Rock County, Wisconsin

Behavioral Health / Criminal Justice Assessment

Final Report

September, 2011

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Section 1
General Overview

Introduction and Background

In September 2010, Rock County, under the auspices of the Rock County Criminal Justice Coordinating Council (CJCC), received a Bureau of Justice Assistance (BJA) Justice and Mental Health Collaboration Planning Grant, the goal of which is to increase public safety through innovative cross-system collaboration for individuals with mental illness or co-occurring mental health and substance use disorders (MI/COD) who come into contact with the criminal justice system. A portion of the grant funding was designated to hire a consultant to conduct a full needs and resource assessment of the mental illness/alcohol and other drug abuse (MI/AODA) service system, with particular focus on the relationship of that system to the criminal and juvenile justice systems in Rock County, and then, based on the findings of the assessment, to work with the Criminal Justice Coordinating Council (CJCC) and its designated mental health (MH)/AODA ad hoc committee to create a strategic plan to deal with MI/COD issues in the County, both in general and in relationship to impact on the County's justice systems. An RFP was issued in November, 2010. ZiaPartners/TriWest responded to the RFP, were awarded the consultation contract, and began work on the project in March, 2011.

The first part of the consultant activity in this project involved performing the needs and resource assessment. This included a review of background materials and policies from MH/AODA services, Criminal Justice and Juvenile Justice Services, and from the work done by the CJCC over the past several years to make progress. Following this initial review, ZiaPartners/TriWest conducted a two-day on-site visit on April 4-5, 2011, the details of which will be described below. Following the visit, additional materials were provided for review, and preliminary recommendations were provided for review and discussion on May 2. There were follow up phone calls on May 13 and June 30, first to discuss the recommendations, and then to discuss feedback from the CJCC and other stakeholders on the recommendations and to plan next steps. In addition, TriWest staff had a series of teleconferences with a Data Workgroup formed under the auspices of the CJCC and its MH/AODA ad hoc committee, performed initial analysis of data sets and data sharing capacity, and provided some preliminary recommendations regarding data collaboration on July 8.

The next steps are to summarize findings from the assessment and the associated recommendations into this Draft Final Report. The Draft Final Report is being presented to Rock County CJCC and stakeholders in advance of the final consultant visit on August 17, which will involve translating the recommendations into the initial framework for a strategic plan for system improvement. We expect to get additional input into the Draft Report both before and after the August 17th visit, and will incorporate that input into a Final Report that will be provided to Rock County in September.

The framework for this project is best described in this quotation from the Rock County BJA grant application:

> **STATEMENT OF THE PROBLEM**: At the intersection of the justice system and the mental health (MH) and AODA systems around the country, many challenges exist. Rock County is no exception. The economic state of the County is dire, with the closing of a key employer, GM, and consequently, the businesses supporting it. Further, benefits are ending for hundreds of these workers, perpetuating the downward spiral. The County has one of the highest unemployment rates in Wisconsin, with the City of Beloit having the highest rate (18.3%). Moreover, the County Jail is burgeoning with inmates, with one inmate dying by suicide in 2009 (23 total suicides in Rock County in 2009, up from 15 in 2008). A crush of adults and juveniles with mental illness (MI) and co-occurring MI and AODA disorders (COD) [MI/COD] overwhelm available resources and are often relegated to the justice system.
>
> Yet many evidence-based, data-driven practices and policies have been developed nationally to address these challenges. **To create a strategic, collaborative plan for systemic change toward identifying and treating system-involved persons with MI/COD, Rock County must undergo a comprehensive assessment of its criminal/juvenile justice, MH, and AODA systems**. This grant will allow the County to perform this essential task. Areas connected to MI/COD need to be studied, including homelessness, Involuntary MH Commitments, County resources, County Jail, Juvenile Detention Center (JDC), and the collaborative structures required to effectively manage the problem. (emphasis ours).

It is our goal in this report to focus less on the problems and barriers (which were well-identified in the initial grant application), and more on the findings that identify improvement opportunities in the system (within limited resources) and therefore contribute to the ability of Rock County to develop solutions that leverage its existing resources and build on its existing strengths. This report will therefore target findings that contribute to the ability of the system "to create a strategic, collaborative plan for

systemic change toward identifying and treating system-involved persons with MI/AODA" both inside and outside the criminal justice system.

Summary of April On-site Visits and Additional Assessment Activities

On-site Visits: April 4-5, 2011

The following consultants provided on-site visits: Christie A. Cline, MD, MBA, and Kenneth Minkoff, MD, from ZiaPartners, and James Zahniser, PhD, from TriWest Group. The three consultants met initially with the MH ad hoc committee of the CJCC as well as with representatives of the CJCC to provide initial introduction and orientation to the consultation process. Following the orientation, the consultants met individually with a variety of settings and stakeholders. For the stakeholder focus groups, Dr. Zahniser used a structured questionnaire that he had developed, for the purpose of organizing stakeholder input.

Dr. Cline: Day One

- Sheriff and Management staff, Correctional Officers, Deputies, Jail Medical, Rock County Education and Criminal Addictions Program (RECAP)
- Juvenile Detention
- Juvenile Probation in Janesville
- Rock County Human Services MH/AODA Division Manager
- Specialty Court Judges
- Community Forum, including residents with co-occurring disorders from Red Road House

Dr. Cline: Day Two

- District Attorney
- Adult Probation and Parole (State) - Janesville
- Homeless Intervention Task Force
- Mercy Options (Behavioral Health Continuum)
- Community Providers

Dr. Minkoff: Day One

- Public Defender and Private Defense Attorney
- Janesville Counseling Center (JCC) staff
- Beloit Area Community Health Center (Executive Director and Behavioral Health Program Manager)
- Beloit Hospital (Nursing Director, Emergency Room managers, Behavioral Health Program staff, psychiatrists, and representative of Beloit Police Department)
- Community Forum, including residents with co-occurring disorders from Red Road House

Dr. Minkoff: Day Two

- Janesville Community Support Program (CSP) (including team psychiatrist)
- Rock County Administrator
- Emergency Detention Social Worker
- Family Crisis Team
- County Human Services: AODA oversight staff
- Community Crisis Response Group
- Crisis Intervention Team
- Programs for Assistance in Transition from Homelessness (PATH) staff

Dr. Zahniser: Day One

- Janesville School Social Workers
- Jackson House
- CSP Focus Group
- Rock County Human Services Administrator
- Juvenile Justice Family Focus Group - Janesville

Dr. Zahniser: Day Two

- Beloit CSP
- Beloit Counseling Center
- National Alliance on Mental Illness (NAMI) Focus Group

- Rock Valley Community Program
- Consumer Focus Group
- Janesville Chief of Police
- Juvenile Justice Family Focus Group - Beloit

At the conclusion of the second day, the consulting team met with the MH ad hoc committee of CJCC, other CJCC representatives and a broader group of community stakeholders, to present their initial findings. This presentation was well-received, and contributed to the subsequent development of a written draft of preliminary recommendations.

Materials Reviewed

Prior to the on-site visit the Rock County Project Coordinator (Elizabeth Pohlman McQuillen) gathered the following materials for the consultants to review:

- Rock County Human Services Budget and Data Reports
  - Juvenile Detention Tracking
  - Child Welfare
  - Child Substitute Care
  - AODA (Detox, Residential, etc.)
  - Clients with Intensive Mental Health Needs (CIMS) (State Hospital, other hospitals, Jackson House, and other crisis funds)
- Rock County Juvenile Justice System Program Resource Guide and MH/AODA review
- Rock County Sheriff Department policies regarding jail inmates and commitments
- Community Crisis Response Group (CCRG) meeting minutes for 2011
- CJCC: Justice and MH Ad Hoc ad hoc committee minutes for 2011
- Drug Court (Community RECAP) program information
- CJCC Community Letter (November, 2010)
- Human Services Department sites and program descriptions, plus minutes of 2009 budget meetings
- Juvenile Justice Diversion Newsletter (May, 2010)

After the on-site visit, the consultants requested additional materials, including the Jail Medical Services Contract and a variety of materials related to data collection in various information systems. The latter materials are described in more detail in the section of this report summarizing the Data Recommendations.

Development of Recommendations and Preparation of the Report

Based on the information gathered during the assessment, the consultants prepared a document entitled *Preliminary Recommendations: Findings and Next Steps*, and provided that to Ms. McQuillen on May 2, 2011. The Preliminary Recommendations were organized around "**Twelve Recommendations**" for a comprehensive strategic plan for overall improvement in the ability of the behavioral health system to address individuals and families with mental health and substance use conditions, particularly the high numbers of individuals and families with co-occurring conditions, AND improvement of the ability to create an effective system approach to those individuals with behavioral health needs with specific involvement in the public safety or criminal justice system. The document was distributed to members of the CJCC, and in particular to the members of the MH ad hoc committee. As noted above, on May 13, the consultants participated in a teleconference with representatives of the MH ad hoc committee to discuss the Preliminary Recommendations and to develop a plan for soliciting input and feedback in order to prepare the final report. This input was provided to the consultants in early June, and a phone call to discuss the feedback occurred on June 30. Initial recommendations regarding opportunities for improvement of data collection and data collaboration between MH, AODA, and Criminal Justice were provided on July 8, and the consultants responded to some initial feedback and questions about data sharing during the week of July 18.

Based on all of the input received, we have created this Final Report which builds on the initial findings and the Twelve Recommendations presented in early June.

Using the Report to Develop a Strategic Plan

Our goal in preparing this report is to help Rock County to develop a strategic plan and an implementation process to help the Rock County Behavioral Health and Criminal Justice system improve its ability to reduce incarceration and to promote more successful recovery outcomes for adults and juveniles (and their families) with mental health and/or substance use conditions and other complex needs.

Consequently, each item in the Twelve Recommendations is designed to facilitate the identification of specific steps or activities in the development of that strategic plan. This report is being distributed to members of the CJCC and its MH ad hoc committee, as well as other selected Rock County stakeholders in preparation for a full day Strategic Planning Meeting on August 17, 2011, which will be facilitated by Dr. Minkoff and Dr. Cline. The goal of this meeting will be to build on the Twelve Recommendations to create the outline of a strategic plan and a process for further development and implementation of that plan following completion of the consultant's engagement.

Glossary of Acronyms

The following glossary is provided as a reference for the acronyms used in this report.

ACT – Assertive Community Treatment

AOD – Alcohol and other drugs

AODA – Alcohol and other drug abuse

APIC – Assess, plan, identify, coordinate

BAC – Blood alcohol level

BACHC - Beloit Area Community Health Center

BH – Behavioral health

BHRSC – Behavioral Health Redesign Steering Committee

BJA – Bureau of Justice Assistance

CAC – Certified Addiction Counselor

CBRF – Community-based residential facility

CC – Counseling center

CCISC – Comprehensive Continuous Integrated System of Care

CCRG – Community Crisis Response Group

CCS – Comprehensive Community Services

CIMS – Clients with intensive mental health needs

CIT – Crisis intervention team

CJ – Criminal justice

CJCC – Criminal Justice Coordinating Council

CLT – Children's long-term

CLTS – Children's Long-Term Support

COD – Co-occurring disorders
CPS – Child Protective Services
CQI – Continuous quality improvement
CRG – Crisis response group
CSOC – Children's system of care
CSP – Community support program
CST – Coordinated services team
DD – Developmental disabilities
DHS – Department of Human Services
DOC – Department of Corrections
DRA – Dual Recovery Anonymous
EHR – Electronic health record
EMTALA – Emergency Medical Treatment and Active Labor Act
FCT – Family crisis team
FQHC – Federally Qualified Health Center
GPS – Global positioning system
IOP – Intensive outpatient treatment program
IPS – Individualized placement and support
JCC – Janesville Counseling Center
JDC – Juvenile detention center
JJ – Juvenile justice
MA – Medical assistance (Medicaid)
MH – Mental health
MI/AODA – Mental illness/Alcohol and other drug abuse
MI/COD – Mental illness or co-occurring mental health and substance use disorders
NAMI – National Alliance on Mental Illness
NIATx – Network for the Improvement of Addiction Treatment
OWI – Operating while intoxicated
PATH – Programs for Assistance in Transition from Homelessness
PO – Probation officer / parole officer
PTSD – Post-traumatic stress disorder
QA – Quality assurance
QI – Quality improvement

RECAP – Rock County Education and Criminal Addictions Program
RFP – Request for proposal
ROSC – Recovery-oriented system(s) of care
RVCP – Rock Valley Community Programs
SAMHSA – Substance Abuse and Mental Health Administration
SUD – Substance use disorder
TIC – Trauma-informed care
WG – Workgroup
YASI – Youth Assessment and Screening Instrument

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Section 2
General Findings and Twelve Recommendations

State of the System

Strengths

The Rock County Criminal Justice Coordinating Committee (CJCC) is a major area of strength in promoting opportunities for improving the overall functioning of the Criminal Justice and Behavioral Health systems. Through the activities of the CJCC in the past few years, Rock County has not only been able to attract funding to initiate and expand its Specialty Drug Court program (Community RECAP, which has recently added psychiatry time and funding for residential slots), it has promoted the creation of a successful community partnership involving judges, law enforcement, community corrections (adult and juvenile), county behavioral health, local hospitals, and other behavioral health providers. There is a shared vision within the partnership, a commitment to making systemic improvements, and excellent leadership that has emerged involving community stakeholders (such as Neil Deupree)—both county-based correctional services and behavioral health services—along with community provider partners, local law enforcement, and state Department of Corrections probation staff, in order to create change. The MH ad hoc committee of the CJCC replicates this partnership, and provides a solid working group to concentrate on behavioral health issues.

In addition, there is a wide range of excellent inpatient and outpatient MH and AODA services (as well as criminal justice diversion programs) that currently exist throughout the county, and within these programs we were particularly impressed with the dedication of the individual staff members. Further, the commitment of the CJCC partnership to make improvements continues in the face of severe budgetary challenges. Finally, during the focus groups we were impressed with the level of energy and passion that consumers and family members had for improving the system, as well as their insights into the system's current strengths and opportunities for enhancement.

Improvement Opportunities

In spite of the strength of the CJCC partnership, however, and in spite of the effectiveness of individual programs, the following finding was abundantly clear to the consulting team:

Rock County behavioral health/criminal justice services do not function well as a "System of Care."

This finding holds at multiple levels:

- There is no empowered structure or process to oversee the development of an integrated MH/AODA behavioral health System of Care.
- There is no empowered structure or process to oversee the development of an integrated behavioral health/criminal justice System of Care.
- The lack of a System of Care approach applies both to adult services and children's services, and both crisis services and routine services.
- The lack of a System of Care approach results in missed opportunities to maximize effective partnerships and collaborations between County Human Services, criminal justice services, community hospitals and other providers.
- The lack of a System of Care approach results in missed opportunities to engage consumers and families as empowered partners in the design and implementation of an effective and responsive system.

Why is the System of Care approach so important?

In systems with limited resources (as all behavioral health and criminal justice systems are), it is particularly important to design the overall functioning of the system to be matched as effectively as possible to the needs, hopes, and goals of the individuals and families with complex mental health, substance abuse, criminal justice, and other needs that are presenting for care. To the extent that the system is not well-designed and organized, it means that existing resources are mismatched or used inefficiently, contributing to poorer outcomes and higher costs**. By contrast, a successful System of Care is more than just the sum of its parts. A well-organized System of Care leverages all of its resources to produce better outcomes at lower costs.**

Because Rock County does not have a well-organized system of care, particularly for individuals with overlapping mental health and substance abuse needs, as well as overlapping criminal justice and behavioral health needs, there are multiple areas where resources are being used inefficiently. This has resulted in overutilization of the most expensive resources: incarceration and out-of-county hospitalization and

detoxification. The good news, however, is that this means that there are multiple opportunities for improvement, within a System of Care approach, that will allow Rock County to make significant progress even within the limitations of its current resources.

It is important to note that System of Care development for criminal justice populations with behavioral health needs cannot be separated from System of Care development for the behavioral health population as a whole. Individuals with or at risk of criminal justice involvement or public safety involvement are present *everywhere* in the behavioral health service delivery system. While specialized services for criminal justice populations (such as specialty courts, or Rock Valley Community Programs re-entry services) are very valuable, success derives from leveraging resources *everywhere* in the system to be more capable of successful interventions to individuals at risk. This means particularly improving services for individuals with co-occurring mental health and substance use disorder issues, who are at the highest risk of criminal justice involvement (as well as homelessness, hospitalization, and poor health). It also means improving behavioral health partnership services at every point in what is termed the *Sequential Intercept Model*—the sequence of "points" from initial police contact, through booking, arraignment, pre-sentencing/ post-sentencing diversion opportunities, jail-based services, and re-entry/community corrections services—so that all services in the system are positioned to facilitate the likelihood of a more successful result at each "intercept."

The best news is that the CJCC partnership and commitment positions Rock County well to respond to the opportunities for System of Care improvement we have identified across multiple service domains. Most of these improvement areas can be accomplished without substantial additional resources, because they involve leveraging existing resources more effectively to provide better care for individuals and families with complex needs who are at risk of criminal justice involvement or at risk of 51-15 or 51-45 commitment. The framework for the overall System of Care development is summarized in the Twelve Recommendations below.

Twelve Recommendations

The Twelve Recommendations provide the framework or outline for the development of a strategic plan for the development of an Integrated Behavioral Health and Criminal Justice System of Care. These steps are based on the consultants' broad-based experience in implementing integrated Systems of Care in other county and state behavioral health and criminal justice systems, including in Wisconsin (e.g., Milwaukee County).

1. Establish an empowered System Redesign Implementation Team.
2. Develop a shared vision of all services being welcoming (including for individuals and families at risk of criminal justice involvement), recovery-oriented, trauma-informed, culturally competent, and co-occurring capable.
3. Utilize a system quality improvement approach to make progress.
4. Collect data that identifies the population at risk and facilitates improvement activities.
5. Organize improvements in the crisis system with particular focus on individuals with co-occurring disorders.
6. Organize improvements in co-occurring capable adult mental health services for individuals with complex needs.
7. Organize improvements in co-occurring capable adult AODA services for individuals with complex needs.
8. Develop a co-occurring capable children's system of care approach in the county.
9. Improve best practice diversion services for adults through specialty courts, routine court services, and probation.
10. Improve best practice diversion services for juveniles through specialty court, family based supports, and flexible wraparound.
11. Improve behavioral health services for individuals in jail and juvenile detention, both in the facility and in transition.
12. Improve access to housing, employment, and peer support for individuals and families, especially those with co-occurring conditions.

In the next section, the findings and recommendations relevant to each step will be provided and explained in more detail.

Section 3
Specific Findings & Recommendations

Starting Places

The most effective starting place for designing a system that is better matched to the needs of its "customers" is to begin by understanding—in detail—the experience of those customers. We were very impressed that the CJCC Mental Health ad hoc committee began our orientation to the system by providing us with what they termed "Table Top" cases for discussion and consideration. These "Table Top" cases provided excellent illustration of the myriad of ways in which individuals with mental health and substance abuse conditions "fall through the cracks." These cases also provide opportunities to connect system-level recommendations with how those recommendations might improve the experiences of "real" consumers and families.

The Table Top cases were so valuable that we thought it would be useful to reproduce one of the cases as an introduction to the specific findings and recommendations, and then to reference the case at various points to demonstrate the connection between recommended improvements and clinical outcomes. This case provides a "concrete example" of how Rock County provides an extensive (and expensive) array of services, but the services are mismatched, the outcomes are poor, the process is inefficient, and system performance is dysfunctional.

Mental Health/AODA/Detention Case Scenario

A 38-year-old woman with a history of AODA treatment and various attempts at sobriety becomes intoxicated. Her family includes her husband, also with AODA problems, and two teenage children, one of whom has juvenile justice (JJ) contact. She also has treatment for Bipolar Affective Disorder (is treated in the private sector) and has at various times been stable on medication but when drinking stops taking her medication and becomes increasingly manic, hypersexual, engages in increased spending (maxing out credit cards) and has just convinced a used car salesman to sell her a car on a credit card that has been maxed out. This has led to referral to Janesville Police Department (auto theft) and when they find her, she is intoxicated, has crashed the car and now is threatening suicide stating that she intended to kill herself when she had the accident.

Due to the accident she is taken to the ER. Her blood alcohol level is .23. She is combative and accusing police and staff of mistreatment. Crisis Intervention is contacted.

Due to her blood alcohol level she cannot be admitted to a psychiatric facility (until the BAC is below .10). A referral to Tellurian Detoxification Unit is attempted but they state that she cannot come to them if on a mental health detention. She must be on a 51.45 detention (for detoxification purposes). She has been charged with auto theft and criminal damage to property and must go to jail for processing when she is released from mental health/AODA custody. She also has a history of diabetes and her blood sugars are unstable. Tellurian is concerned about this admission due to the lack of medical backup at their facility.

The ER has cleared her medically and police are awaiting instruction as to where she can be admitted. Janesville Police Department has initiated a 51.45 and has written a 51.15 detention for processing pending her discharge from the detox unit.

The client has now become threatening and attempted to leave the ER and the physician has given her an injection of Haldol to sedate her. She is eventually admitted to Tellurian Detox facility.

Twenty-four hours later, Crisis Intervention is contacted stating she is ready for discharge and is no longer incapacitated by alcohol. She is picked up by Rock County Sheriff (due to pending criminal charges and jail hold) and brought to Crisis Intervention for a suicide assessment.

