

**MOSES<sup>1</sup>**  
**High Utilizer of Multiple Systems (HUMS) “Familiar Faces” Proposal**  
(07-19-17)

**The Problem**

Our community has a group of individuals with a mental health and/or substance use disorder who are high utilizers of the local criminal justice system – specifically, the Dane County Jail where they are seen over and over again. They are the so-called “Familiar Faces.” Many of these individuals experience complex chronic health conditions including: histories of trauma, substance use disorders, mental health and chronic homelessness. It is likely that this group is frequently using law enforcement, alcohol and drug detoxification (detox), emergency room services, hospitals and other resources. Because of their impact on more than one system, they are frequently referred to as High Utilizers of Multiple Systems (HUMS).

Can this cycle be broken? Can these individuals receive interventions that will better address their underlying issues and keep them out of the criminal justice system and the various crisis care systems?

**Background**

One of the noteworthy “high utilizer” studies and efforts was started in Camden New Jersey about a dozen years ago when Dr. Jeffrey Brenner, a local family physician, agreed to ride along on a police officer’s beat patrol for a period of time. He was moved by this experience in several ways. Many of the individuals they interacted with on the patrol rides were having chronic health crises yet it was apparent that had no ongoing help and care. Dr. Brenner also suspected that these individuals were using many resources every time they had a crisis yet the health and life outcomes for them was terrible. In order to prove this point, he requested and was able to obtain data from all of the hospitals in Camden. His subsequent analysis had a profound impact on New Jersey and on the Country.

Fareed Zakaria said the following in a CNN interview: “New Jersey’s Camden Coalition of Healthcare Providers founder and family medicine practitioner, Jeffrey Brenner, used medical billing records to find that just 1% of patients accounted for 30% of health care costs in Camden. And that's not all he discovered in the city's three hospitals. He says: "We learned that someone went 113 times in one year. Someone went 324 times in five years. In similar workup in Trenton, they found someone who went 450 times in one year." These were people with complicated medical histories and chronic illnesses. One patient alone racked up \$3.5 million in medical bills over a five year period. As Brenner says, "They're the difficult patients to treat, and no one is being paid and incentivized to pay attention to them." What's more, Camden's problem is America's problem. Just 5% of Americans accounted for half of our nation's health care costs in 2009. This is perhaps the crucial statistic to understand about America's health care problem.

Dr. Brenner also showed that on-going care for these individuals could improve their lives and dramatically reduce costs, reduce trips to the emergency room, and reduce crises that require law enforcement to be involved. This led to legislation in New Jersey and to federal legislation that now allows states to establish “Accountable Care Organizations” and to seek federal waivers to proactively serve high utilizer individuals. If the state can show a savings in Medicaid expenditures, they can use the savings to provide on-going preventive care.

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<sup>1</sup>MOSES stands for Madison Organizing in Strength, Equality, and Solidarity. MOSES is a non-partisan interfaith organization that works to promote systemic change for social justice issues with a focus on mass incarceration. There are currently 23 congregations and organizations in MOSES. MOSES is one of eleven local chapters of the statewide WISDOM organization. WISDOM is focused primarily on prisons and statewide issues. MOSES has decided to put part of its focus on the Dane County criminal justice system and the jail.

This work has inspired many of the recent high utilize initiatives. While Dr. Brenner approached his effort primarily from the health side, it is not surprising that some communities have approached it from the criminal justice side by first identifying individuals who have frequent interactions with law enforcement, frequent arrests, and frequent stays in the county jail. It is not surprising that the two populations overlap. This group is referred to as the high utilizers of multiple systems (HUMS).

Many studies have been done. Most focus on high utilizers of emergency medical services, but not exclusively. One national survey looked at criminal justice involvement and concluded: “Recent criminal justice involvement was associated with both hospital and ED utilization among vulnerable subgroups: uninsured, those with a substance use disorder, and those reporting serious psychological disorders.”<sup>2</sup>

Several communities have carefully studied this group and have developed initiatives. Please see Appendix A for detailed summaries of the HUMS in the following communities: State of Washington and King County Washington, San Francisco, San Diego, Corporation for Supportive Housing (CHS) FUSE Initiative (multiple states), and Los Angeles.

### **Goals and Objectives**

The first goal is to reduce the number of HUMS with mental illness who are repeatedly arrested and booked into the Dane County Jail for low-level nuisance crimes, like shoplifting, trespassing, disorderly conduct, and theft or, if they are under Department of Corrections (DOC) Supervision for a crimeless revocation due to a rule violation.

