

IMPLEMENTING A DATA- INFORMED FAMILIAR FACE STRATEGY:

Lessons from 2 SJC Sites

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THE **STEPPINGUP** INITIATIVE

Stepping Up is a national initiative to reduce the number of people with mental illnesses and co-occurring substance use disorders in jails.



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#StepUp4MentalHealth
www.StepUpTogether.org

Six Years AND COUNTING

More than **540** counties
across **45** states have
joined Stepping Up to
reduce the prevalence of
mental illness in jails.



48%

of Americans live in a
Stepping Up county.



30+ Innovator
Counties
are blazing the trail
in data collection.



Approximately **2 million**
times each year, people who have
serious mental illnesses are booked
in jails.



5 states have
launched statewide
Stepping Up
initiatives.



Familiar Faces Projects in Three Stepping Up and SJC Sites

- The counties:
 - Bernalillo County, New Mexico
 - Fulton County, Georgia
 - Polk County, Iowa
- Project consisted of bi-monthly calls with the sites to discuss project progress, troubleshoot challenges, and connect sites with each other for peer-to-peer learning
- Three-part webinar series and three-part site snapshot series translated knowledge from the sites to the field

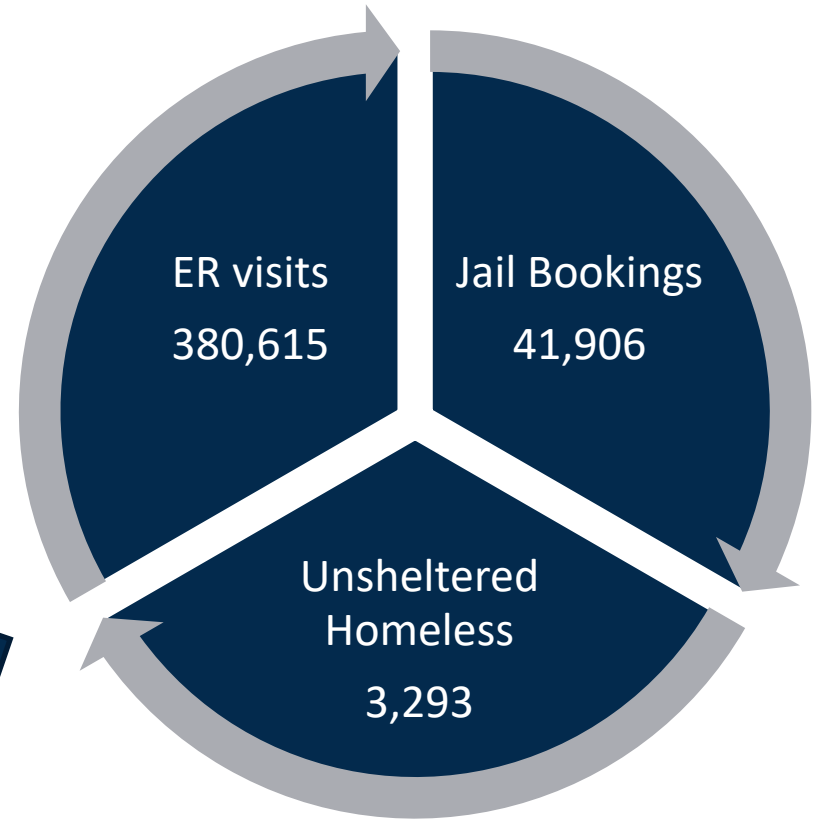
Primary Takeaways from the Three Sites

- Bernalillo County, New Mexico
 - Developed a formula weighting relevant events by severity to identify the priority population
 - Connecting people leaving jail to services, especially “rapid releasers”
 - Developing a process and platform for data integration
 - Community partners got creative and pivoted in response to the Covid-19 pandemic to continue connecting people to services
- Fulton County, Georgia (to follow)
- Polk County, Iowa
 - Developed a data platform that aggregates the top 100 Familiar Faces
 - Embedded a mental health clinician to the 911 Call Center to reduce police/emergency medical services dispatch
 - Engaging people in treatment and connecting them to treatment for substance use disorders
 - Relationships with county agencies are critical for making Familiar Faces projects work