Crisis Intervention meets with her and she denies that her behavior was suicidal in nature. She states she is not suicidal. She has a private provider and states she will see her doctor when she gets out of jail. In the meantime her spouse has been calling complaining of her sexual behavior with other men and stating she has not been taking her medication. She has her medications at home; she is being admitted to the jail (it is Friday) and will not appear in jail court until Monday afternoon. Her husband is not home when staff calls to have him bring her medication to the jail and he is not expected to be at home this weekend. It is unclear how these medications will be provided.

In attempting to develop a safety plan for her, Crisis Intervention has instructed jail staff that she is ok to be put in with the general population. However she has no medication and has not been taking them consistently prior to this detention. She has had no medication at detox. Further, when she is ready for release from jail, there will be no discharge planning unless she becomes psychotic or suicidal, thus establishing eligibility for county MH services.

This case demonstrates a number of improvement opportunities at the heart of our findings. Here is a partial list of items that can be improved or developed:

- Crisis intervention protocols for working with clients with co-occurring disorders
- Crisis intervention protocols for continuity of care through the crisis
- Admission protocols and co-occurring disorder capability of both the psychiatric inpatient unit and the detoxification program

- Protocols necessitating extensive time in the ER for both the client and the police
- Usual protocol that requires sequencing of detoxification (51.45) first before psychiatric inpatient care (51.15) in a client who has active symptoms in both areas
- Processes that lead to overutilization of expensive out-of-county transport by the Sheriff's Department
- Protocols for pre-booking diversion for clients with behavioral health decompensation
- Communication between county providers and private providers
- Communication with and involvement of family members
- Access to behavioral health treatment in the jail
- Transition planning from the jail to the community
- Availability of continuing co-occurring capable or integrated MH/AODA care in the community for the client and family
- Access and eligibility protocols to rapid intervention services in the community for a complex client with criminal justice involvement transitioning from higher-end care (hospital or jail)
- Mechanisms for organized partnership and collaboration between behavioral health services and community corrections services to coordinate the management of shared clients in the community

At the conclusion of this report, we will illustrate how the implementation of the recommendations in this report might result in an alternative experience for this client (within existing resources), and as a consequence, for the system as a whole.

Recommendations

Recommendation 1: Establish an empowered System Redesign Implementation Team.

Specific Findings

- As noted previously, in order for Rock County to achieve the maximum leverage within scarce resources for the population of individuals with mental health and substance use disorders (particularly those with criminal justice involvement and co-occurring conditions), a system-wide change process will be required.

- Opportunities for improvement within individual programs and subsystems certainly exist, as do opportunities to try to find new resources to create specialized programming. However, because additional funding is likely to be scarce and limited relative to the broad scope of the issues, and because each single area of improvement tends to interact with others (as will be seen below), a system-wide process is required in order to leverage more change.
- As shown in the Table Top Case, even one "typical" case can illustrate multiple improvement opportunities that involve multiple behavioral health and criminal justice entities. However, before we can focus on the details of any one area of improvement, we have to begin with looking at the structure within Rock County that would organize any complex change. **Our first observation is that there is no clearly defined and empowered structure or entity that holds responsibility for system design, development and implementation of system protocols, and oversight of system improvement activities.**
- As in other Wisconsin counties, the county human services and behavioral health services have been positioned more as a separate silo of county-operated service delivery than as a convener and designer of a true "Rock County Behavioral Health System of Care" that targets the population of Rock County as a whole (not just "priority clients for County funding"), prioritizes individuals with the most complex needs and at greatest risk (including risk of criminal justice involvement) and involves all of the behavioral health resources and criminal justice resources in the county. This under-positioning of the county as a "system convener and designer" has been exacerbated by the closing of the county inpatient unit. Consequently, there has not emerged a locus for Behavioral Health System Design and Implementation for either adults or children in Rock County.
- The CJCC—and its associated MH ad hoc committee—have developed into a wonderful partnership for collaboration in planning, advocacy, resource acquisition (via grants), and program development. However, the CJCC is not (at least not currently) positioned to be a System Redesign Implementation Team that is formally empowered by key county leaders to organize and coordinate a system improvement process. In fact, the MH ad hoc committee is specifically labeled the "Ad Hoc" committee, reinforcing its informal positioning within the system.
- What we learned in the focus groups (N.B. Focus Group findings are included in detail in Appendix A) is that many consumers and family advocates are seeking a place at the "system design table" and are passionate about improvement and have much to offer, but do not have access to a routine structure or process for providing ongoing, meaningful and empowered input into system development and implementation of redesign efforts.

Action Steps for Rock County

1. **Develop an initial consensus to create an empowered Behavioral Health/Criminal Justice System Redesign Steering Committee**. This consensus commitment should appear in the Strategic Plan.

2. **Identify a starting place to develop this Behavioral Health Redesign Steering Committee (BHRSC).** This committee should NOT replace the CJCC, which retains an important function as a community collaborative looking broadly at Criminal Justice issues. A reasonable starting place might be to formalize the CJCC MH ad hoc committee as the *beginning* of the BHRSC.

3. **Identify formal representation of key stakeholders in behavioral health (both County and non-County) and criminal justice to have official "seats" on the BHRSC.** The group should be developed over time as a representative partnership between County leadership, other providers, criminal justice representation, and consumers and families. This partnership should inform the identification of the Chair and Co-Chair, one of whom should be the County MH/AODA Division Director, and the other of whom should be a non-County representative.

4. **Identify consumer and family partner representation on the BHRSC**. Community representatives on the MH ad hoc committee have already identified potential representation. There should be a selection process developed to ensure that representatives are viewed as credible by their peers.

5. **Obtain formal chartering of both the BHRSC itself, and the process described below, by County Administration, as well as other key constituencies in the community (e.g., Hospital leadership) to provide a mandate for the ongoing transformation that is needed**. The charter should include specific deliverables or objectives based on the Strategic Plan. The consultants can share examples of chartering documents from other county systems as a template.

Recommendation 2: Develop a shared vision of all services being welcoming (including for individuals and families at risk of criminal justice involvement), recovery-oriented, trauma-informed, culturally competent, and co-occurring capable.

Definitions

- **Welcoming**

  Welcoming is a foundation for designing a System of Care that is built to respond to high-expectation "customers" with co-occurring mental health, substance abuse, and other complex needs, who are most in need, most at risk, and who have the poorest outcomes and the highest costs. Welcoming references the specific technology of "customer service" and establishes the goal that individuals with complex needs are welcomed for care wherever and whenever they present. Another aspect of welcoming is the removal of arbitrary access barriers that interfere with "welcoming," such as the rule that states that individuals cannot be evaluated or admitted for psychiatric care until their alcohol level is below 0.10, or admission rules that literally exclude anyone with criminal justice involvement because of presumed "behavioral risk." For a more comprehensive description of welcoming systems, see: *Minkoff K & Cline CA, Developing welcoming systems for individuals with co-occurring disorders: the role of the Comprehensive Continuous Integrated System of Care model. Journal of Dual Diagnosis (2005), 1:63-89*.

- **Recovery-Oriented**

  Recovery-oriented services are designed so that all programs are organized to work in partnership with individuals and families with complex needs to help them experience the promise and hope of achieving "recovery," and/or use their strength or "resiliency" to make progress toward achieving their own self-defined, person-centered goals for a happy, hopeful, and meaningful life. Recovery is not defined as recovery "from" a chronic condition like addiction or serious mental illness or trauma, but rather recovery of the human being who has one or more such conditions, to achieve pride, self-worth, hope, dignity, and meaning. Recovery orientation further implies that clients and families are empowered as partners in change, both at the system level and the clinical service level; staff work WITH clients, rather than doing things TO clients in order to make progress. In addition, Recovery-Oriented Systems of Care (ROSC) for both MH conditions and AODA conditions emphasize the importance of ongoing professional, peer, and community supports to make step-by-step progress over a long period of time in the face of one

or more chronic, incurable, and stigmatizing conditions, RATHER than focusing on a single episode of "acute care" or a prescribed "treatment mandate" that is expected to result in permanent success. Wisconsin Department of Human Services (DHS) is encouraging consumer and family involvement in county system-level processes in order to support statewide implementation of Recovery-Oriented Systems of Care, and is supporting implementation of evidence-based practices such as Peer Support and Recovery Coaching, as well as Supported Employment, to assist individuals with severe psychiatric and substance disorders make progress toward the goal of having a meaningful life, including productive work.

- **Co-occurring Capable**

  Within the mission and resources of any type of behavioral health program, co-occurring capability development involves designing *every* aspect of that program on the assumption that the next person or family coming to its door will have *both* mental health and AODA issues, and the program needs to routinely provide appropriately-matched integrated services within all of its activities. The concept of co-occurring capability is based on the recognition that individuals and families with co-occurring mental health and substance use conditions (including gambling, trauma, and even nicotine dependence) are associated with poorer outcomes and higher costs in every domain (including criminal justice), and need to be identified as a priority for care in all settings. Further, people with co-occurring conditions are sufficiently prevalent in every treatment or service setting that they should be considered an "expectation, not an exception." Finally, it is well-established that integrated attention to both mental health and substance use issues in a single setting will produce better outcomes at lower costs than only treating mental health and substance use issues in separate settings or at separate times. There is sufficient clinical knowledge now available to define principles and practices of successful treatment for individuals and families with co-occurring conditions in any setting, and there is sufficient organizational knowledge to help any program retool itself to deliver these integrated practices routinely within its baseline resources and design. Finally, a component of co-occurring capability is that *all staff providing services (regardless of level of licensure, and including both behavioral health and criminal justice service providers) become welcoming, recovery-oriented, and co-occurring competent as well*. Wisconsin DHS supports the development of co-occurring capability statewide, as will be discussed further below. For a more in-depth discussion of co-occurring capability, see: *Minkoff K &. Cline CA, Dual diagnosis capability: moving from concept to implementation. Journal of Dual Diagnosis (2006), 2(2):121-134.*

- **Trauma-informed**

  The Trauma-informed Care movement is based on the recognition that individuals with behavioral health conditions are highly likely to have experienced significant physical, emotional, and/or sexual trauma in their lives that is contributory to their conditions (even if they do not have the formal diagnosis of Post-Traumatic Stress Disorder), and significantly affects their ability to engage in safe and healing relationships, including within the treatment setting. Trauma may include early life trauma, domestic violence, combat trauma, as well as traumatic experiences occurring within treatment settings or public safety settings (such as restraint or seclusion). Trauma-informed care requires consistent application, at the program and clinician level, of principles and practices consistent with welcoming, recovery orientation, and co-occurring capability, but with a focus on the recognition of trauma as an expectation, prioritization of creating welcoming and safe relationships that are not re-traumatizing, and integrating attention to trauma-related issues into all treatment experiences. The State of Wisconsin has identified a state level TIC Coordinator, Elizabeth Hudson, who has helped to organize over 70 TIC Committees in various counties, tribes, and state institutions. For more information on TIC, and what is happening in Wisconsin, see the Trauma-Informed Care pages on the Wisconsin DHS website.

- **Culturally Competent**

  Cultural competence implies that all services and all persons delivering care are organized to welcome individuals and families with cultural and linguistic diversity, empathize with their experience (including their experience of mental health and/or substance use problems) as defined by their cultural context(s), and engage them in relationships and services that are safe and respectful, honor their cultural framework, and inspire progress toward recovery as they would define it. Cultural competency includes, but is not limited to, engaging people who are non-English-speaking and working with racial minorities. It recognizes that each individual and family has a unique "cultural" context that is defined by multiple variables, and tries to match services to each individual or family in a way that fits that unique culture most effectively.

- **Comprehensive Continuous Integrated System of Care (CCISC)**

  CCISC is a model for designing systems, and a process for helping systems to get there within existing resources. CCISC is based on the goal of designing systems to be more effectively matched to the needs and hopes of the individuals and families with co-occurring conditions, including trauma, criminal justice involvement, homelessness, disability, and so on, that are coming to the door. CCISC

implementation is a quality improvement process in which *all* programs, and *all* persons delivering care make progress toward becoming welcoming, recovery-oriented, trauma-informed, culturally competent, and co-occurring capable, within base resources. As such, it is an effective framework for improving *system outcomes* for complex populations with overlapping needs, such as the behavioral health/criminal justice population. Wisconsin DHS has licensed the CCISC Toolkit to be available to counties, and is currently helping to support CCISC implementation in Milwaukee County, and in four counties and seven tribes in Northern Wisconsin. For more information and background on CCISC, see the following article*: Minkoff K & Cline CA, Changing the world: the design and implementation of comprehensive continuous integrated systems of care for individuals with co-occurring disorders. Psychiat Clin N Am (2004), 27: 727-74.*

- **Children's System of Care (CSOC)**

  This concept is consistent with all of the above in terms of values and principles, but focuses on children and families with complex needs. CCISC includes children's services in its framework. CSOC will be described in greater detail in the recommendations in Step 8.

Specific Findings

- Although there is clearly a shared commitment to having a quality service system that takes good care of the citizens of Rock County while providing for health and public safety within scarce resources, there is not a clearly articulated system vision and a process for achieving that vision. Note that on July 14, two representatives from Rock County attended a Milwaukee County CCISC "Change Agent" meeting, in an effort to learn more about CCISC implementation as a system vision and process, and to determine whether such a process might be applicable to Rock County.
- The Table Top Case illustrates that although crisis presentation of individuals with active co-occurring conditions in jails and emergency rooms is an expectation, programs are not designed to routinely welcome and serve *both* issues. As a result, clients bounce through the system (what is known as "ping-pong" treatment) and experience poor outcomes, high costs, and continued re-traumatization (e.g., incarceration rather than treatment in response to behavior associated with relapse of mental illness) that diminishes hope and empowerment, and makes it less likely that the person will engage in continuing care. Further, in this example, the experience of the client, and her family, is *not* of being engaged as an empowered partner in figuring out how to best make progress toward their own inspired recovery goals and to leverage existing professional and family supports. The

application of the alternative framework (welcoming, recovery-oriented, co-occurring capable care) will be illustrated in the conclusion of this report.

- With regard to co-occurring mental health and substance use disorder services in particular, the concept that services for individuals and families can be routinely integrated is simply not universally well understood. Although there are pockets of progress toward integrated service provision (for example in the CSPs, in Beloit Hospital intensive outpatient treatment program (IOP), in Beloit Area Community Health Center), it is more common that services for co-occurring mental health and substance use conditions are provided in a parallel or sequential manner. In fact, most of the people we interviewed had little or no exposure to or experience with the concept of co-occurring capability or how to design programming or interventions to provide integrated mental health and AODA services. In addition, although there are places and programs working on improving staff competencies to provide integrated services to clients and families with co-occurring conditions, there is no organized system-wide workforce development strategy for addressing this issue across the board.
- With regard to trauma-informed care (TIC), which is particularly relevant to the experiences of individuals involved with criminal justice, there is interest in and some familiarity with the statewide trauma-informed care process, but no organized TIC implementation process across the county.
- With regard to recovery-oriented service system development, there is underdevelopment of a consumer/peer recovery perspective in adult MH, limited family advocacy and peer support in children's services, and a small starting place for Recovery-Oriented System of Care (ROSC) development in the addiction system.
- Cultural competency is also an under-addressed issue in the county, which is particularly important given the County's demographics and specific population needs in Janesville and Beloit. Many people we interviewed described the history of racial tension between Janesville and Beloit and the different racial composition of the population in different parts of the county, and reported to us that the service system does not address issues of cultural competency openly as an improvement issue, nor have a dedicated framework for exploring potential access barriers for racial minorities that may be connected to overutilization of hospitalization and incarceration for those populations.
- Within the subsystem that focuses on services to children, there is awareness of Children's System of Care principles (family-driven, strength-based, resiliency-oriented), and a few places in which those principles inform service delivery (particularly within the Family Crisis Team and Juvenile Justice Diversion Services)

but there is no formal vision or process for developing a county-wide Children's System of Care in accordance with those principles. ***This issue will be discussed in more detail in Step 8.***

Next Steps

1. **Articulate a system-wide vision, as part of the Strategic Planning Process, for all services to become welcoming, recovery-oriented, trauma-informed, co-occurring capable and culturally competent**. The system-wide vision should attend to both Adult System of Care and Children's System of Care development, and incorporate a partnership with all services delivered within the criminal justice system.
2. **Develop a consensus process, under the auspice of the empowered BHRSC, to define the vision, to engage a wide array of county behavioral health and criminal justice partners to support the vision, and to have each partner agree to work formally on improving** its ability to be welcoming, recovery-oriented, trauma-informed, culturally competent, and co-occurring capable.
3. **Use the CCISC process that is being supported elsewhere in Wisconsin as a vehicle for organizing progress across the county**. This process can help to organize your strategic plan and identify specific steps for each partner to take to make progress toward this vision, using the CCISC Toolkit, already being utilized in other parts of Wisconsin, so that the whole system commits to making progress within existing resources at every level. Obtain consultation and technical assistance, and develop partnerships with DHS staff that are supporting this activity (Susan Gadacz, Elizabeth Hudson, Cheryl Lofton) and with the other counties involved.
4. **Initiate a Rock County Trauma-Informed Care/Welcoming Change Agent Committee**. Elizabeth Hudson can help Rock County form this group and provide models used by other counties to make progress within existing resources. The TIC Committee should be a formal subcommittee of the BHRSC, and can become the starting place to develop a more comprehensive clinical change network to improve recovery-oriented co-occurring capability.
5. **Organize a Consumer/Family stakeholder Committee that will function as a regular subcommittee of the BHRSC**. Consumer and family representatives on the BHRSC will engage with this group in order to have wider and more encompassing consumer input. The voice of consumers and families at the table will ensure that the BHRSC will make better decisions regarding how to meet the needs of the system customers, and how to incorporate peer support and self-help

into the service mix more extensively as cost effective modalities for helping more individuals and families make progress.

6. **Within the CCISC process, design a system-wide workforce development strategy to help all behavioral health and criminal justice staff improve their ability (within their job and within their level of training) to become welcoming, recovery-oriented, trauma-informed, culturally competent, and co-occurring capable**. Formal trainings may be helpful in providing an introduction to this approach, but in the long run are not the most effective way to promote on-the-job competency. Within the CCISC approach, each program designs a quality improvement process in which staff are partners in learning new competencies (step-by-step and on-the-job) in accordance with basic principles of successful intervention that are anchored in program policies, procedures, and paperwork over time. Joining that staff development approach with a county-wide continuous quality improvement (CQI) process could be particularly helpful. For example, the county could track consumer and family feedback on the quality and cultural competence of services, as well as indicators of access to and utilization of community-based services versus restrictive settings (emergency room, hospital, jail) for all populations combined and across different race/ethnicity groups. (Differences across race/ethnicity groups in access to and outcomes from services are often called "behavioral health disparities.") Stakeholders can then work together to design system improvement strategies, including workforce enhancement efforts, targeted to the access and outcome indicators most in need of improvement.

7. **Plan for a system-wide orientation and kickoff training event to get started.** In order to engage partners at all levels in this transformation, we would recommend that once the consensus has been built and the strategic plan outlined, that the BHRSC set up a large county-wide "event" for *all* stakeholders (consumers and families, front-line service providers, managers, etc.) to learn the basic principles of how to become welcoming, recovery-oriented, trauma-informed, and co-occurring capable, and be welcomed to join the system-wide change process as outlined in the strategic plan.

Recommendation 3: Utilize a system quality improvement approach to make progress.

Definition

- **Continuous Quality Improvement (CQI)**

  CQI can be regarded as the "organizational best practice" for any organization or system to make progress toward a comprehensive culture shift to become more vision-driven and customer-oriented. CQI has to be distinguished from Quality Assurance (QA), which is more accurately termed Compliance Monitoring. CQI on the most basic level involves using a defined technology (e.g., Plan-Do-Check-Act cycles) for continuously improving performance related to complex issues in order to more effectively meet the needs of customers. Wisconsin, in fact, is the "home state" of NIATx (Network for the Improvement of Addiction Treatment, founded at the University of Wisconsin in Madison), which is a national project teaching provider agencies (originally AODA agencies primarily, but now MH agencies as well) to use CQI processes to improve access and retention in care. NIATx is partnering in the CCISC implementation process (which uses a systemic CQI approach) in Milwaukee. CQI at the system level is a framework for creating a "horizontal" and "vertical" system-wide partnership at *every* level so that all programs and all staff are designing *continuous* quality improvement activities to make step-by-step ongoing process toward a "big vision" (such as welcoming, recovery-oriented, trauma-informed, co-occurring capable, culturally competent care). Horizontal partnership means that all agencies and subsystems are welcome to join the process, and each agency is positioned to help the others be successful. Vertical partnership means an organized structure that empowers senior county managers, agency executives, program managers and supervisors, front-line clinical staff (change agents) and consumers/families to work collectively to improve the system. Each partner is responsible for measurable steps of successful improvement in his or her own domain. Collectively, everyone works together to assume collective responsibility for using a common vision and process to improve the experience of the most challenging customers. For more information on NIATx, go to www.niatx.org. For more information on using CQI in CCISC implementation, go to www.ziapartners.com.

Specific Findings

- The Rock County CJCC has begun to apply customer-oriented quality improvement strategies to designing care. This is excellent. Examples include using "Table Top" case discussions to understand the experiences of real people in the system. The

relatively new Crisis Response Group (CRG) that is looking at process improvement within the flow of service response to individuals in crisis is a particularly strong example of a good system CQI process at work. The CRG is reviewing the experiences of individuals in police custody accessing emergency services, and literally "studying the process" and its multiple contributors, identifying potential interventions (Plan), working collaboratively to try some new approaches (Do), studying the results (Check), and revising the plan to make continuing progress. (Act).