The second goal is to reduce the use of other expensive systems by the same individuals such as ambulance services, police, hospital, detox, and homeless shelters.

The third goal is to provide housing, services, and case management to break the HUMS cycle.

The following objectives support these goals:

1. Develop the data and other tools and agreements needed to identify the HUMS and the costs that they incur across multiple systems (jail, law enforcement, emergency rooms, hospitals, courts, homeless centers, and social services).
2. Increase access and capacity across the continuum of community-based mental health treatment delivery. *(Without community-based treatment, jail diversion programs would do little but put people with mental illness back out on the street, where they do not have the housing, medication, treatment, or social supports they need to change the behaviors that resulted in arrest in the first place.)*
3. Increase the capacity and accessibility of crisis stabilization and 23-hour observation facilities. *(Such facilities – sometimes called crisis/restoration centers – should have the added benefit of being able to connect individuals with appropriate treatment or services at discharge.)*
4. Increase the availability of minimal-barrier, supportive housing for people with a criminal history, substance abuse disorder, and/or mental illness. *(Without stable housing and wrap-around services, people struggling with homelessness and mental illness who have been diverted from jail will not be successful in the community and will likely have additional encounters with law enforcement.)*

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<sup>2</sup>J Gen Intern Med. 2014 Sep; 29(9): 1226–1233.

Published online 2014 May 10. doi: [10.1007/s11606-014-2877-y](https://doi.org/10.1007/s11606-014-2877-y)

PMCID: PMC4139534

**Increased Hospital and Emergency Department Utilization by Individuals with Recent Criminal Justice Involvement: Results of a National Survey**

5. Improve law enforcement response to mental health crises: by expanding CIT training to all law enforcement officers, fire, EMT, and 911 center workers, and by developing mobile co-response teams, in which a law enforcement officer and a mental health professional respond to calls together. *(This training focuses on how to deal with a mental health crises, how to deescalate, how to connect to supports.)*
6. Create a Management Guidance Team from organizations representing housing providers; substance abuse and mental health treatment providers; community health centers and hospitals; Medicaid Managed Care organizations, Dane County Department of Human Services; criminal justice organizations including courts, law enforcement, the District Attorney's office, and DOC; State Division of Mental Health and Substance Abuse Services; Dane County and city governments; and community advocacy organizations. This team will look at the whole picture, identify required components, and ensure efforts are well coordinated. *(To be successful, a strong leadership framework must be put in place. This will provide collective ownership and a forum for identifying problems and implementing continuous improvement.)*
7. Use a Care Management Team to create and track an individual's care plan and to work with family and other designated support people. *(These are similar to IEP plans used for special education that identify what needs to be done and then track progress over time. These plans will provide comprehensive and integrated services to adults who are experiencing behavioral health challenges (mental health conditions and/or co-occurring substance abuse issues), need an intensive level of community-based support, and may be experiencing homelessness.)*
8. Maximize the use of Medicaid, Medicaid Administrative Claiming (MAC), Targeted Case Management (TCM), and other state and federal funding sources. Explore setting up an Accountable Care Organization to serve HUMS and capture federal dollars for demonstrated savings. *(These can be a major funding source and are not currently fully utilized.)*
9. Improve data collection and analysis at the Dane County Jail and at other critical intervention points dealing with individuals who are HUMS. *(This is needed to measure the outcomes of the goals and objectives.)*

## **Measured Outcomes** (Measures of success for the selected HUMS group)

*(Note: It will be important to come up with measurable outcome targets. These need to come from additional discussion and review of similar efforts in other communities.)*

1. Break the cycle by reducing the number of repeat bookings into the Dane County Jail.
2. Increase ongoing connection (not just referral) with community-based mental health services.
3. Help the individuals to achieve the following outcomes:
  - a. Improved health
  - b. Improved housing stability
  - c. Reduced emergency department usage
  - d. Reduced criminal justice involvement
  - e. Improved client satisfaction
4. Significantly reduce (by 50% or more) instances of the following:
  - a. Jail days
  - b. Hospital stays
  - c. Ambulance transportation
  - d. Emergency Room visits
  - e. Arrests
  - f. Other\*

\*Crisis, detox, homeless shelters, legal assistance, psychiatric emergency response team, etc.