IDENTIFYING AND SERVING FAMILIAR FACES IN FULTON COUNTY, GA

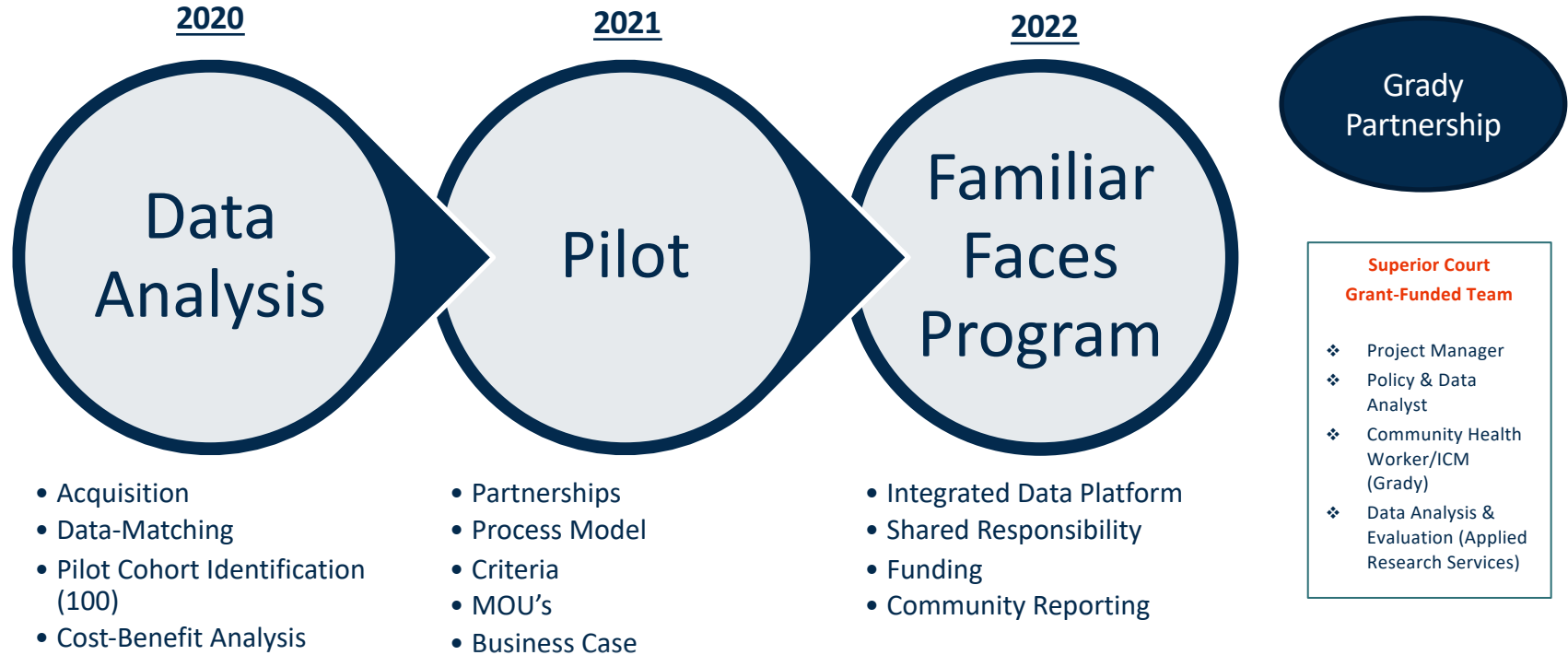
Why Focus on Familiar Faces?

- Small group of people with complex needs interacting with many systems- psychiatric, medical, jail, & homeless services
- Services not adequately meeting needs-cycle repeats
- Need more holistic approach
- High-cost (Human & \$\$\$)



Volume Challenges (2019)

Familiar Faces Project (BJA Funded)



← **COLLABORATIVE SERVICE DELIVERY APPROACH** →

Identifying Familiar Faces

■ Jail “Source” Data

- 3-year data extract (2017-2019)
 - Fulton County Jail
 - Atlanta City Detention Center
- Bookings & releases
- All jail episodes
- Reorganized from charge-based to episode-based
- Coded based on charge types and level of seriousness
- Validity checks

• Systems Cross-Reference (Touch Points)

- Grady Health Systems - 28% match
- Atlanta Police Department - 87%
- Policing Alternatives & Diversion Initiative - 3%
- Fulton County DBHDD - 42%
- Dept. of Community Supervision - 82%
- HMIS (Homeless Data System) - 80%
- Emory Law & Psychiatry (Competency) - 18%

Pilot Project Key Jail Data Takeaways (2017-2019)

100 Familiar Faces

Booked 2001 times

38,821 bed days

Average length of stay: 20 days

FCJ: 1.5% of bookings (\$3.1 million)

ACDC: 1.5% of bookings (\$615,000)



Total “Crimes of Interest”

FCJ: 8-10% of bookings (\$9.3 million)

ACDC: 30-35% of bookings (\$7.5 million)