- However, there is no indication that there is a formal system-wide Quality Improvement partnership or process that creates a framework for *all* stakeholders to use "best practice" data-driven QI strategies to improve service delivery and outcomes, with a particular focus on individuals with co-occurring conditions, the people who are most at risk of criminal justice involvement and other poor outcomes.
- Individual providers have varying expertise in the technology of Quality Improvement. Some AODA providers reported that they had exposure to NIATx, for example. This will be a system strength that facilitates using this CQI technology for *system* improvement rather than individual program or practice improvement alone.
- Most importantly, *all* the people and organizations we spoke with expressed interest in participating in a partnership to improve the system as a whole, and expressed willingness to work on their own improvements as part of that process. The major concern expressed is that there is a true partnership. Many non-county providers have experienced themselves as "outside" the county system rather than working in partnership with the county to create the system. There is opportunity to change this fairly quickly, if all the partners can be brought to the table in a way that allows each partner to be respected for its contribution, and successful in achieving its improvement targets.

Next Steps

1. **Use the Strategic Planning Process to articulate a quality improvement partnership in which all the participants in the system change process are committed to their own quality improvement activities and outcomes, in relation to the common vision**. The Strategic Plan should identify small but significant "steps" for each partner to take to be successful in demonstrating effective participation in the partnership, and successful improvement in becoming more welcoming and co-occurring capable.

2. **Structure the CQI process so it is clear how to make progress and how each partner is accountable for its own improvements**. Within the CCISC framework, there are specific tools and steps that each program can utilize to structure its QI activity to become more welcoming, recovery-oriented, trauma-informed, and co-occurring capable. ZiaPartners/TriWest can provide those tools and steps, along with training on basic clinical principles for system design, consultation on how to use the tools and steps to make progress, and assistance in negotiating the process.

3. **Empower front-line staff and consumers to be partners in the CQI process, both within each program and within the system as a whole**. Developing teams of Change Agents to work in partnership with leadership empowers more participants in the system redesign, and creates a deeper change process. This is the goal of involving front-line staff in the Trauma-Informed Welcoming Change Agent team, and creating organized consumer/family input. Leadership works *with* staff and consumers rather than doing things *to* staff and consumers, so the change is bottom-up as well as top-down.

4. **Emphasize data in the CQI process**. The quality improvement process has to be data-driven, with measurable outcomes of progress. Data needs include aggregate data (described in the next recommendation) as well as data on the experiences of real people (as in Table Top cases), so that changes in policy, procedure, program operations, and clinical practice are responsive to the challenges experienced by actual consumers and families who are the "customers" of the system.

5. **Identify workgroups or subcommittees within the larger process to focus on quality improvement in certain areas**. For example, the CCRG is a current workgroup focusing on quality improvement in crisis response. In later sections of the report, we will recommend a workgroup focusing on children and youth system of care development, and a workgroup focusing on transitions between criminal justice and behavioral health services.

Recommendation 4: Collect data that identifies the population at risk and facilitates improvement activities.

See Appendix B for the Rock County Data System Recommendations and the Data Map Summary. This section summarizes the major findings and recommendations. More detail is available in the Appendix.

Specific Findings

- The Data Work Group that was formed after our initial visit is the beginning of a productive partnership to improve data collection and data sharing throughout Rock County.
- Various partners in the system (see the Data Map in the Appendix) collect a considerable volume of data elements, and this can form the basis of designing more useful approaches to data collection and information sharing. Currently, however, there are no organized data-sharing partnerships or agreements between criminal justice and behavioral health except in the Specialty Courts.
- Further, there are significant data gaps throughout the system in relation to tracking both the flow of individuals with mental health and substance use issues through both behavioral health and criminal justice services, as well as being able to collect data regarding treatment participation and outcomes.
- Data gaps include lack of data on the prevalence of co-occurring conditions in both adults and families, both in community and criminal justice settings.
- Data communication between behavioral health settings and criminal justice settings and services regarding individual clients is spotty. This results in both unnecessary re-incarcerations as well as in difficult transitions into and out of jail and detention. This is one of the most significant complaints raised in community focus groups.
- Where there is a framework for data collection, such as the use of the Youth Assessment and Screening Instrument (YASI) in the juvenile justice system, it is not clear how the data collected translates into a framework for service-matching that is clinically relevant and can be routinely communicated across the boundary between criminal justice and behavioral health services. We received a report indicating that YASI screening had identified a high percentage of youth with mental health and/or substance use conditions, but the extent to which they receive services for the identified needs is much lower.

Next Steps

1. **Formalize and expand the Data Workgroup.** This workgroup should become a standing subcommittee of the BHRSC, and incorporate wider representation from providers and criminal justice partners with various data sets.
2. **Prioritize improvement of data-sharing regarding individual clients moving through the continuum of criminal justice and behavioral health services.** A simple, but extremely important quality improvement activity is to improve the extent to which information is shared between the jail and appropriate treatment

providers (at all points or intercepts in the jail process, from booking to release), and vice versa, between probation and treatment providers, and so on. This may involve working to establish specific procedures for obtaining releases, tracking contact and communication, and demonstrating improvement. It is possible to include specific metrics for client-specific data-sharing as a performance indicator within the Jail Medical contract as well.

3. **Based on nationally-recognized models for county system data-sharing, explore and implement mechanisms to routinely track arrest data and match the data to clinical enrollment, as well as the possibility of developing Business Associate agreements within the system that facilitate information sharing, particularly for clients in crisis.** In addition, some county systems (e.g., Dallas) have relatively well-developed computerized platforms for tracking the jail population with behavioral health needs, and linking to appropriate treatment providers. These can be explored and adapted for Rock County over time.

4. **Improve recognition of the number of individuals that have co-occurring mental health and substance use conditions.** Within the emerging system quality improvement process defined above, establish a commitment for each partner to work on simple data-collection improvements such as screening and identification of how many individuals or families (in behavioral health and criminal justice settings) have mental health, substance use, and co-occurring conditions. Although an initial focus on simply counting the population may seem like a "small step," it has been our consistent experience that improvement in recognition of the population improves the likelihood of individuals with complex needs receiving appropriate care. ***"If we don't count you, it's because we are organized as if you don't count."***

5. **Begin to track data on identified high utilizers of behavioral health and criminal justice services.** This becomes an opportunity to address data "gaps" that currently make it hard to track client outcomes and service participation. Each "data partner" can begin by identifying its own high-utilizer group, and describing common characteristics of high utilizers, as well as tracking outcomes and costs. This information is shared in the Data Workgroup to look for trends and patterns. At the same time, individual "Table Top" stories of high utilizers are shared, to identify improvement opportunities for the target population that can be implemented (and tracked) in a resource-neutral fashion.

6. **Develop a mechanism for collection of "project management" data to track progress in the System Redesign effort.** Project management data includes mechanisms by which the BHRSC can monitor the progress of each partner in

making measurable progress toward becoming more welcoming, recovery-oriented, and co-occurring capable.

Recommendation 5: Organize improvements in the crisis system with particular focus on individuals with co-occurring disorders.

Specific Findings

- **Our overarching finding is that the Rock County crisis service "system" is not well designed to address the needs of individuals and families with complex conditions, particularly those with co-occurring mental health and substance use disorders**. This makes it more likely that individuals in crisis will wind up in higher-end services (sometimes multiple high-end services, as in the Table Top case described earlier) such as detox, hospitalization, or jail.
- As is the case in many behavioral health systems, scarcity of resources results in crisis response becoming more reactive to extreme crisis rather than proactive in engaging individuals early in the crisis process so that intervention is possible before commitment is warranted. As a result, Rock County experiences a high utilization rate of detoxification and hospitalization, as well as incarceration, which results in disproportionate expenditures on those levels of care, further compromising available resources.
- The crisis "system" does not actually function as a system. Many components of crisis response in both Beloit and Janesville are offered by multiple providers. However, those elements are not seamlessly linked into a welcoming and integrated safety net. If the goal is that any person or family in the *early* stages of a crisis—including a crisis that involves both mental health symptoms and active substance use—would be able to call a central number, be welcomed into a relationship that would evaluate the crisis and provide ongoing integrated intervention in the community over a period of days or weeks, to transition the person or family into continuing care, that type of response is available in only a very limited fashion. Family Crisis Team (FCT) is one program which emphasizes this type of service, but the capacity of that service could be utilized more efficiently and effectively as part of a total system approach.
- From a resource perspective, crisis response capacity in the system as a whole is small relative to the provision of more routine non-crisis services, although more of the individuals presenting for service are presenting in crisis situations with complex needs and do not fit well or engage well in conventional programming or

routine care. In the county counseling centers, resources for short-term flexible engagement are limited compared to services (e.g., CSP) that involve long-term high-intensity services.

- The lack of effective protocols for managing individuals with co-occurring needs in crisis is particularly concerning. The best practice for an individual presenting in psychiatric crisis who is using substances is to welcome the person as they are, evaluate the level of risk, stabilize the person in the least restrictive setting, and then work with the person over time to provide continuing integrated crisis intervention. The routine practice in Rock County has been to send that person to out-of-county detox *first*, rather than to work with the psychiatric crisis in an integrated manner. Thus, the woman in the Table Top case would ideally be admitted to a crisis bed (if voluntary and medically stable) or to a psychiatric inpatient unit directly (if involuntary and out of control) *without* waiting for either detox or for her alcohol level to drop. Detox medication protocols can and should be readily provided in psychiatric crisis settings at all levels of care. This does not happen routinely in Rock County.
- The Community Crisis Response Group (CCRG) has emerged since January, 2011, as a place where real partnerships are forming and detailed problem-solving is taking place. However, there is much to do, and guidance will be needed to know the many options for how other systems solve similar issues. The current partnership with the Southern Region Crisis Grant Initiative is a helpful way of leveraging additional support and guidance from other counties in Wisconsin.
- Linda Hoag's role as "crisis tracker" is extremely valuable, and can be utilized as a driver for identifying and changing outmoded protocols and procedures. Beginning to collect Table Top stories of individuals who have poor outcomes and high costs can provide systematic information to the CCRG to develop improvements.
- Initiation of mobile crisis will be helpful in facilitating more diversion and in filling some gaps in the crisis net, but in and of itself will not create a dramatic change without attention to designing a comprehensive, integrated, and proactive crisis response system.
- Current policies, procedures, and protocols used by police, behavioral health, and emergency rooms make it more likely that individuals in crisis will be incarcerated or committed and require expensive overuse of law enforcement time and detox and hospital beds. The CCRG has begun to develop improvements in those protocols, but within Rock County in general, crisis protocols make it difficult for individuals brought in with potential charges and active behavioral health concerns to be easily

shifted into the behavioral health system, with either charges being dropped, or (if not dropped) incarceration avoided.

- A "crisis system" provides ongoing flexible and integrated crisis intervention, and not just emergency "one-shot" crisis response. In Rock County, there is limited ability to provide crisis intervention services that can engage challenging individuals in ongoing and flexible follow up and therefore reduce the need for higher levels of care, including incarceration.
- The Crisis Residential Facility for adults (Jackson House) is regarded as a successful program, and its services are very valuable. However, the facility does not routinely admit individuals who are using substances, which makes it more difficult to divert individuals who present with active co-occurring conditions. In addition, there is inadequate crisis-diversion capacity in the county as a whole, and there is no crisis-diversion bed capacity for children and adolescents.
- Mercy Hospital has an extensive continuum of inpatient, day hospital, and outpatient services for adults and children with mental health and substance use disorders, and is clearly making efforts to be a good partner with Rock County Human Services in provision of acute care/crisis response. However, it does not appear that all the high-end services within the Mercy Hospital continuum are fully leveraged to participate in the crisis safety net continuum, particularly for individuals who are uninsured or underinsured.
- Beloit Hospital Emergency Department has been challenged by having been charged with Emergency Medical Treatment and Active Labor Act (EMTALA) violation for its handling of a psychiatric emergency situation, which has contributed to the development of more complex procedures that make it more difficult for individuals in psychiatric crisis to move on to an appropriate disposition. Another dynamic, however, is that Beloit Hospital (since the closure of the County Inpatient Psychiatry Unit, and since Beloit does not have its own unit) has not fully organized itself to be "in the mental health business" for individuals presenting with behavioral health needs throughout that system, including in the ER.

Next Steps

1. **Begin to design a welcoming, integrated, proactively responsive behavioral health crisis system.** The CCRG can be positioned as a Crisis Subcommittee of the BHRSC, and be charged with creating this system. Steps in this process involve articulating a vision of how crisis response should occur, and mapping current crisis capabilities in *all* providers in the county, in order to develop some

recommendations about how to move collectively to coordinate the services "mapped" into a more cohesive crisis continuum in accordance with the vision.

2. **Commit to improving a welcoming crisis response across the entire system.** Within the larger system-improvement approach, all the partners in the system need to work on improving their ability to welcome and engage individuals and families with co-occurring conditions in crisis, and eliminating "arbitrary" rules that interfere with that process. Examples of such rules include denying access to individuals whose alcohol level is above the legal limit of intoxication, or denying access to individuals with a criminal justice history.

3. **Prioritize resources for the development of a welcoming, flexible, and integrated crisis continuum.** Crisis response, including continuing short-term crisis intervention for individuals in trouble who are not engaged in ongoing service, has to be viewed as a *priority* for the whole system, rather than as a workaround. Overutilization of higher levels of care depletes available resources for the type of crisis system that could prevent the overutilization; this cycle needs to be broken. The system needs to think collectively about making it easy for individuals in crisis (with the expectation that they will have co-occurring conditions) to get connected to flexible short-term help that meets them where they are and helps them to resolve the crisis over a short period and make progress toward their goals. Customers of the crisis system (law enforcement, probation, emergency rooms, and, of course, consumers and families) should routinely participate in conversations about how to enhance crisis response design, and to make it easier for individuals to get help before they completely decompensate or before they require re-incarceration.

4. **Expansion of crisis intervention team (CIT) training for police officers and sheriff's deputies should be pursued.** Some counties have developed processes to engage all officers to participate in CIT training over time. It is important, however, to encourage voluntary participation as much as possible, so the process begins with those officers who are most interested, and they begin to disseminate the value of the training to others.

5. **Rework procedures to facilitate diversion and reduce overuse of detoxification.** The Community Crisis Response Group should take on the task, with assistance, of reworking the protocols for how to manage individuals with mental health and substance use issues in crisis, so that it is easier for charges to be dropped, for detox to be avoided, for continuity to be maintained, and for individuals with or without insurance to be diverted from either jail or commitment. ZiaPartners would be willing to provide consultation and technical assistance in developing these alternative protocols.

6. **Engage community hospitals as key partners in the crisis system.** The hospital partners in both Beloit and Janesville can be capable "private" partners in the public behavioral health crisis system design process. This involves acknowledgement that each hospital system is truly in the public behavioral health "business," as part of its community hospital mission, and therefore has an interest in improving the outcomes of individuals with behavioral health needs who present in their emergency rooms. Beloit Hospital, for example, might identify a "Behavioral Health Product Line" leader who could redesign the existing outpatient array to be more supportive of both its own ER and the Beloit Police, as priority customers, and to facilitate engagement in welcoming relationships of individuals who might not be ready to participate in "usual treatment" for MH and/or AODA conditions. Within a public-private crisis partnership, it will be possible to create services and processes that take pressure off the emergency rooms and facilitate responsive community-based care.

7. **Expand crisis diversion.** Planning should begin to design flexible and cost-effective approaches to expansion of crisis diversion "capacity." Many mechanisms for doing this could be explored. One example is to utilize the Mercy Hospital continuum more effectively, including for some individuals in the Mercy ER who are uninsured. Another example involves development of short-term "evaluation" sites (including 24-72-hour beds) for individuals in crisis. Many county systems identify unused space in local hospitals or similar facilities and use existing mobile crisis response staff to provide short-term engagement and stabilization, without referring for commitment or even Jackson House. The woman in the Table Top, for example, might have been successfully diverted from both detox *and* jail if there had been a safe place in the hospital for an extended evaluation and intervention process that would have allowed her to settle down enough to possibly be sent home with her husband, with the expectation of next-day follow up.

8. **Implement Critical Time Intervention strategies at key transition points.** Critical Time Intervention is an evidence- based practice that provides structured short-term interventions to negotiate transitions from hospital to community or jail to community. Recognizing that these transitions represent "crises" (due to the high risk of recidivism resulting from lack of continuity of care) can leverage existing crisis response resources to provide cost-effective interventions that will result in better outcomes.

9. **Expand peer involvement in crisis.** There is burgeoning research on the value and cost effectiveness of involving peer support workers as members of a crisis response team or crisis response system. These individuals are able to intervene in

situations where professionals may be unsuccessful, and help the individual in crisis have "peer support" to facilitate connections with continuing care.

Recommendation 6: Organize improvements in co-occurring capable adult mental health services for individuals with complex needs.

Specific Findings

- County-operated adult mental health services located in Beloit and Janesville are organized into CSP and Counseling Center programs. The CSP provides a high-intensity team-based rehabilitative case management approach for a relatively small number of long-term consumers who have limited turnover. The Counseling Center staffing is much smaller, and is planning to add case management to facilitate its transition (well underway) from a "therapy" service to a more flexible and crisis responsive "therapeutic case management service." CSPs and counseling centers each have relatively new program managers and are working to improve their collaboration and their co-occurring capability (including stage-matched motivational interventions for individuals that are continuing to use substances actively). However, the "flow" of individuals through these services is limited, and the capacity to flex service intensity up and down to respond to crises for both new and existing clients is less than optimal. The staff in both services—including the psychiatrists—are committed to the county and are interested in working as design partners to learn more about flexible funding models and flexible clinical models to improve system functioning.
- There are hospital-based ambulatory mental health services in Beloit and Janesville that have a somewhat public sector mission. These are high-quality counseling services with psychiatric participation, but they each tend to serve a more high-functioning population rather than individuals who may be very actively co-occurring, in unstable crisis coming from the ER, and/or involved significantly with the criminal justice system. As one police officer stated, "I don't consider my local hospital as a referral site for the types of people I run into." Also, co-occurring service delivery is more likely to be regarded as participation in parallel mental health and substance abuse services rather than as engagement in truly integrated services in a single setting.
- The Beloit Area Community Health Center (BACHC) is a Federally Qualified Health Center (FQHC) that is in a process of retrenchment due to administrative challenges (in the whole center, including behavioral health) with a Nurse Practitioner in a

behavioral health leadership role who is comfortable with both quality improvement strategies and with co-occurring clients. The BACHC is very eager to grow, and to be a more complete partner within the county system; however, it has not yet been participating in CJCC. Discussions have begun between BACHC and the County behavioral health leadership regarding an improved partnership regarding health and behavioral health. Further, the BACHC gets an incentivized Medicaid rate for behavioral health services as an FQHC that may be more than twice what the county can collect. This creates some opportunities to leverage additional resources.

- There are other non-county adult mental health providers in the county, including some who work with various types of Medicaid and sliding scale populations. However, they do not experience themselves as being organized into a "System of Care" in the county, so much as experiencing themselves working in a disconnected way with a small subset of clients in need. There is great interest in improving coordination and partnership.
- The adult MH CSP and Counseling Center services do coordinate care with probation, but the coordination and partnership is not systematic. Rather, individual case managers will connect on occasion with individual probation officers; there is no team-based approach.
- There are flexible funding streams available through the Wisconsin Medicaid Waiver, such as Comprehensive Community Services (CCS), that might enhance the county's ability to design more customer-oriented and integrated services for individuals with complex needs. To date, the county has not pursued CCS certification because of concerns about expansion of entitlements. The DHS specialist in CCS (Cheryl Lofton) has reported to us that she is very interested in developing integrated services and wants to work with any interested county to provide technical assistance on how to use CCS to its advantage.

Next Steps

1. **Develop the vision and process to achieve recovery-oriented co-occurring capability in *all* adult MH programs (as well as AODA programs, see below) in the county**. All adult MH (county-operated, community hospital, FQHS, and other providers) services can begin to work in a quality improvement partnership to formally improve recovery-oriented co-occurring capability development, in partnership with county leadership, and within existing resources.
2. **Prioritize quality improvement activities on improving the successful diversion and transition of high-risk individuals in crisis**. Within the larger system redesign framework described above, develop a "working team" of adult service

providers (including both MH and AOD, county and non-county) and begin to develop a quality improvement partnership to produce better system design for high-risk populations. We would recommend using some "table top" stories to identify existing strengths and capacities in each provider, and learn how the group can be engaged in improving their responsiveness in providing flexible crisis support for the clients identified in the stories. Learning from these "typical" situations will inform broader system design opportunities within the partnership.

3. **Improve design flexibility within county-operated adult MH services**. Within the county adult system, consider making CSP and CC a single outpatient design team in each location, and provide staff training and support to encourage full flexibility to work across usual boundaries to engage individuals in crisis. This can mean access to high-level CSP services for a few weeks or a few months, with transition to lower levels of intensity, with opportunity to flex up if crisis re-emerges.

4. **Expand peer support capability**. Strongly consider mechanisms for designing peer support activities within county mental health services and the system as a whole, as a means of providing recovery-oriented and flexible "coaching" and support, at lower cost. Peer support leaders in neighboring counties (e.g., Milwaukee) might be available to provide technical assistance in this effort.

