1065; P.L. 239-2019 established the Jail Overcrowding Task Force comprised of 13 members charged with the following responsibilities:

- Conduct a statewide review of jail overcrowding to identify common reasons and possible local, regional, and statewide solutions.
- Study the issue of how to reduce recidivism for convicted felons in county jails by offering programs that address:
  - mental health and drug and alcohol treatment services;
  - educational programs; and
  - other evidence-based programs designed to reduce recidivism.
- Submit a report to the governor, chief justice, and legislative council not later than December 1, 2019.

Overview of Meetings

The Task Force's initial meeting was held on August 1, 2019, in Indianapolis to review the statutory charge and discuss member expectations. At the meeting on August 23, 2019, in Indianapolis the Task Force discussed the following topics: (1) availability of jail data, including two local examples of population data and trends, (2) regional meeting dates, locations, and logistical considerations, and (3) areas of focus for the regional meetings, process for public testimony, and specific presentation topics.

The first regional meeting was held on September 30, 2019, in French Lick. The presentations were provided by the Association of Indiana Counties, the Indiana Sheriffs' Association, and the Office of Judicial Administration. The Task Force also received public testimony from eight individuals.

The second regional meeting was held on October 30, 2019, in Valparaiso. The presentations were provided by the Office of Attorney General, Justice Reinvestment Advisory Council and the Evidence Based Decision Making Initiative Pretrial Workgroup, Jail Medical Service Providers, and the Porter County Criminal Justice System. There were also two individuals who provided public testimony.

The final regional meeting was held on November 6, 2019, in Anderson. The presentations were provided by the Division of Mental Health and Addiction, Indiana Sheriffs' Association, Indiana Prosecuting Attorneys Council, Indiana Public Defender Council, the Probation Officers Professional Association and the Indiana Association of Community Corrections Act Counties. Public testimony was also provided by two individuals.

The final meeting of the Task Force was held on November 25, 2019 in Indianapolis to discuss and approve recommendations for the final report.

Links to Relevant Resources and Information

In addition to the links provided elsewhere in this report, below are additional resources:

- Justice Reinvestment Advisory Council
- Division of Mental Health and Addiction
    - Recovery Works
- Department of Correction Community Correction Division
    - Grants and HEA 1006 Grants
- Indiana Office of Judicial Administration
    - Pretrial Release
    - Text notification reminders
    - Supervised Release System
- Probation Officers Professional Association of Indiana
- National Institute of Corrections
    - Evidence Based Decision Making Initiative
    - Evidence Based Practices Resources

Task Force Findings and Recommendations

Findings

The Task Force now makes the following findings based on the information presented and knowledge from their collective professional experience:

1. While many counties are experiencing jail overcrowding, some counties are not faced with those same conditions. Numerous factors contribute to jail overcrowding, but the number of factors and the degree to which these factors contribute to local jail populations vary by county. Although not an exhaustive list, county jail populations are impacted by:
    a. the age and size of existing facilities,
    b. shifts in inmate population, including shifts in the number of male and female inmates,
    c. high percentages of inmates with mental health and addiction issues,
    d. availability of treatment facilities and mental health beds at the state and local level,
    e. types of holds and combination of holds keeping inmates from being released (i.e. pretrial, serving executed sentence, supervision violations, holds for other counties or jurisdictions, etc.),
    f. bond amounts when individuals are of limited means;
    g. increase in number of Level 6 filings,
    h. the number of pretrial detainees,
    i. length of time for case processing,
    j. plea agreements and sentencing practices,
    k. the number of community supervision violations and revocations, and
    l. varying procedures for periodic review of inmate status.

2. The lack of real time jail data and the use of unconnected, multiple jail management systems impedes the ability for state and local criminal justice partners to collect accurate data and fully analyze specific characteristics of the jail populations in a timely, efficient manner to identify and address population trends.

3. The use of multiple jail management systems limits the ability to reliably aggregate data due to a lack of standard data definitions and standard reporting requirements as well as various data entry practices.

4. The data systems in use by the jails, prosecutors, defense attorneys, courts, and supervision agencies lack connectivity that could enhance communication and knowledge of inmates' status within the system. Gaps in this level of information sharing can result in failure to appear warrants if courts cannot verify the person is being held in another county jail or court hearings may need to be continued to allow sufficient time to plan for individuals to be transported from other counties.

5. Some criminal justice data is only available by compiling survey responses, which only provides a snapshot of information (e.g. jail population characteristics) while other data is collected for specific purposes or limited populations (e.g. sentencing abstracts). Data provided through these methods merely expose symptoms of issues but are not detailed enough to address the underlying causes and trends or evaluate adjustments in policy or procedure to appropriately address the causes.

6. Resources available within each county vary widely and these system inputs directly impact the ability to support a range of alternatives to incarceration, a full continuum of treatment and service options within the community and secure facilities, and appropriate staffing levels for criminal justice stakeholders and providers to provide effective, efficient case processing, supervision, treatment programs and supporting services for individuals in the criminal justice system.

7. Criminal justice involved individuals experience gaps and delays in accessing treatment services when Medicaid and Veterans Administration benefits are terminated during incarceration. Additional gaps in service delivery occur as individuals are transferred between and among facilities and community-based programs.

The wide range of considerations to address these and other factors contributing to jail overcrowding requires collaboration and evaluation by multiple stakeholders within the state and local criminal justice systems. Any solutions to address jail overcrowding must target the specific needs and challenges faced by the criminal justice stakeholders and community partners.

Recommendations

The Task Force makes the following recommendations:

A. Initial Recommendations: The first two recommendations of the Task Force are critical to any subsequent efforts to sustain on-going review and analysis of jail population trends and address need areas:

   1. The General Assembly should enact a legislative proposal from the Justice Reinvestment Advisory Council, which is supported by the Evidence Based Decision Making Policy Team, to formally incorporate Evidence Based Decision Making Team and accompanying workgroups into the Justice Reinvestment Advisory Council structure.

   2. This Jail Overcrowding Task Force should transition to a workgroup under the Justice Reinvestment Advisory Council to continue evaluating and assessing jail overcrowding and related issues, assist with identifying and implementing evidence based best practices, and providing education and technical assistance to counties.

   Implementing these recommendations quickly will provide a structure and framework to establish best practices, conduct system reviews, develop model policies, and provide technical assistance emphasizing the necessary collaboration between state and local stakeholders. These recommendations build upon the current statutory charge for the Justice Reinvestment Advisory Council to review and evaluate local correctional programs (including county jails) and to promote development of incarceration alternatives and recidivism reduction programs. The Justice Reinvestment Advisory Council currently collaborates with the Indiana Evidence Based Decision Making Policy Team, comprised of state and local criminal justice stakeholder representatives, and its workgroups.

B. Short-term and Long-term Recommendations: This section of recommendations is organized within broad categories and labeled as short-term (items which can be completed within a one to two-year timeframe) and long-term (items that address more complex system issues, which require on-going strategies or cannot be completed in a two-year timeframe) to aid in prioritizing action by state and local stakeholders and informing policy decisions and funding. The Task Force agrees to the following:

1. Data and Evaluation:

    i. Short-term –

        1. The Indiana Department of Correction, in partnership with the Indiana Criminal Justice Institute, should continue with the RFP process for enhancing a unified, statewide victim notification system for use by all Indiana Sheriffs' Departments and Department of Correction. Expanding on this effort, all jails should be required to provide clearly defined, specific, real time data relevant to the jail population. Real time jail data should be communicated via interfaces with the Odyssey Court Case Management System, the Indiana Prosecutor Case Management System, the Public Defender Information System, the Supervised Release System used by community supervision agencies, and the Department of Correction.

    ii. Long-term –

        1. Criminal justice stakeholders should use this statewide jail data system as a component for measuring recidivism and conducting research and evaluation on key performance measures and program outcomes.

    Implementing these recommendations will increase communication among stakeholders regarding a person's jail status, improve the ability to aggregate information on the jail population to identify trends and problems that contribute to jail overcrowding, allow for more accurately measuring recidivism, and conducting on-going research and evaluation of key performance measures and program outcomes.

2. Behavioral Health treatment, programs, and services:

    i. Short-term –

        1. The General Assembly should consider pursuing legislation to amend the criteria for termination of Medicaid upon incarceration.

        2. Sheriffs, the Indiana Department of Correction, community supervision staff and treatment providers should guide and assist individuals leaving incarceration in completing and submitting Medicaid benefit applications. For example, the use of a community

corrections case manager in the Porter County jail connects the inmate with assistance in preparing for reentry.

ii. Long-term –

1. The Division of Mental Health and Addiction, Community Mental Health Centers and local treatment providers should continue to expand access to evidence based treatment services along the continuum of the criminal justice system, including the full range of medication assisted treatment (MAT), within the community, jails, and Department of Correction. All treatment programs should have established eligibility criteria to guide placement decisions, so individuals are receiving the proper services without solely relying on secure settings for service delivery. For example, crisis centers should be available within local communities to help stabilize individuals in acute crisis and connecting them to appropriate resources. Currently, Boone, Tippecanoe, and Vigo Counties are implementing jail treatment services in partnership with the Division of Menth Health and Addiction.

2. The Division of Mental Health and Addiction, Community Mental Health Centers and local treatment providers should continue to increase access and improve processes for providing behavioral health services to individuals, including those diagnosed with severe mental illness (schizophrenia, bipolar disorder, and major depression), severe substance use disorders, and those who lack competency. For example, Marion County Mental Health Court has two full time recovery coaches to connect clients with different organizations and systems using a recovery-oriented model. The investigator for the Tippecanoe County Public Defender's Office reviews cases to identify individuals with mental health needs and coordinates with jail staff, jail medical team, and mental health service providers to address individual needs.

3. Sheriffs, the Indiana Department of Correction, the Division of Mental Health and Addiction, community supervision agencies, and treatment providers should establish partnerships and develop procedures to coordinate an individual's access to behavioral health treatment programs and services along the continuum of the justice system. A case manager from community corrections is embedded in

the Porter County jail to provide case management and connect the person with community supervision and provider services. Also, Grant County uses a jail re-entry coordinator to identify individuals for community-based programs.

Implementing these recommendations will decrease the delay for individuals to receive treatment services to address their behavioral health needs, allow individuals to receive clinically appropriate services regardless of their criminal justice placement or status, and create a more seamless transition between services within facilities and community-based services for individual as they move through the criminal justice system.