Familiar Faces are booked in **TEN times** more frequently

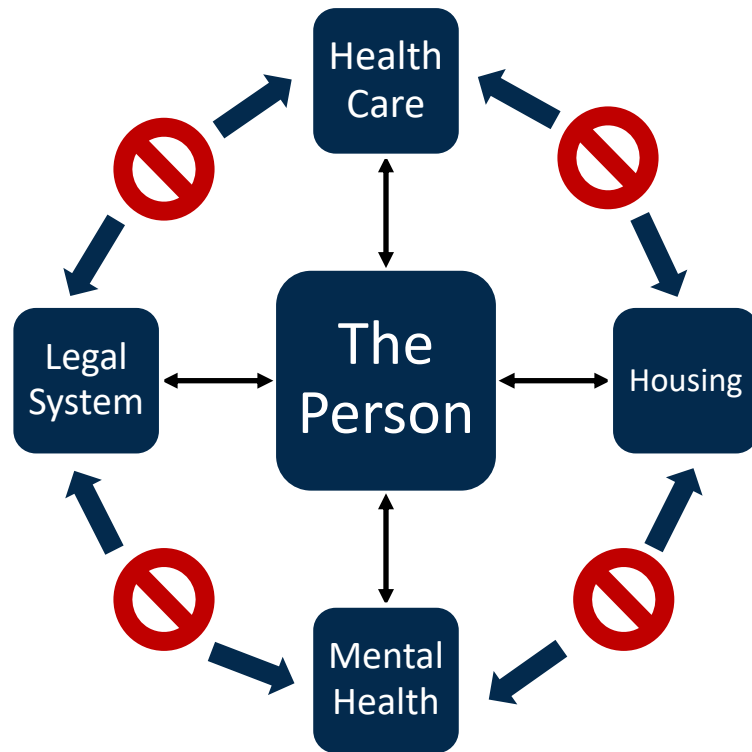
Familiar Faces use **TWENTY times** the number of bed days

Women overrepresented in population: **THREE times** more common

Significant racial disproportionality: **92% Black/African American**

The Data-Sharing Problem

While people and service providers can communicate directly, the ability for service providers to identify and communicate about people in common is often blocked.



Short-Term Solution

Stepping Up

Fulton County has joined the Stepping Up Initiative! This is a national initiative to reduce the number of people with mental illnesses in jails. See more at <https://steptoegether.org/the-problem>.

An important note on the data on this page: These numbers only include people who completed the Correctional Mental Health Screening upon being booked into jail. Not everyone is eligible to complete this screening, and thus these numbers are not reflective of all bookings.

On this page, CMHS stands for Correctional Mental Health Screening.

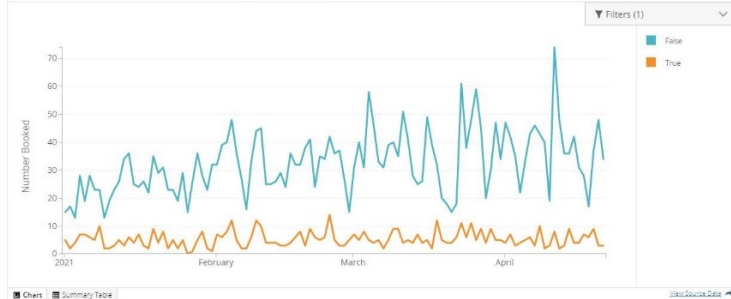


Key Measure 1: Reduce the number of people booked with mental illness.

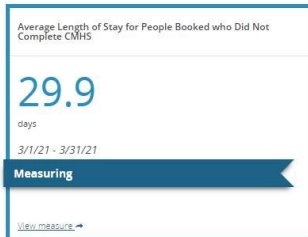


Number of People Booked

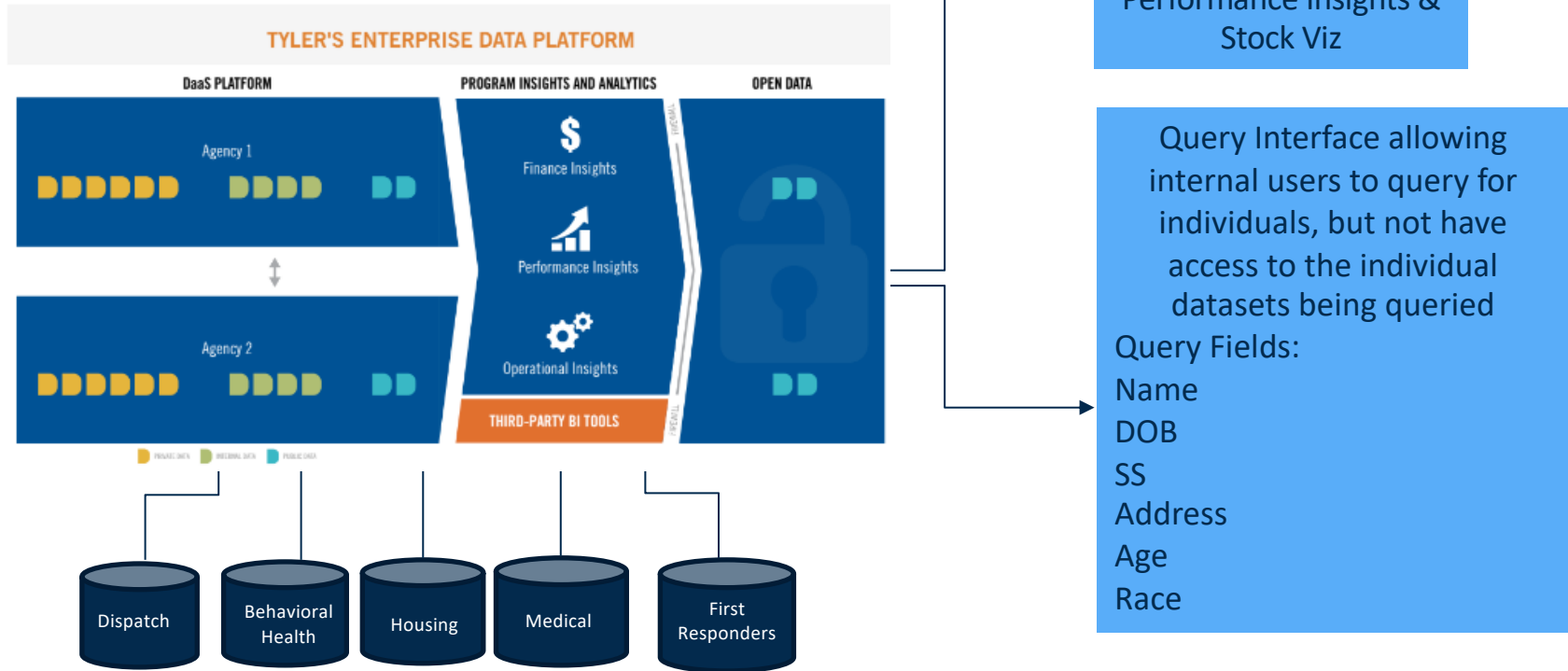
With and without mental illness. True = Likely mental illness. False = mental illness unlikely.