5. **Explore CCS funding**. Obtain DHS consultation and develop a plan to evaluate whether and how to proceed. Also, improve awareness and capability of county MH staff to track funding and reimbursement issues with clients, including organizing an improvement process targeted at getting more clients attached to Medicaid.

6. **Engage hospital-based services as partners in designing a responsive continuum of services for individuals with complex needs in the community**. Each hospital-based counseling provider should re-examine its role in supporting behavioral health as a key "product line" serving *all* hospital services. The ER, acute care services (psych and medical) should be regarded as priority targets for behavioral health services in each hospital. Further, formal and informal rules that may create access barriers for individuals in crisis or who have criminal justice involvement need to be eliminated. Note that because the hospital-based services have *their own institutions* as a customer, these priorities could be relatively independent of payer source, since effective ambulatory engagement is likely to reduce repeated presentations at more expensive services.

7. **The Beloit Area Health Center should be engaged as a full partner in system design**, and mechanisms developed for creating flexible services in the FQHC that

take advantage of the higher rate, permit hiring of additional staff (or out-posting of existing county staff), and include walk in and crisis intervention capability for individuals with complex and co-occurring conditions.

8. **Organize teamwork and partnership with probation**. Designated probation officers should partner routinely with each of the Beloit and Janesville county teams and hospital programs.

Recommendation 7: Organize improvements in co-occurring capable adult ADOA services for individuals with complex needs.

Specific Findings

1. There are excellent AODA providers within the county, and many consumers with co-occurring disorders have reported very positive experiences with these services. However, there is no formal design of a co-occurring-capable recovery-oriented system of care (ROSC) in AODA.
2. In addition, there is no designated position with both the responsibility and the expertise to design and oversee the development of an effective, efficient, recovery-oriented, and co-occurring capable array of AODA services. Kate Flanagan is an energetic, motivated, and highly capable manager of the Behavioral Health Division, but she freely acknowledges that she needs to have someone on her leadership team with both the expertise and the dedicated time to manage the AODA "subsystem" in the county.
3. AODA resources are limited, but the limitation is felt more powerfully because of overuse of detoxification at Tellurian (mostly for 51.45 commitments), and because 90% of the AODA funding is expended on residential treatment.
4. There is very limited access to sober community living. We met with the house manager and some clients from one six-bed local program (possibly the only local program) which seems to be well-regarded by the clients and by other providers, and works well with individuals who have co-occurring mental health concerns.
5. Commonly, AODA services utilize an abstinence-based approach in which clients may be easily terminated for using. At the same time, routine MH services also have a limited framework for working in an integrated manner with clients who may be actively using. Therefore a large group of clients (and more likely those involved with the legal system) don't fit well anywhere and therefore may fall through the cracks of the system.

6. The relationship or partnership between AODA and MH services—including access to medication—is informal at best, even when services co-exist within a single agency. Thus, clients with co-occurring issues may experience what has been termed "parallel" treatment or "ping-pong" treatment.
7. Recovery coaching and formal peer support specialist services in AODA services are essentially absent.
8. There is great concern about the burgeoning heroin and oxycontin epidemic in the county, which results in further concern about the limited access to opiate maintenance treatments in the county.

Next Steps

1. **Identify an AODA leadership person (with AODA system expertise) within the county.** This individual would report to the MH/AODA Division Manager within County Human Services, and would have dedicated responsibility for managing the AODA continuum. This position could potentially be developed by re-allocation of existing position resources to emphasize the importance of strong leadership. In any case, within the framework described in the recommendations below, this position would be more than likely to pay for itself by improving efficiency of utilization of high-end (residential and detox) AODA resources.
2. **Develop the vision and process to achieve recovery-oriented co-occurring capability in *all* adult AODA programs (as well as MH programs, as described above) in the county.** All adult AODA services can begin to formally improve recovery-oriented co-occurring capability development, in partnership with county leadership, within existing resources.
3. **Prioritize quality improvement activities on improving the successful diversion and transition of high-risk individuals in crisis**. As above in Recommendation 6, within the larger system redesign framework described above, develop a "working team" of adult service providers (including both MH and AOD, county and non-county) and begin to develop a quality improvement partnership to produce better system design for high-risk populations. One of the most important objectives is to develop alternative strategies to detox admission (or alternatives to re-incarceration for those on probation) for individuals in crisis with active substance use. We would recommend using some "table top" stories to identify existing strengths and capacities in each provider, and learn how the group can be engaged in maintaining engagement and providing flexible crisis support for the clients identified in the stories. Learning from these "typical"

situations will inform broader system design opportunities within the partnership, and ideally reduce treatment termination due to "relapse."

4. **Develop a more flexible and cost-effective continuum of services, including expansion of sober living options.** Work in partnership with providers, under the auspice of the BHRSC, to develop and pilot mechanisms that allow existing AODA resources to be managed and utilized more flexibly. Ideally, providers should be incentivized to engage many consumers and provide flexibility and continuity of community-based co-occurring capable services rather than being incentivized primarily to fill beds. This can include incentives to develop unstaffed or minimally staffed co-occurring capable sober living options that feed ambulatory services. The current sober living provider expressed interest in these types of incentives.

5. **Create more flexible utilization management through a continuum of levels of care for AODA services**. Identify local venues that can become short-term "sobering stations" with flexible crisis support in lieu of the high utilization of detox. In addition, begin to develop a utilization management strategy (utilizing the American Society for Addiction Medicine Patient Placement Criteria-PPC 2R) that facilitates *short-term* "residential services" transitioning to sober living with accompanying outpatient supports, including flexible supports for individuals who may slip or lapse while in services, and groups or programming designed for individuals with significant needs who are not yet ready to stop using (earlier stages of change).

6. **Design integrated programming in all AODA services based on the high prevalence of co-occurring issues, particularly for those with high criminogenic risk**. This includes integration of cognitive reframing for criminal thinking into AODA services, increase of trauma-related programming, and attention to mental illness education for all AODA clients.

7. **Initiate and expand access to peer-based recovery coaching to promote continuity and success for individuals with addiction and co-occurring issues**.

8. **Develop organized partnerships between AODA and MH/health services in both Beloit and Janesville, in which AODA services are viewed as a "priority client" of health and MH services**. Within these partnerships, each type of service creates mechanisms to help the other type, through consultation, education, and in-reach, to work more effectively in delivering integrated services to its existing populations, so more people can get what they need in a single door (more efficiently), and fewer people are referred back and forth to duplicative services or fall between the cracks.

9. **Organize teamwork and partnership with probation.** Designated probation officers should partner routinely with each significant AODA program in the County.

Recommendation 8: Develop a co-occurring capable children's system of care approach in the county.

Definition

- **Children's System of Care (CSOC)**

  CSOC is an evidence-based model for designing a community partnership to work with children and families with complex needs. The starting place for CSOC is establishing a community partnership between representatives of children and families seeking service along with MH, AODA, Juvenile Justice, Education (including local schools), Child Welfare, and Developmental Disability Services. The partnership establishes a continuum based on principles of care, such as child-/family-centered, empowered strength-based partnerships, integrated teamwork, and leverage of community supports and peer supports. The community partners meet regularly to coordinate *all* services in the community, as well as developing protocols for team-based intervention care planning for high-need families.

Specific Findings

- As noted earlier, the application of "system of care" principles is applied in a small number of cases in the Coordinated Services Team (CST), an interdisciplinary team approach coordinated with the Family Crisis Team in partnership with other county child and family services. There is also access to an ongoing wraparound service—Children's Long-Term Support (CLTS)—for families in which the children are at risk of out-of-home placement. The "system of care" approach is currently underdeveloped, however, and there is no System of Care leadership table for children, adolescents, and families. Further, the application of this approach is very limited, and leads the experienced "system of care" clinicians in the FCT to be mispositioned in relation to their potential capacity to influence care in the system as a whole.
- Co-occurring capable service delivery with regard to either children/adolescents or families with co-occurring issues is very rare. The one specific "co-occurring program" cited, at Crossroads, simply co-locates a MH day program with an adolescent outpatient AODA program in a single organization. It is not clear even how much those two programs coordinate care with each other.

- As with the adult system, flexible crisis response within behavioral health for complex children and families is limited. For example, the Family Crisis Team has evolved to provide long-term in-home treatment (including home-based waiver services), while retaining responsibility for short-term crisis assessment and stabilization. This evolution has been in response to service gaps for families involved with Juvenile Justice and Child Welfare, but results in a more limited ability to respond to families in crisis. In addition, Mobile Crisis Responders from the crisis unit should be better trained to respond to the unique needs of children and adolescents and their families who are experiencing a mental health crisis.
- As with the adult system, community-based (non-county) behavioral and social services for children and adolescents are not well-coordinated with each other into a systemic approach, though there appears to be willingness to come to the table.
- There is no formal mechanism for identifying, engaging, and empowering family advocates, teen mentors, and other peer supports within the child and adolescent behavioral health system as a whole.

Next Steps

1. **Establish a Children's System of Care process.** Within the larger BHRSC system improvement process outlined earlier, create a "subsystem" focus (e.g., a CSOC Subcommittee) on Children's System of Care, including MH, AODA, Developmental Disabilities (DD), Child Protective Services (CPS), Juvenile Justice, local schools, and health facilities. Involve family advocates and recovering teens (Youth Mentors). Adopt both CCISC principles (welcoming, trauma-informed, co-occurring capability) and CSOC principles to guide a quality improvement process for implementation countywide. (This might position Rock County to secure a future Children's System of Care Grant. Note that TriWest has specific experience in writing successful Children's System of Care grants for state and county systems.) Co-occurring capability should apply not only to individual youth with co-occurring MH and AODA issues, but also to co-occurring families, where one member has one kind of problem, like a child with an emotional disturbance, and another member has another kind of problem, like a family member or caregiver with a substance use issue.
2. **Commit to consensus CSOC and CCISC principles for addressing youth and families with complex needs.** Consensus development can begin in the Strategic Planning process. The framework for application of both (CCISC and CSOC) sets of principles is that within a "family partnership," building on strengths and hopeful goals to address multiple issues in an integrated fashion, families (and youth) can make step-by-step progress in addressing those multiple issues more

cost-effectively over time, minimizing the use of expensive placements or incarceration. This shift requires a broad commitment to adoption of a new philosophy and mechanisms to document and celebrate progress across the whole county, in order to have the impact that is most desirable.

3. **Explore CCS funding.** Again, plan for use of flexible Medicaid waiver dollars to support a wider array of services and family-centered program development for complex families. Further, explore how to use Medicaid dollars flexibly to support expansion of family-based wraparound capacity throughout the county (not just within county-operated services).
4. **Establish formal "partnerships" between MH and AODA services for youth.** The goal is that those types of services support each other to improve co-occurring capability, so that services for youth with co-occurring conditions become integrated rather than parallel or duplicative.
5. **Develop a process for identifying and training Family (or Parent) Advocates and Teen Peer Mentors.** These individuals provide valuable and cost-effective capacity to engage and support high-risk youth and families with very complex needs.

Recommendation 9: Improve best practice diversion services for adults through specialty courts, routine court services, and probation.

Definitions

- **Sequential Intercept Model**

  The Sequential Intercept Model ("Use of the Sequential Intercept Model as an approach to decriminalization of people with serious mental illness." Munetz et al, Psychiatric Services [2006] 57[4]:544-49) is a conceptual framework for communities to use to organize improvements at the interface of the behavioral health and criminal justice systems. It defines a series of points of interception at which interventions can be designed to facilitate diversion, as follows: law enforcement and emergency services; initial detention and hearings; jail, court, and forensic screenings and evaluations; re-entry from prison and jails; and community corrections and community support services. Using the model, communities can organize quality improvement strategies that evolve over time to increase diversion of people with behavioral health needs from the criminal justice system into community treatment. The GAINS Center has materials available to guide

communities in using the Sequential Intercept Model within a community system improvement approach, consistent with recommendations in this report.

- **APIC Model**

  APIC is a best-practice model for conceptualizing a systematic approach to discharge and transition planning from jails to community support, published by the National GAINS Center (Osher, Steadman, & Barr, 2002). APIC stands for Assess (including strengths, supports, and risks in mental health, substance abuse, and public safety areas), Plan (including a comprehensive and integrated plan to provide matched support in each area), Identify (refers to organizing a network of community services that are responsible for and responsive to individuals being released), Coordinate (refers to mechanisms for community oversight to ensure that the services work together collaboratively and that individuals do not fall through the cracks). See also "Outpatient Services for the Mentally Ill involved in the Criminal Justice System," an American Psychiatric Association Task Force Report, October, 2009.

- **Specialty Courts (or Diversion Courts)**

  These are specialized court "programs" that are designed to both divert individuals with various types of behavioral health needs into treatment services, as well as to provide a structured monitoring and support team (which includes the judge, district attorney, and probation, as well as treatment providers) to regularly oversee progress and design appropriate positive and negative contingencies to help the individual succeed. Specialty courts may be more specifically targeting individuals with substance-abuse-related behaviors and crimes ("drug courts"), individuals with serious mental illnesses ("mental health courts"), individuals or families in the child welfare system ("family courts"), individuals with particular offenses ("Operating While Intoxicated [OWI] courts"); may target adults or juveniles; and may (depending on the local jurisdiction) focus on populations of varying severity or at varying points in the sequential intercept (e.g., pre-adjudication vs. post-sentencing; misdemeanants only, non-violent felonies only, or both). All specialty courts have the expectation of working with individuals and families with co-occurring mental health and substance use conditions, and therefore need to be co-occurring capable in their basic design.

Specific Findings

- The CJCC, as previously noted, has developed a highly effective collaborative planning process that has supported a partnership between senior leadership and community stakeholders representing both criminal justice and behavioral health.

However, there is not at present a coordinated county-wide strategic implementation plan, with measurable quality improvement targets, using evidence-based models (e.g., Sequential Intercept, APIC) to improve overall behavioral health/criminal justice system functioning. In addition, there is no specific committee, analogous to CCRG, where there is a coordinated partnership to track the experiences of individual clients who may be already incarcerated, on the verge of release, or involved with community corrections.

- Law enforcement (police department) representatives from all the major municipalities in Rock County, along with the sheriff's office, are participating with the CCRG in attempting to improve policies and procedures related to emergency detention, to facilitate criminal justice diversion as early in the "sequential intercept" as possible.
- With assistance from the CJCC, Rock County has developed and/or expanded Community RECAP specialty drug court (including hiring a psychiatrist to address co-occurring issues) and a specialty mental health and AODA veteran's court. These specialty courts have been successful and are well-regarded. A specialty OWI court is about to get off the ground. However, only a very small minority of individuals (fewer than 50 per year) with behavioral health conditions and criminal justice involvement come in contact with specialty court services.
- There is remarkable leadership from judges (e.g., Judges Daley, Werner and Bates) supporting the expansion of specialty courts, and dissemination of "best practice" diversion approaches for offenders with behavioral health conditions into all areas of the local criminal justice system. The judges indicated to us that they are interested as well in supporting improvement of co-occurring capability in the behavioral health system as a whole.
- There is also a remarkable consensus (compared to many other similar communities) between the district attorney's office, the public defender's office, and the private bar for supporting additional best practice diversion approaches for individuals with behavioral health conditions.
- The "bracelet" program has been very successful in reducing jail census and pressure to expand the jail. Further, this program has increased community acceptance of the potential for sentencing alternatives to reduce jail tenure without compromising public safety.
- Wisconsin Department of Corrections (DOC) Regional Division of Community Corrections is a full partner in the Rock County CJCC process. The adult probation officers have been trained in mental illness and are interested in understanding how to work more effectively with individuals with behavioral health conditions.

However, the training they have received has not provided sufficient instruction on best-practice strategies for balancing accountability for behavior with accommodating the challenges related to behavioral health disorders and disabilities. Further, there is a lack of organized partnership between probation officers and behavioral health service programs, even for individuals who are not guilty by reason of insanity. Probation officers reported that they often feel there is no backup for dealing with many types of behavioral health crisis other than to surrender the offender.

- Consumers, families and other stakeholders are supportive of expansion of diversion programming, and improvement of coordination and communication between all levels of the criminal justice system and the behavioral health system. In relation to community services in particular, there were numerous reports expressing concerns about lack of communication between probation and clinicians, as well as abrupt interventions by probation officers that result in re-incarceration.
- Rock Valley Community Programs (RVCP) provides excellent and well-regarded residential transitional programming for individuals with behavioral health needs who are re-entering the community from prison. RVCP clinicians and consumers alike report however that many clients have a great deal of difficulty with connection to routine MH services (e.g., psychiatric medication), integrated co-occurring services, and continuity of care.

Next Steps

1. **Develop a formal process for improving Criminal Justice and Behavioral Health care coordination and clinical outcomes, using the Sequential Intercept Model**. In particular, under the auspices of the BHRSC, identify a criminal justice/behavioral health (CJ-BH) subcommittee, to design quality improvement processes at each point of the Sequential Intercept, and to track the experiences of individual clients, analogous to the work being done by CCRG regarding the improvement of the emergency detention and crisis response systems. This workgroup would be operating in a framework defined by the vision that *all* services are becoming welcoming, recovery-oriented, and co-occurring capable. Table Top cases may be very helpful in guiding this workgroup.
2. **Engage criminal justice system representatives as full partners and participants in system redesign**. Within the larger BHRSC system improvement framework described above, engage judges, district attorneys, public defenders, and probation officers in learning the principles of successful intervention for individuals with behavioral health conditions and criminal justice involvement, and how to apply those principles to design appropriate treatment interventions

(using the APIC model for example) and to create proper incentives for ensuring accountability while supporting the development of capacity to maintain community tenure. Probation officers should be engaged with behavioral health clinicians to work as "change agents" in the process.

3. **Develop guidelines for communication, coordination, and transition planning between criminal justice settings and behavioral health programs**. These may include guidelines and markers of progress for information sharing, for communication and planning (using APIC), and for welcoming and engagement of criminal justice referrals as a priority for attention.

4. **Improve teamwork between community corrections and clinical services**. Develop a plan for building teamwork between designated probation officers and clinical services teams in both Janesville and Beloit. This will facilitate the ability of those clinical teams to welcome and engage high-risk individuals, and to provide consultation and support for probation officers providing supervision for those same individuals. In addition, all probation officers should be treated as "priority customers" for access to crisis support, so that if there is concern about the potential decompensation or relapse of one of their probationers, they can receive rapid assessment and intervention in order to forestall re-incarceration.

5. Apply specialty court principles of successful intervention in "regular courts" and "regular probation." While seeking additional funding to expand specialty courts, develop some pilot approaches for introducing specialty court principles into some "regular" courts. The goal is to eventually incorporate successful "practices" into base funding for all criminal justice proceedings.

6. Identify the re-entry population as a priority population for access to services. Develop protocols for how individuals in RVCP and other individuals at risk of incarceration (or re-incarceration) can be prioritized for access to routine behavioral health services (including medication evaluations) as well as to flexible crisis response if needed in order to forestall probation violation and re-incarceration.

Recommendation 10: Improve best-practice diversion services for juveniles through specialty court, family-based supports, and flexible wraparound.

Specific Findings

- The Rock County Juvenile Justice and Prevention Services leadership has a strong commitment to the application of CSOC principles within JJ services, and would

welcome the opportunity to participate as a full partner in the design of a CSOC in Rock County.

- In this regard, the Rock County Juvenile Justice and Prevention Services have made clear progress in incorporating best-practice principles and practices into designing a comprehensive services array. There is a remarkable array of diversion services, including TATE, Early Intervention. Evening and Weekend Report, High-Risk Offender Program, CST, and various Community Service options.
- Juvenile Justice has begun routine behavioral health screening with the YASI, and reports that approximately 50% of all youth had MH needs, and 50% had AODA needs. However, less than half of all those flagged receive services. Further, access to co-occurring disorder services is almost non-existent.
- The Juvenile Justice Specialists, and the Juvenile Justice Division as a whole, do not have an organized or routine framework for partnering with community and clinical service providers working with youth and families. In addition, the Juvenile Justice Specialists would welcome the opportunity to participate in a system-wide workforce development process that would expand collaboration and competency to provide strength-based wraparound services to individuals and families with co-occurring MH and AODA issues and other complex needs.
- There is a recognized need for more capacity to provide family-based interventions using strength-based, system of care, and wraparound principles to help high-risk youth to avoid re-offending. There are a few out-of-county in-home intensive services providers, and little availability for individuals with Medicaid or no insurance. There is not a system framework in Rock County for beginning to increase the local capacity to provide those types of services, though there is both willingness and available local expertise that could help that to occur.
- There is untapped opportunity to maximize use of Medicaid dollars (with federal match) vs. use of unmatched county dollars in serving youth and families with complex needs in the juvenile justice system.
- There is currently no family court and no specialty court addressing juveniles with behavioral health issues in Rock County.

Next Steps

1. **Engage Juvenile Justice as a full partner in the Children's System of Care development process.** Within the system improvement framework described above, involve the juvenile justice division and its service workers as full partners in the development of a children's system of care approach to working with both

offenders and families, and to engaging all staff and all "programming" to be strength-based and co-occurring capable.