3. Case Processing:

   i. Short-term –

      1. Criminal Justice stakeholders should reduce reliance on arrest warrants for non-violent offenders, both pretrial and post-conviction, by developing cite and release procedures, using release matrices, and implementing strategies to prevent failures to appear such as text notification reminders. The Evidence Based Decision Making Policy Team and its Pretrial Workgroup have published a best practice manual for pretrial release and supervision decisions discussing release matrices and text notification reminders. Eleven pilot sites have been working to implement these practices, which can inform the work in other counties. As of November 25, 2019, 55 counties already use text notification reminders for court hearings. Also see, the Justice Reinvestment Advisory Council's Pretrial Report.

      2. Prosecutors should expand prosecutor diversion programs and support pilot programs that include providing treatment services as a main component. Currently, the Indiana Prosecuting Attorneys Council and the Evidence Based Decision Making Risk Reduction Workgroup is developing framework for felony diversion programs to prepare for future pilot activities.

   ii. Long-term –

      1. Criminal Justice stakeholders should support making public defenders available at initial hearings to aid in release decisions while considering funding and training resources. The pretrial pilot sites

can serve as examples for ensuring public defense attorneys for initial hearings.

2. Criminal Justice stakeholders should develop procedures to divert severely mentally ill individuals away from the criminal justice system through early mental health screenings and assessments.

Implementing these recommendations will allow for more informed release decisions, reduce opportunities for indigent individuals to be held pretrial solely based on the inability to pay bond, allow non-violent offenders to maintain their connections to the community (e.g. employment, housing, etc.), reduce instances for failures to appear, expand diversion opportunities so individuals can engage in services for those within the criminal justice system as well as those who can be treated without criminal justice involvement.

4. Community Supervision:

   i. Short-term –

   1. Criminal justice stakeholders should expand Indiana's pretrial reform initiative to include the use of assessments and evidence based pretrial supervision practices. The Task Force also endorses the Justice Reinvestment Advisory Council's Pretrial Report prepared pursuant to Section 14 of House Enrolled Act 1065; P.L. 239-2019. For additional information, see the Pretrial Release materials on-line, including the Evidence Based Decision Making Pretrial Workgroup's best practices manual.

   2. Criminal Justice stakeholders should expand and enhance use of graduated incentives and sanctions to address offender behavior while on community supervision, including a range of sanctions that incorporates the use of the continuum of supervisions programs while maintaining focus on necessary therapeutic adjustments. For example, problem solving court eligibility criteria can include individuals in violation status of other community supervision programs to provide increased case management services while incorporating therapeutic responses. The Evidence Based Decision Making Risk Reduction Workgroup, in cooperation with the Indiana Office of Court Services, is working with nine counties to provide technical assistance to implement the Indiana Minimum Standards for Probation Incentives and Administrative Sanctions Programs

adopted on May 1, 2019. Examples of counties using these best practices include Bartholomew, Hamilton, Lawrence, Wabash, and Wayne counties.

ii. Long-term –

1. Criminal justice stakeholders should expand the availability and capacity of alternatives to incarceration (e.g. problem-solving courts, probation and community corrections, etc.), and the use of evidence based treatment services within the community to reduce reliance on incarceration. Examples of counties with multiple problem-solving courts include Allen, Bartholomew, Delaware, Grant, Hamilton, Marion, Madison, Monroe, Porter, Vanderburgh, and Wabash.

Implementing these recommendations will enable counties to make more informed pretrial release and supervision decisions, allow community supervision agencies to further implement incentives and sanctions to promote behavior change with accountability, increase capacity for individuals to be supervised and receive treatment resources in the community. Examples of counties that have implemented or are expanding implementation of Evidence based practices within community supervision include Allen, Bartholomew, Grant, Hamilton, Hendricks, Monroe, Morgan, Porter, Rush, Vigo, Wabash, and Wayne.

5. Resources:

i. Short-term –

1. The General Assembly should review and study local tax resources, including but not limited to the local jail income tax under IC 6-3.6-6-2.7, and public safety income tax under IC 6-3.6-6-8 to provide additional flexibility to local fiscal bodies so resources can be allocated to address local criminal justice system needs.

2. The General Assembly should appropriate additional funding for the misdemeanor Recovery Works pilot project authorized in IC 12-23-19-2(d).

3. Criminal justice stakeholders should support an increase in community supervision staffing levels to promote risk and needs based community supervision practices. This would include providing

additional resources to the Indiana Department of Correction for the Community Corrections and HEA 1006 grants. Additional staffing will reduce community supervision officer caseload sizes, adding capacity for community supervision agencies to supervise additional Level 6 offenders and other offender populations within the community.

4. The General Assembly should review the reimbursement for felons held within county jails.

ii. Long-term –

1. Criminal justice stakeholders should assess and evaluate the need for resources to support the criminal justice system to efficiently and effectively carryout the purposes of the system. The system needs appropriate resources and capacity to properly address working with individuals engaged in the criminal justice system. Capacity assessments would include jails, prosecutors, public defense, courts, community supervision, jails, and behavior health services available along the continuum of the system.

2. Each stakeholder group should develop and implement a framework to identify where additional resources are necessary to balance workload and key performance measures to evaluate system outcomes. These tools could aid in acquiring the appropriate resources to achieve these outcome measures.

Implementing these recommendations could provide local flexibility in allocating existing revenues to address broader criminal justice needs, increase access to services and treatment, and expand community supervision capacity while allowing for more effective and meaningful supervision.

The above listed recommendations are designed to assist the state and all Indiana counties with addressing the jail population and implementing strategies for reducing recidivism with evidence-based programs and services. The Task Force did not exclude recommendations based solely on fiscal impacts. The Task Force acknowledges implementing these recommendations will involve more detailed analysis and review of fiscal resources to implement sound strategies and solutions targeted to address jail overcrowding and expand access to evidence-based programs and services throughout the criminal justice system to reduce recidivism.

Conclusion

Members of the Task Force wish to commend the efforts of Indiana's Sheriffs who, in many cases, have been doing more with less, and who have individually, and through the Indiana Sheriffs' Association, and with the assistance of their County and often with State assistance, have sought and obtained short term solutions, created programs and services or otherwise undertaken efforts that have distinguished themselves as public servants. Our hope is that these efforts do not go unnoticed and that a concentrated effort be made to expand upon the successes, explore new initiatives and obtain community and state support for increased resources, more options and adequate funding.

An Alternative to the Police:
New Funding is Available for Community-Based Mental Health Services

The new COVID-19 relief bill – the American Rescue Plan, H.R. 1319 – provides new federal funding for community-based mental health services.

Section 9817 of the American Rescue Plan, which went into effect on April 1, increases the amount of federal reimbursement available under the Medicaid program for one year for what the law calls Home and Community Based Services (HCBS). There may be future legislation that extends this funding.

The law adds an additional 10% to the federal "match" rate. If a state's match rate was 60% (the federal government paid 60% of the cost), for example, the new match rate would be 70% (with the federal government paying 70% of the cost). The new match cannot be more than 95%.

HCBS are services that help people live and participate in the community -- like intensive case management, peer support services, assertive community treatment, skills training, and supported employment. These services also help individuals avoid criminal justice involvement and may be used to divert people from jail or other congregate settings, and to facilitate re-entry.[1]

The enhanced match can be used for mobile mental health crisis teams, including as an alternative to the new funding option for such services created in a separate provision of the law.[2]

In the American Rescue Plan, what is encompassed by the term HCBS extends beyond services previously labelled as "HCBS" in Medicaid. Among other things, HCBS includes, and the enhanced match applies to:

1. case management services,

2. mental health rehabilitative services, which encompasses a broad range of skill building and other services such as assertive community treatment, peer support services, and services to help individuals secure and maintain housing,

3. services in a waiver (including a Section 1115 Medicaid demonstration waiver) or provided through the Section 1915(i) option, such as supported employment and start-up costs for individuals transitioning to community housing, which may include security deposit, furniture, and utility startup,[3] and

4. "[s]uch other services specified by the Secretary of Health and Human Services."

The new funding is meant to expand existing service capacity by supplementing what states now spend on community-based services. The law provides that the "State shall use the Federal funds … to supplement, and not supplant, the level of State funds expended for home and community-based services for eligible individuals through programs in effect as of April 1, 2021," and that the "State shall implement, or supplement the implementation of, one or more activities to enhance, expand, or strengthen home and community-based services under the State Medicaid program." It is estimated that the enhanced match could generate nearly $13 billion in new services.

The U.S. Department of Health and Human Services may provide further guidance on use of the funds in the future.

See American Rescue Plan (Section 9817) at https://www.congress.gov/117/bills/hr1319/BILLS-117hr1319enr.pdf.

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[1] *Defunding" the Police: and People with Mental Illness*, Bazelon Center for Mental Health Law (Aug. 2020), http://www.bazelon.org/wp-content/uploads/2020/08/Defunding-the-Police-and-People-with-MI-81020.pdf; *Diversion to What? Evidence-Based Mental Health Services That Prevent Needless Incarceration,* Bazelon Center for Mental Health Law (Sept. 2019), https://secureservercdn.net/198.71.233.254/d25.2ac.myftpupload.com/wp-content/uploads/2019/09/Bazelon-Diversion-to-What-Essential-Services-Publication_September-2019.pdf; Martone et al., *Olmstead at 20: Using the Vision of Olmstead to Decriminalize Mental Illness* (Sept. 2019), https://www.tacinc.org/wp-content/uploads/2020/02/olmstead-at-twenty_09-04-2018.pdf.

[2] *An Alternative to the Police: New Funding is Available for Mobile Mental Health Crisis Teams*, Bazelon Center for Mental Health Law (April 2021), . https://secureservercdn.net/198.71.233.254/d25.2ac.myftpupload.com/wp-content/uploads/2021/04/ARP-mobile-crisis-provisions-final.pdf.

[3] *When Opportunity Knocks: How the Affordable Care Act Can Help States Develop Supported Housing for People with Mental Illnesses*, Bazelon Center for Mental Health Law 15-16 (April 2014) (discussing 1915(i) option), http://www.bazelon.org/wp-content/uploads/2017/01/When-Opportunity-Knocks.pdf.