Key Measure 2: Reduce the length of stay for people booked with mental illness.



Enterprise Data Platform HIPAA Domain



Long-Term Solution



POLICING ALTERNATIVES & DIVERSION INITIATIVE

PAD's mission is to reduce arrest and incarceration of people experiencing extreme poverty, problematic substance use, or mental health concerns, and increase the accessibility of supportive services in Atlanta and Fulton County.

PAD uses a consent-based, harm reduction approach to connect people to housing, social services, recovery support, income, and other resources

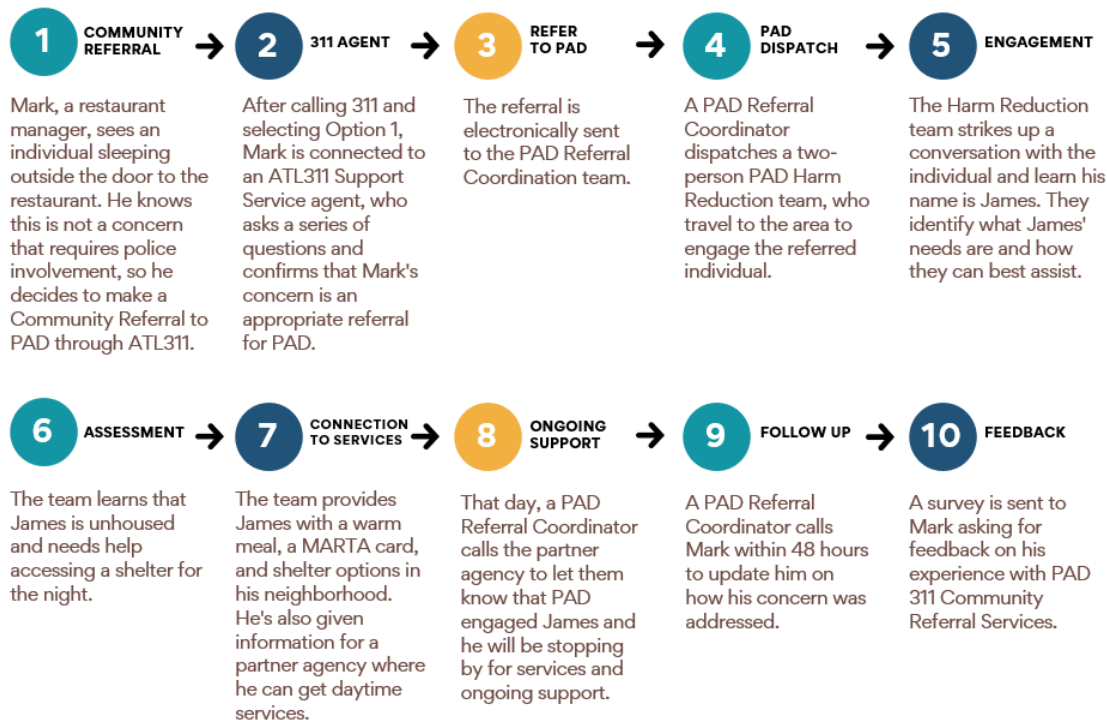


PAD addresses community concerns related to substance use, mental health and extreme poverty through two core strategies:

1. Provide pre-arrest diversion for people detained by law enforcement who are experiencing challenges with mental health, substance use or poverty
2. Provide alternative response to people referred through City of Atlanta 311 related to quality-of-life concerns (disturbance, public indecency, substance use, poverty)