## **How and When**

This can be done incrementally and be built off of steps that have already been taken. *(See Appendix B for useful resources.)*

1. Continue to reinforce commitments made through County Resolution #556 and by the Criminal Justice Council (CJC) prioritization.
2. Bring together the Dane County participants in the Stepping-Up<sup>3</sup> initiative to review this initiative and help develop next steps.
3. While there are many individual efforts in Dane County that are positive, they are fragmented and not well connected. It is program-centric and not people-centric. For this proposal to be successful, multiple pieces must fit together in a planned way. There should be a management guidance team appointed that will look at the whole picture, identify the needed pieces, and make sure that they operate as a whole.

A first step towards assembling such a team is to look at successful efforts in other communities to identify the key stakeholders. Then, there should be a series of discussions with the stakeholders to review this proposal and develop a consensus for action. Likely stakeholders will include the police, the Sheriff, the County Board, the County Exec, hospitals, and providers.

4. There is widespread community support to keep people with mental illness out of the criminal justice system. Groups such as MOSES, NAMI, and the League of Women Voters are continuing a dialogue with stakeholders in the criminal justice system and with the broader public to raise awareness of mental health

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<sup>3</sup>This is a national initiative to reduce the number of people with mental illness in jails. It is an initiative of the National Association of Counties, the American Psychiatric Association, and the Council of State Governments.

issues and to advocate for change. These groups need to be part of this project. They can help with an education campaign for the general public.

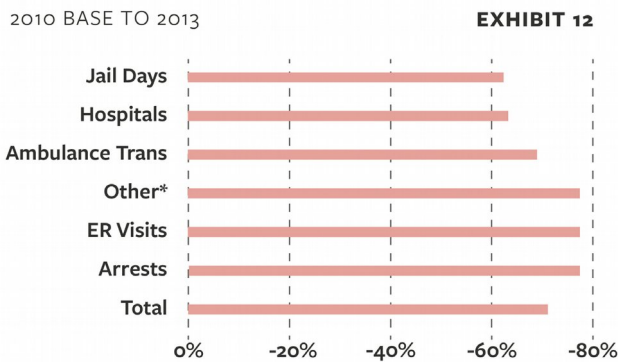
### Costs and Opportunities

While individual parts of this proposal may have significant costs, there are also opportunities for funding and for savings. Significant savings can be achieved if there are reductions in recidivism, emergency room visits, and mental health crises. That is another reason why it is important to have a management guidance team to look at the whole picture. Other communities have found that by working together, the stakeholders were able to do more with the resources that were already being spent and were much more effective in accessing other resources and grant opportunities.

On the cost side, all of the communities that have implemented HUMS projects have emphasized the need to provide housing. To do this will require a significant commitment and funding.

The San Diego Project 25 showed significant reductions in high cost services:

### Project 25's Impact on Public Service Expenses



\*Includes: Crisis House, detox centers, homeless shelters, legal assistance, Psychiatric Emergency Response Team

## Appendix A –

**State of Washington survey:** Most of the counties we visited have begun identifying high utilizers of jails, but few are focusing on high utilizers of multiple systems (HUMS), meaning people with chronic physical and/or behavioral health disorders who are repeatedly showing up in jails, hospital emergency rooms, and/or shelters, presumably because their behavioral health needs are not being met through less expensive means.

Additional data are available about pretrial detainees waiting in Washington jails for court-ordered services from the Washington State Department of Social and Health Services (DSHS) (Trueblood Diversion Plan 2016). These are people who have been charged with a crime but who may not be able to understand the judicial process or the charges against them, or they may not be able to aid in their own defense. Among this population:

- 70 percent had had at least two arrests during a recent 12-month period.
- 67 percent had had between two and five referrals since 2012 for services to restore their competency to stand trial.
- 62 percent had received outpatient mental health services during a recent 12-month period, and 50 percent had received residential services.
- 55 percent had a substance use diagnosis, but few had received substance use treatment services during a recent 12-month period. Only 3.2 percent of respondents had received outpatient treatment during a recent 12-month period, and 2.6 percent had received residential treatment.
- 46 percent ranked housing as the most helpful diversion service, followed by medication management (13 percent of respondents), case management (15 percent), and employment (8 percent).
- 43 percent were eligible for Medicaid.