Monroe County, Indiana: Consultation on Criminal Justice Reform

Preliminary Demographic Research Document

July 2019

I. Basic Demographics:

Monroe County is home to approximately 146,000 people, nearly 92% of whom were born here.

A. Poverty:

Monroe County's income and resource profile indicate heightened levels of need as compared to other counties in Indiana. Most notably, Monroe County reported the highest poverty rate in the state as compared to other counties in Indiana[i].

- **21.6% of residents** lived below the poverty line in 2017, exceeding the state average by approximately 80% percent.
- The county median household income in the same year ranked 62nd in the state as the 50th percentile of households **earned $49,180**.
- **17.2% of children** under the age of 18 lived below the poverty line, which earned Monroe County a state ranking of 46th across all other Indiana counties:

Income and Poverty	Number	Rank in State	Percent of State	India
Per Capita Personal Income (annual) in 2017	$39,880	49	88.3%	45,1
Median Household Income in 2017	49,180	62	90.8%	$54,1
Poverty Rate in 2017	21.6%	1	162.4%	13.3
Poverty Rate among Children under 18	17.2%	46	96.6%	17.8
Welfare (TANF) Monthly Average Families in 2018	55	22	0.9%	6,0
Food Stamp Recipients in 2018	7,612	18	1.3%	605,8
Free and Reduced Fee Lunch Recipients in 2018/2019	5,300	22	1.0%	514,9

Sources: U.S. Bureau of Economic Analysis; U.S. Census Bureau; Indiana Family Social Services Administration; Indiana Department of Education

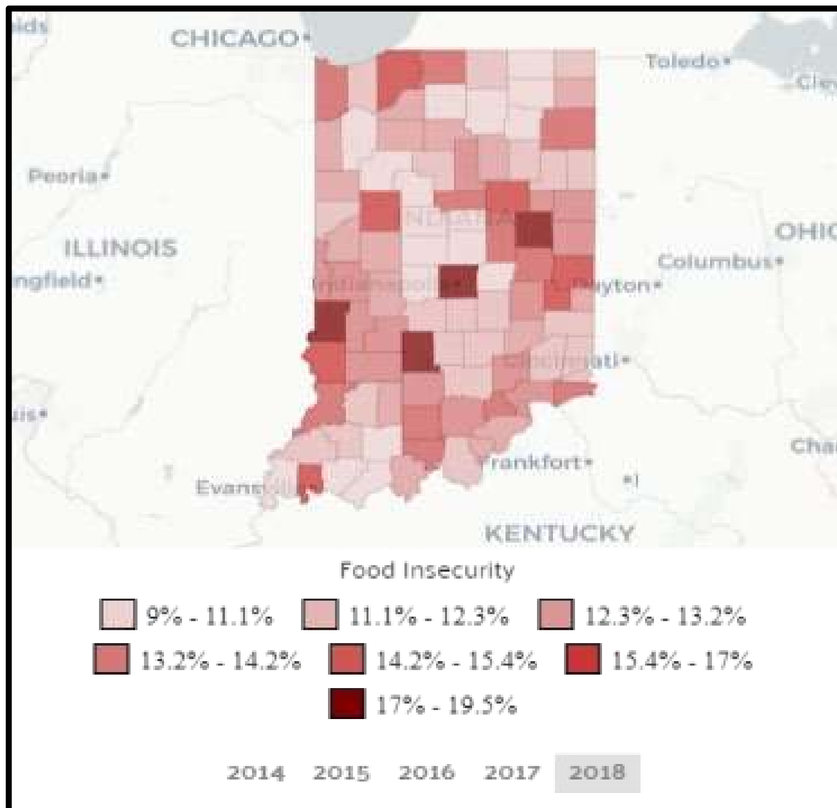
An average of 55 families per month benefitted from TANF assistance in 2018, while over 7,500 families benefitted from Food Stamp services[ii].

- Over a 10-year interval, this figure marks a decrease of approximately 80% in the number of eligible families benefitting from TANF services. Food Stamp recipients totaled 7,612 in 2018, marking a continuation of longitudinal trends across a 10-year period. Monroe County ranks 18th

in the state for Food Stamp recipients, and this 2018 metric marks a slight decline of 4.4% over this same interval.

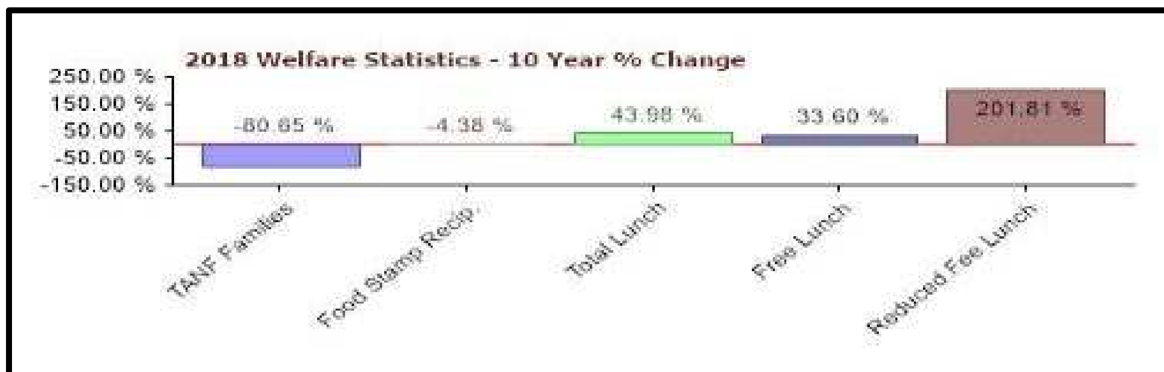
- Food Stamp benefits, therefore, report a higher level of stability as compared to TANF benefits, possibly because TANF's means-tested structure and administrative burden are discouraging eligible families from applying or continuing to receive benefits.

Monroe County reports the second-highest prevalence of food insecurity in Indiana[iii]:



In the above map, Monroe County is one of the four most darkly shaded counties. Compared to neighboring counties, its food insecurity conditions are notably worse.

- Free and reduced lunch recipients in Monroe County totaled 5,300 in 2018, ranking 22nd in the state among other counties.



- Over a ten-year interval, free lunch recipients increased by 33.6%; the population benefitting from reduced lunch services increased by over 200 percent in 2018, corroborating that food insecurity in Monroe County is a significant element of its poverty conditions[iv]

There are also significant racial strata dividing those living below the poverty line in Monroe County. In 2017, white families were far less likely than families in almost all other racial groups to live below the poverty line.[v]

- White households comprise 86.4% of the Monroe County population, while only 9.7% live below the poverty line.[vi]
- Comparatively, Black or African American households represent 3.6% of the county population, of which 48.9% live below the poverty line. This trend is present across American Indian, Asian, and Hispanic/Latino households.

B. Educational Attainment:

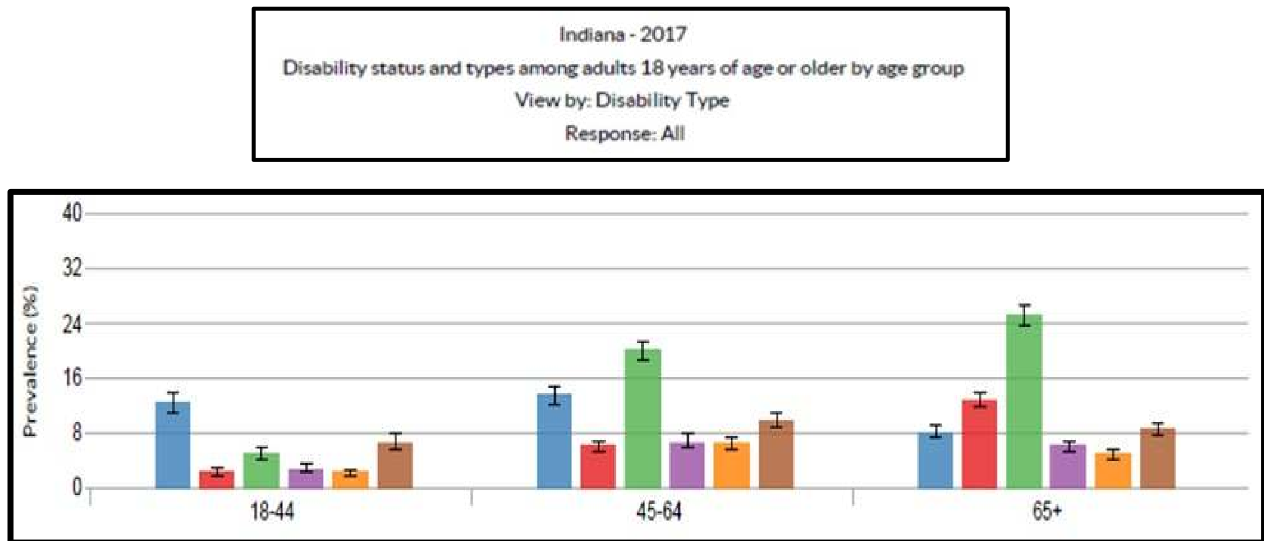
The 2015-2018 Monroe County Community Health Assessment and Improvement highlights that "Monroe County falls in the top 10th percentile of all U.S. counties regarding the high level of education of its residents, with a high school graduation rate of 94% and 77% of adults with at least some college education."[vii]

- Of the population over the age of 25, 21.8% have earned a high school diploma or equivalency;
- 6.8% hold an associate degree or partial college education, and
- 45.8% hold a bachelor's or graduate degree.
- 8.1% of the county population has not earned a high school diploma. There were 21 high school dropouts in Monroe County in 2018, marking a net change of -47.5% from 2017.[viii]
- The state of Indiana reported a net change of -8.2% in high school dropouts, indicating that Monroe County is achieving progress in that it is following statewide trends.

