DMHA Cultural Linguistic Competency Project

Bill Wilson, Jail Services Coordinator,
Indiana Sheriff's Association

- 30 Years experience working in corrections
- Adjunct Instructor Criminal Justice-Ivy Tech University
- National consultant on jail services
- Instructor for Indiana Law Enforcement Academy Jailers School

DMHA Cultural Linguistic Competency Project

Kellie Meyer, M.A., President

Kellie Meyer Training Solutions

- President of Kellie Meyer Training Solutions
- Advisor to International Association of Chiefs of Police (CIT)
- Established CIT for Corrections for National Institute of Corrections (NIC)
- Partner with Center for Naval Analysis- Developed Crisis Intervention Teams Curriculum
- Trained Opioid Response Teams, Quick Response Teams, Firefighters and EMTs
- Enhanced Community Health Worker Programs and Certification
- Established De-escalation and communication training resulting in 70% reduction in use of force in correctional settings

Learning Objectives

Introduce CIT
(Crisis Intervention Team) Program

Examine the system impact of mental illness in jails and prisons

Start the conversation of Community Collaboration, Diversion, and CIT for jails

Combine cultural best practices into our program

Crisis Intervention Team (CIT) Program

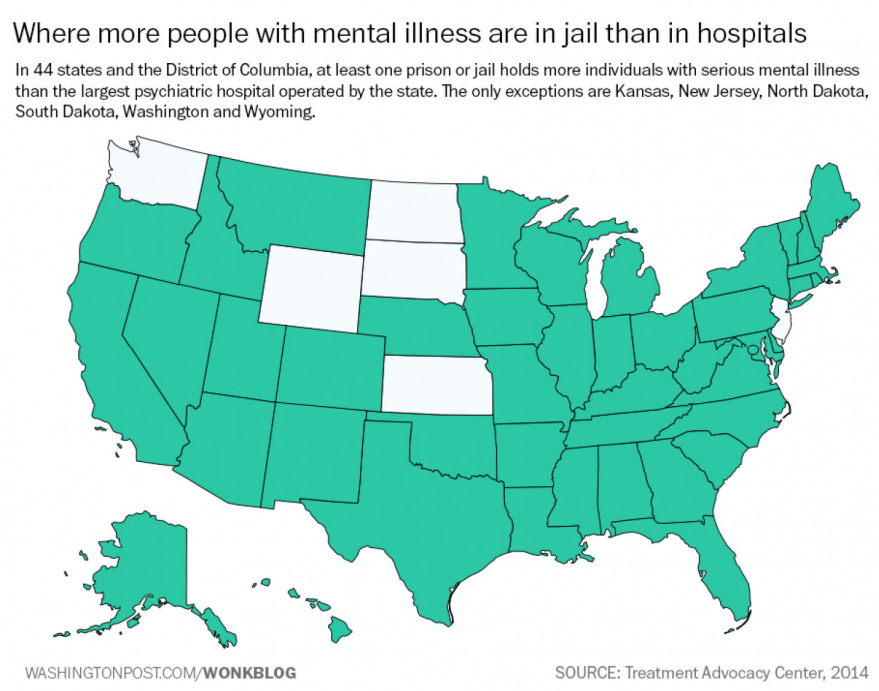
It is a community partnership of law enforcement, mental health and addiction professionals, individuals who live with mental illness and/or addiction disorders, their families, and other advocates.

It is an innovative first-responder model of police-based crisis intervention training to help persons with mental disorders and/or addictions access medical treatment rather than place them in the criminal justice system due to illness-related behaviors. It also promotes officer safety and the safety of the individual in crisis.

The CIT model, known as the **"Memphis Model"** was first developed in 1988 and has spread throughout the country.

In September 2007, a group of individuals who were dedicated to advancing CIT programs convened in Memphis to develop the Core Elements document. This effort was led by the founders of CIT, Randy Dupont, Ph.D, University of Memphis and Major (retired) Sam Cochran, Memphis PD.