These data suggest that people with mental illness are cycling in and out of Washington’s criminal justice system, many of them without receiving treatment. If these individuals match national profiles of people with mental illness who are in jail, they are likely to have a substance abuse disorder, be poor or homeless, and have been repeatedly sexually and physically abused (Steadman 2014). They may also have a chronic physical health problem that will shorten their life by 13 to 30 years (DeHert et al. 2011). Historically they have lacked health insurance, in spite of their high physical and behavioral health care needs—needs that have remained largely unaddressed because of their social conditions, such as poverty, unemployment, low educational achievement, low literacy rates, and homelessness (Hanig 2015).

## Appendix A –

### King County – Familiar Faces

Following preliminary scoping conversations with several internal and community stakeholders during 2014, one of the initial populations of focus that emerged was individuals with a mental health and/or substance use disorder who are high utilizers of the local criminal justice system – specifically, the King County Jail- the so-called “Familiar Faces.” Many of these individuals experience complex chronic health conditions including: histories of trauma, substance use disorders, mental health and chronic homelessness. These individuals experience instability in many aspects of their lives and are familiar to the various service and provider crisis systems.

Data matching was a significant process victory for the Familiar Faces initiative, as three distinct King County Departments, City of Seattle, and other housing and social service partners, broke down traditional data silos to share information. This exercise in gathering data gave the Design Team a much more comprehensive picture of the Familiar Faces population and showed the following:

- The Familiar Faces are disproportionately people of color compared with King County as a whole and overall jail population
- In 2013, there were 1,273 Familiar Faces. In 2014, there were 1,252 Familiar Faces.
- 94% of all people with 4 or more jail bookings have a behavioral health indicator.
- 93% had at least one acute medical condition (average 8.7 conditions); 51% had at least one chronic health condition (average 1.8 conditions)
- More than 50% were homeless
- The Most Serious Offenses (MSO) were:
  - Non-compliance (41%) – Failure to appear for court, supervision violations, etc.
  - Property crime (18%)
  - Drugs (13%)
- Only 8.5% of 2014 Familiar Faces (FFs) had opted-in to any of the three adult specialty courts during 2014 (Drug Diversion Court or either the King County or City of Seattle Mental Health Courts)
- About 50% of the 2013/14 FF’s (aged 24 and under) have had contact with the juvenile justice system
- Despite having at least four bookings in the King County Jail, over 40% of FF also had municipal jail episodes during the same year (there are 5 municipal misdemeanor jails in King County in addition to the King County Jail’s two sites in Seattle and Kent)

## Appendix A –

### San Francisco (2011)

The most costly user of publicly financed emergency health services in San Francisco – a "frequent flyer" in emergency room parlance – is 49, Caucasian, schizophrenic, and addicted. He had been listed in at least two concurrent city systems as homeless (either continuously or episodically) for 16.6 years. He's a frequent caller of ambulance (more than four times a month), a frequent user of detox and sobering center services, and a high utilizer of mental health services (including psych emergency). He is very, very ill. Based on three years of mortality data for very similar people, his chances of dying this year alone range from one in 10 to one in 20.

Four years ago, a tiny group of committed people set out to figure out how to track, and help, those people who are failing (and being failed by) our public health safety net systems. The brilliance of their approach was to take isolated silos of data and merge them together. No employee had to change how he worked or modify a database. All they had to do was dump their data to a central digital safety-net warehouse.

The HUMS database, as of February 2, 2011, contains 227,223 people, with data going back as far as 1992. Of those 227,223 people, 18 percent (50,266) have at some point been listed as homeless by two or more different systems. Of the people who received services last year, 6 percent (16,494) were listed as homeless by two or more data systems during 2009-2010.

That number, 16,494, is markedly higher than the current official estimates of the number of homeless in San Francisco. Homelessness is a state of constant churn into and out of marginal housing options. This higher number may represent a more accurate estimate of the numbers of people dealing with transitory homelessness in a year.

High utilizers of ambulance services are defined as having used an ambulance more than four times a month. Collectively, this subgroup racked up 3,093 transports, 74 percent of them for sobering center clients.

In 2009-2010, 477 people were ranked as High Utilizers of Multiple Systems, and they used \$20 million worth of urgent/emergency services — an average of \$42,067 each.

The average age was 47.8, 75 percent were male, 92 percent spoke English, 49 percent were Caucasian, 29 percent were African American, and 12 percent were Latino.

Thirty nine percent were high utilizers of ambulance services, 77 percent had used urgent/emergency substance abuse services, and 75 percent had used urgent/emergency mental health services.