2. **Identify an array of community partners to improve access and capacity to provide family-based wraparound services.** Identify clinical programs and agencies that have potential capacity to provide team-based interventions for high-risk families, and connect juvenile workers to these clinical programs or teams to enhance service delivery and outcomes. Seek to include services that may provide "natural supports" to families, as well. The goal is to build more capacity within all services for children and families to deliver co-occurring capable "wraparound" types of interventions that are designed for engagement of youth and families with complex needs.

3. **Engage the Juvenile Justice Specialists as partners and "change agents."** As with the adult probation officers, provide training to juvenile service workers in the core principles of successful intervention with complex youth and families, and provide practice opportunities to learn how to apply those skills within the framework of juvenile probation. Juvenile Justice Specialists should be represented on the Rock County CCISC Change Agent team, along with clinical service workers.

4. **Position the system to attract system of care funding**. Rock County might consider preparing for the next round of funding for Children's System of Care development grants that are periodically available through the Substance Abuse and Mental Health Administration (SAMHSA). In addition, Rock County should explore how CCS might enable certain services now provided exclusively with county dollars can potentially be provided through Medicaid.

Recommendation 11: Improve behavioral health services for individuals in jail and juvenile detention, both in the facility and in transition.

Specific Findings

- The County Jail plays an important role in the continuum of services for individuals with behavioral health needs. The Rock County Sheriff has made a commitment to reducing the overall jail population, and has been very successful in avoiding the need for a new jail through the bracelet program and other diversion efforts. He is using $6 million garnered from avoiding jail expansion to create a state-of-the-art medical facility within the jail, and expressed willingness to incorporate behavioral health service capacity within that new facility.

- The Sheriff has a $700,000 annual contract with a correctional medical services company. This contract includes two hours per week of psychiatry time, plus some social work and nursing time that is available for behavioral health services. Unfortunately, there are few specific and relevant deliverables within the current correctional medical services contract that relate to participation as a behavioral health system partner, and to assessment, treatment, medication, and discharge planning for individuals with behavioral health needs in the jail. This is an area that could readily be improved within existing resources when the contract is re-negotiated.
- Substance abuse services are provided within the jail, but they are not designed to be co-occurring capable, and are disconnected from the mental health services provided through the above contract.
- The jail is not collecting routine screening data on the prevalence of mental illness, substance use disorders or co-occurring disorders within the jail. Based on anecdotal reports and experiences of other county jails, it is likely that 15-20% of jail inmates have serious mental illness, almost all of whom will have co-occurring substance use disorders. It is likely that approximately 70% of jail inmates will have any significant behavioral health condition that contributes to their incarceration. Under-identification of behavioral health needs in jail has been connected with difficulties with jail-based services as well as with transition planning and coordination of care. Fortunately, there are evidence-based MH and AODA screening tools available for use within jails by jail personnel. (See the Jail MH Screen developed by Steadman and others for the GAINS Center, as well as the GAINS Center report on jail-based co-occurring MH/AODA screening by Peters and others.)
- Routine protocols for information sharing are not present in either the Jail or the Juvenile Detention facility. These protocols have been developed in other jurisdictions and are adaptable to Rock County. (See Appendix B on Data Sharing, and see the report produced by the Bureau of Justice Assistance and the Council for State Governments Justice Center entitled "Information Sharing in Criminal Justice – Mental Health Collaborations.")
- Stakeholders of all types expressed concerns about behavioral health services within the jail, including access to medication (including medications brought in by families), limitations of formulary, poor communication with community providers and families, and very limited transition or discharge planning. There is no formal mechanism at present to routinely track and improve those types of incidents within a quality improvement framework.

- There are also significant improvement opportunities at the juvenile detention facility. Within the juvenile detention facility, there is both a secure wing, and a less secure "shelter" wing. Within the secure wing, there is some organized attention to behavioral health screening and intervention for juveniles. However, there is considerable need to improve capacity to address inmates with serious mental health conditions. Within the shelter wing, the services are less clearly organized, and there are many juveniles who are very high-risk without a clear approach to care within the facility, nor within the community. Leadership in the juvenile detention facility is very interested in working in partnership with community resources to identify and implement any improvement opportunities that can be developed in this process.

Next Steps

1. **Include Jail-based services and Juvenile Detention services as full partners in the system redesign process.** Within the system change strategic planning process described above, the BHRSC in Rock County would need to articulate the behavioral health needs of the jail and detention populations as a clear community priority, equivalent to (at least) the needs of individuals in state prison or state hospitals.
2. **Improve screening, identification, and awareness of the prevalence of the behavioral health population.** The BHRSC (and the BH/CJ subcommittee in particular) should work in partnership with the Sheriff's Office and Juvenile Detention staff to develop a mechanism for universal screening, and to improve the collection and reporting of data on the prevalence of mental health conditions (including, but not limited to, more serious conditions), substance use disorders, and developmental disabilities in the facilities. This will help generate information for both system-level performance improvement, as well as support appropriate resource planning within both facilities.
3. **Develop adequate capacity and accountability for Jail and Juvenile Detention behavioral health services.** Based on the available data, there should be a plan for needed capacity of behavioral health service delivery in the jail and in detention. There are national standards for psychiatric care in jails that can be used to guide this planning. The existing jail medical services contract should be modified to include quality indicators, performance metrics, and contract incentives/penalties related to screening and data collection, medication access, successful behavioral health treatment for high-risk inmates, and adequate community coordination and transition planning.

4. **Integrated behavioral health capacity into the new Jail medical services facility.** The BHRSC and the Sheriff's department should partner in the design of a state-of-the-art behavioral health component in the new medical services facility that could facilitate more successful management of inmates, reduce the likelihood of suicide and other sentinel events, reduce costs related to assaults and injuries, and facilitate more rapid transition to successful community services.
5. **Improve the ability of Juvenile Detention "shelter" services to function within a continuum of "juvenile crisis diversion" services.** In particular, the BHRSC (and appropriate workgroups) should partner with the Juvenile Detention leadership to identify mechanisms for improved service delivery in detention and better partnership in provision of wraparound crisis response to juveniles in "shelter." The community can collaborate in identifying alternative mechanisms for "juvenile crisis diversion" for juveniles that can be stabilized in lower levels of care.
6. **Create a formal process for data-driven quality improvement of Jail and Juvenile Detention transitions.** Transition planning from jail and detention for individuals with MH and/or AODA issues is an excellent "sequential intercept" target for community-wide quality improvement activity coordinated within the BHRSC framework. The APIC model combined with CCISC principles provides a helpful framework for conceptualizing standards for co-occurring capable transition planning. The community quality improvement process would involve looking at the "flow" of individuals into and out of jail or detention, and designing process improvement (Plan-Do-Check-Act) cycles to increase the percentage of individuals who connect to continuing integrated care with appropriate medication and other services in place.

Recommendation 12: Improve access to housing, employment, and peer support for individuals and families, especially those with co-occurring conditions.

Definitions

- **Permanent Supportive Housing**

  Supportive housing (or "Housing First") models are evidence-based practices designed for individuals with mental health disabilities, usually with active co-occurring conditions, who need assistance to maintain housing, but are not well-matched to either standard group homes or interested immediately in discontinuing substance use. Given that "sobriety" is not a pre-condition for community housing

for the general population, these programs help clients identify community living situations of their choice (and affordability) and then provide wraparound support to help them succeed in those settings, by helping them decide the right amount of mental health services and the right amount of substance use in order to be successful in their housing. For more information, see materials by Tsemberis and others on Pathways to Housing.

- **Supported Employment**

  Individualized Placement and Support (IPS) is a SAMHSA evidence-based practice toolkit for adults with serious mental illness. (It is effective with those with active co-occurring substance use as well). IPS helps individuals who are interested in working to identify job preferences, obtain competitive work, and provide on-the-job support to help them succeed.

Specific Findings

- Housing is a priority concern expressed by multiple stakeholders that contributes to poor behavioral health and criminal justice outcomes in Rock County, as in many other communities. There is an active Homeless Intervention Task Force, and a PATH team that has made progress in engaging individuals in finding and keeping housing, and in expanding housing access.
- There is very limited access to organized sober living in Rock County. We met a house manager and four (of six) residents of one program which seems to work well with co-occurring clients. There is no systemic plan for expansion of sober homes.
- There are approximately 95 small Community-Based Residential Facilities (CBRFs) in Rock County, with limited capacity to work with individuals who have significant behavioral health challenges.
- Rock County does not have an organized framework for designing and implementing "damp" or "wet" housing options, such as permanent supportive housing. This results in great difficulty for individuals with co-occurring issues being able to get and keep housing, and enhances criminal justice risk in the population.
- Further, there is limited access to temporary supportive housing for people in crisis.
- Employment was also raised as a concern, particularly with plant closures and job loss in the community. There is not a broad county-wide plan for implementation of evidence-based supported employment at present.
- Both consumers and families commented on the absence of an organized empowered voice for consumers or families, as well as a lack of organized peer

support services, other than 12-Step meetings, within Rock County. There is lack of availability of peer support services for individual adults, with either single or co-occurring conditions, as well as lack of peer outreach and mentoring for families who are struggling. Specific co-occurring recovery support, such as **Dual Recovery Anonymous (DRA)** is under-developed as well. In the focus groups, participants expressed great interest in the potential for development of these services, which can be a very cost-effective approach to expanding the safety net.

Next Steps

1. **Create a focus for Housing and Employment planning within System Redesign.** Within the larger BHRSC framework, there needs to be organized planning (perhaps starting with identifying the Homeless Intervention Task Force as an organized subgroup) to focus on improved housing and employment for individuals with behavioral health needs. This group could recommend standards or protocols for "damp" and "wet" housing options in Rock County, arrange introductory trainings in these approaches, and develop plans for service providers to learn how to support individuals in those settings.
2. **Incentivize the development of independent sober homes.** At the same time, AODA funds might be used to incentivize local providers to develop sober living options that can evolve to become self-supporting.
3. **Introduce evidence-based supported employment.** Rock County Human Services should introduce Supported Employment training to its clinical service teams, and work in partnership with Rehabilitation Services to create supported employment options for consumers at risk.
4. **Provide support to organize empowered family and consumer advocacy to partner in system redesign.** The BHRSC should engage local consumers and family advocates who might be potential leaders, and provide resources for leadership training and advocacy development. In addition, each participating provider might facilitate the development of one co-occurring peer recovery support group (e.g., Dual Recovery Anonymous) and one family support group on site. National experts (e.g., Tim Hamilton of DRA) can be brought in to stimulate peer support development across the county.
5. **Develop mechanisms to expand access to peer support workers and recovery coaches.** There should be investigation of how other counties in Wisconsin have garnered flexible resources to fund peer support workers and recovery coaching for both adults and juveniles. Peer support workers and consumer family advocates can be the most valuable and inspired partners to help the whole

system to become more recovery-oriented, and thereby inspire more individuals at risk of criminal justice involvement to invest their hope and energy into success in the community. There is a system in Iowa (in Dubuque), for example, that has used peer coaches to accompany individuals with behavioral health needs to court appearances in specialty court. This has proven so successful that the judges have sought court funding to expand access to this service.

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Section 4
Summary and Next Steps

Summary

Section Three has provided "Twelve Steps of Recovery" for the Rock County behavioral health, human services, and criminal justice delivery systems, with a range of specific recommendations for how to implement those steps, as much as possible by leveraging existing resources to make progress.

What happens next? The intent is that this report does not simply sit on a shelf. This report is intended to provide Rock County both a vision of hope, and a framework for designing a step-by-step strategic plan for how to get there. In this concluding section, we will attempt to provide an illustration of that vision, and then outline next steps for how this report can be used to organize the development of a Strategic Plan for System Redesign.

Vision of Hope

Readers of this report might wonder how the steps and processes outlined in this report would have an impact on the lives of "real people" in Rock County. In order to provide an illustration, we thought we would use the Table Top case that we described at the beginning of this report (page 15) to illustrate how the system of care process described in this report could result in an "alternate experience" for the woman and her family.

> *A 38-year-old woman with a history of bipolar disorder and alcohol dependence has had previous AODA treatment and sees a private psychiatrist for mood-stabilizing medication. Her family includes her husband, also with AODA problems, and two teenage children, one of whom has juvenile justice contact. She has had periods of recurrent success, but she and her husband have difficulty asking for help, so they have been instructed (this time around) to contact crisis services at the earliest sign of relapse, to see if she can be more quickly stabilized. In the past few weeks, the woman has become somewhat hypomanic, even on her medication. The husband is concerned so he calls crisis, who agrees to meet with him and his wife for an early intervention. They contact her private psychiatrist as well to attempt to coordinate additional support and medication adjustment, and monitor progress for a few weeks. She initially improves, but then she continues to get more hypomanic, leading her to*

relapse on alcohol. This in turn leads her to stop her medication abruptly, even though her doctor advised her not to do so. The husband alerts the crisis team who attempts to do some outreach. In a few days, however, she becomes increasingly manic, hypersexual, engages in increased spending (maxing out credit cards) and has just convinced a used car salesman to sell her a car on a credit card that has been maxed out. This has led to referral to Janesville Police Department (auto theft) and when they find her, she is intoxicated, has crashed the car. She feels hopeless and desperate because she knows that she has created a big mess for herself, and now is threatening suicide stating that she intended to kill herself when she had the accident.

Due to the accident she is taken to the ER. Her blood alcohol level is .23. She is combative and accusing police and staff of mistreatment. Crisis Intervention is contacted. Because crisis intervention already has a relationship with the family and the private psychiatrist, their initial contact with the woman in the ER is very welcoming and positive. They let her know that they are glad that she did not get injured in the accident, that they are sorry they were not able to get her intervention plan to work fast enough, and let her know they want her to be safe and return to her previous stability, with even closer monitoring and better medication management, as soon as possible.

She feels safer and more hopeful with this approach, calms down fairly quickly and agrees to take some tranquilizing medication in the ER to address her acute mania. The police have filed charges (for auto theft and property damage), but have a procedure where they are able to leave her in the ER in care of the crisis team, with the understanding they will be re-contacted if she attempts to leave without an appropriate disposition. The crisis team engages in an intervention meeting with her and her husband, with consultation from her psychiatrist on the phone. Her alcohol level is by now about .13. She is not displaying significant withdrawal symptoms as her relapse was relatively recent, so no medical detox appears to be indicated. Consequently, she would be eligible for Jackson House if she were agreeable to go, or potentially for direct admission to the Mercy Inpatient Unit if she needed a commitment. There is no requirement that she receives detox first, nor a requirement that her alcohol level has to be below .10 before admission.

After some discussion with her and her family, she expresses willingness to go to Jackson House, because of her previous positive relationship with the crisis team, and their promise to stay connected with her while she is there to make sure everything goes all right. In order to reassure her about Jackson House, she calls them from the ER, and is reassured by their welcoming manner on the phone, and the fact that they clearly convey that they enjoy working with people like her who are in mental health crisis and who have been actively drinking. Her private psychiatrist calls Jackson House as well, with some medication suggestions to rapidly stabilize her manic condition, and she is admitted after only a few hours in the ER. Her husband agrees to bring in her all her medication from home that

evening. She also has a history of diabetes, but her sugars in the ER were only mildly out of control, so she does not need medical admission for diabetes, and is able to go to Jackson House with the understanding that she will be re-stabilized there on her diabetic regime. Note that neither the police officers nor the Sheriff's deputies have been tied up for hours with unnecessary monitoring or transportation. Further, an expensive and unnecessary detox admission is avoided entirely.

She spends five days in Jackson House and is under much better control, though still hypomanic. Jackson House is able to arrange a continuing care plan (through Janesville Counseling Center backed up by the Crisis Team) where she and her husband can get regular phone monitoring and up to three-times-per-week contact until she is stable enough to be followed in routine outpatient services. (Note that she is identified as a priority client for this service because she is both at risk of hospitalization and at risk of incarceration, as well as that she has bipolar disorder and alcohol dependence.) She agrees to return to AA and contact her sponsor, but has practiced some skills at Jackson House (which has implemented co-occurring capable programming including some skills training manuals for overcoming addictions in individuals with mental illness) to help her use her sponsor more actively, and to ask for help prior to relapsing. She has been charged with auto theft and criminal damage to property and must go to jail for booking and processing when she is released from Jackson House. She and her husband schedule this appearance with their attorney. Rock County has initiated a pilot pre-booking diversion procedure where individuals whose crimes are clearly connected to behavioral health decompensation, and who are now stabilized and engaged in treatment, can avoid incarceration. In this program, she can be sent home on bail with an agreement to continue treatment, and to report weekly to the court (initially) concerning her progress. The understanding is that if she violates this process, she can be remanded back into the criminal justice system, while if she is successful in this process, charges could be lowered or dropped. There is also an option to pay restitution in lieu of criminal charges. There is a probation officer who regularly works with the JCC team that is assigned to this case. The case is also going to be tracked by the Rock County BH/CJ improvement team to make sure she gets the services she needs and does not get lost to follow up. The family signs all necessary releases to ensure communication between all members of this "team," including the private psychiatrist.

After two months, she is much improved. She is seeing JCC staff (case manager) only once a week, in addition to her private MD, and checking in regularly with her probation officer. She returns to court, and her case is continued for one year, pending continued stability and progress. She and her family arrange a restitution plan with the car lot owner. She agrees that it will be helpful for her to work with her family and her team, including the PO, to help her stay on track through identifying early warning signs of relapse with her bipolar disorder or any slips with her drinking, in order to engage her in receiving additional support much

more quickly. She also reports that she has felt very welcomed by the crisis services, and would be more willing to work with them sooner rather than later if problems should arise.

This vignette illustrates how a system-wide improvement process, based on shared values of welcoming, hopeful, strength-based, co-occurring capable services, can result in improved outcomes and lower costs within the basic service array already available in the county. This is the vision that we are hoping that you will use to organize yourselves in your strategic planning process to be able to achieve.

Strategic Planning

The next step in this process is to organize a community-wide strategic planning and implementation process to achieve this vision. This process will begin, with the help of the ZiaPartners consultants, on August 17. In order to guide Rock County in this process, we have provided an example of a possible implementation framework for a chartered system redesign quality improvement partnership in Appendix C. This template is one we use in other state and county systems to help them craft a common vision, and define, within a quality improvement partnership, a set of steps that each partner will agree to take to make progress toward the vision. Please note that the draft template is exactly that—a draft. We have included enough content in the draft to give you an idea of what kinds of things can be included, so you can see how to make progress within available resources. However, the community conversation on August 17 is the place where we will organize a strategic planning conversation based on the report. This conversation will help you to determine your own priorities as a county system, and to decide whether and how to use this draft template as a starting place for your "Rock County Strategic Plan," into which you would be able to insert your own priorities, activities, and commitments to action.

Conclusion

In closing, the ZiaPartners/TriWest consulting team would like to thank all the Rock County programs and individuals who participated in this process for your exceptional cooperation, willingness, and openness. We know you have the potential and capability to make continued progress in the direction of an inspiring vision for your system, and to greatly improve services for the individuals and families with complex needs who are seeking help in Rock County. We look forward to your sustained efforts and hope to be able to continue to work with you in the future.

Appendix A
Summary of Interviews and Focus Groups

Stakeholder Interviews and Focus Groups
April 4-5, 2011

Summary

Key Informant Interviews were conducted with behavioral health administrators and providers, as well as with several leaders in the criminal justice and law enforcement systems. In addition, consumers, family members, and advocates participated in **focus groups** that discussed issues related to services for people with behavioral health problems and who also have involvement with the criminal justice system. The aim of the interviews and focus groups was to identify gaps in services, as well as strengths that could be utilized to enhance the system of care for people with behavioral health problems and criminal justice system involvement.

Predominant, Cross-Cutting Themes

Several cross-cutting themes emerged from the interviews and focus group. These are listed below under gaps/problems and strengths/initiatives. Neither of these lists is completely comprehensive, but they do offer a helpful overview of the key issues that were addressed by many different interviewees and focus group participants.

Gaps and Problems

Domain	Gap/Problem
Co-Occurring Disorders and AODA	▪ Consumers with co-occurring mental illness and substance use disorders almost always receive MH and substance use disorder (SUD) services from different providers. As one therapist said, "My clients tell me, 'I have too much I have to do – go here for alcohol and drug treatment, go there for MH treatment.'" ▪ Staff report that, historically, they have been discouraged from obtaining AODA service credentials ▪ Many participants indicated that AODA services are very difficult for people with mental illnesses to get, in general. Beloit consumers, in particular, appear to have difficulty accessing AODA services.
System of Care for Children	▪ There are few outpatient behavioral health resources for children, especially for those with severe emotional disorders who need wraparound and similar services to be able to stay in the home and avoid unnecessary placement in institutions and residential care. (Although the new Children's Long-Term waiver is adopting a wraparound service.) ▪ Services that do exist do not engage families and parents effectively. ▪ There is no system of care coordinating body for children's services that takes responsibility for the system as a whole. ▪ As with adults, MH and SUD treatment is not integrated. ▪ AODA services in schools are being cut. ▪ There is not inpatient AODA treatment in Rock County. ▪ Transportation is often a problem, in part, because not all insurance that children/families have cover it. It is often a barrier to participation in treatment.
Coordination between Criminal Justice and Behavioral Health	▪ Many behavioral health staff indicated there has historically been poor communication and coordination between criminal justice (e.g., the jail) and behavioral health. ▪ Consumers consistently indicated that there was difficulty in making the transition between jail or prison to the community – there sometimes has not been a good plan for community-based services, and lack of resources in the community make planning difficult. ▪ Officers often have to wait way too long in Emergency Rooms and Hospitals as they accompany consumers. There needs to be better coordination with crisis services, which also need to be more mobile.