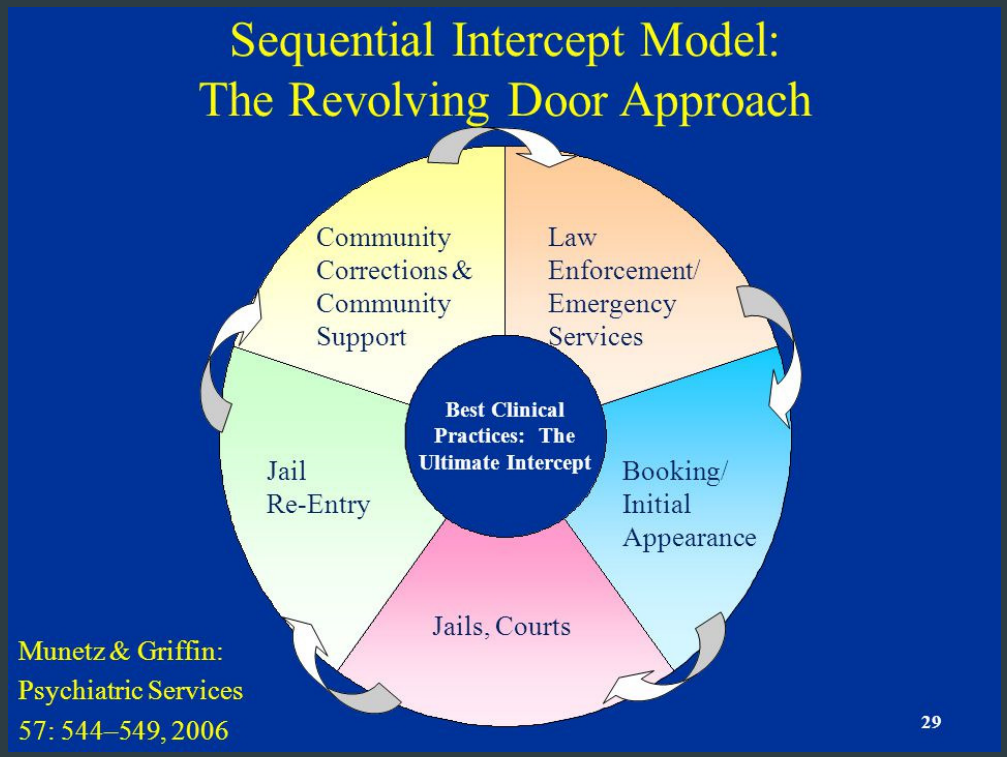
The Problem

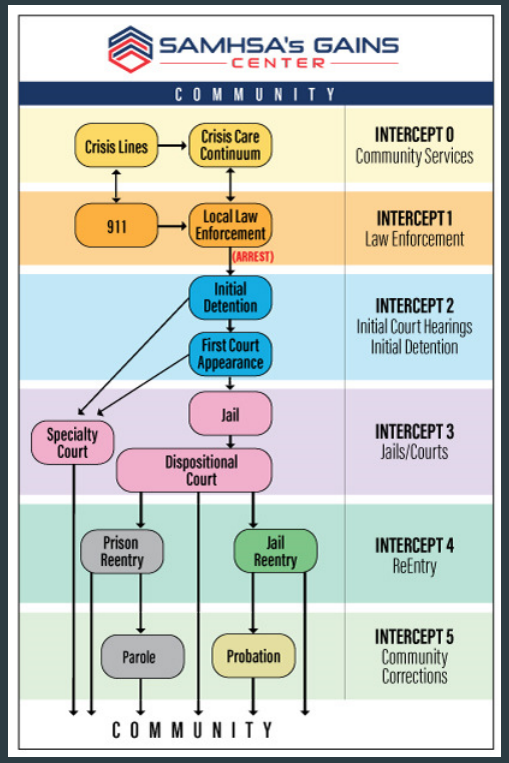

Where more people with mental illness are in jail than in hospitals
In 44 states and the District of Columbia, at least one prison or jail holds more individuals with serious mental illness than the largest psychiatric hospital operated by the state. The only exceptions are Kansas, New Jersey, North Dakota, South Dakota, Washington and Wyoming.
WASHINGTONPOST.COM/WONKBLOG
SOURCE: Treatment Advocacy Center, 2014

Sequential Intercept Model

- Mark R. Munetz, M.D.
- Patricia A Griffin, Ph.D.