C. Disability Rates:

- 8.5% of those under 65 in Monroe County have a disability.[ix] Other estimates surmise that 9.7% of Monroe County Residents have a disability.[x]

- Statewide distributions of disability types:[xi]



Percentage Breakdowns (Among entire Indiana population 18 years and older):[xii]

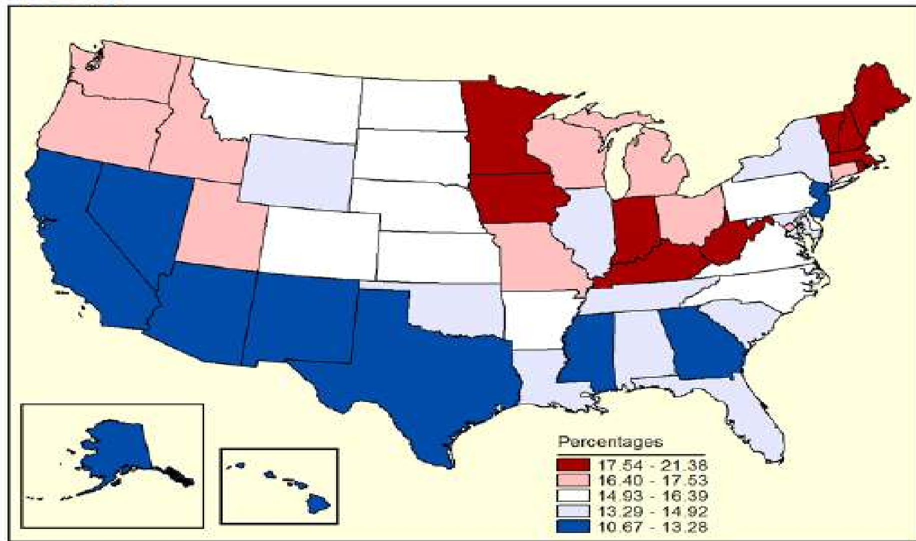
Cognitive Disability	12%
Hearing Disability	5.2%
Mobility Disability	12.9%
Vision Disability	4.5%
Self-Care Disability	3.9%
Independent Living Disability	7.9%

Note: Mental illness may be included in either Cognitive Disability or Independent Living Disability and mental illness is likely undercounted.

Mental Illness Rates:

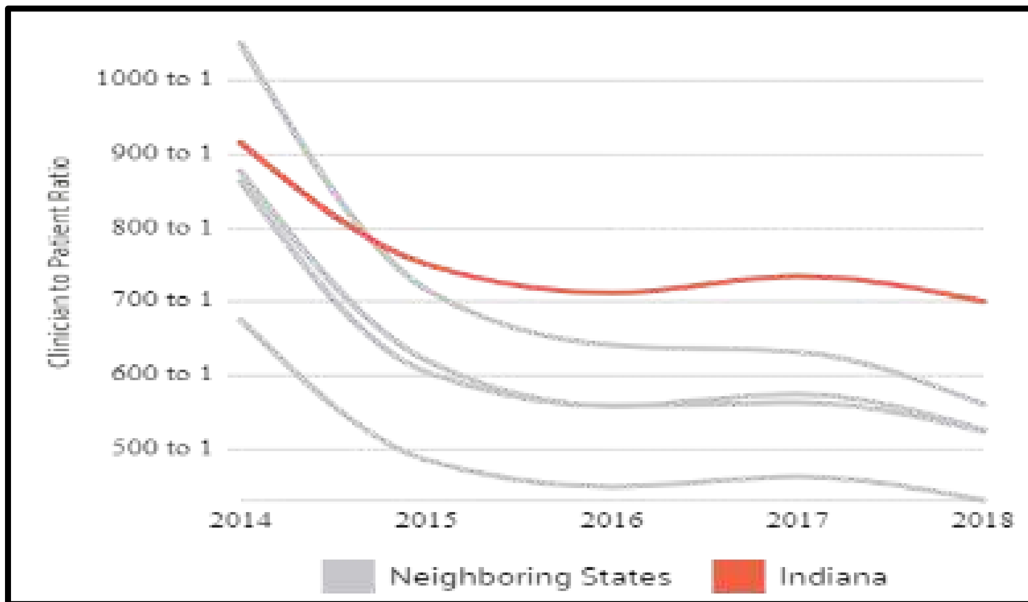
- In 2016, 7.69% of Indiana adults had a major depressive episode.[xiii] 7.69% of Monroe County's adult population is approximately 11,300 people.
- In the same year, the state reported that 4.93% of adults had a serious mental illness. 4.93% of Monroe County's adult population is approximately 7,240 people.
- 41.6% of adults in Indiana with mental illnesses report having used a mental health service (2015).[xiv]
- The United Health Foundation reported that 14.7% of adults in Indiana reported "frequent mental distress" in 2018, which ranks 42nd in the U.S. (only 8 states have a higher prevalence).[xv]
- However, national survey data show between 20 and 25% of Indiana (adult and juvenile) residents reported having a mental illness (of any kind), making it one of nine states to have the highest prevalence of this variable. 20% of Monroe County's population is about 29,300 people.
- Between 17.5% and 21% of residents in Indiana reported having received treatment for a mental illness, making it one of 11 states to report this level of prevalence.

Figure 29a ***Received Mental Health Services in the Past Year among Adults Aged 18 or Older*****, by State: Percentages, Annual Averages Based on 2016 and 2017 NSDUHs**



Source: SAMHSA, Center for Behavioral Health Statistics and Quality, NSDUH, 2016 and 2017.

- Monroe County is one of three in Indiana to be designated as a Mental Health Care Health Professional Shortage Area by IU Health Bloomington Hospital.[xvi]

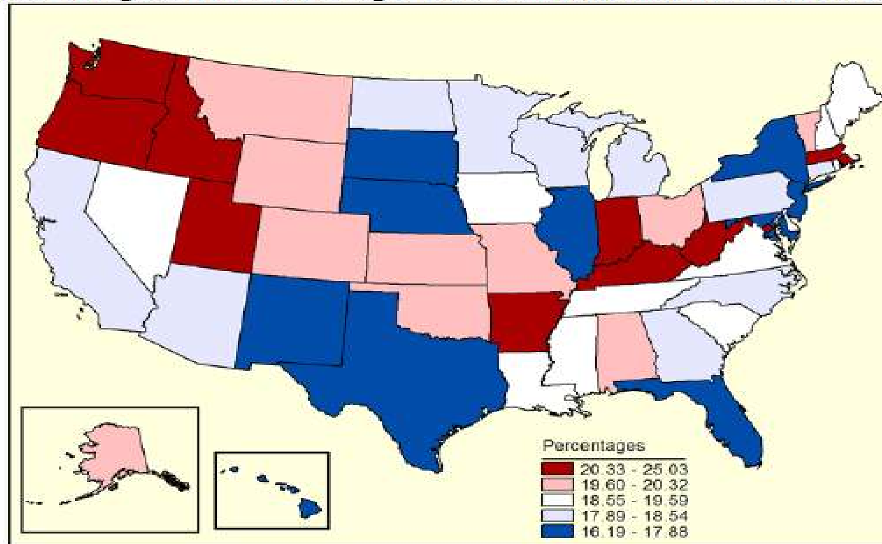


- Mental Health providers in Monroe County see an average of 444 patients per year, as of 2018.[xvii] This marks a 6.33% decrease from 2017. It reflects a continuation of the overall 4-year trend of improving patient to clinician ratios at the state level:
- *However, it is notable that the* ***shift in patient to clinician ratio has been driven as well by the ultimate decline in the total number of providers****, from 916 providers in 2014 to 701 in 2018. So*

it may be that the decline in the number of providers ***has discouraged Indiana residents from seeking help*** *for mental illness.*

- *National Survey on Drug Use and Health (2016-17)*[xviii]*:*

Figure 28a ***Any Mental Illness in the Past Year among Adults Aged 18 or Older,*** **by State: Percentages, Annual Averages Based on 2016 and 2017 NSDUHs**



Source: SAMHSA, Center for Behavioral Health Statistics and Quality, NSDUH, 2016 and 2017.

Substance Use Disorder Rates:

- In 2016, Indiana reported 7.12% of people age 12+ had Substance Use Disorder.[xix]
- In the same year, the state reported a Drug Overdose Death rate of 24 people per 100,000. In 2017, this number increased to 29.4 people per 100,000.[xx]
- State Opioid Overdose Death Rate: 13 deaths per 100,000. This statistic specifies opioid overdose-related deaths, as compared to all drug overdoses. **Opioids are therefore responsible for approximately half of overdose-related deaths in Indiana.**
- In Indiana as a whole, drugs were responsible for **9 out of 10 poisoning deaths in 2017**. Of this total, 90% were unintentional. **The rate for males was 1.9 times higher than that of females**, and people **ages 25-34 had the highest overdose death** rate among all ages. [xxi]

- (See map) Indiana reported that between 6.78% and 7.44% of its residents aged 12 and older were diagnosed with a substance use disorder.[xxii]

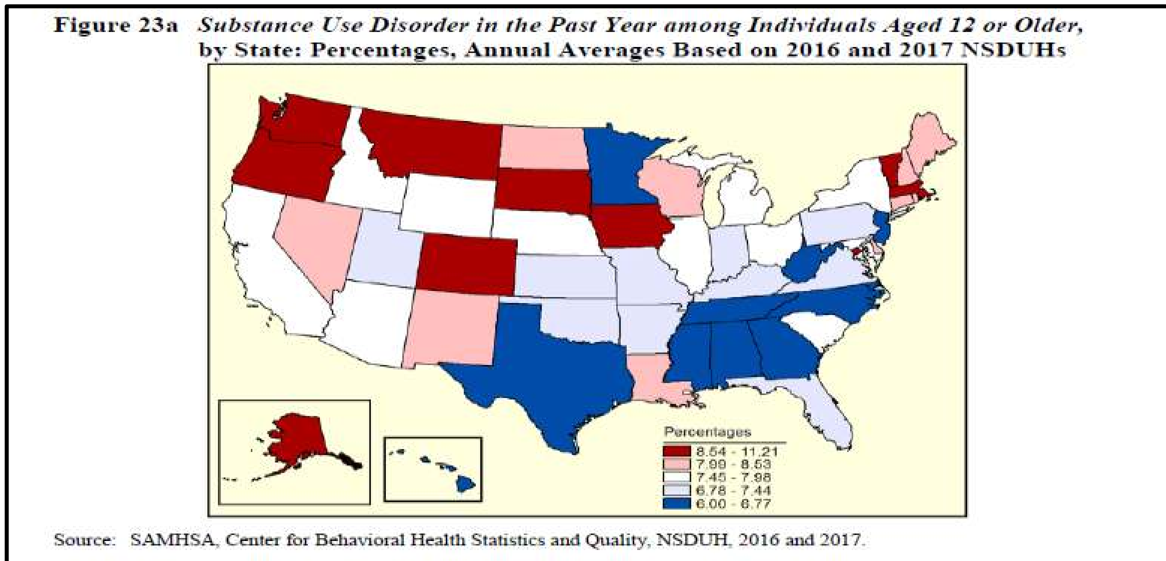


Figure 23a ***Substance Use Disorder in the Past Year among Individuals Aged 12 or Older,*** **by State: Percentages, Annual Averages Based on 2016 and 2017 NSDUHs**

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, NSDUH, 2016 and 2017.