Domain	Gap/Problem
Availability of Services within the Criminal Justice System	▪ Many participants said that not enough services are available within the jail. The jail does have a couple hours a weeks of psychiatry services and a half-time social worker—and these are better resources than not at all—but many people with needs are not getting access to evaluation and treatment in the jail. ▪ Rock Valley Community Programs plays a vital role within the system of care, but staff and consumers there are exasperated with the lack of access to needed behavioral health services. Lack of access makes the process of preparing for full community immersion extremely difficult. ▪ Many stakeholders also perceive there to be a lack of diversion and restorative justice programs for consumers. This perception was especially strong in Beloit. However, the diversion program for youth was highly regarded.
Housing	▪ Housing was consistently identified by consumers and providers alike as one of the biggest challenges facing the system right now. ▪ Housing is particularly difficult to obtain for people with co-occurring disorders who have criminal justice system involvement.
Intensive Community-Based Options for Adults	▪ CSP programs are well-liked, but consumers felt there needed to be more slots available. CSP staff did indicate that the wait to be accepted into a CSP can be as long as four months. ▪ Crisis Stabilization at Jackson House is highly regarded, but the view that Crisis Stabilization services need to be expanded is also widely shared. ▪ Crisis Services need to be more mobile. ▪ There is an Intensive Outpatient Program at Mercy, but according to one program leader, the County has not yet been able to contract with them for those services.
Staff Training Needs	▪ Several stakeholders felt the criminal justice system and law enforcement need training in responding to behavioral health issues. Consumers and family members perceived staff often to be too physical and not skillful enough in handling difficult behaviors. In addition, confidentiality and privacy are not always handled well. ▪ Some behavioral health provider staff felt that the system's cultural competence was not high, which may decrease access for some sectors of the population ▪ Some participants felt that services were not trauma-informed, despite the fact that so many consumers are coping with past trauma.

Domain	Gap/Problem
Consumer and Family Empowerment	▪ Neither consumers nor parents of children/youth with whom we spoke knew of mutual support groups in the community. They indicated that it would be wonderful to have them available. ▪ There did not appear to be either a consumer movement or a parent movement within the county. Consumers and parents seem to have infrequent engagement in policy and program development. ▪ Peer Support was not something consumers felt they had access to in the county. Parents also did not know of any peer Parent Navigators or any similar roles for parents within the system.

Strengths/Initiatives

Domain	Strengths/Initiatives
Co-Occurring Disorders	▪ The Department of Human Services is excited about some new developments that are taking place. For example, staff are now being encouraged to work toward integration of MH/SUD services within the Counseling Centers and CSP programs. ▪ Staff at Beloit CC reported that the county is hiring a Case Management position, which must be filled by someone who has a Certified Addiction Counselor (CAC) credential. The person would be available to both Janesville and Beloit for assistance in responding to consumers' AODA needs. ▪ Some MH staff reported a desire to receive training in SUD treatment.
Community Support for Adults	▪ CSPs are well-conceived programs that are moving in an even better direction, as they seek to function more as teams (more like Assertive Community Treatment [ACT] teams) and as they begin to incorporate AODA functions. ▪ Co-location and better coordination of CSPs and CCs sets the stage for more careful placement in and movement to the appropriate level of care. ▪ CSP Case Managers have worked heroically, in many cases, to establish trusting relationships with landlords that have enabled them to obtain housing for even some of the consumers for whom housing is most difficult to find. ▪ Leadership at the County level is progressive and CSPs are becoming increasingly recovery- and empowerment -oriented. They have "won over" and earned the trust many of the consumers with whom we met.
Law Enforcement	▪ Police Chief David Moore and staff have developed innovative new programs that involve creative partnerships. ▪ Some of the new emphasis on alternatives in the Sheriff's Office, such as ankle bracelets, are a welcome sign to many stakeholders.

Domain	Strengths/Initiatives
Programs for Children and Youth	▪ The diversion program that has locations in Janesville and in Beloit is highly regarded. ▪ There is a an anti-drug group in the county, Partners in Prevention (now being called Janesville Mobilizing for Change) that has passionate and committed leadership. ▪ The County is moving in the direction of more wraparound with its Children's Long-Term (CLT) waiver effort. ▪ There is a knowledgeable, experienced, and perceptive group of School Social Workers. ▪ There are some parents who are passionate about seeing the system improve.
Criminal Justice System	▪ Although resources in the jail are minimal, the Social Worker and Psychiatrist working there seem to be very effective and committed professionals. There is a basic service there and good talent upon which to build.
Crisis Services	▪ Jackson House's Crisis Stabilization appears to be an excellent resource. ▪ The County would like to expand Jackson House and also develop a comparable program for children. ▪ The crisis service is trying to become much more mobile.
System Resilience	▪ Despite the recent and looming cuts, providers and administrators alike – especially on the adult side where services are not as bleak – remain energetic and are full of ideas.

Program and Key Informant Interviews April 4-5, 2011

Monday, April 4

The table below summarizes many of the key findings from interviews with various behavioral health and criminal justice staff.

Interview	Findings
Janesville Schools Social Workers *Met with 6 School Social Workers and 1 head of AODA programs within the school*	**Gaps/Problems**
	▪ No inpatient treatment in Rock County for AODA. There is a facility in Rosecrantz, but it's not in Wisconsin so cannot always get it paid for. ▪ Affordable, local AODA services not available. ▪ Transportation is not always covered by insurance so getting to appointments is difficult for children/families. ▪ To get Day Treatment, have to have co-occurring mental illness, so that limits access to that level of care for people with AODA.
	Threats
	▪ Funding is being eliminated for the school alcohol/drug prevention and counseling program. ▪ Project Success, a grant-funded Drug/Alcohol program led to availability of full-time staff at charter schools and to offering drug/alcohol groups, but these are being cut.
	In Place
	▪ Partners in Prevention, an anti-drug group in the county that can apply for various grants. They are converting this to Janesville Mobilizing for Change.

Interview	Findings
Jackson House (CBRF) and Dr. Singer	**Gaps/Problems**
	▪ Continuum of care concerns: No one is in charge of seeing that people with behavioral health problems in jail get services upon release. There is a need for **crisis services** or someone to make a connection and a plan beforehand. Although Jackson House is meeting a lot of need for crisis stabilization and community transition it is at 100% capacity about half the time and needs to be expanded. ▪ Services in jail are not adequate. Dr. Singer, who is the psychiatrist at Jackson House but who also works 4 hours every 2 weeks in the jail, described working there as a very challenging experience. He only has enough time to see the absolutely most acute cases and many people are going without needed services. So far, he has seen 143 people in the jail and most of them are repeat visitors to the jail. He sees a lot of people with co-occurring serious mental illnesses (most common are Bipolar Disorder, Major Depression and Post-Traumatic Stress Disorder [PTSD]) and Substance Use Disorders. (At Jackson House, also, there is a lot of PTSD.) Fifteen percent (15%) of his caseload in jail is suicidal. ▪ The county used to provide its own alcohol/drug treatment but now it's contracted out and difficult to get access to AODA services. ▪ There is **no integration of MH and SUD care**. People have to go to separate providers to get each. ▪ There ought to be an **official liaison** between the jail and the outpatient services ▪ Another big gap is **housing** – it is especially difficult to obtain for people who have involvement in the criminal justice system ▪ Sometimes people "bounce back" to Jackson House. This often occurs when the outpatient service follow-up is not ideal and when people run out of medications. If people don't have case management that often does not bode well for tenure in the community. ▪ There is a need for more **restorative justice** approaches – drug courts, etc.
	Strengths/Initiatives
	▪ They feel very positively about Jackson House and the role it is playing in helping people make a successful transition back to the community. ▪ Jackson House is helping a lot of people to make the transition to the community. They are often at 100% capacity and there is a need for even more crisis stabilization in the county.

Appendix A: Summary of Interviews and Focus Groups

Interview	Findings
Human Services Administration, Charmian Klyve & Phil Boutwell	**Gaps/Problems** ▪ Good movement toward co-occurring capability in CSPs but there is still a need for shifts in orientation and for training ▪ Good movement toward mobility with crisis, but it's still too office-based. She envisions more "boots on the ground" in the community that can help people with intensive and crisis needs, versus "hauling people here and hauling people there." ▪ There has been an increase in suicides – double from last year – suggesting that, overall, services are not adequate enough, not accessible enough. ▪ Badger Care is going to require a higher premium (from $130 / mo. to $200/mo.) and that's going to be difficult for some people. Right now, it only covers psychiatric services, not counseling. Young criminal offenders sometimes need Badger Care and the increase in premium, they're afraid, will make it more difficult for many of them to access care. ▪ Would like to expand Jackson House (crisis stabilization) – more beds, another group of beds, perhaps. ▪ "We're diverting fewer people from jail than in the past, due to security concerns." ▪ Example of cuts: reduction of AODA block grant to the county = $150,000; Badger Care premium increase; 10% county allocation for MH and AODA combined + decrease of $764,000 in basic allocation to the DHS, as a whole.

Interview	Findings
Human Services Administration, Charmian Klyve & Phil Boutwell (continued)	**Strengths/Initiatives** ▪ COD – Kate Flanagan has been working hard to get more providers trained in AODA and providers are "starting to do a little better job," but there is still a need for a shift in thinking and for more re-training. ▪ Also, working to "go mobile" with the crisis service. The team is learning how to intervene earlier on. ▪ Want to expand crisis stabilization to serve children and youth. ▪ They co-located Janesville CSP and Janesville CC and they're happy about that because now people can move more easily across levels of care and there is better coordination. ▪ Children's Long-Term Waiver – they're using **wraparound** to serve high-need/high-level difficulty cases of children with MI and developmental disorders. They're using the waiver program to draw down 60% federal + a county match. However, there is a need to develop the provider community and to add more foster homes. ▪ They have become a part of a consortium that counties buy in to. This allows them to place people in longer-term residential care (e.g., Nursing Homes) in other counties at less cost than they would otherwise – often these are people needing specialize care (geriatric psychiatry, behavioral management). Less cost is due to being able to circumvent, through participation in the consortium, the medical assistance (MA) supplementation rule. ▪ They have also recently started a Point of Entry project, focusing on better triage for people coming into the system and a Utilization Review Committee to help develop more precise placement of people in services – "the right service, at the right time, for the right individual." ▪ They are looking at a different information system. Right now they have Med Sys which is not very good at helping to track how much service is being delivered to who, where. They want to move to more automation including, eventually, electronic health records (EHRs). Would like to share data more. ▪ They want to implement CIT training for officers.

Tuesday, April 5

Interview	Findings
Beloit Community Support Program, 3 Staff Members	CSP is a clinical case management approach where staff have 16:1 to 20:1 consumer:staff ratios. Under Kate Flanagan's leadership, there has been a move toward adopting a more ACT/team-based approach, so they are working on various aspects of ACT fidelity.
	Gaps/Problems
	▪ **AODA** – they do a recovery group at the CSP program, but it's not as specific to SUD issues and COD issues as it needs to be; they have difficulty getting their clients into good AODA programs. "In Janesville there is a certified alcohol/drug counselor, but she no longer takes our referrals." There also is a gap in long-term AODA services. Probation and Parole once had a COD group, but they're not sure that's still available. ▪ Another problem is that when consumers finally do get into AODA services somewhere, there's a philosophical difference, relative to the CSP, which adopts more of a harm-reduction model, versus the abstinence approach. ▪ It's particularly difficult to get services in the criminal justice system. ▪ There is difficulty in how systems work together – communication with probation/parole, for example, can be sticky and they have had to work to gain trust. Whereas POs might see a slip-up, they (CSP) might see progress made, with bumps in the road. ▪ It often takes people referred to CSP—even from Rock Valley or some place like that—3 to 4 months to get into the program. A need for more slots. ▪ **Housing** is a big challenge. When consumers have a criminal justice history, it's very difficult to get housing/HUD housing; they have worked hard to develop some landlords who have come to trust them, however. ▪ Coordination with criminal justice system has been problematic. "There is a lot of putting out fires." Communication is sometimes difficult. Once, a consumers' global positioning system (GPS) malfunctioned (something that helps Sheriff's Office track people on community release) and he had to be taken back to the Sheriff's Office from the CSP site, even though he hadn't done anything wrong and was even following through with treatment, etc. There have been some difficult experiences with consumers and law enforcement- misunderstandings and very unfortunate results of lack of knowledge and experience with mental illness. ▪ Medications are difficult to get in jail.
	Strengths/Initiatives
	▪ They work a lot with Rock Valley and they like them because they see it working better when people come from a half-way house as they try to re-enter the community from the criminal justice system. ▪ They feel good about trying to function more like an ACT team. ▪ Their assessment/evaluation of clients is very holistic and comprehensive, and they feel they do a good job on legal and criminal justice system issues.

Interview	Findings
Beloit Counseling Center, **3 Staff members**	This program involves more therapy but therapists function as clinical case managers also. There is no attempt to be an ACT program, however. Still a somewhat more traditional model, although the therapists are very oriented toward responding to and meeting clients' needs. Consumers can have some pretty serious problems—they're not all "walking wounded" in this program, in part, because the CSP is often hard to get into. "We're set up for therapy, but we end up working with people who have case management issues."
	Gaps/Problems

	▪ Lack of psychiatric care in jail and at Rock Valley Community Programs (half-way house). It's difficult for clients to get medications in jail.
	▪ Communication with criminal justice system not the greatest. "We sometimes won't find out for 10 or more days that one of our clients has had to go back to jail."
	▪ Some people who would quality for CSP don't have the right payer source, so they get placed at the CC ("CSP takes only Medicaid now.").
	▪ Sometimes there is a "duplication of resources." For example, with forensic commitments – client is under probation but in mental health section of probation – sometimes little communication with CC.
	▪ Lack of outpatient AODA – one staff member: "90% of AODA funds in the county go to the residential level of care."
	▪ **COD** – there needs to be better integration of MH/SUD care and it needs to be more holistic; there are a lot of AODA issues with their clients, especially the 10-15% or so who are involved in the criminal justice system. **One therapist said, "Clients tell me: 'I have too much I have to do – go here for alcohol and drug treatment, go there for MH treatment'."**
	  ▪ COD is a "huge problem" in our system.
	  ▪ Historically, we've said we do not treat AODA issues and getting training for that has actually been discouraged, in the past.
	  ▪ "We're supposed to refer out."
	  ▪ Coordination with AODA is not good.
	▪ **Trauma** histories is a big concern – care in the system (criminal justice, behavioral health, etc.) is not always trauma-informed
	▪ Diversity of community is not reflected in Beloit CC staff. Although Spanish translator is very good, it's not appropriate to be dealing with trauma and related issues through a translator. Client load also does not reflect community diversity (Hispanic and African-American), perhaps because of lack of cultural competence. (The all White staff were very clear that cultural competency has not been a strong point. They were somewhat self-critical and concerned about the Hispanic and African-American communities.)
	▪ Children's Issues: **The County stopped serving kids a few years ago. When Badger Care came, we were told that kids could now go other places.** The services that kids receive elsewhere are too child-focused and not enough family-focused. Private providers don't think they provide anything other than traditional services. Need more mental health/school coordination.

Interview	Findings
Beloit Counseling Center, **3 Staff members** (continued)	**Strengths/Initiatives** ▪ Beloit Health System Counseling Center is good on AODA issues – they have a social worker who understands COD issues. ▪ **Mercy has an Intensive Outpatient Program, "but we [the County] haven't been able to come to an agreement with them on using that program."** ▪ Their Dialectical Behavioral Therapy group at the CC is good and they deal with a lot of AODA issues in that group. ▪ They (Rock County) are adding a **new therapist/case manager and that person will have to have a CAC credential** – this is part of an effort to be more COD-sensitive. The position will work out of both Beloit and Janesville and will be available to both sites. ▪ Some of the Beloit CC staff believe that they should all be trained in AODA and capable of providing SUD treatment integrated with MH treatment.
Chief David Moore, Janesville Police Dept **(with Chad Sullivan)**	**Gaps/Problems** ▪ We do have a **need for some training** – does not like CIT so much because of the time involved (overtime etc.) but does see the need for ALL officers to get basic training in behavioral health. ▪ There is a need for **better coordination with crisis services.** Crisis needs to be more mobile, and they are glad that is starting to happen. ▪ We spend too much **time waiting at hospitals**. Mercy Hospital – there is a "police hold form" that can be used now to allow officers to go back out on the beat until the time they are needed back at the hospital to accompany a person with behavioral health problems. (Crisis and the police are called back by Mercy together, which is important, also.) ▪ The force is a bit stretched thin – the citizen to officer ratio has gone up. ▪ There is a real problem in emergency rooms, where it sometimes seems as though the staff are not cooperating appropriately with other providers (e.g., hospitals) or with law enforcement. There have been some very frustrating experiences recently, in which officers had to sit with very agitated and disruptive people in the open ER, with children around, rather than being allowed to wait in a less public place. ▪ Heroine and responding to other drug issues are taking a lot of our officer time right now. There is a high correlation, they have found, between property crimes and drug use – they think better services for AODA issues could help reduce some of that prevalent problem. ▪ There is a lack of services for children ages 5 to 11. There is a need for in-home family treatment.

Interview	Findings
Chief David Moore, Janesville Police Dept (with Chad Sullivan) (continued)	**Strengths/Initiatives** ▪ We have come a long way. It used to be that with 51.15 (commitment code) our officers were too quick to place a hold on a person, because of fear of what might happen if they didn't do that. But, now, we realize we can ask others for input and for help and we're more confident in being able to enact some other types of interventions. ▪ Our focus in the department now is on problem-solving, versus just reacting. ▪ They have a very **exciting Domestic Violence Response Team project, which involves a partnership with the YWCA**. Within 72 hours they follow up with people who have been assaulted and provide some education about breaking the cycle of violence, as well as attend to needs. This also sends a message to perpetrators that the issue is not going to be easily dropped. Their domestic violence restraining has gone way up. ▪ They wonder whether this partnership with the YWCA on domestic violence issues might be a prototype for how they could partner with concerned volunteers in the community behavioral health issues. They would like to see a cadre of about 20 people who were trained in the Welcoming, Hopeful, Engaging and Empathetic approach that Dr. Cline mentioned in the opening meeting – volunteers who could help people with behavioral health issues make the adjustment to the community. ▪ They also have a very exciting project on gangs right now, in which they are responding assertively when one gang member gets in trouble by educating and encouraging other members of the gang to consider other routes in their life. ▪ Their sober streets initiative is helping neighbors to look out for people who have five or more DUIs. ▪ On too much **time waiting at hospitals**: Mercy Hospital – there is a "police hold form" that can be used now to allow officers to go back out on the beat until the time they are needed back at the hospital to accompany a person with behavioral health problems. (Crisis and the police are called back by Mercy together, which is important, also.) ▪ There is good cooperation between law enforcement and probate right now.

Stakeholder Focus Group
April 4-5, 2011

A total of **22 consumers, family members, and advocates** were interviewed individually or in small groups:

- April 4 – **Janesville Community Support Program** – focus group with seven (7) adult consumers
- April 5 - **National Alliance on Mental Illness** – focus group with seven (7) family members and advocates
- April 5 - **Rock Valley Community Programs** – individual interviews with four (4) adult consumers
- April 5 – **Rock County Youth Development and Diversion Programs** – Focus group with four (4) parents of youth in Beloit

Stakeholders were asked to share their experiences with the criminal justice system, their perceptions of gaps and problems in the system, and their experiences with programs that are working well. If they did not address the issue independently, they were also asked about services to people with co-occurring mental illness and substance use disorders, as well as about issues encountered in the transition between systems—for example, in making the transition from jail to the community.

In two of the focus groups we were able to obtain participants' ratings of the focus group themes that emerged in the discussion. In these cases, themes are shown in tables, along with the average rating score for each theme. The lower the score (the closer to 1.0) the more important the participants perceived the theme to be.

Focus Group Findings

Janesville Community Support Group Adult Consumers Focus Group

An ethnically/racially diverse group of seven (7) male and female consumers was interviewed in a focus group format at the Janesville Community Support Program.

Consumers were asked to describe their experiences with law enforcement and the criminal justice system in Rock County, and they also identified gaps in the system of services, as well as what was going well.

- Consumers' Experiences with Law Enforcement/Criminal Justice

  Consumers identified and rated four themes. These are listed below, along with their ratings of each theme's importance.

Consumers' Experience with Law Enforcement and the Criminal Justice System				
Theme – What is Working Well	**Among Most Important**	**Important**	**Somewhat Important**	**Not as Important**
1. Sometimes **mistreated** – being disrespected and having their traumatic experiences (e.g., sexual assault) discounted or not taken seriously.		1.9		
2. **Difficult to get medications**		1.9		
3. **Not enough help with the transition from jail or prison to the community**			2.6	
4. Staff need **training** to handle mental illness and substance abuse.		1.7		

- Consumers' Perceptions of Issues Related to Transition Between Systems

  The table below provides a summary of consumers' ratings of three different themes concerning their perceptions of the issues involved in the transition between systems. All three themes focused on the issues in the transition between jail and community behavioral health programs.

Issues in the Transition Between Systems				
Theme – What Could Improve	**Among Most Important**	**Important**	**Somewhat Important**	**Not as Important**
1. **Need more help from the jail** in getting connected with services—within the jail and out in the community.	1.4			
2. **It takes too long to get connected with community programs** once released.		1.7		
3. **Need more options to choose from** when getting out of jail.		1.7		

- Consumers' Perception Concerning Gaps in the System

  Consumers identified three key gaps in the system. The table below provides a summary.