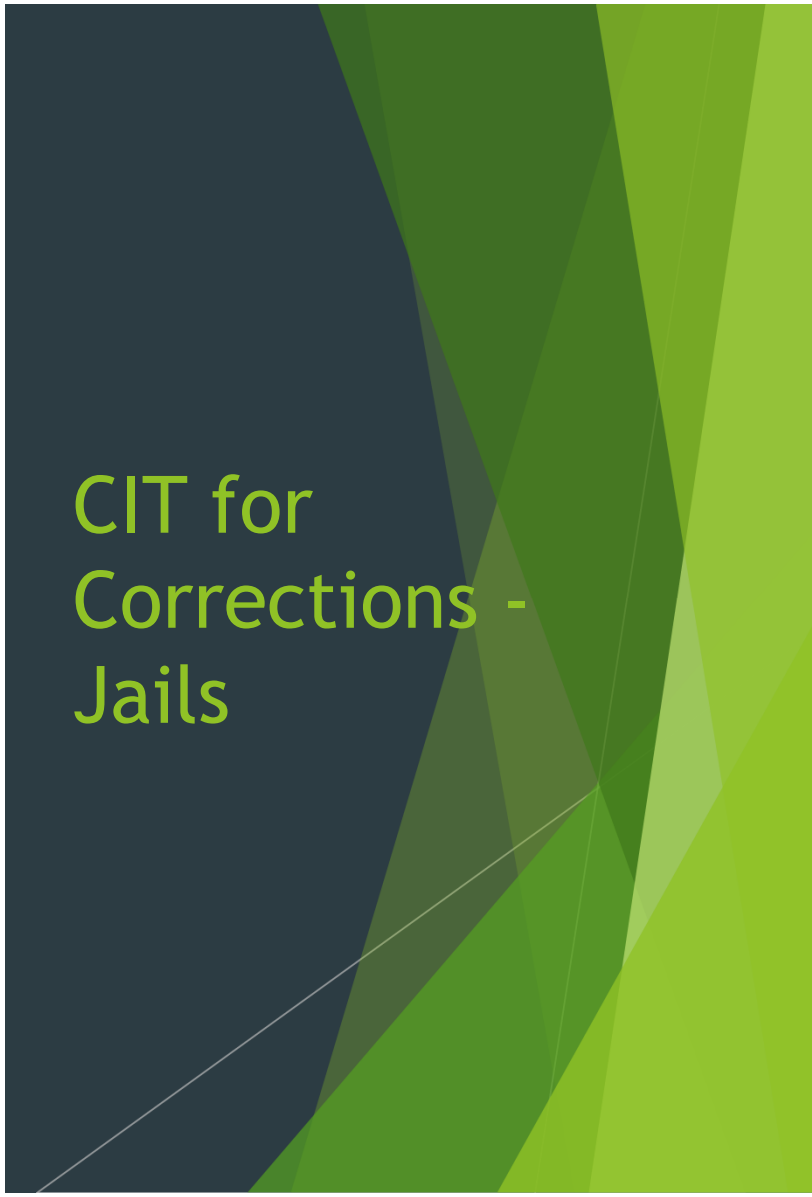
- Dr. Munetz is chief clinical officer of the Summit County Alcohol, Drug Addiction, and Mental Health Services Board, 100 West Cedar Street, Suite 300, Akron, Ohio 44307 (e-mail, mmunetz@neoucom.edu). He is also affiliated with the department of psychiatry at Northeastern Ohio Universities College of Medicine in Rootstown.
- Dr. Griffin is senior consultant for the National GAINS Center for People with Co-occurring Disorders in the Justice System and the Philadelphia Department of Behavioral Health.