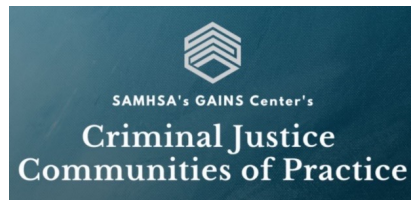
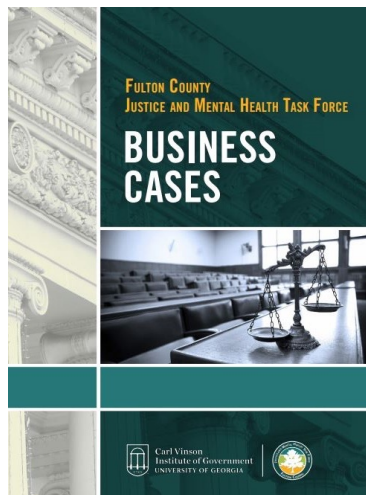
How Community Response Services through ATL311 Work



ATLANTA'S CENTER FOR DIVERSION & SERVICES



Multiple initiatives generated momentum for an alternative to jail for people experiencing behavioral health concerns and extreme poverty



Creating “somewhere else to go” advances city & county goals to reduce de facto use of jails as crisis centers



- 22,000+ people detained at ACDC between 2017 – 2020 were held for charges associated with homelessness, mental illness, and substance abuse (30%)
- 5,800+ people detained at Fulton County Jail between 2019 – now screen positive for mental health concerns (15%), and remain in jail 2x as long (58 days)
- 10,000+ Fulton County bookings between 2017-2019 were for low-level charges associated with homelessness, mental illness, and substance abuse

Sources: Fulton County Justice & Mental Health Task Force; Fulton County Superior Court

Strategic location in Downtown Atlanta

- 8,000 sf on 2nd floor (of 471,000 sf)
- Separation between DOC and Diversion
- Dedicated entry
- Easy transfer from vehicles
- Potential for outdoor space



First responder and law
enforcement unloading

Diversion Center Location

 Diversion Center Dedicated
Entry

Center for Diversion and Services at ACDC



- Potential to **divert 10,500 jail bookings annually** from ACDC and Fulton County jail
- **Potential to divert 4,400 police custody admissions** from Grady's ER and Psychiatric ER Services

Goals for the Center for Diversion and Services

1. Provide a service-based response to people with mental illness, substance abuse, and chronic homelessness, avoiding the criminal justice system as a form of response
2. Reduce the number of people with mental illness, substance abuse, and chronic homelessness from entering the city and county's jails
3. Connect clients to services in the community
4. Preserve law enforcement and medical resources
5. Build out a full continuum of care over time to serve the Atlanta metro area

What is a Center for Diversion and Services?

A law-enforcement drop-off point offering co-located services and connections to additional resources for people experiencing mental illness, substance abuse issues and extreme poverty

- Efficient law enforcement drop off (pre-arrest diversion)
- Screening & needs assessment
- Sobering room
- Peer support & referrals
- Housing assessment and placement
- Case management and legal aid
- Non-emergency medical care (basic wound care, health screenings)
- Warrant resolution clinic (reduce bookings on technical violations)
- Amenities: pantry, laundry, showers, lockers, MARTA cards, living room, meals

FREQUENT UTILIZER RESEARCH

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- The authors are solely responsible for the content of this presentation.

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3 Overarching Research Goals

1. Examine the frequent utilizer population
 - Focus on intersecting needs and systemic barriers that lead to repeated jail admissions
2. Record techniques used to reduce returns to jail
 - Focus on collaboration with community-based service providers
3. Evaluate these techniques
 - Focus on the role of behavioral health and racial/ethnic inequities

Approach

- Multi-Method
 - Descriptive analysis of jail population
 - Policy implementation and impact analysis
 - Semi-structured interviews with community partners
 - Site observations
- Multi-Informed
 - Data analysis informed by discussions with jail partners, service providers, and people with lived experiences of jail programs

3 Project Sites

- Mecklenburg County, North Carolina
- Harris County, Texas
- Pennington County, South Dakota

CURRENT PRESENTATION

Identifying People with Frequent Contact



Type

The specific legal-system contact being measured (e.g., arrests, jail bookings, days in jail)



Number

The number of contacts are measured in two ways:

- A set threshold (e.g., 3+ contacts)
- A proportion of the total population of people booked into jail (e.g., 800 most frequently booked people)



Time Period

The set period of time over which contacts are counted (e.g., 1, 2, or 5 years)



Additional Systems

The inclusion of contact with other systems in addition to legal system contact (e.g., emergency services, hospitals, homeless services)

3 Project Sites

- Mecklenburg County, North Carolina
- Harris County, Texas
- Pennington County, South Dakota