Indiana Injury Prevention Resource Guide:

- "In January 2015, the prescription drug abuse epidemic in Indiana gained national prominence for its link to an epidemic of acute HIV infection in a rural city resulting from sharing syringes while injecting oral oxymorphone (OPANA®). As of June 2015, 169 people have been diagnosed with HIV; approximately 88% of those are coinfected with hepatitis C. The affected county, **[Scott County**][xxiii], ranks second in the state for average age-adjusted prescription drug overdose mortality rates (33.48 for years 2002-2013)."[xxiv]
    - Scott County is in southeastern Indiana, in roughly the same region as Monroe County though they do not share a border.
- Of the 1,288 total deaths in Monroe County in 2016, 22 were reported to be drug-related.[xxv]
- There were 30 total suicide deaths in Monroe County in 2016.
- There were 78 confirmed cases of Hepatitis C (acute and chronic) in Monroe County in 2016, as well as 6 new cases of HIV.[xxvi]
- "*The* [State Epidemiological Outcome Work Group (SEOW)] *created the priority scores tool to be able to* ***measure and compare the severity of substance abuse among Indiana counties****. By looking at the severity of consumption and consequences of alcohol and other drugs (measured by the rate and the frequency of occurrence),* ***counties received a priority score based on their need for intervention****. Each category was made up of different indicators that all could be found in county level data. The overall substance abuse priority score was developed to* ***assess severity of consumption and consequences of alcohol and other drugs*** *within each county."*

- "Monroe [County] ranked in the top 25% for priority scores for methamphetamine use. According to the Indiana State Police, 35 meth labs were seized in Monroe County in 2015. The most labs, 245, were seized in Delaware County." (p.29)
    - SEOW rankings for Monroe county on the state level: Marijuana priority: 6 (tied); Cocaine/heroin: 8 (tied); Prescription Drugs: 3; Overall Substance abuse: 5. (p.30)
- Monroe County ranks 1st in the state for alcoholic beverage expenditure (p.30)
- *"Monroe County was among the top 10% of all Indiana Counties in five categories of drug/alcohol use in 2013, 2014 and 2016 and 4 categories in 2015…"*[xxvii]

Priority Ranking for Substance Abuse in Indiana

Rank Top 10% Indiana Counties	2013 Priority #/ Score		2014 Priority #/ Score		2015 Priority #/ Score		2016 Priority #/ Score	
Alcohol	2	240	2	230	2	220	2	230
Marijuana	4	217	4	233	3 (tied)	217	6 (tied)	167
Cocaine=Heroin	7	213	7	200	in top 25%	188	8 (tied)	175
Prescription Drugs	6	200	4	213	3 (tied)	213	3*	200
Overall Substance Abuse	3	199	2	203	2	192	5	174
* four counties tied for 2nd								

fig. 17 Priority Rankings for Substance Abuse in Indiana
Indiana State Epidemiological Outcome Work Group, 2013-16

- Nationwide, **Whites and Native Americans had similar rates of alcohol use disorders and both rates were higher than those for other racial/ethnic groups**. The rate of drug use disorders was estimated to be similar for Non-Hispanic Whites, Non-Hispanic Blacks, and Native Americans and all were significantly higher than rates of drug use disorders among Asian/Pacific Islanders and Hispanics.[xxviii] In spite of similar prevalence of alcohol and drug use disorders among Whites and Blacks, incarceration rates for alcohol- and drug-related offenses are significantly higher among Blacks.

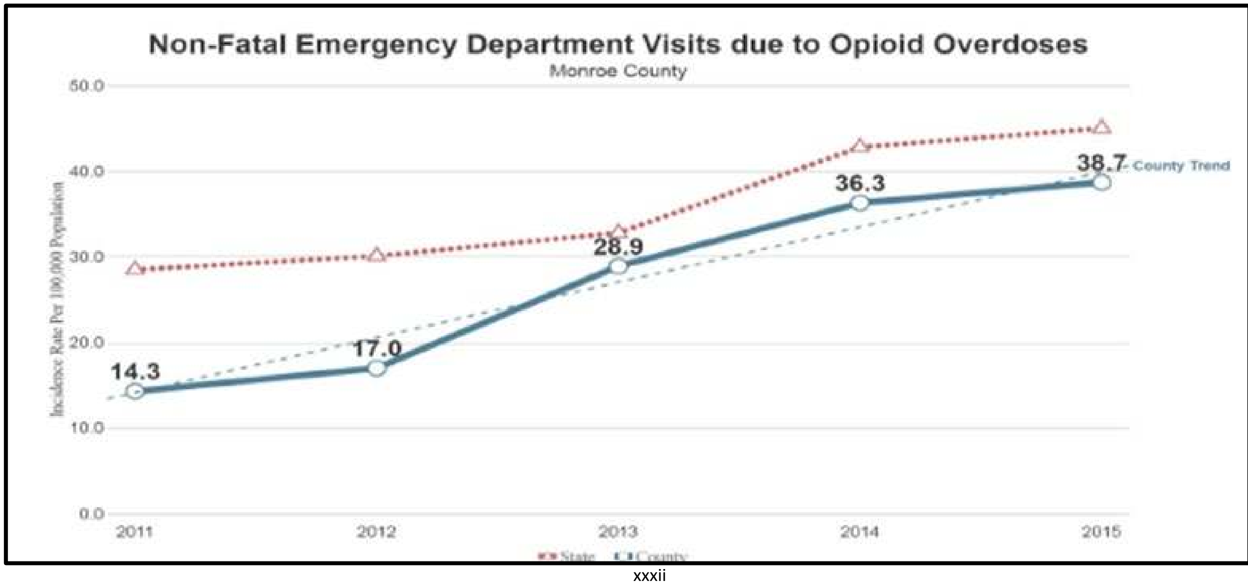
D. Homelessness Rates:

- Statewide estimate of chronically homeless individuals: 486 in the year 2017[xxix]
- Statewide homelessness resource metrics:[xxx]
    - Nighttime residence unsheltered: 249
    - Nighttime residence in shelters: 2,476
    - Nighttime residence in hotels/motels: 1,266
    - Veterans experiencing homelessness: 539
    - Persons experiencing chronic homelessness: 449

- Unaccompanied Young Adults experiencing homelessness: 268
- Total family households experiencing homelessness: 481

II. Addiction and Mental Health Services:

- In 2016, **60.5 people per 100,000** in Monroe County visited the Emergency Department for an opioid-related reason. The Indiana average is 104.5 per 100,000.[xxxi]
- In the same year, 34.4 people per 100,000 visited the ER for heroin-related reasons. The Indiana average is 70.7.



[xxxii]

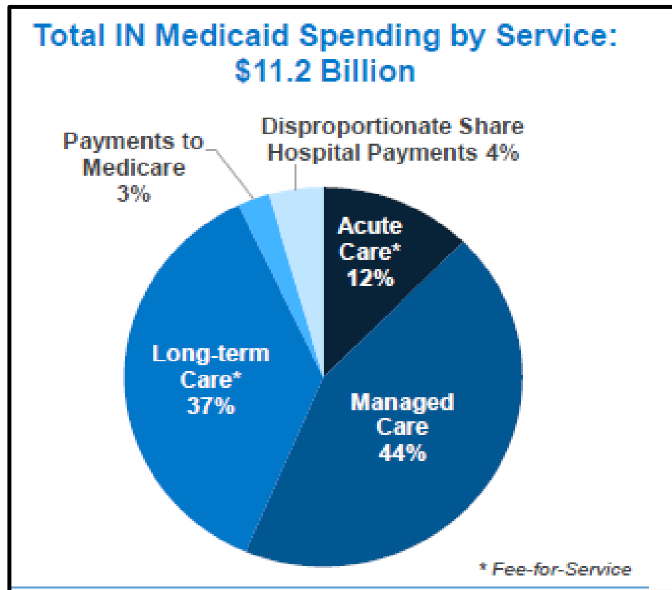
Substance abuse treatment systems in Indiana and elsewhere "have traditionally used an acute-care approach to address SUDs. The new paradigm proposed by the Substance Abuse and Mental Health Services Administration (SAMHSA) is a continuing-care model. It acknowledges the long-term nature of SUDs and emphasizes the need for ongoing access to services built around the concept of recovery. Recovery-oriented systems of care (ROSC) require agencies and providers to develop a full continuum of SUD services. This continuum of services should include … nontraditional services, such as recovery maintenance, peer services, and community-based recovery support services."[xxxiii]

A. Number of People Accessing Non-Crisis Addiction Services:

- In 2013, there were approximately 26,000 admissions to substance abuse treatment programs in the state of Indiana.[xxxiv] Most of these admissions (93.1%) were to outpatient treatment centers, with only 10.5% and 12.0% going to residential or hospital inpatient care, respectively.