Adding Intercept 0

- 1988 CIT was established as a result of a fatal shooting of a young man with mental illness by the Memphis Police Department
- Today, this diversion program is known as the The Memphis Model for police officers
- Where do jails fit in?
- 2010 NIC (National Institute of Corrections) saw the need to develop CIT for Corrections:
  - Authors:
    - Kellie Meyer, M.A., Indiana
    - Tom Simpatico, M.D., Vermont
    - Michele Saunders, MSW, Florida
    - Craig Hanks, MPA (Superintendent/Warden Prisons, Indiana
      - Mike Dooley, Programs NIC, Colorado
- 2019 NIC (National Institute of Corrections) updates curriculum
  - Kellie Meyer, M.A., Kellie Meyer Training Solutions
  - CNA (Center for Naval Analysis)



Starting the conversation

- Can we divert?
- How do we divert?
- If we can't divert, what can we do?
  - Diversion Initiatives
  - Build communication and collaboration
  - Collect Data
  - Improve Jail Screening
  - Review Jail Release Issues
  - Address Jail Staffing Concerns

How do we start this difficult conversation?

- Who's at the table to open this discussion?
  - PD and First Responders
  - CMHC, FQHC, Detox facility
  - Judge, Courts
  - Community support partners, City Council and/or those who determine the jail budget (including building a new jail) Mayor
  - University and other collaborators

Identifying the resources that exist in your community

Partnership with medical

- Transport
- Housing
- Stabilization
- Funding streams, Medicaid provided services,

Neighboring communities

Program funds

Establishing the necessary SOPs and MOUs

- Suicide
- Substance Use
  - (Opioid concerns and new programs)
  - HIV
  - Alcohol
- Mental Illness
- Aggressive Behaviors
- New administration
- UOF and De-escalation Needs

CIT For Corrections
The Benefits

- Trained Officers for an immediate response
- Reduced injuries to officers, inmates, staff; reduced liability
- Greater access to mental-health services for inmate or probationer
- Improved communication between disciplines
- Heightened preparation for crisis situations
- Fewer grievances
- Integrated Policies and Procedures to prevent crisis and respond to crisis
- Enhanced re-entry efforts with established partnerships

Training

Training All staff and key stakeholders

Identifying timing of concurrent trainings so that all staff are trained on shift

Selecting instructors and topics relevant to your clientele

Shadowing other stakeholders to better understand and implement service delivery

Determining the continuum of care

Transition/re-entry

Parole Probation

Community health workers and other support

Enhancing Cultural awareness

A good CIT program creates a better understanding of the cultural differences of our clientele as well.

Culture and Mental Health Care

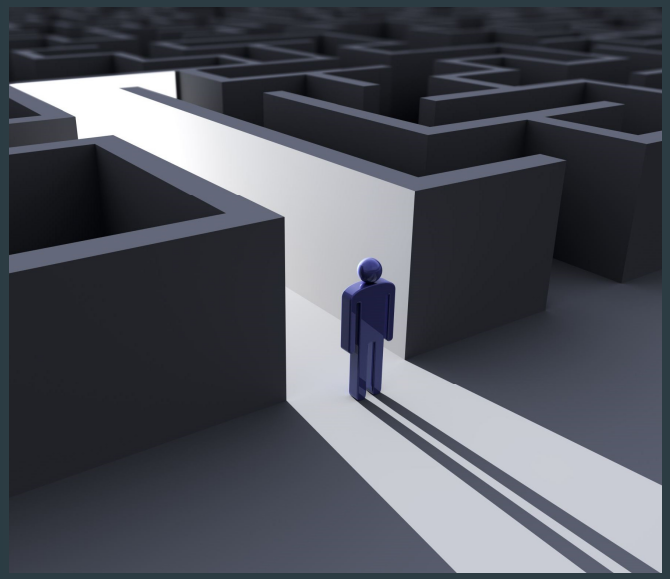
- Challenges to the mental health system: 2001 us surgeon general's report indicated:
  - US mental health system may be ill prepared to meet the mental health needs of racial, ethnic groups due to deficiencies in the level of cultural competence among service providers of all types.
  - Racial and ethnic minorities have less access to mental health services than do whites. They are less likely to receive needed care. When they receive care, it is more likely to be poor in quality.

Finding Scholarly reviews for cultural competence and mental illness

Why is it so difficult to discuss cultural competency or mental illness?