Twenty seven percent had a diagnosis of schizophrenia, and 15 percent had had legal conservators at some point. Sixteen percent were HIV-infected, and 42 percent had hepatitis C.

The top 100 used \$8.1 million worth of urgent/emergency services alone in that year.



## Appendix A –

### San Diego Project 25

Project 25 was designed to determine if the provision of permanent housing with intensive individualized support, coupled with an identified, “Medical Home,” could significantly reduce the use and cost of various public programs by their most frequent homeless users in the San Diego metropolitan area.

- Project 25 focused on homeless individuals who were the most frequent users of public services, including emergency rooms, hospitals, jails, and ambulances.
- The individuals studied ranged in age from 22 to 61, with a median age of 47. Five were Veterans. All of the individuals studied had some form of mental illness, a serious physical disability, and/or a diagnosable substance abuse disorder. Many had all three.
- Using administrative data matched across multiple systems ensured that those selected for the project were the most frequent users of public services and incurred the highest costs community wide. Also, it ensured that those targeted were most in need.
- In the base year 2010, the expenses of all public services used by the 28 individuals totaled approximately \$3.5 million.

## Appendix A –

### Corporation for Supportive Housing (CHS) FUSE Initiative

The Frequent User Services Enhancement (FUSE) initiative is a supportive housing program developed by CSH with support from various government agencies that provided housing and support services to individuals who were frequently cycling in and out of jails, homeless shelters, and hospital emergency rooms in 2008. A two-year follow up evaluation found that FUSE participants spent significantly fewer days in jails and shelters and engaged in less cycling between public systems. These service use reductions resulted in significant cost savings to the government and tax payers.

FUSE is a CSH signature initiative that helps communities identify and engage super utilizers of public systems and place them into supportive housing to break the cycle of repeated use of costly crisis health services, shelters, and the criminal justice system. It provides a double win for communities, allowing public systems to cut costs while improving outcomes for some of their most vulnerable community members. The model represents an opportunity to transform the homeless, health, and criminal justice systems to increase housing stability, reduce emergency health care use and recidivism to jail, and break the cycle of multiple crisis service use, resulting in public cost offsets. As a comprehensive, systems change approach to tackling the frequent user problem, successful implementation of FUSE requires not only significant local investment time, energy and resources – but also strong political and civic will.

FUSE is a nationally recognized model that has been implemented in more than 20 communities nationwide. Because the model promotes use of data to target and track tenants based on their use of systems, outcomes findings have consistently shown reduced system use – and costs – that appeal to communities looking to implement an evidence based solution to the frequent user/high utilizer problem. The FUSE model has been included in the United States Interagency Council on Homelessness' (USICH) “solutions” database as a “promising practice.

The definition of a frequent user varies by community, and is often driven by the community’s own cross system data matching efforts. A data match can help to illuminate precisely the extent of homeless individuals, as shown through an HMIS system, and jail involved individuals, hospital frequent “flyers,” and/or users of other systems. A couple examples we have seen communities use are:

A number of FUSE programs that focus on homeless frequent users of local jails have used the “4 stays in 5 years” criteria for program eligibility. For these programs, the eligibility criteria for the program is at least 4 stays in each system over the past 5 years, with at least one stay in each in the most recent year before the data match. Often, a behavioral health condition, substance use disorder, or other disability (typically broadly defined) is added to the criteria.

The goal of many FUSE initiatives is to reduce public costs. While translating jail time and homeless system usage into dollars involves using average daily rates and booking costs, health costs to hospitals, managed care plans, and state Medicaid systems can be accurately calculated with the right data. A couple FUSE programs have used a “top decile” eligibility approach by creating an eligibility list (or tool) based on a person’s presence in the top 10% of a cost distribution once all costs are calculated/estimated across systems.

## **Appendix A –**

### **Los Angeles 10TH DECILE PROJECT TO HOUSE HIGH NEED HOMELESS**

The 10th Decile Project is using the triage tool developed by the Economic Roundtable to identify individuals experiencing homelessness who continuing crises in their lives that create very high public costs.

The triage tool was developed based on two key propositions:

1. The greatest risk to homeless individuals is of continuing crises in their lives, particularly crises that cause encounters with hospitals and jails.
2. The most compelling basis for prioritizing access of homeless individuals to the scarce supply of permanently subsidized supportive housing is the public costs that will be avoided when they are housed. The triage tool was developed by the Economic Roundtable's statistician, Jay Sumner. It is a system based tool for identifying the one tenth of homeless persons with the highest public costs, and the acute ongoing crises that create those high costs. This 10th decile is the highest need segment of a much larger homeless population needing housing.