Pennington County Site Lead

Liz Hassett

Grant Manager



Profile of Pennington County, SD

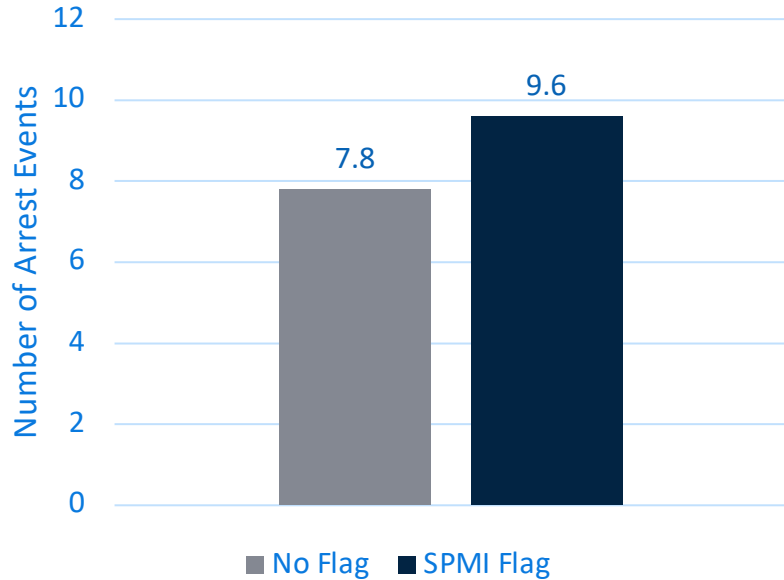
- Population: 113,775
- Average Jail Population: 622
- Emphasis of evaluation
 - Homelessness
 - Substance use
- Primary partner: Care Campus
 - Detox centers
 - Crisis care
 - Residential and outpatient treatment

Behavioral Health Tracking in Pennington

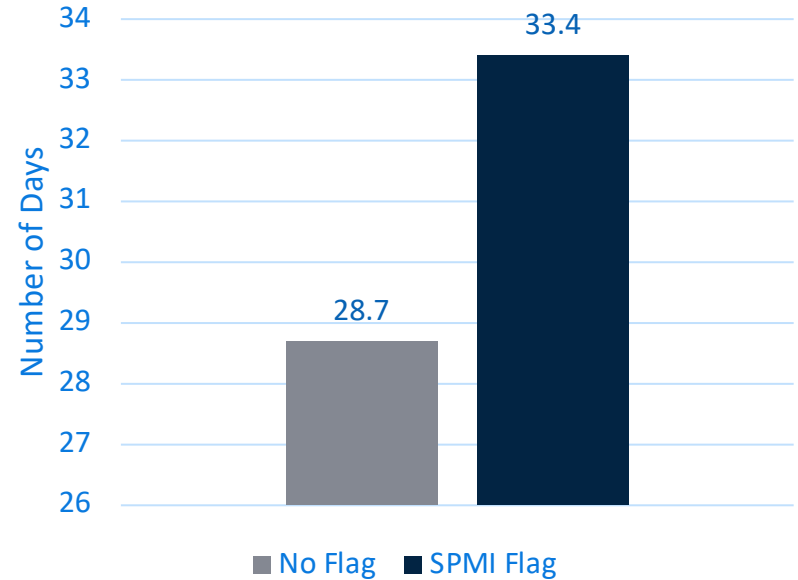
- Raw jail data included 4 behavioral health flags
 1. Severely and Persistently Mentally Ill (SPMI), defined by staff
 2. Seen by Psychiatric CNP or Physician and/or on mental health medications
 3. Seen by mental health on a regular basis (at least every 2 months)
 4. History of self-harm/suicide risk
- Discussions with jail staff → use SPMI indicator for evaluation
 - 11% of jail bookings between 2016 and 2021