B. Mental Health and Substance Abuse Capacity

State Spending and Budgets for Mental Health/Substance Abuse Services[xxxv]:



III. Monroe County Budget

A. Monroe County Budget 2017; Relevant Expenditures:[xxxvi]

- **Total Expenditures: $15.5 million**
  - Health: $1.19 million
  - Health Maintenance: $72,672
  - Public Safety LOIT: $1.17 million
  - County Offender transportation: $3,000
  - Juvenile Facility COIT: $2.58 million
  - Probation User fees, Adult: $309,313
  - Diversion User Fees: $413,382
  - Court Alcohol/Drug Services Fees: $350,848
  - County Corrections/Misdemeanant: $80,518
  - Alternative Dispute Resolution: $21,000

B. Monroe County 2018 Budget (relevant Expenditures):[xxxvii]

- **Total: $13.08 million**
  - Health: $1.27 million
  - Local Health maintenance: $72,672
  - User Fees, Adult Probation: $317,351
  - User Fees, Juvenile Probation: $18,883
  - County Offender transportation: $3,000
  - User Fees- Diversion Programs: $317,080
  - User Fees, Drug/Alcohol Court: $291,709
  - User Fees: Project Income/Job: $687,781
  - For Context:
    - Civic Center: $2.04 million

C. Monroe County 2019 Adopted Budgets ():[xxxviii]

- **Total: $16.5 million**
  - Health: $1.3 million
  - Local Health Maintenance: $72,672
  - User Fees for Adult Probation: $320,520
  - County Offender transportation: $3,000
  - Use Fees, Drug/Alcohol Court: $155,595
  - User Fees, Diversion Programs: $232,825
  - User Fees: Project Income/Job: $578,285
  - Misdemeanant/County Corrections: $117,450
  - For Context: (Same budget):
    - Home Rule for Monroe County (Public Safety): $1.89 million
    - Convention and Visitors Bureau: $2.13 million

D. Three-Year Budget Trends:

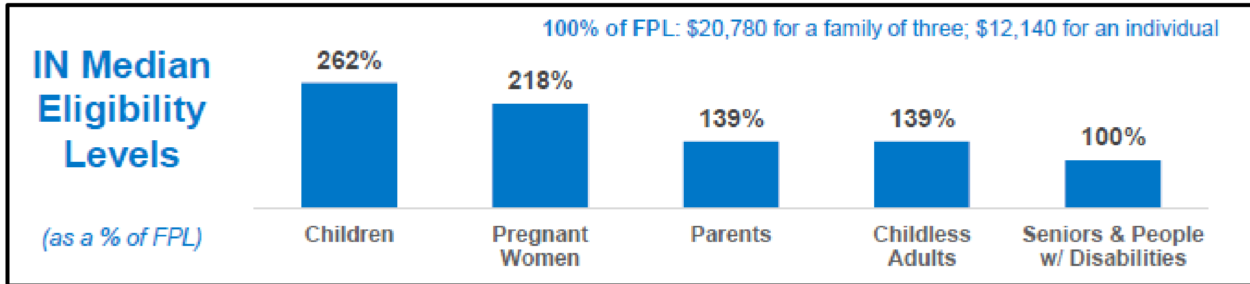
- **Health Spending** net change 2017-19: +$110,000, approximately a 10% increase from 2017 spending.
- **Public Safety** spending net change: +$720,000, approx. 62% increase from 2017 spending.

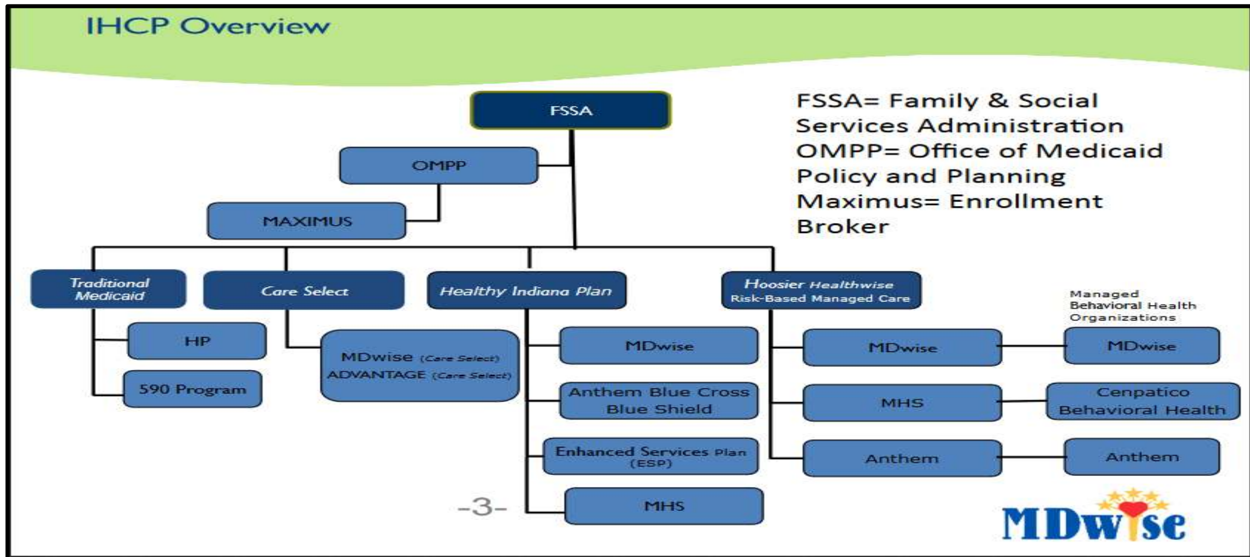
    - **Adult Probation** fees: +$11,207, approx. 4% increase from 2017 spending.
    - **Diversion Programs**: net change -$180,557, approx. 44% decrease since 2017.
    - **Drug/Alcohol Court User Fees**: net change -$195,253, approx. 55% decrease since 2017.
- **2017 Major takeaway**: The county spent more on a Juvenile facility ($2.58 million) than on Diversion Programs, Drug/Alcohol Court fees, and Probation user fees **combined ($1.07 million)**. The sum of these services is also less than Public Safety expenditures. (The Juvenile COIT fee appears to be a construction expenditure, given that it does not appear in the 2018 budget or the 2019 adopted budgets.)
- **2018 spending** shows the same trend as the year before; MC spent more on the Civic Center ($2.04 million) than those same three items (Diversion, D/A Court, and Probation fees) combined ($926,140).
- **The 2019 budget** suggests the same thing. Spending on the same three items totaled $708,940 compared to $1.89 million spent on Home Rule for Monroe County (Public Safety). This total spending for Diversion/Drug and alcohol Court fees/Probation fees marks a 34% decrease in spending in these areas since 2017.

IV. Indiana Medicaid Information

- Federal and state contribution to Medicaid in Indiana:
    - FY 2017: Federal contribution totaled 72.2%, while state contribution totaled 27.8%.[xxxix]
        - FY2020 Federal match covers 65.84% of Medicaid coverage.[xl]
- In Indiana, Medicaid covers[xli]:
    - 1 in 6 adults ages 19-64
    - 1 in 3 children
    - **3 in 7 individuals with disabilities**
    - 51% of children with special health care needs
- Number of people served (specifically the number of clients with a mental illness or substance use disorder): [xlii]
    - **5,820** individuals with disabilities received Hoosier Care Connect benefits in April 2019.[xliii]
        - **1,101** individuals in Monroe County received Hoosier Care Connect Benefits in April 2019.
    - **769** individuals categorized as “Working Disabled MEDWORKS” or “Working Disabled MEDWORKS Improved” received Hoosier Care Connect benefits in April 2019.

- Waiting List: there are 1,368 Indiana residents who qualify as having an Intellectual/Development Disability on the waiting list for Medicaid section 1915(c) Home and Community Based Services Waivers





xlivxlvxlvi

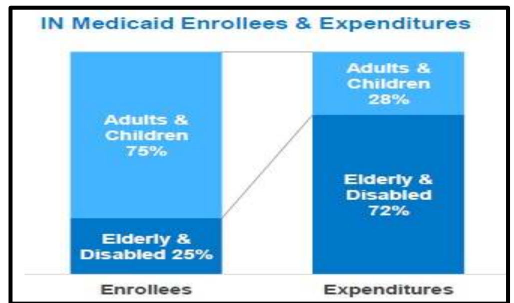
- The available programs include:
  - Traditional Medicaid
    - For disabled applicants to qualify for benefits, the individual's disability must meet the definition of the Social Security Administration.
    - Disability qualification is determined by the Medical Review Team through the applicant's medical records and may request procedures in order to collect the necessary information.
    - The Division of Family Resources "is responsible for determining initial and continuing eligibility for Medicaid disability." In order to qualify, "a person must have a significant impairment that is expected to last a minimum of 12 months. The **MRT** makes this decision and notifies the **DFR**.
      - "An individual receiving Supplemental Security Income (SSI) or Social Security Disability Income (SSDI) for his or her own disability

automatically meets the State's disability requirement without requiring a separate disability determination by MRT."[xlvii]

- Income limit for disabled individuals: $1,040 per month as compared to an Adult (family of 1) benefit which has an income limit of $1,454 per month.[xlviii]
- Home and Community Based Services (Programs and Waivers): Options are meant for individuals with special "medical or developmental needs to live in the least restrictive setting" while receiving the care they need.
  - Options include: Adult Mental Health and Habilitation, Aged and Disabled Waiver, Behavioral and Primary Healthcare Coordination, Child Mental Health Wraparound, and other waivers which provide options for family and community needs.[xlix]

- Managed Care Programs: Healthy Indiana, Hoosier Care Connect, Hoosier Healthwise.

[l]



[li]

V. Insurance Profile of Monroe County:[lii]

- 91.6% of county population has health coverage; 55% on employee plans, 10.7% on Medicaid, 9% on Medicare, 15% on non-group plans, 1.39% on military/VA plans.
- As of 2017, 8.36% of Monroe County residents are uninsured. Between 2016 and 2017, the percent of uninsured citizens declined from 9.8% to 8.36%. Medicaid enrollment appears to have increased from 2015 to 2017.
  - State Uninsured Level in 2017 for those under 64: 8%[liii]
  - National Uninsured Level in 2017 for those under 64: 10%
  - State Uninsured Level for those 19-64, 2017: **11%**[liv]

- National Uninsured Level for those 19-64, 2017: **12%**

- Per capita personal health care spending was $8,300 in 2014[lv], which matched the state average spending per capita ($8,300) and slightly exceeded the national average of $8,045.[lvi]
    - National per capita Health care spending: $10,739 in 2017.[lvii]
- Within 100 miles of Bloomington, IN there are 45,051 medical professionals that are in-network for Hoosier Care Connect plan members (elderly, blind/disabled who do not qualify for Medicaid).[lviii]

VI. Need versus Capacity Assessment

A. Need:

- Indiana ranked 41st out of 51 (all 50 states and D.C.) for Prevalence of Mental Illness, which is composed of six variables related to mental health issues.[lix]
- This ranking correlates with higher prevalence of mental health issues and substance abuse programs and suggests a significant area of need. This is especially true considering the results of the NSDUH survey which reported between 17-21% of the Indiana population as having received care.
- In the Access to Care assessment, Indiana ranked 33rd out of 51. There were nine measures used to calculate this ranking related to unmet need, insurance status, consistency of treatment, and workforce support availability.[lx]
    - This corroborates the NSDUH survey (below), which showed a significant portion of Indiana residents, almost 14% between the ages of 18 and 25, as needing care but not receiving it.