Gaps in the System				
Theme – What Could Improve	**Among Most Important**	**Important**	**Somewhat Important**	**Not as Important**
1. It takes too long to get **housing**.		1.6		
2. There is a need for **more services to people with co-occurring** mental illness and substance use disorders.			2.6	
3. There is a need for **more community support programs**, like this one at Janesville CSP.		1.9		

Adult Consumer Interview Findings

Four consumers were interviewed individually at Rock Valley Community Programs (RVCP), a half-way house for people making the transition from jail or prison to the community. RVCP staff indicated that it was preferable not to interview the consumers in a group, as they would be much less forthcoming in a group setting.

Prior to the individual interviews, the RVCP staff made several very strong points about the current system of care. In particular there was deep concern about the lack of availability of services to people in their program. They indicated that the people they serve often wait longer than would be ideal for a psychiatric evaluation, and then they often are not able to receive services, once it is determined the person has a mental illness. This theme was illustrated in one of the individual interviews, during which a young man indicated he had been waiting six weeks to see a psychiatrist for an evaluation, despite the fact that he is experiencing auditory and visual hallucinations, has anger management problems, and suffers from insomnia.

Below is an overview of the results from individual interviews with four consumers. By the time the staff interview had been completed, there was only about 5-10 minutes remaining for each consumer. It was explained to consumers that if information from the interviews was to be used in a report, their names would not be tied to information they gave in the interviews, in order to maintain anonymity.

- Consumer 1
  - Services at RVCP had been "pretty effective" for this person.
  - Counseling services [from a subcontractor] have been helpful. Counseling and other services for substance use problems are good, in general.
  - A big problem, however, has been that the person has not been able to obtain medications for psychiatric problems.

- Another, less significant, concern is that the person wishes there was better access to Narcotics Anonymous and Alcoholics Anonymous meetings.
- This person was asked about services for co-occurring mental illness and substance use and the person indicated receiving them once before—but in a different state.

- Consumer 2
  - This consumer also was receiving some treatment in the community. Therapy sessions have gone well.
  - In the past, there have been several challenges. For example, transportation has been a problem; it has been difficult to get to providers and to appointments. In addition, there has not been good continuity of care between providers. This consumer had a psychiatrist in a neighboring city which the consumer really liked, but there had not been good communication with this provider and continuity of care has been a concern.
  - This consumer also said that not much treatment had been available in the criminal justice system.
- Consumer 3
  - This consumer indicated services have been difficult to obtain. The consumer indicated having a diagnosis of a serious mental illness and that the consumer had been waiting for two to three weeks to be seen for an evaluation. (A staff member that the consumer had asked to sit in on the interview indicated that the consumer actually had actually been waiting about twice that long.)
  - The consumer also indicated having a lot of difficulty with insomnia and with auditory and visual hallucinations. Another problem is with anger management. The consumer expressed concern that the consumer was working hard to control anger and irritability, despite not having access to medications and other psychiatric treatments.
  - Another problem for this consumer was that several work experiences had been disrupted. Apparently, consumers at RVCP often respond to requests from various employers for brief work. This consumer had become very frustrated after employers discontinued the consumer's work because the consumer happened to be among a group of RVCP workers, a few of whose members had not performed optimally. This consumer was being unfairly treated and even punished, despite behaving responsibly. (The staff worker seemed to verify that this consumer's concerns were valid.)

- Consumer 4
  - The last consumer interviewed reported having been in prison for over 10 years. The transition out of the criminal justice system, so far, had been extremely difficult and frustrating.
  - The state of Wisconsin has not allowed this consumer to attend Alcoholics Anonymous meetings, which have been very helpful in the past. Also because there are many places in the community where the consumer is not allowed to go, the consumer finds it difficult to engage in basic community-based functions, such as shopping.
  - The consumer also has been waiting a long time for some type of housing to open up in the community.
  - Overall, it feels to this consumer like there is a lot of "red tape" and that the consumer spends a lot of time waiting for opportunities to open up.

National Alliance on Mental Illness Focus Group

A focus group was held with members of the Rock County NAMI. Seven family members and advocates attended. Although it was not clear in all cases whether participants were family members, the majority of those who spoke during the focus group spoke from their experiences with a sibling or a child who was receiving services or experiencing the criminal justice system.

The tables below summarize the themes that emerged from the focus group with NAMI.

- Family Members' Experiences with Law Enforcement/Criminal Justice

  Family members and advocates identified seven different themes related to their experiences with loved ones experiencing the law enforcement and/or criminal justice systems. Following is a summary of the themes and participant's ratings of their importance.

Family Members' Experience with Law Enforcement and the Criminal Justice System				
Theme – What Could Improve	**Among Most Important**	**Important**	**Somewhat Important**	**Not as Important**
1. Law enforcement and criminal justice system staff sometimes **lack education about mental illness**.	1.0			
2. **Rules** about how to handle people with mental illness within the criminal justice system **are sometimes too rigid.**		2.5		

Family Members' Experience with Law Enforcement and the Criminal Justice System				
Theme – What Could Improve	**Among Most Important**	**Important**	**Somewhat Important**	**Not as Important**
3. **Behavior management by law enforcement** within the criminal justice system sometimes **is too physical and not skillful enough**.		2.5		
4. There is often a **lack of coordination between the criminal justice and behavioral health systems.**	1.5			
5. **Law enforcement officers need CIT training.**		1.75		
6. **There is a lack of access to medications within the criminal justice system.**		1.75		
7. Some **new alternatives** to incarceration, such as the use of ankle bracelets, are very welcome.		1.75		

- Family Members' Perceptions of Issues Related to Transition Between Systems

  The table below provides a summary of participants' ratings of three (3) different themes concerning transitions between criminal justice and behavioral health care systems.

Issues in the Transition Between Systems – Family Members' Ratings				
Theme – What Could Improve	**Among Most Important**	**Important**	**Somewhat Important**	**Not as Important**
1. **There is a lack of coordination between the systems.**		1.6		
2. **There is a lack of communication resources.**	1.4			
3. **There often is a violation of privacy and confidential information** when involved in the criminal justice system.	1.4			

- Family Members' Perceptions Concerning Gaps in the System

  The table below summarizes the eight themes that emerged from a discussion of gaps in Rock County's system of behavioral health services, as well as participants' ratings of the themes' importance.

Gaps in the System – Family Members' Perceptions				
Theme – What Could Improve	**Among Most Important**	**Important**	**Somewhat Important**	**Not as Important**
1. **Counseling services** are too difficult to obtain.	1.4			
2. There is a need for a **drug court for juveniles.**		2.3		
3. There need to be **more programs that divert people from the criminal justice system and into treatment.**		1.6		
4. There is a **lack of facility-based and other high-intensity treatment** in Rock County.	1.2			
5. **Need more crisis stabilization services like Jackson House.**	1.4			
6. **Need more services to people with co-occurring mental illness and substance use disorder.**		2.4		
7. Need better **access to psychiatrists.**		1.6		
8. Need better **access to Community Support Program level of care.**		2.0		

Parents of Youth Involved in the Juvenile Justice System

On Tuesday evening, April 5, a focus group was held with four parents at the offices of Rock County Youth Development and Diversion Programs, located at the River of Life Church in Beloit. Two of the parents had a daughter who had participated in the diversion program, and one parent had a son who had participated in the program. All three of those parents indicated that the program had been excellent, but that it was time-limited and there was a need for something that was more ongoing.

One parent had a son who recently had gotten involved in the juvenile justice system and who had a probation officer who suggested the mother attend the focus group, in order to learn more about the diversion program. During much of the focus group, this mother was coached by the other parents in how to navigate and negotiate the system and educated about the system. The fourth and final parent was a mother of a son who had been involved in the system for several years and who recently had been placed in treatment foster care.

This focus group did not lend itself well to theme ratings, as much of the sessions involved the parents educating, coaching and supporting one another, and it was

determined by the focus group leader that interrupting the meeting to specify and rate themes would not have been appreciated.

Nevertheless there were several clear themes that emerged from the discussion. The most prominent theme was the experience of **not having the system "step up and help us**." All parents indicated they found it difficult to get the services that their children needed and, that, instead, **it seemed that their boys and girls had to act out in some way to get the services they needed.** For example, one girl's parent indicated that it wasn't until she was ordered by a judge into residential treatment (in a county six hours' drive from Beloit), after violating her probation for the third time, that his daughter was able to get intensive mental health treatment. In fact, it was in the residential treatment program that mental health professionals—a psychiatrist and neuropsychologist—diagnosed her with Bipolar Disorder and explained to the parents that she had a mental illness and what that means.

Similarly, another parent indicated that her son was not able to get access to mental health treatment until she placed him in treatment foster care, after finding that she could not manage his difficult behavior at home. This parent was a very knowledgeable woman who had some graduate training in mental health, and who described several different efforts to try to get appropriate services for her son, so it was clear that the problem was not one of a lack of parenting skill.

One parent put it this way: There are services at the extreme ends of the continuum, but not in the middle. "There is no funding for intermediary level services," she said. So, for example, someone can be court-ordered to treatment at a long-term residential facility, once problems become severe enough. Or, someone might be able to get some brief counseling at a school. However, **if a person has severe emotional disturbance and/or significant substance abuse problem it is difficult to find an intensive outpatient service that can provide ongoing treatment and support to the child and family**. The parent quoted above indicated that if the proper services and supports were in place, then she would be able to care for her son with Bipolar Disorder at home, and would not have to place him in treatment foster care. She wondered aloud whether it would not be less expensive to provide intensive community- and home-based services than to place someone in treatment foster care. Another parent said, "Unless your child fits the system requirements for helping you, there's nothing you can do." All parents agreed that the system is not adaptive in meeting the needs of children and youth and that it was extremely rigid.

Additional services that parents said were needed included **mobile crisis and crisis stabilization services** for children and youth. One parent indicated they thought that the crisis intervention program in the county often will not take on a client who is a minor. In any case, a broader crisis continuum of services was seen as needed.

Another problem that was identified was that **mental health and substance use problems are not treated together**, but are, in these parents' experience, at least, always treated separately. Their experience has been one of being batted back-and-forth between systems.

Parents had experienced several encounters with law enforcement and with the juvenile justice system. They reported difficulties of having to pay for various court-related costs, and with waiting in detention facilities for a mental health placement for long periods of time. One parent wondered if it was even legal to detain a youth for a long time when there was no actual charge against the youth. The long wait—one example was with the Shelter Care program, which functions as a juvenile jail, according to the parents—was associated with the lack of behavioral health services available in the community.

The focus group leader asked parents if they and their children had ever received a wraparound service or Multisystemic Therapy, two evidence-based approaches that have been found to help youth with behavioral health problems and juvenile justice system involvement. None of the parents had even heard of those approaches, let alone participated in one of those types of services, except for one of the parents, who had heard of the term "wraparound," but did not have any experience with it.

Parents were also asked if they had participated in a parent support group. **None had known of any parent support groups available in the county**, nor had they ever participated in one. All indicated that they would love to participate in a support group, and, in fact, the hunger for such an experience was so strong that, as mentioned briefly above, the parents in effect converted the focus group into a support group. One parent made a very long and supportive statement to a mother whose son had more recently become involved in the juvenile justice system, explaining to her that his difficulties were not her fault and that she should not allow the system to drill into her the idea that she is somehow deficient. It was a very emotional moment in the meeting and several people referred back to it later, indicating that it was the type of message that parents are not receiving but need to receive. Interestingly, the mother later revealed that she was not the biological mother of the youth and that she had agreed to become his guardian when the biological parents became incapable of caring for him. One parent mentioned the idea of parent mentors or navigators that would be helpful to have in the system, so that parents who are new to the system have some help and know where to get the most appropriate services.

All parents present indicated they would like to participate in parent support groups and some of the more experienced parents present expressed a desire to have more parent involvement in processes of planning for children's systems of care in Rock

County. **No parents knew of any opportunities for parents to have a voice in program development, system planning, or system evaluation.**

Some positive points, in the midst of a generally dire conversation, were the following. First, one parent reported a very positive experience with an AODA counselor at Beloit Place who helped his daughter with some substance use issues. Second, as mentioned above, three of the parents had positive things to say about the diversion program. The only problem was that it was time-limited and their youth needed something that was more continuous, given the long-term nature of their psychiatric problems and, in one case, substance use problems.

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Appendix B
Information and Data Systems Recommendations

Summary

With the help of representatives of several county agencies—representing both behavioral health (BH) and law enforcement/criminal justice (CJ)—TriWest Group and Zia Partners have reviewed several different Information Systems that contain data on people involved in BH and CJ systems. The review has enabled us to produce three documents for review by the Criminal Justice Coordinating Council:

1. A "Data Map – Working Document," contained in an Excel spreadsheet, provides a thorough overview of the data fields and data elements found in each data set. This document is considered a "working document" because it can continually be updated, as data systems evolve.
2. The "Data Map – Summary," a condensed version of the Data Map – Working Document, has also been created, and it summarizes the data fields that are common and unique to each of the data systems reviewed. This document (in pdf format) provides a one-page overview of the overlapping and non-overlapping aspects of each data system analyzed.
3. The present document, "Information and Data Systems Recommendations," uses the data map documents described above as the basis for making recommendations as to how participating Rock County agencies might use their data systems in productive, collaborative ways.

In our review, we found that each system currently collects a great deal of information that can be leveraged in aggregate reporting or streamlined individual case management. However, there are gaps in the extent to which useful information is captured, particularly about the presence of co-occurring mental health and substance use issues. In addition, there are barriers to useful cross-system data sharing, including the number of different locations where pieces of information reside and the lack of a common identifier across the systems. Addressing the data-sharing issues definitively could be resource-intensive (mostly in terms of time and effort), although worth pursuing, as resources and time allow. Nonetheless, there are actions that can be taken

in the near-term with regard to both the gaps in content AND the cross system data-sharing to make use of the momentum that has been created by the CJCC and by the ad hoc data systems workgroup that assisted us in examining the data systems.

We offer the following recommendations for enhancing the quality of information collected and the collaborative use of data systems to support the primary goals of the Criminal Justice Coordinating Council (CJCC). Recommendations are organized according to what can be accomplished in the near term, versus what might represent longer-term projects that might require more intensive effort and additional resources.

Near-Term Recommendations

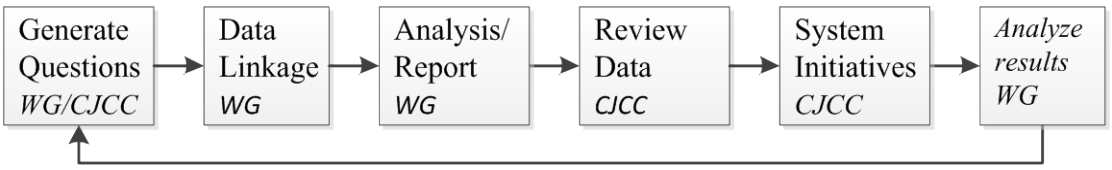
1. **Establish a cross-system data workgroup** comprised of the agency representatives that assisted TriWest and Zia Partners in the examination of data systems during this consultation. The workgroup should meet regularly to plan both special cross-system data linking projects that would be conducted in order to provide actionable data, and develop recommendations for increasing data system integration for ongoing, "real-time" data analysis.
    a. We recognize that a more permanent version of the workgroup that was formed for this consult might need to have somewhat different representation, in some cases (for some participating agencies).
    b. However, it will be important for the workgroup to include staff in each participating agency who will be able to advocate effectively, within their respective agencies, for the workgroup's recommendations.
2. Develop a quality improvement process to improve recognition of the population with co-occurring MH and AODA issues in EACH data set.
    a. Individuals who have co-occurring disorders are associated with poor outcomes and high costs in the criminal justice system but are commonly under-recognized in the data system, contributing to difficulty identifying their needs and ensuring that they receive appropriately matched integrated services.
    b. Beginning to improve routine screening and counting of these individuals in ALL data sets contributes to system wide improvement with relatively small resource expenditure.
    c. Initial data improvement targets can be very simple, based on using simple data fields that track the presence of co-morbidity as Yes, No, or Maybe, without a need for complex diagnostic analysis.

3. **Carry out a *Focused Project* on a targeted sample of people who are "high-utilizers"** of Criminal Justice systems and of restrictive/expensive care in Behavioral Health Systems.

   a. Extract and link data from current data systems to examine the services received and the costs incurred by a sample of 30 or more high-utilizers.
   b. A clear definition of what constitutes a "high-utilizer" will need to be agreed upon by participating agencies. The definition could include, for example, those who have had more than one episode of jail time in the past three years *and* who have utilized an excessive number of inpatient services (mental health and/or substance abuse) and/or crisis services. People who have a lot of jail utilization and who have one or more behavioral health diagnoses, but not necessarily a lot of behavioral health service utilization outside of the jail setting, could also be included in the analysis. In any case, a precise definition will need to be agreed upon by each agency involved. Another possibility is to run some analyses of the use of restrictive settings (jail, hospital, ER) and identify the top 30 users. Then, additional analyses could be conducted of those 30 people. Merely identifying the top 30 high-utilizers would be a significant project.
   c. Create focused questions before designing a process for extracting and linking specific data elements from existing data systems. This will likely require a workgroup of individuals from each system (as recommended above), that can facilitating extracting and linking data (using a common identifier developed for the special project) in an external system (much like the supplemental MS Access databases) that can be used as the basis for conducting data analyses. Once analyzed, the extracted/linked data set can be used as the basis of a report to the CJCC.
   d. Focused questions could include, for example,

      - "How much did the high-utilizers use of services (behavioral health and jail) cost the system annually, on average?" [Cost data could then be compared to the typical cost for the most intensive community-based service program in the county.]
      - "What is the relationship between specific mental health and/or substance use diagnoses, the availability of integrated services in the community, and the amount of time spent in the justice system?"
      - "What was the average amount of time lag between release from jail and receipt of an appropriate community-based service?" (Analysis could examine the lag time for receiving ANY community-based service, until the capacity to assess service appropriateness is available.)

e. The list above is provided as a point of departure for developing a focused set of questions to ask of the linked data. The workgroup, however, should work in collaboration with the CJCC to generate the most pressing questions. Pressing system issues may change somewhat between the time these recommendations are received and the time the workgroup is able to begin working on a joint project.
f. After completing its analysis the workgroup should present its findings to the CJCC, which, in turn, should use the findings to recommend programmatic initiatives that would focus on, for example, meeting people's needs for BH services in a timely manner or on better coordination of care across CJ and BH systems. And, the CJCC should report back to the data workgroup on additional, or more detailed, questions that need to be asked of the data.
g. Ideally, there would be an ongoing, continuous process of generating focused questions, planning for data linkage, conducting data analyses and producing reports, reviewing reports, planning system intervention initiatives, and analyzing system intervention results.



4. **Consider the use of a "flag" variable in systems** so that individuals involved with multiple disorders and/or involved in multiple systems can be flagged for targeted reporting. For example, the "legal status" code in Medisys could be used to run specific reports on the diagnoses and service usage of criminal justice system-involved individuals.

5. **Use aggregate reports already generated** by each system, as well as new aggregate reports that could be produced with currently available data fields, to compare and discuss emerging trends and patterns in individuals served, service use, lengths of stay, etc. The cross-systems data workgroup could review aggregate reports from participating agencies. This could serve several additional purposes, besides the regular review of utilization trends and all the benefits that would accrue from such an analysis. First, it could also help all agencies, collectively, identify gaps in current reports—areas where necessary data for decision-making (such as the prevalence of co-occurring conditions) are not reported—that that could be filled with existing data. Second, it could help individual agencies identify variables/data fields they could uniquely report on that are not in current reports.

a. For example, it may be useful to examine short-term outcomes in the AODA data set, or treatment progress/employment outcomes in the TAD data base (RECAP program). (See the Data Map – working Excel document in Excel, developed by TriWest and the ad hoc work group, which shows outcomes data available across the different data systems.)
b. These types of analyses and associated reports might help identify areas where services are having positive effects and where outcomes are not as impressive. And, they may also cause the group to think of additional outcomes-related data (that are not necessarily labeled as "outcomes") that could be useful in understanding the extent to which services are having desirable effects. One such example might be an analysis of changes in YASI dynamic risk scores in youth over time (available through the RCHSD Juvenile Justice and Prevention Services Division; again, see the Data Map – working document), or the connection between YASI findings and service provision for multiple disorders.

Longer-Term Recommendations

1. **Creating a means for data systems to be linked in a more automatic "real-time" way** may improve community-based case management/community support services at the individual level. This could facilitate communication between the criminal justice system and behavioral health services agencies, and it might help support the system's capacity to divert people from jail to treatment services and facilitate processes of moving people from jails to treatment services.

   a. We recognize that this longer-term recommendation would require significant technological enhancements and significant allocation of new resources (or redeployment of existing resources).
   b. However, the allocation of resources should be weighed against the possibility of lowering the costs of services, which can be estimated in focused studies of high-utilizers (see above).

2. Data elements that currently are most lacking across the systems are those related to **client outcomes**, including, for example:

   a. Discharge location
   b. Provision of integrated services for individuals with identified co-occurring conditions
   c. Degree to which treatment progress is made with regard to one or more conditions

d. Whether prescribed amount of service is received and whether client is retained in services as long as is needed
e. Jail recidivism
f. Indicators of recovery, such as changes in housing or employment status and increased ability to self-manage one's illnesses
g. Hospitalization and re-hospitalization

Finally, the recommended cross-system data workgroup could be the point of responsibility for determining what kinds of outcomes are most important for each system and developing ways to track those outcomes.