SPMI Flag and Jail Contact

Number of Arrest Events



Length of Stay in Jail per Arrest Event



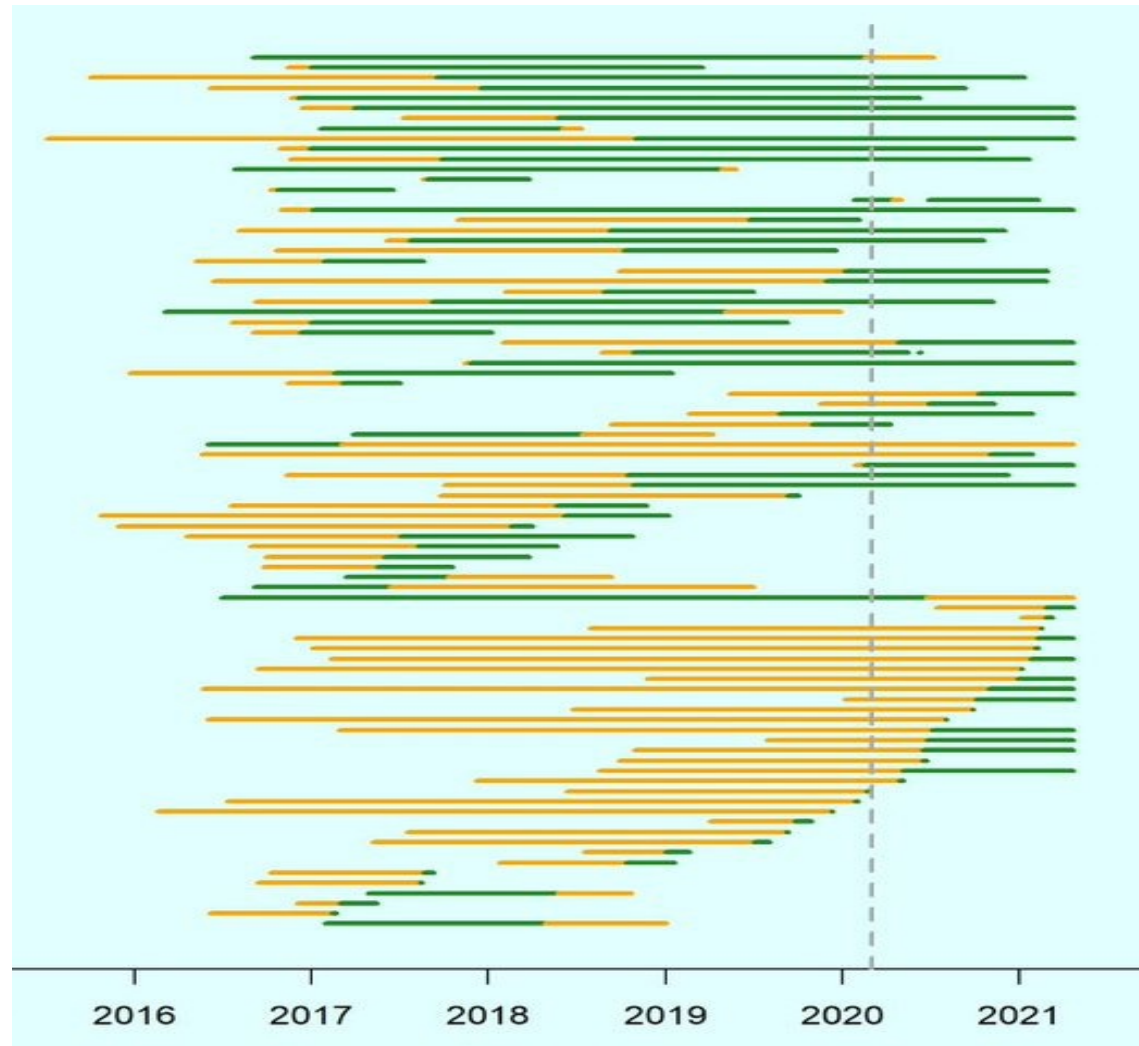
SPMI FLAG AND CONSISTENCY

SPMI Flag and Consistency

- SPMI flags not always consistent across jail contacts
- 86 people had inconsistent SPMI flags
 - 74 people
 - No SPMI flag on initial booking but SPMI flag at subsequent booking
 - 12 people
 - SPMI flag at earlier booking but not later booking

SPMI Flags over Time

- Each line one person across arrest events
 - Yellow = SPMI flag
 - Green = no SPMI
- Dotted line is COVID onset
 - March 2020