B. Capacity:

- Within Adult Evidence-Based Practices, Indiana is below the national average in providing almost every measure of care availability except for Supported Housing:[lxi]

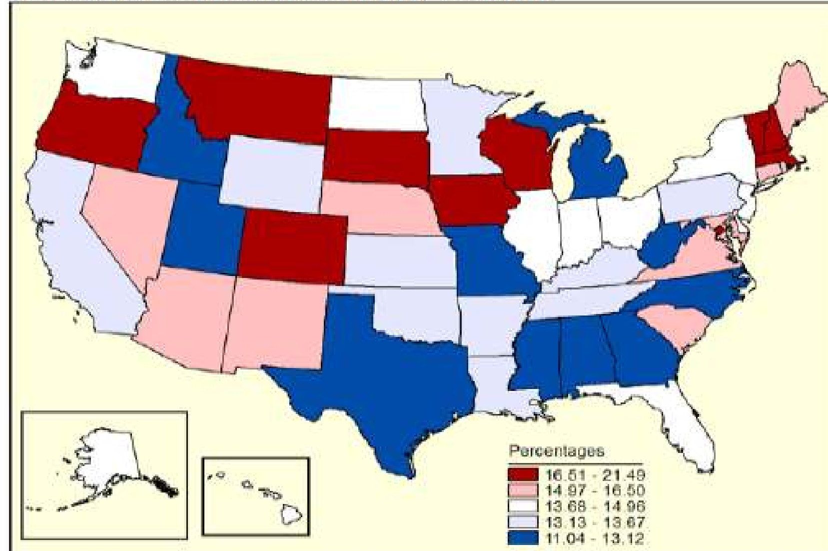
Adult Evidence-Based Practices	State Number	State Rate	U.S.	U.S. Rate
Assertive Community Treatment	879	1.1%	74,032	2.1%
Supported Housing	4,800	5.8%	89,414	3.0%
Supported Employment	1,203	1.5%	62,596	2.0%
Family Psychoeducation	-	-	35,658	2.8%
Integrated Dual Diagnosis Treatment	3,540	4.3%	237,513	11.7%
Illness Self-Management and Recovery	6,870	8.4%	318,831	20.0%
Medications Management	-	-	554,087	34.6%

- According to the same report, Indiana is behind on three Outcome measures as well:

Outcome	State Number	State Rate	U.S.	U.S. Rate
Adult Criminal Justice Contacts	1,639	2.8%	27,291	3.9%
Juvenile Justice Contacts	418	1.1%	6,885	3.1%
School Attendance (Improved)	-	-	14,973	33.4%

- 2016-17 data from the NSDUH Survey, show state-level gaps between those who needed treatment and those who got it. It is notable that these data likely underreport this population; it is also unclear if it includes those who are incarcerated.[lxii]
    - Among Indiana residents age 18-25, 13.68% needed but did not receive treatment for substance use in the past year. This indicates the possibility of an affordability or capacity issue in Indiana health care.
    - Among Indiana residents age 26 or older, the proportion of persons fitting the same description is notably smaller, only about 5.72%. Compared to the proportion of those aged 18-25, it appears that younger Indiana residents in need of treatment for substance use are generally less likely to receive treatment.
    - This is also true for those who needed but did not receive treatment for illicit drug use; 5.51% among those 18-25, 1.58% for those 26 or older.
    - Approximately 17.82% of all respondents aged 18-25 received mental health treatment.
        - **17.62%** of individuals 26 or older received mental health treatment.
        - In comparison to other items in this survey, we can note that while 17.8% of individuals in this sample received mental health treatment, approx. 13.8% of respondents also needed treatment but did not get it.
    - However**, a higher proportion of those 18-25 years old (7.85%) reported having a serious mental illness as compared to 4.72% of those 26 and older.** Residents age 18-25 were generally more likely to have a mental illness, serious or otherwise.

Figure 26c *Needing But Not Receiving Treatment at a Specialty Facility for Substance Use in the Past Year among Adults Aged 18 to 25*, **by State: Percentages, Annual Averages Based on 2016 and 2017 NSDUHs**



Source: SAMHSA, Center for Behavioral Health Statistics and Quality, NSDUH, 2016 and 2017.

INDIANA

Table 40 Selected Drug Use, Perceptions of Great Risk, Past Year Substance Use Disorder and Treatment, and Past Year Mental Health Measures in *Indiana*, by Age Group: Percentages, Annual Averages Based on 2016-2017 NSDUHs

Measure	12+	12-17	18-25	26+	18+
PAST YEAR SUBSTANCE USE DISORDER AND TREATMENT					
Illicit Drug Use Disorder[1,2,8]	2.48	2.52	6.22	1.82	2.47
Pain Reliever Use Disorder[2,8]	0.74	0.49	1.23	0.69	0.77
Alcohol Use Disorder[8]	5.24	1.58	10.69	4.75	5.63
Substance Use Disorder[1,2,8]	7.14	3.29	14.61	6.33	7.56
Needing But Not Receiving Treatment for Illicit Drug Use[1,2,9]	2.18	2.31	5.51	1.58	2.17
Needing But Not Receiving Treatment for Alcohol Use[9]	4.94	1.56	9.84	4.52	5.31
Needing But Not Receiving Treatment for Substance Use[1,2,9]	6.54	3.16	13.68	5.72	6.90
PAST YEAR MENTAL HEALTH ISSUES					
Serious Mental Illness[4,10]	--	--	7.85	4.72	5.19
Any Mental Illness[4,10]	--	--	27.45	19.75	20.90
Received Mental Health Services[11]	--	--	17.82	17.62	17.64
Had Serious Thoughts of Suicide[12]	--	--	11.05	3.99	5.04
Major Depressive Episode[4,13]	--	13.77	13.52	7.02	7.98

Conclusions

- **Basic demographics** show markers of inadequate health care, increasing prevalence of substance abuse disorders, and indicators of socioeconomic instability.
    - Monroe County had the **highest poverty rate** in the state in 2017, as well as one of the highest rates of food insecurity in the state.
    - The county ranks **among the highest in the state in terms of need for drug use intervention, as well as for prevalence of mental illness/shortage of aid scores**.
- Coverage of mental health counseling and substance use treatment are limited **below APA recommended annual quantities. Coverage in this respect is insufficient.**
    - There is a significant treatment gap for Indiana residents with respect to mental illness and substance use disorder treatment. **More than half of adults who need treatment do not get it.**

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[i] StatsIndiana, Indiana Public Utility Data. Accessed 04 June 2019. Monroe County Poverty rate in 2017: 21.6%; The state average was 13.3%. http://www.stats.indiana.edu/profiles/profiles.asp?scope_choice=a&county_changer=18105. This is corroborated by data from SAIPE, which is based in census data findings. United States Census Bureau, Small Area Income and Property Estimates. https://www.census.gov/data-tools/demo/saipe/#/?map_geoSelector=aa_c&s_county=18105.

[ii] TANF average families benefitting from services shows a decline of over 200 families across a 10-year period, reporting an average of 55 families in 2018. Food Stamp benefits reported 7,612 total beneficiaries with a slight decline of 349 families over a ten-year period. Free and reduced lunch services reported an increase in beneficiaries by 33.6% and 201.8%, respectively. Source: StatsIndiana, Indiana Public Utility Data and the United States Census Bureau. (see footnote [1]).

[iii] Data USA: Monroe, Indiana. “Health/Social Needs”. Data provided by the County. Monroe County reports a 17.8% prevalence of food insecurity, which ranks second in Indiana among all counties. https://datausa.io/profile/geo/monroe-county-in/#health

[iv] STATSIndiana, Indiana Public Utility Data, “Welfare Statistics in 2018”. http://www.stats.indiana.edu/dms4/new_dpage.asp?profile_id=314&output_mode=1

[v] U.S. Census Bureau sourced from American FactFinder, year 2017. https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_17_5YR_S1702&prodType=table. 9.7% of white families live below the poverty line, compared to 48.9% of Black or African American households, 20.8% of American Indian households, 32.1% of Asian households, and 8.6% of Latino or Hispanic Households. This racial disparity is increasingly stark among female-led households with no husband present: 31.8% among whites, 83.2% among Black or African American households, 0% of American Indian households, 65.3% of Asian households, and 21.3% of Latino or Hispanic households.

[vi] County racial demographics: StatsIndiana, Public Utility Data. https://www.stats.indiana.edu/profiles/profiles.asp?scope_choice=a&county_changer=18105&button1=Get+Profile&id=2&page_path=Area+Profiles&path_id=11&menu_level=smenu1&panel_number=1

[vii] Monroe County Community Health Assessment and Improvement Plan, 2017. Monroe County Health Department. https://www.co.monroe.in.us/egov/documents/1532305275_35693.pdf Corroborated by StatsIndiana and U.S. Census Bureau Data (2016 and 2017). http://www.stats.indiana.edu/dms4/new_dpage.asp?profile_id=302&output_mode=1

[viii]StatsIndiana, Public Utility Data. There were 21 high school dropouts in Monroe County in 2018, marking a -47.5% over-the-year change from 40 dropouts in 2017. http://www.stats.indiana.edu/dms4/new_dpage.asp?profile_id=326&output_mode=1

[ix] United States Census Bureau. "Quickfacts; Monroe County, Indiana". 2013-2017. https://www.census.gov/quickfacts/fact/table/monroecountyindiana#

[x] "U.S. Disability Statistics by State, County and Age", Disabled World, 2015, https://www.disabled-world.com/disability/statistics/scc.php#county

[xi] "Disability and Health Data System", Centers for Disease Control and Prevention. https://www.cdc.gov/ncbddd/disabilityandhealth/dhds/data-guide/status-and-types.html