The 10th Decile Project builds on the service delivery network and experience from the Los Angeles FUSE (Frequent User Systems Engagement) Project piloted by CSH's Los Angeles office (<http://www.csh.org/la>) and the Economic Roundtable, in collaboration with Housing Works (<http://housingworksca.org/>) and OPCC (<http://www.opcc.net/>), as well as Homeless Health Care Los Angeles (<http://www.hhcla.org/>).

## Appendix B – Useful Resources

### Wisconsin

1. Dane County Jail Update Study Final Report, Mead & Hunt, December 2016, [https://www.danesheriff.com/documents/pdf/Dane%20County%20Jail%20Update%20Study\\_Final%20Rpt\\_DEC%202016.pdf](https://www.danesheriff.com/documents/pdf/Dane%20County%20Jail%20Update%20Study_Final%20Rpt_DEC%202016.pdf)

### New Jersey

2. New Yorker Article about Dr. Jeffrey Brenner's Work, January 14, 2011, <http://www.newyorker.com/news/news-desk/atul-gawande-on-the-super-utilizers>

### California

3. Fresno Restoration Center Project Strategic Action Plan, March 2014, <http://www.fresnobl.org/wordpress/wp-content/uploads/2014/04/Fresno-Restoration-Center-Project-Strategic-Action-Plan.pdf>
4. Meet San Francisco's 477 Most Expensive HUMS (High Utilizers of Medical Services), May 3, 2011, <http://www.docgurley.com/2011/05/meet-san-franciscos-477-most-expensive-hums-high-utilizers-of-medical-services/#sthash.UXRdvXkr.dpbs>
5. Project 25 Report (Project 25 focused on homeless individuals in San Diego who were the most frequent users of public services, including emergency rooms, hospitals, jails, and ambulances.), April 2015, [https://uwsd.org/files/galleries/Project\\_25\\_Report.pdf](https://uwsd.org/files/galleries/Project_25_Report.pdf)
6. (Los Angeles County) 10TH DECILE PROJECT TO HOUSE HIGH NEED HOMELESS - Social Innovation Fund (SIF) Grant Awarded to the Economic Roundtable Team, 2012-present, Economic Roundtable, <https://economicrt.org/current-projects/10th-decile-project-to-house-high-need-homeless/>

### Michigan

7. Recommendations for Addressing The Needs of High Utilizer/Super Utilizer Patients in Michigan, Michigan Department of Community Health, December 2014, [https://www.michigan.gov/documents/mdch/High-Super\\_Utilizer\\_Report\\_Healthy\\_MI\\_Act\\_12-2014\\_487676\\_7.pdf](https://www.michigan.gov/documents/mdch/High-Super_Utilizer_Report_Healthy_MI_Act_12-2014_487676_7.pdf)

### Washington State

8. Jail Diversion for People with Mental Illness in Washington State - A Study Conducted for the State of Washington Office of Financial Management, November 21, 2016, <http://www.ofm.wa.gov/reports/Jail%20Diversion%20for%20People%20with%20Mental%20Illness%20in%20Washington%20State%20Study.pdf>
9. King County Health and Human Services Transformation The Familiar Faces Initiative, June 2016, <http://www.naco.org/sites/default/files/documents/Familiar%20Faces%20Brief.pdf>

## Alabama

10. Crisis center could save hundreds of thousands in medical, jail costs, Montgomery Advertiser, January 27, 2017, <http://www.montgomeryadvertiser.com/story/news/2017/01/27/crisis-center-could-save-hundreds-thousands-medical-jail-costs/96887670/>

## Kansas

11. Police are learning to deal with the mentally ill (Kansas), The Kansas City Star, 08/17/2012 | Updated: 05/16/2014, <http://www.kansascity.com/news/local/article307181/Police-are-learning-to-deal-with-the-mentally-ill.html>
12. Mental health crisis center opens in KC as alternative to jail, emergency room, October 28, 2016, <http://www.kansascity.com/news/local/article111139112.html#storylink=cpy>
13. MENTAL HEALTH AND CRIMINAL JUSTICE Case Study: Johnson County, Kan., updated March 17, 2017, [http://www.naco.org/sites/default/files/documents/Johnson%20County%20Mental%20Health%20and%20Jails%20Case%20Study\\_FINAL.pdf](http://www.naco.org/sites/default/files/documents/Johnson%20County%20Mental%20Health%20and%20Jails%20Case%20Study_FINAL.pdf)