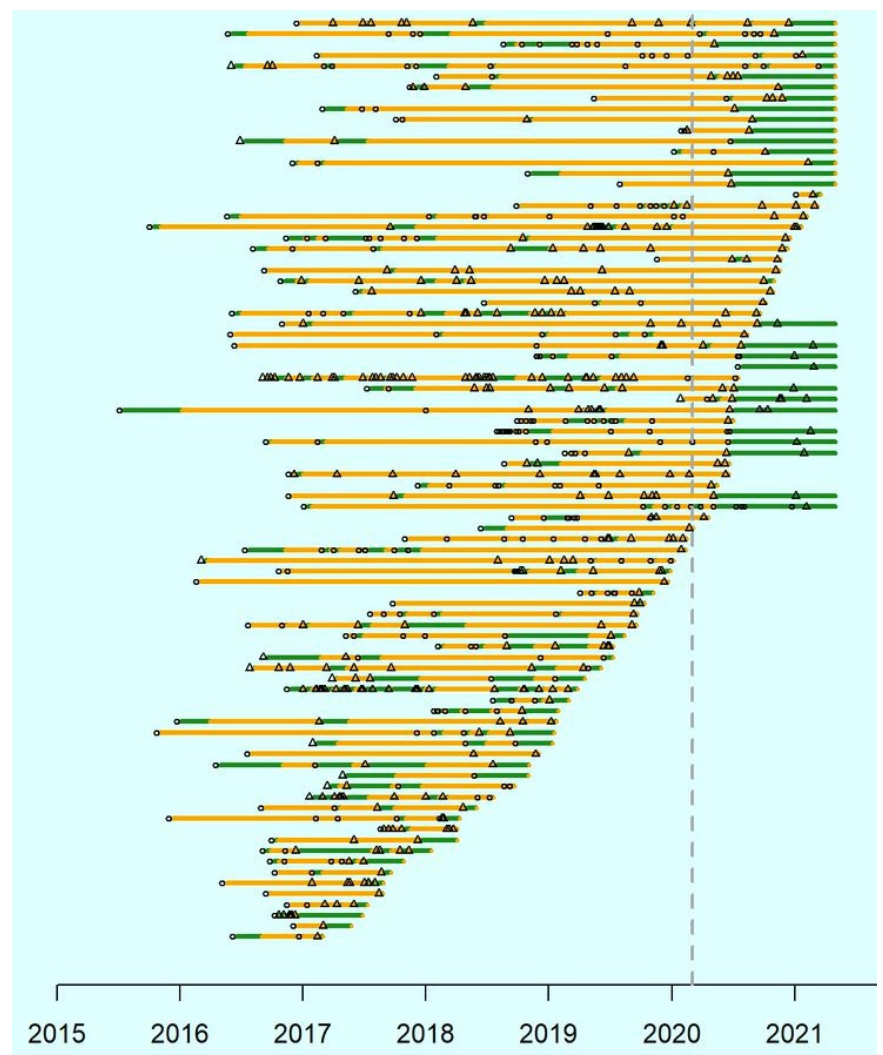


Time to Identification of SPMI

- Considerable variation in time from initial jail contact to SPMI identification overall
- Longer time in jail before SPMI identification
 - Women compared to men
 - Black people compared to white people

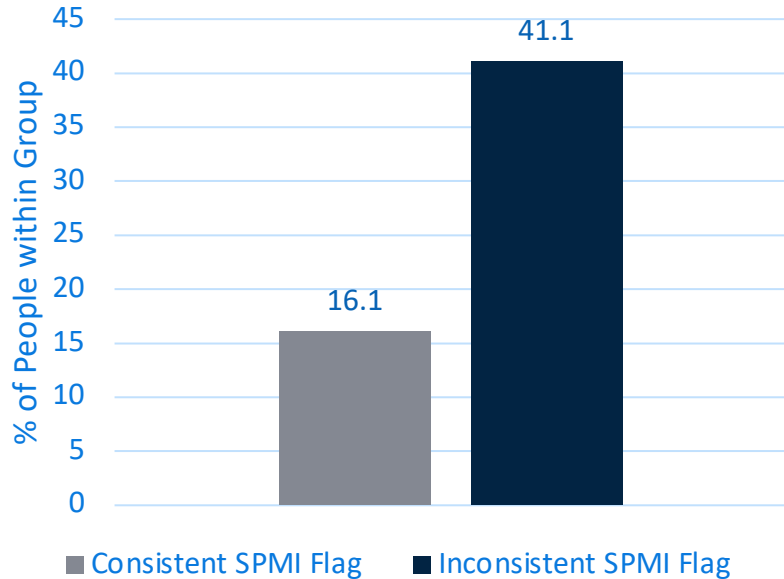
Time to SPMI Flag

- Each line one person across arrest events
 - Yellow = time in jail
 - Green = time in community
- SPMI Flag
 - Circle = no
 - Triangle = yes
- Dotted line is COVID onset
 - March 2020

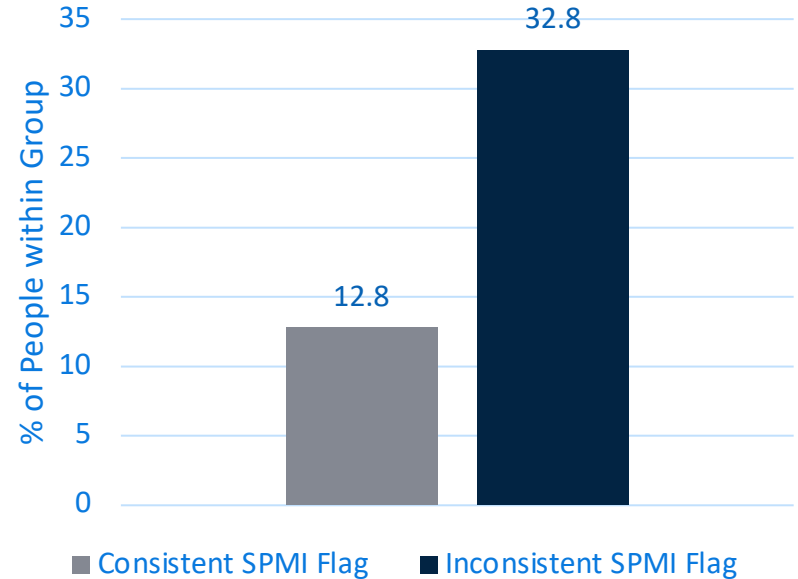


SPMI Flag Inconsistency and Care Campus Use

Referral by Law Enforcement



Use of Detox Beds



CONCLUSION

Conclusion

- People with SPMI flag experience more arrest events and longer stays
 - Programs specializing in behavioral health treatment may reduce repeat jail bookings
- Unexplained inconsistency in SPMI flag over time
 - Implications for service access and delivery, especially for women and people of color
- Potential confounding of SPMI symptoms and substance use
 - Implications for access and delivery of appropriate services
- Opportunities for improved screening and identification
 - Use of standardized screening instruments
 - Screening for both SPMI and substance use

DISCUSSION

THANK YOU!

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