For a printer friendly version, select all cells, right click and select "unhide."		**Available Data Sets**										
		AODA Services (Funding) [Supplemental DB]	**Crisis Intervention (CDA) [Supplemental DB] - contact sheets; case notes**	**eWiSACWIS**	**HSRS (Human Services Reporting System).**	**Juvenile Probation (JP) [Supplemental DB]**	**Law Records Management System (LRMS)**	**Medical Records (nurses files)**	**MedSys/CareVoyant**	**Offendertrak**	**TAD Database**	**Youth Assessment Screening Instrument-Caseworks**
	"Unified" Data Element	RCHSD	RCHSD	Wisconsin Department of Children and Families (DCF)	Wisconsin Department of Health Services (DHS)	RCHSD	various law enforcement	Nurse records from Jail	Rock County Human Services Department (RCHSD)	Rock County Sheriff's Office	County RECAP Program(Dara)	RCHSD Juvenile Justice and Prevention Services Division
Database	**Database type/details**	Supplemental MS Access DB desktop	Supplemental MS Access DB desktop	SQL on DCF server; web-accessed; uses same ODBC DSN as Medisys. ****This column can be completed once the upgrade is complete and the data diction is available.**	Not applicable to this project.	Supplemental MS Access DB desktop	MS SQL; desktop; limited web	Scanned paper files		Oracle DB; desktop client		Hosted by orbis partners (web system) -- upgrading to be able to pull that data down nightly onto their SQL server. Goal to pull the YASI data and add those risk scores to their JJ data systems.
Descriptors	**Source for info in data map (sample file, verbal description, etc)**	Written description	Written description	System currently being upgraded and data dictionary not available. Can link with Medsys can query w/Access or Crystal (ex. to CSV)			Written description (Elizabeth Pohlman)	Written description (Elizabeth Pohlman	description -- data dictionaries	Written description (Elizabeth Pohlman)		
	File export type (excel, flatfile, etc.)			ODBC DSN (same as Medisys) + manual			Manual (e.g. Crystal)			Excel		
	Extraction/data sharing protocols (FTP, manual, etc.)			Can pull down data 24 hours later and run reports out of medsys (child protective services reports).	Don't really get any reports to this system, not used as a data system.					Manual (3rd party software automated)	Sent to state monthly	
	Additional notes		Series of Medsys tables that they link into though MS Access.							Roster is shared as an .html to the rest of the county	What are "phase" and "status"? Need more info on progress data	
Client/Patient Identifiers	**Client Name (1)**	Last_Name	Last_Name			Last_Name			Household_Member_Last_Na	Name_Family	fname	
	Client Name (2)	First_Name	First_Name			First_Name			Household_Member_First_Na	Name_First	mname	
	Client Name (3)	Middle_Initial	Middle_Initial			Middle_Initial			Household_Member_Mid_Ini	Name_Other	lname	
	Client Name (4)								Middle_Name		aname	
	SSN	Social_Security_Number	Social_Security_Number			Social_Security_Number			Social_Security_Number	Social_Security_Number	ssn	
	Date of Birth	Birth_Date	Birth_Date			Birth_Date			Birth_Date	Date_Of_Birth	birthdate	
	Age										admitage	
	Legal System ID (1)					CCNO				STATE_ID	SID (State ID)	
	Legal System ID (2)									FBI_ID	FBIID	
	Legal System ID (3)										DOCID	
	Legal System ID (4)										courtcaseID	
	Program Specific / Unique ID / Proprietary ID	Pt_No (Patient Number)	Patient_Number			Patient Number			Patient_Number (Medsys generated)	PRIMARY_IDENTITY_ID/BOOKING_ID/ENTITY_ID		
	Other ID								Resident_Number			
Client/Patient Characteristics	**Age**	Birth_Date	Birth_Date			Birth_Date				Date_Of_Birth	birthdate	
	Gender	Sex	Sex			Sex			sex	CODE_GENDER	gender	
	Race/Ethnicity (1)	Race_Code	Race_Code			Race_Code			RACE_CODE	efs_sfx_offender_race	race	
	Race/Ethnicity (2)	Address	Address			Address	property/contact info			Street_Number	ethnicity	
	Address (1)	Street_Name				Street_Name				Street_Name	address	
	Address (2)	City	City			City				City_Town_Locale	city	
	Address (3)	STATE_CODE	STATE_CODE			STATE_CODE				State_Province_Region	state	
	Address (4)	Zip_Code				Zip_Code				Postal_Code	zip code	
	Address (5)		Residency_Codes								County	
	Other contact	Emergency Contact	Contact Person (with phone)			Emergency Contact				Free Text Field	Emergency contact info	
	Phone Number	Phone	Phone			Phone				Telephone_Record_Id	phonehome/cell/wprk	
	Email	Email_Address	Email_Address							None		
	Needs [SA/MH/COD] 1	AssessmentFinding	Client Characteristic (1-3)			Assess/Evaluation		medical info	ICD9 Code (principle diagnosis)			Var scores on risk/protective factors
	Needs [SA/MH/COD] 2	multiple diagnosis variables/sep ICD9 co	Presenting Problem (1-3)			YASI scores (offending risk)			onset date			
	Needs [SA/MH/COD] 3	Referring_Source	Diagnostic Impression (1-4)			Admit diagnosis (1-3)						
	Needs [SA/MH/COD] 4		Commitment_Status			yes/no vars: past abuse, etc.			Admit_diagnosis 1-3 (ICD9)			
	Need/Service Matching		Present AOD/MH Treatment									
	Treatment History		Past AOD/MH Treatment									
	Placement History/Current placement					record of JJ placement type			Legal_Status_Code	Housing Location		
	Criminal Offenses (1)	CrimJustClt (yes/no) Crim justice client	Pending_Legal_Charges (Description)			court adjudications/sentencing	incident info/arrests			ARREST_REASON	Offenses	
	Criminal Offenses (2)		Pending_OWI				citations/warrants			CHARGE_STATUS		
	Veteran Status		Veteran Status									
	Education & Income	Occupation_Code				Occupation_Code					various (ed & income) variables	
	Marital Status	MARTIAL_STATS_CODE				MARTIAL_STATS_CODE				Database also has "handess", eye color, etc. for ID	marital	
Encounter Level	**Disposition/Referral**	StartedTX	Referral_Source									
	Appointments Made (1)	NoShow	**(see Medisys for encounter level data)**									
	Appointments Made (2)	WaitList										
Ecoounter Level	**Encounter/Authorization Identifier (1)**	AuthNumIndex	Contact_Number									
	Encounter/Authorization Identifier (2)	Admission_Number										
Authorization	**Encounter Type (1) (SUD/MH/COD)**	AuthType	Anonymous_Contact				51.15/51.45 (holds/commits)				admit_type	
	Encounter Type (Authorized) (2)	series of "admit from ..." variables	Ongoing_Contact									
	Auth Date/Start Date	Status (of authorization), approved Y/N								START_DATE	admitdate	
	Auth Time/Start Time											
	Length of Encounter									RELEASE_DATE (with START_DATE)	exitdate (with admit date)	
Encounter Level	**Encounter Type (Actual/Claims)**	ServiceType							Admission_Type Code			
Actual/Claims	**Service Date/Start Date**	StartDteRange							Admit_Date			
	Service Time/Start Time											
	Length of Actual Service	EndDteRange (with Start)							Discharge_Date (with Admit_Date)			
	Amount of Service (possibly including cost)	ServiceAmount										
	Secondary Encounter Type/modifier/precedure code								Procedure Codes (1-3)			
	Provider	FacilityCode							Program Code			
	Cost of Encounter (Service, Incarceration, etc)	AuthAmount/TotCharge										
	Payee data	FundingType										
	outcomes (short term)	Outcome									treatment progress/employment	

		Available Data Sets									
		AODA Services (Funding) [Supplemental DB]	Crisis Intervention (CDA) [Supplemental DB] - contact sheets; case notes	eWiSACWIS	Juvenile Probation [Supplemental DB]	Law Records Management System (LRMS)	Medical Records (nurses files)	MedSys/Care Voyant	Offendertrak	TAD Database	Youth Assessment Screening Instrument-Caseworks
"Unified" Data Element		RCHSD	RCHSD	Wisconsin Department of Children and Families (DCF)	RCHSD	various law enforcement	Nurse records from Jail	Rock County Human Services Department (RCHSD)	Rock County Sheriff's Office	County RECAP Program(Dara)	RCHSD Juvenile Justice and Prevention Services Division
Client/Patient Identifiers	Client Name(s)	✖	✖	**PENDING	✖	✖		✖	✖	✖	
	Age									✖	
	Legal System ID(s)				✖	✖			✖	✖	
	Program Specific / Unique ID / Proprietary ID	✖	✖		✖			✖	✖		
	Other ID							✖			
Client/Patient Characteristics	Age	✖	✖		✖				✖	✖	
	Gender	✖	✖		✖			✖	✖	✖	
	Race/Ethnicity	✖	✖		✖	✖		✖	✖	✖	
	Address	✖	✖		✖				✖	✖	
	Other contact	✖	✖		✖				✖	✖	
	Phone Number	✖	✖		✖				✖	✖	
	Email	✖	✖						✖		
	Needs [SA/MH/COD]	✖	✖		✖		✖	✖			✖
	Need/Service Matching		✖								
	Treatment History		✖								
	Placement History/Current placement				✖			✖	✖		
	Criminal Offenses	✖	✖		✖	✖			✖	✖	
	Veteran Status		✖								
	Education & Income	✖			✖					✖	
	Marital Status	✖			✖				✖	✖	
Encounter Level: Referral	Disposition/Referral	✖	✖								
	Appointments Made [1]	✖									
Ecounter Level: Authorization	Encounter/Authorization Identifier [1]	✖	✖								
	Encounter Type [1] (SUD/MH/COD)	✖	✖			✖				✖	
	Encounter Type (Authorized) [2]	✖	✖								
	Auth Date/Start Date	✖							✖	✖	
	Auth Time/Start Time										
	Length of Encounter								✖	✖	
Encounter Level: Actual/Claims	Encounter Type (Actual/Claims)	✖	✖					✖			
	Service Date/Start Date	✖	✖					✖			
	Service Time/Start Time										
	Length of Actual Service	✖	✖					✖			
	Amount of Service (possibly including cost)	✖	✖								
	Secondary Encounter Type/prOcedure code							✖			
	Provider	✖	✖					✖			
	Cost of Encounter (Service, Incarceration, etc)	✖	✖								
	Payee data	✖	✖								
	outcomes (short term)	✖	✖							✖	

Appendix C
Example Implementation Framework for a Chartered System Redesign Quality Improvement Partnership

Rock County has begun a process to work in partnership with consumers, families, providers, and other stakeholders to transform the Rock County behavioral health and criminal justice system to be designed at every level to be about the needs, hopes, and dreams of the individuals and families needing care. Within Rock County, the representatives of the Criminal Justice Coordinating Committee (see attached list of members) have invited collaboration with all community partners in health, behavioral health and criminal justice:

- To build a welcoming, recovery-oriented, trauma-informed, culturally competent and integrated system for individuals and families.
- To apply children's system of care principles.
- To develop a framework for behavioral health and criminal justice integration.
- To use limited resources to achieve an inspired vision.

In designing this system, all stakeholders are aware that individuals and families in Rock County with co-occurring psychiatric and substance conditions, as well as co-occurring health conditions, cognitive conditions, and other complex needs, are a population with poorer outcomes and higher costs in multiple clinical and criminal justice domains. They are often inadequately served in mental health, substance abuse, and primary care treatment settings, resulting in over-utilization of resources in the criminal justice system, the acute care system, the homeless and housing services continuum, the aging and disability system, and the child welfare system. In addition to having poor outcomes and high costs, individuals and families with co-occurring conditions are sufficiently prevalent in all behavioral health care settings that they are considered an expectation, not an exception.

Therefore, in order to design a system that meets the needs of our customers, all of us in Rock County recognize that all services have to be able to welcome, engage, inspire and serve individuals and families with co-occurring conditions and complexity.

Appendix C: Example Implementation Framework

Components of the Rock County Human Services and Criminal Justice system have undertaken many efforts during the last several years to transform the system to better address the needs of the people coming to the door, including addressing those with behavioral health issues in the criminal justice system. These efforts have included:

- CJCC
- Specialty Courts
- Juvenile Justice diversion programs
- Bracelet program
- CCRG
- Mobile crisis implementation
- *ADD OTHERS*

Within these efforts, it has become increasingly clear that individuals and families with complex, co-occurring conditions—including those at risk of criminal justice involvement—are present with regularity in all settings—not just a few special projects or programs—so it is necessary to build capacity to address their needs in everything we do. Consequently, a consensus has emerged that recognizes the need for a broad *system* approach to improve hope and recovery services for individuals and families with complex co-occurring needs. By developing recovery-oriented, co-occurring capabilities (which may include not only mental health and substance abuse, but also diversity, health, cognitive impairments, trauma, housing needs, etc.) in all programs and clinicians, we will create a system of care that is welcoming, recovery-oriented, culturally competent, trauma-informed, and integrated.

In order to accomplish this goal, Rock County has identified and adapted the CCISC model as a framework for quality-improvement-oriented, integrated system design and implementation. The basic principles of CCISC have been described by Minkoff and Cline (2004, 2005), and are listed in the attached appendix.

This charter document outlines the initial activities of Rock County Human Services (including MH/AODA, JJ, etc.), Rock County Sheriff's Department, Mercy Hospital, Beloit Hospital, District Attorneys and Judges, Specialty Courts, Beloit Area Community Health Center, RVCP, other MH and AODA providers, local police departments, Community Corrections, in partnership with providers, consumers, families, and other stakeholders to organize the first action steps for implementation of system change at each level of the system and to do it within base resources.

The system transformation process outlined in this charter is intended to be fully aligned with other major strategic initiatives that are already under way, and to build

upon the energy and resources committed to those initiatives. The process is intended to be open to all system components, providers, and other partners that may wish to join in at a later date. The process also recognizes and respects the varied stages of change readiness and implementation capabilities that may exist among interested parties to this charter, and welcomes the participation of all. The goal is to leverage every dollar in the system to support the outcomes and services for the people who need us the most.

The CCISC Agreement

In the context of all of the above, **Rock County MH/AOD Divisions, Criminal justice system services etc., hereby agree to utilize the Comprehensive, Continuous, Integrated System of Care (CCISC) model as a framework for designing county-wide system redesign, in order to improve welcoming access to services, hopeful engagement, and progress toward recovery for individuals and families with co-occurring/complex conditions within the context of existing resources.**

This charter document is an initial draft working document that outlines action steps for each level of the service system during the first year, as listed below.

Action Steps

Action Steps for County Leadership

1. **Say it out loud.** Adopt this charter document as an official policy statement, and disseminate officially to all stakeholders in draft.
2. **Partnership.** Commit to working in a quality improvement partnership with providers and stakeholders.
3. **Project Management and Communication.** Identify a "core implementation team" to manage the project. Create vehicles for communication to all providers and participants. Organize process for implementation/adopting/modifying of this charter statement over the course of the first 6-12 months of this process.
4. **Behavioral Health Redesign Steering Committee.** Develop an empowered partnership BHRSC to serve as a formal empowered structure to steer or advise the implementation of this quality improvement process. This may emerge from the MH/AOD Ad Hoc Committee of the CJCC. Steering Committee membership shall include representation from the county, providers, consumers and families in

the behavioral health and criminal justice systems. Persons who have been identified as Change Agents shall be encouraged to participate on the Steering Committee.

5. **Develop Workgroups for priority areas.** These might include: Children's System of Care (CSOC) development, Crisis improvement (CCRG), Housing and Homelessness (Homeless Intervention Task Force), Data Workgroup, Consumer/Family Advocacy, and Behavioral Health/Criminal Justice interface (BH/CJ). Each workgroup will have a particular charge, and target implementation objectives to be defined by the BHRSC. Examples below:
    a. CSOC will establish a working group to define consensus and implementation steps related to both CSOC and CCISC principles, to expand capability to offer wraparound support to families with complex needs.
    b. CCRG will work on developing welcoming protocols for individuals in crisis who are actively using substances, to reduce the number of individuals referred for 51.45 detox.
    c. BH/CJ will work on developing an information sharing protocol between BH and CJ, and a consumer tracking and communication mechanism.
    d. Housing will work on expansion of sober housing, and defining guidelines for permanent supportive housing in Rock County.
    e. Data: Improving data on co-occurring prevalence in each setting
    f. Consumer/Family: Improving peer support for consumers and families…
6. **Use the ZiaPartners/TriWest 12 Recommendations as a road map for change**.
7. **Ask for help to implement system redesign.** Provide consultation, training and technical assistance for the system and for each provider to be able to make progress, and to facilitate change at each level. Engage assistance from other counties and DHS where applicable. Develop strategies to support workforce development.
8. **Welcome the Partners**. Encourage (not require) provider and other partner participation during 2011 in moving toward attainment of welcoming, recovery-oriented, trauma-informed, culturally competent, co-occurring disorder capability, as identified in this charter.
9. **Welcoming Policy**. Develop the expectation—by written policy—of welcoming access and hopeful engagement for individuals and families with co-occurring conditions, including those with criminal justice involvement, in all portals of the system.

10. **Improve Access**. Identify improvement targets across the system to facilitate timely access for individuals with complex behavioral health needs who are at risk of decompensation or re-incarceration.
11. **Screening and Data Improvement**. Begin a process to facilitate the ability of each behavioral health and criminal justice program to screen for and report information on consumers with co-occurring conditions, beginning with simple data on the prevalence of individuals and families with co-occurring conditions.
12. **Information Sharing**. Begin a process of routine information sharing between CJ and BH providers, with improvements in obtaining releases, and documenting communication of clinical information during transitions.
13. **Funding Flexibility**. Obtain consultation from DHS re: implementation of CCS in Rock County. Prepare for application for a CSOC Grant.
14. **Trauma-informed Committee and Change Agent Development**. Support ongoing development of a county TIC (with assistance from DHS TIC Coordinator) and a CCISC change agent team representing change agents from the county, from each provider, and from consumers/families/other stakeholders. Connect with change agent teams elsewhere in Wisconsin.

Action Steps for County and CBHO and Hospital-based MH and AODA Treatment Programs, Criminal Justice Settings (Specialty Courts, Jail Health, Probation, JJ, Juvenile Detention and Shelter) , and Advocacy Organizations

(Steps 4-9 are for clinical/ service delivery agencies only)

1. **Say it Out Loud.** Adopt this Charter as an agency or organization or program, and provide training to all staff and involved consumers/families regarding the initiative and the CCISC/CSOC principles as adapted by Rock County.
2. **Formal Commitment.** Agency leadership shall make a formal commitment to achieve recovery-oriented co-occurring capability for all programs; announce officially to all staff, and communicate to all staff the CCISC implementation process.
3. **Quality Improvement (QI) Team.** Develop an empowered QI leadership team, representing all levels of the agency and program, including consumers and families if appropriate.

4. **Change Agent/TIC Development.** Identify change agents representing front-line clinicians, consumers, and family members who are interested in working in partnership with leadership in creating welcoming, recovery-oriented, trauma-informed, co-occurring capable services.
5. **Self-Assessment for Each Program.** Organize a baseline conversation to perform a self-survey of recovery-oriented co-occurring capability for each program using the COMPASS-EZ™ at annual intervals. The tool can be adapted for criminal justice settings.
6. **Improvement Plan.** Based on the program self-survey, develop a program-specific QI action plan outlining measurable and achievable changes to move toward co-occurring disorder capability. Monitor the progress of the action plan at six-month intervals. The plan will address whatever makes sense and inspires the program, but all plans will address the following agreed upon targets:
7. **Welcoming and Access.** Work on improvement of "welcoming" and access for individuals and families with complex needs including those who have criminal justice involvement and those who are at risk of re-incarceration or decompensation, who may not easily engage or who need quicker and more flexible response.
8. **Hope, Strength, and Recovery.** Work on engaging everyone seeking services in empathic, hopeful, integrated, strength-based recovery partnerships.
9. **Screening and Counting.** Work on improvement of routine integrated screening, and improvement of data collection, related to identifying individuals and families with co-occurring mental health (including trauma) and substance use conditions.
10. **Competency Development.** Adopt the goal of welcoming, recovery-oriented, trauma-informed, cultural and co-occurring competency for all staff, regardless of whether or not they are licensed or certified, as part of the agency's long-range workforce development plan. Help clinicians have fun, feel inspired in their work, and learn how to deliver and document integrated care.
11. **Competency Assessment.** Organize a direct-service staff and supervisor recovery-oriented co-occurring competency self-survey using the CODECAT-EZ™, approximately six months after beginning implementation of the action plan above, and use the findings to develop a program-specific and achievable competency improvement plan, starting with welcoming.
12. **Partnership and Communication.** Begin to develop a partnership with the "other" type of agency (between mental health and substance abuse treatment or advocacy

agencies) to build mutual support and collaboration, including information sharing, and in developing recovery oriented co-occurring capability.

Is this list too long? Too short? Other issues can be considered, though usually it is better not too bite off too much at the beginning.

Steering Committee Initial Adoption Date:_____