## Missouri

14. Hitting the streets to help KC's 10 thorniest mental health cases, The Kansas City Star (Missouri), October 18, 2016, <http://www.kansascity.com/living/health-fitness/article108826082.html#storylink=cpy>
15. Kansas City (Missouri) Assessment and Triage Center Powerpoint, <http://media.kshb.com/pdf/KCATC-PPT.pdf>

## Texas

16. MENTAL HEALTH AND CRIMINAL JUSTICE Case Study: Bexar County, Texas, June 1, 2016, <http://www.naco.org/sites/default/files/documents/Bexar%20County%20-%20Mental%20Health%20and%20Jails%20Case%20Study.pdf>
17. Houston Recovery Center Sobering & Addiction Recovery Programs (includes screening for mental health issues), May 24, 2016 <http://houstonrecoverycenter.org/sobering-center/>
18. San Antonio became a national leader in mental health care by working together as a community – Can Massachusetts learn its lessons?, Boston Globe, December 2016, <http://apps.bostonglobe.com/spotlight/the-desperate-and-the-dead/series/solutions/>
19. Blueprint for Success: The Bexar County Model, <http://www.fairfaxcounty.gov/policecommission/subcommittees/materials/jail-diversion-toolkit.pdf>
20. Virtual Tour of The Restoration Center – The Center for Health Care Services – Bexar County, September 24, 2015, [https://www.youtube.com/watch?v=FD\\_wv49tO1Q](https://www.youtube.com/watch?v=FD_wv49tO1Q)

## Florida

21. MENTAL HEALTH AND CRIMINAL JUSTICE Case Study: Miami-Dade County, Fla., June 1, 2016, <http://www.naco.org/sites/default/files/documents/Miami-Dade%20County%20-%20Mental%20Health%20and%20Jails%20Case%20Study.pdf>

### **Minnesota**

22. Minneapolis Preliminary Report Officer Interactions with Mental Health Issues: A Policy Study, May 2016, <http://www.ci.minneapolis.mn.us/www/groups/public/@civilrights/documents/webcontent/wcmstp-174908.pdf>

### **New York**

23. The Rikers Island Hot Spotters: Defining the Needs of the Most Frequently Incarcerated, American Journal of Public Health, November 2015, <https://www.ncbi.nlm.nih.gov/pubmed/26378829>

### **National Survey**

24. Increased hospital and emergency department utilization by individuals with recent criminal justice involvement: results of a national survey, Journal of General Internal Medicine, September 29, 2014, Various authors, <https://www.ncbi.nlm.nih.gov/pubmed/24817280>

### **Stepping Up Initiative**

25. Reducing the Number of People with Mental Illnesses in Jail Six Questions County Leaders Need to Ask, Stepping Up Initiative, January 2017, [https://stepuptogether.org/wp-content/uploads/2017/01/Reducing-the-Number-of-People-with-Mental-Illnesses-in-Jail\\_Six-Questions.pdf](https://stepuptogether.org/wp-content/uploads/2017/01/Reducing-the-Number-of-People-with-Mental-Illnesses-in-Jail_Six-Questions.pdf)

### **Substance Abuse and Mental Health Services Administration (SAMHSA)**

26. SAMHSA Presentation to American Correctional Association, Behavioral Health and Criminal Justice: Challenges and Opportunities, By Pamela S. Hyde, J.D., SAMHSA Administrator, July 21, 2012, <https://view.officeapps.live.com/op/view.aspx?src=https://store.samhsa.gov/shin/content/SMA12-PHYDE072112/SMA12-PHYDE072112.ppt>

### **Corporation for Supportive Housing (CHS) FUSE Initiative**

27. The Frequent User Services Enhancement (FUSE) initiative web site, <http://www.csh.org/csh-solutions/community-work/introduction-to-systems-change/fuse/fuse-overview/>

### **Council of State Governments - Midwest**

28. Small group, big health care bills ‘Super utilizers’ of health care system are major drivers of Medicaid — and state — spending, By Kate Tormey, September 2013 ~ Stateline Midwest, <http://www.csgmidwest.org/policyresearch/0913superutilizers.aspx>