The Surgeon General's Resources 2021

Title	Type	Type
Surgeon General's Workshop on Women's Mental Health	Workshop	2006
Report of a Surgeon General's Working Meeting on The Integration of Mental Health Services and Primary Health Care	Working Meeting	2001
Mental Health: Culture, Race, and Ethnicity	Report Supplement	2001
Report of the Surgeon General's Conference on Children's Mental Health	Conference	2000
The Surgeon General's Workshop on Self-Help and Public Health	Workshop	1987
Report of the Surgeon General's Workshop on Pornography and Public Health	Workshop	1986



Barriers to accessing treatment and Stigma

Beginning culture change by reducing Stigma

- When we use terms like “the mentally ill” or “the homeless” we are categorizing.
- It sounds like……“Oh, those people”
  - Let’s use first person language
    - Examples
      - A person with a mental illness
      - A person diagnosed with bipolar disorder

Urban, Rural and Suburban Jails will look very different

- Each community will implement core basic principles, however, operate uniquely
  - People running the programs
  - Resources available and travel time
  - Unique needs of the clientele

CIT For Corrections

CIT is More Than Just Training

- It is an ongoing, ever-changing Program.
- It is a partnership between Custody and Medical staff who quickly assess a potentially critical mental health crisis and take immediate proactive action.
- This partnership is heightened when crisis occurs and situations are handled safer, quicker, and more effectively.
- It is a change in culture – for the institution and the community

Training all staff

Understanding when and how to take action to avoid crisis situations	Identifying high risk areas
Shift change reporting; frequent exchange of information throughout shifts; regular exchange of information between custody staff and medical	Planning appropriate activities and recreational time
Continuity of programming with service providers during re-entry	Identifying new collaborations and partnerships as your program grows

- **Knowledge Building**
  - Understanding mental illnesses and substance use disorders, special populations
  - Legal Issues, policies, procedures, protocols
- **Personal Contact**
  - Consumer and Family perspective
  - Field visits
- **Skill Building and Problem Solving**
  - Risk assessment and Crisis intervention/De-escalation training
    - Active Listening
    - Motivational Interviewing
    - Role Play/Scenarios
  - Cultural competency
    - Implicit Bias
    - Explicit Bias
    - Protective Bias
  - The role of a Care-giver
  - Self-care

Nothing is impossible, the word itself says 'I'm possible'!

Audrey Hepburn

The Stride Center

Monroe County
Crisis Diversion Program

Background

- Large collaboration convened as Monroe County Substance Use Disorder Coalition
- Representation from 38 organizations

Coalition Identified the Need:

- To reduce unnecessary incarcerations and hospitalizations of individuals with behavioral health and substance use disorders
- Free up valuable and limited police resources
- Decrease criminal justice system costs
- Connect these individuals to resources

How can we do this?

- Add a coordinated intervention option that intercepts or “diverts” them prior to jail-booking or hospital transport.

Models Researched:

- Crisis Intervention Team (CIT)
- Law Enforcement Assisted Diversion (LEAD)
- The Living Room model (TLR)

Key Finding:

- Diversion most successful if police have a designate PLACE to transporting them

What we know

Individuals with behavioral health, SMI, SUD, and co-occurring disorders

- Are 3-6 times more likely to be involved in the criminal justice system than the general population
- The majority of these individuals have not committed any violent crime (Lamberti & Weidman, 2004; National Association of Counties, 2016).

The Stride Center: Program Description

- Place for law enforcement to transport person in crisis
  - **Location**: 312 N. Morton St (Monroe County providing in-kind space)
- Open 24/7/365
- Voluntary participation
- Law enforcement transports and is able to do quick 5 minute hand off
- **23 hour stays**
- De-escalate and Destigmatize
  - Provide calm, friendly environment
  - Person is a “guest”
  - Work with peer-based staff to identify needs and connect to resources
- Access to shower, clean clothes, snacks

Low Level Offenses

- Panhandling
- Criminal Trespass
- Public Urination
- Public Intoxication
- Disorderly Conduct
- Possession of a controlled substance
- Possession of marijuana
- Possession of paraphernalia
- Level 6 drug possession or syringe possession

Stride Statistics

NUMBERS OF GUESTS

150 unique guests
609 total guests

Time of Day

318 guests on 1st shift
208 guests on 2nd shift
83 guests on 3rd shift

Time of Day (Unique guests)