[xii] "Disability and Data Health System", Centers for Disease Control and Prevention. https://dhds.cdc.gov/SP?LocationId=18&CategoryId=DISEST&ShowFootnotes=true&showMode=&IndicatorIds=STATTYPE,AGEIND,SEXIND,RACEIND,VETIND&pnl0=Chart,false,YR2,CAT1,BO1,,,,AGEADJPREV&pnl1=Chart,false,YR2,DISTYPE,,,,,PREV&pnl2=Chart,false,YR2,DISSTAT,,,,,AGEADJPREV&pnl3=Chart,false,YR2,DISSTAT,,,,,AGEADJPREV&pnl4=Chart,false,YR2,DISSTAT,,,,,AGEADJPREV

[xiii] Data USA: Monroe County, Indiana. "Behavioral Health Conditions", 2016. https://datausa.io/profile/geo/monroe-county-in/#health

[xiv] Data U.S.A.: Monroe County, Indiana. "Health/Access and Quality." https://datausa.io/profile/geo/monroe-county-in/#health

[xv] "Indiana Summary 2018" America's Health Rankings, United Health Foundation 2018. https://www.americashealthrankings.org/explore/annual/measure/PH_funding/state/IN

[xvi] "Community Health Needs Assessment", Indiana University Bloomington Hospital, 26 November 2019. https://cdn.iuhealth.org/resources/Bloomington-Hospital-CHNA_2018-compressed.pdf?mtime=20181219131956

[xvii] Data U.S.A.: Monroe County, Indiana. "Health/Patient to Clinician Ratios." https://datausa.io/profile/geo/monroe-county-in/#health

[xviii] "2016-2017 National Survey on Drug Use and Health National Maps of Prevalence Estimates, by State", Substance Abuse and Mental Health Services Administration 2018. See annual reports for more State and Sub-state level data. https://www.samhsa.gov/data/data-we-collect/nsduh-national-survey-drug-use-and-health

[xix] Data USA: Monroe County, Indiana. "Health/Behavioral Health Conditions", 2016. https://datausa.io/profile/geo/monroe-county-in/#health

[xx] "Drug Overdose Death Rates in Indiana and the United States 2013-2017", Indiana State Department of Health, last updated 20 December 2018. https://www.in.gov/isdh/27392.htm

[xxi] Indiana Special Emphasis Report: Drug Overdose Deaths", State of Indiana Health Department, 2017. https://www.in.gov/isdh/files/2017%20SER.pdf

[xxii] "2016-2017 National Survey on Drug Use and Health National Maps of Prevalence Estimates, by State", Substance Abuse and Mental Health Services Administration 2018. See annual reports for more State and Sub-state level data. https://www.samhsa.gov/data/data-we-collect/nsduh-national-survey-drug-use-and-health

[xxiii] "HIV Infection Linked to Injection Use of Oxymorphone in Indiana," National Center for Biotechnology Information, National Institute of Health, 21 July 2016. https://www.ncbi.nlm.nih.gov/pubmed/27468059

[xxiv] Shultz, J. Indiana State Department of Health Resource Guide, "Indiana Injury Prevention Resource Guide", 2015. https://www.in.gov/isdh/files/Preventing_Injuries_in_Indiana.pdf

[xxv] Monroe County Health Department. "Monroe County Community Health Assessment and Improvement Plan", 2015-2018. https://www.co.monroe.in.us/egov/documents/1532305275_35693.pdf

[xxvi] Monroe County Health Department. "Monroe County Community Health Assessment and Improvement Plan", 2015-2018. https://www.co.monroe.in.us/egov/documents/1532305275_35693.pdf

[xxvii] Monroe County Health Department. “Monroe County Community Health Assessment and Improvement Plan”, 2015-2018. https://www.co.monroe.in.us/egov/documents/1532305275_35693.pdf

[xxviii] “Treatment and Recovery for Substance Use Disorders in Indiana,” Center for Health Policy, October 2016. Indiana University. https://www.in.gov/bitterpill/files/Treatment%20and%20Recovery%20Report.pdf

[xxix] Data U.S.A.: Monroe County, Indiana. “Health/Social Needs.” https://datausa.io/profile/geo/monroe-county-in/#health

[xxx]United States Interagency Council on Homelessness. “Indiana Homelessness Statistics,” January 2018. https://www.usich.gov/homelessness-statistics/in/

[xxxi] “Overdose Response Monroe County”, Indiana State Department of Health 2019. https://www.in.gov/isdh/27876.htm

[xxxii] “County Profiles of Opioid Use and Related Outcomes”, Indiana State Department of Health 2017. https://www.in.gov/fssa/

[xxxiii] Id.

[xxxiv] “Treatment and Recovery for Substance Use Disorders in Indiana”, Center for Health Policy, October 2016. Indiana University. https://www.in.gov/bitterpill/files/Treatment%20and%20Recovery%20Report.pdf

[xxxv] [xxxv] Henry J. Kaiser Family Foundation, “Medicaid in Indiana”, November 2018. http://files.kff.org/attachment/fact-sheet-medicaid-state-IN

[xxxvi] “Monroe County 2017 Budget”, Monroe County Government, generated 30 November 2017. https://www.co.monroe.in.us/egov/documents/1530641464_85123.pdf

[xxxvii] “Monroe County 2018 Budget,” Indiana State Government 2019. https://www.co.monroe.in.us/egov/documents/1530640030_65364.pdf

[xxxviii] “Monroe County Adopted Budget 2019”, Indiana State Government 2019. https://www.co.monroe.in.us/egov/documents/1542129035_96913.pdf

[xxxix] “Federal and State Share of Medicaid Spending,” Kaiser Family Foundation 2019. https://www.kff.org/medicaid/state-indicator/federalstate-share-of-spending/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[xl] “Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier” Kaiser Family Foundation 2019. https://www.kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/?currentTimeframe=0&selectedRows=%7B%22states%22:%7B%22indiana%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[xli] Henry J. Kaiser Family Foundation, “Medicaid in Indiana”, November 2018. http://files.kff.org/attachment/fact-sheet-medicaid-state-IN

[xlii] “Medicaid Monthly Enrollment Reports”, Indiana State Government, Family and Social Services Administration 2019. https://www.in.gov/fssa/ompp/4881.htm

[xliii] “Hoosier Care Connect is a health care program for individuals who are aged 65 years or older, blind, or disabled and who are also not eligible for Medicare.” Indiana State Government, Family and Social Services Administration, 2019. https://www.in.gov/medicaid/members/26.htm

[xliv] “Waiting List for Medicaid section 1915(c) Home and Community Based Services Waivers”, Kaiser Family Foundation 2017. https://www.kff.org/health-reform/state-indicator/waiting-lists-for-hcbs-waivers/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[xlv] Henry J. Kaiser Family Foundation, “Medicaid in Indiana”, November 2018. http://files.kff.org/attachment/fact-sheet-medicaid-state-IN

[xlvi] "MDWise 101: ICHP Overview", MDWise 2013 Annual ICHP Seminar. https://www.mdwise.org/MediaLibraries/MDwise/Files/For%20Providers/Continuing%20Education/MDwise_101.pdf

[xlvii] "Member Eligibility and Benefit Coverage", Indiana Health Coverage Programs, Indiana Family and Social Services Administration 2018, p.52. https://www.in.gov/medicaid/providers/630.htm

[xlviii] "Medicaid Eligibility Factors", Indiana State Government, 2019. https://www.in.gov/medicaid/members/59.htm

[xlix] "Medicaid Eligibility Factors", Indiana State Government, 2019. https://www.in.gov/medicaid/members/59.htm

[l] Henry J. Kaiser Family Foundation, "Medicaid in Indiana", November 2018. http://files.kff.org/attachment/fact-sheet-medicaid-state-IN

[li] Henry J. Kaiser Family Foundation, "Medicaid in Indiana", November 2018. http://files.kff.org/attachment/fact-sheet-medicaid-state-IN

[lii] Data U.S.A: Monroe County, Indiana. "Health", 2018. https://datausa.io/profile/geo/monroe-county-in/#health

[liii] "Health Insurance Coverage of Nonelderly 0-64" Kaiser Family Foundation 2017. https://www.kff.org/other/state-indicator/nonelderly-0-64/?currentTimeframe=0&selectedRows=%7B%22wrapups%22:%7B%22united-states%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[liv] "Health Insurance Coverage of Adults 19-64" Kaiser Family Foundation 2017. https://www.kff.org/other/state-indicator/adults-19-64/?currentTimeframe=0&selectedRows=%7B%22wrapups%22:%7B%22united-states%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[lv] Data U.S.A: Monroe County, Indiana. "Health", 2018. https://datausa.io/profile/geo/monroe-county-in/#health

[lvi] "Health Care Expenditures per capita by State of Residence", Henry J. Kaiser Family Foundation 2014. https://www.kff.org/other/state-indicator/health-spending-per-capita/

[lvii] "National Health Expenditures 2017 Highlights", Centers for Medicare and Medicaid Services 2017. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/downloads/highlights.pdf

[lviii] "Provider Directory", Indiana State Government Indiana Medicaid for Members 2019. https://www.in.gov/medicaid/members/114.htm

[lix] "Prevalence of Mental Illness", Mental Health America 2019. http://www.mentalhealthamerica.net/issues/ranking-states. *Mental Health Prevalence* was calculated using the following variables: Adults with Any Mental Illness, Adults with Substance Abuse disorders in the Past Year, Adults with Serious Thoughts of Suicide, Youth with at least one Major Depressive Episode in the Past Year, Youth with Substance use disorder in the Past Year, and Youth with Severe MDE.

[lx] (see [90]) *Access to Care* was calculated using the following variables: Adults with AMI who did not Receive Treatment, Adults with AMI reporting unmet need, Adults with AMI who are uninsured, Adults with Disability Who Could Not See a Doctor due to Costs, Youth with MDE who did not receive MH services, Youth with Severe MDE who received Consistent Treatment, Children with Private Insurance that did Not Cover Mental or Emotional Problems, Students identified with Emotional Disturbance for an Individualized Education Program, and Mental Health Workforce Availability.

[lxi] "Indiana 2017 Mental Health National Outcome Measures (NOMS): SAMSHA Uniform Reporting System, SAMSHA 2017. https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/Indiana-2017.pdf

[lxii] "2016-2017 National Survey on Drug Use and Health National Maps of Prevalence Estimates, by State," Substance Abuse and Mental Health Services Administration 2018. Accessed 06 June 2019. See annual reports for more State and Sub-state level data. https://www.samhsa.gov/data/data-we-collect/nsduh-national-survey-drug-use-and-health