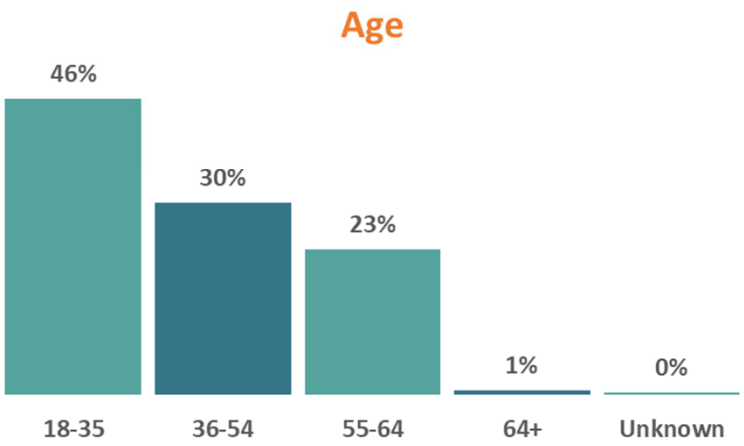
61 guests on 1st shift
54 guests on 2nd shift
35 guests on 3rd shift

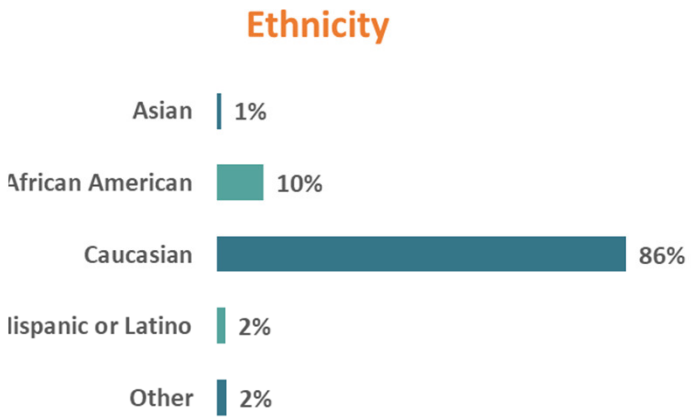
Stride Statistics Cont.

REFERRALS

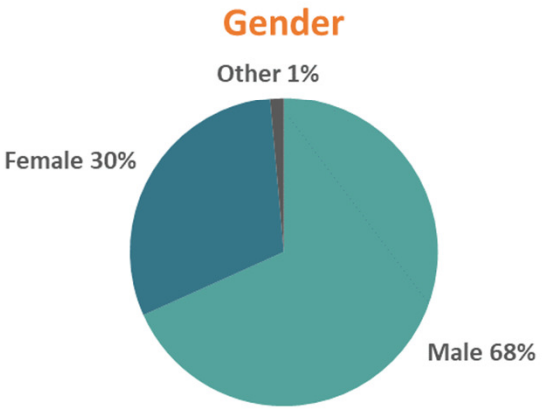
- 100 BPD
- 32 Sheriff
- 16 IU Health BH
- 12 IU Health ED
- 12 IUPD
- 1 Ellettsville
- 339 Self-referrals (guests who have returned)
- 55 Phone from Guest (since 1/19/2021)
- 32 Phone from Staff (since 1/19/2021)
- 10 NRS (Non Referral Source) (since 3/26/2021

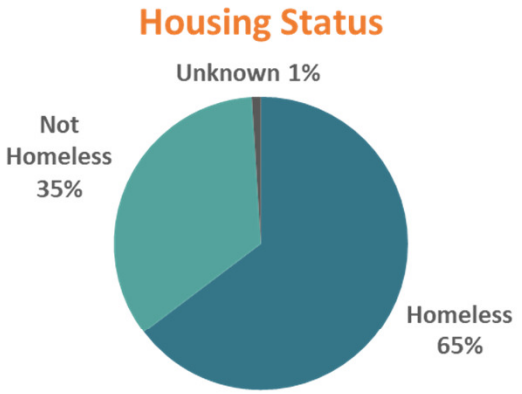
Images

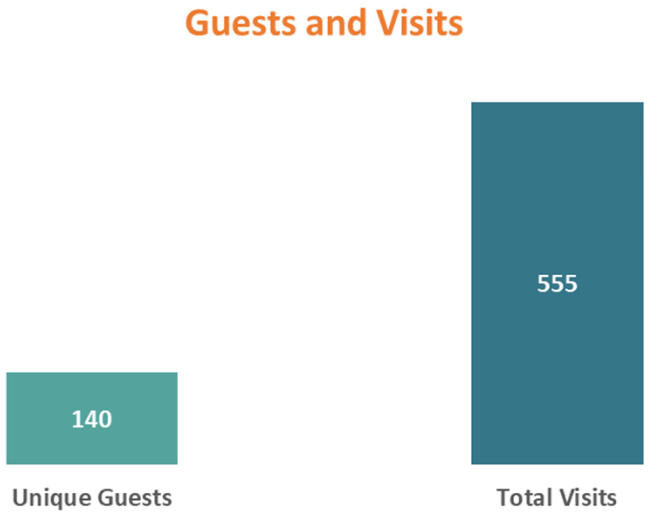

Age
46%
30%
23%
1%
0%
18-35
36-54
55-64
64+
Unknown


Ethnicity
Asian
1%
African American
10%
Caucasian
86%
Hispanic or Latino
2%
Other
2%

Images Cont.


Gender
Other 1%
Female 30%
Male 68%


Housing Status
Unknown 1%
Not Homeless 35%
Homeless 65%


Guests and Visits
140
555
Unique Guests
Total Visits

Guest Stories Cont.

Guest 1 was referred by BPD for mental health concerns. He expressed a desire to find a PCP, begin therapy services, and apply for disability. As staff engaged further with guest, it was determined that he did not have insurance. Staff assisted guest in applying for HIP. Guest expressed some relationship issues with family so staff informed him of the expectations in the facility and explained he could remain here for a period of time. Some time had passed and guest began complaining about abdominal pain. After staff called for an ambulance, guest appeared to black out and become unresponsive. He was transported to the hospital and returned to Stride after discharge. The therapist was available upon his return and completed a Centerstone intake. Guest expressed a history of SI, but after being assessed, it was determined no safety concerns at this time. Guest will be connected to Centerstone for ongoing services and is able to return to Stride as needed.

Guest Stories Cont.

Guest 2 was referred by the BPD social worker due to a family conflict. Guest expressed some reluctance to stay, however she allowed staff to engage with her and as time passed, she become more comfortable and interactive. While here, staff assisted guest in applying for public housing and insurance and identified some alcohol use. Goals expressed by guest include getting her daughter back who is currently in the foster care system. Staff determined guest is scheduled for an intake with Centerstone the first of December. The offer was made to guest to return to Stride and that intake could be completed sooner. The guest left planning to contact the BPD social worker and find shelter for the night. Update- Guest has returned three additional times to continue engaging in services and this week completed a Centerstone intake. Staff has worked with her to get presumptive eligibility until she can get her insurance officially. Staff also assisted guest in making phone calls trying to address concerns financially about how to get the multiple prescriptions. Intake therapist has contacted the main building to get her connected to a team for additional services since having completed the intake.

Guest Stories Cont.

Guest 3 Update- Guest was originally referred by BPD and has visited the Stride Center multiple times. Early on guest presented with substance use issues. He wanted to go to treatment with staff assisting him in getting admitted. Since then, he successfully completed the program, went to transitional living, has found a job, and is saving money to buy a car. Although he no longer lives locally, guest has continued to check in by phone updating staff about progress and receiving assistance as needed. Guest returned to town this week for a court date and visited the facility to check in and say hi to staff.

Guest Stories Cont.

Guest 4 Update- guest was originally referred by BPD for trespassing and substance use issues. This week, the guest contacted Stride to update staff. Guest reported she has been sober for 30 days, has just completed a rehab program, has moved into a transitional living situation and is now employed. The guest requested assistance with coordinating care with outpatient services which have previously been arranged. Stride staff contacted a couple staff working with the guest providing guest contact information and informing staff guest is wanting to continue to engage in those services.