THINK **BIGGER** DO **GOOD**
POLICY SERIES

Bringing Treatment Parity to Jail Inmates with Schizophrenia

Mark R.Muntez, M.D., Erik Messamore, M.D., Ph.D., Sara E. Dugan, Pharm.D., B.C.P.P., B.C.P.S.

Summer 2018

Dear Reader,

Now is a time of change in health and human services policy. Many of the changes could have profound implications for behavioral health. This paper is one in a series of papers proposing solution-oriented behavioral health policies.

The past decade has been a time of steady advances in behavioral health policy. For example, we have met many of the objectives related to expanding health insurance coverage for people with behavioral health conditions. Coverage is now expected to be on a par with that available to individuals with any other health conditions, although parity implementation has encountered roadblocks. Coverage of evidence-based treatments has expanded with insurance, but not all of these services are covered by traditional insurance, necessitating other sources of funding, such as from block grants.

Much has improved; much remains to be accomplished.

As funders, The Thomas Scattergood Behavioral Health Foundation and Peg's Foundation believe that now more than ever philanthropic support in the area of policy is critical to improving health outcomes for all. We ask that you share this paper and the others in the series with your programmatic partners, local, state, and federal decision makers, advocacy organizations, and voters.

We believe that these papers analyze important issues in behavioral health policy, can inform policy-making, and improve health outcomes. In the back of the paper, there are suggested ways of how one can use the paper to further share these solution-oriented ideas and advocate for change. We hope these papers help to extend progress and avoid losing ground at a time of change in policy.

Sincerely,

Joseph Pyle, M.A.
President
Scattergood Foundation
Founding Partner of Series

Rick Kellar, M.B.A.
President
Peg's Foundation
Founding Partner of Series

Howard Goldman, M.D., P.h.D.
Series Editor

We would like to acknowledge the following individuals for their participation in the convening and the ongoing process that led to the conceptualization of the papers in this series.

Colleen L. Barry, Ph.D., M.P.P.
Bloomberg School of Public Health at John Hopkins University

Cynthia Baum-Baicker, Ph.D.
Thomas Scattergood Behavioral Health Foundation

Lisa B. Dixon, M.D., M.P.H.
Columbia University College of Physicians and Surgeons, New York State Psychiatric Institute

Arthur Evans, Ph.D.
American Psychological Association

Alyson Ferguson, M.P.H.
Thomas Scattergood Behavioral Health Foundation

Richard G. Frank, Ph.D.
Harvard Medical School

Rachel Garfield, Ph.D.
Kaiser Family Foundation

Aaron Glickman, B.A.
Perelman School of Medicine, University of Pennsylvania

Howard Goldman, M.D., Ph.D.
University of Maryland School of Medicine

Pamela Greenberg, M.P.P.
Association for Behavioral Health and Wellness

Kimberly Hoagwood, Ph.D.
New York University School of Medicine

Michael F. Hogan, Ph.D.
Hogan Health Solutions

Chuck Ingoglia, M.S.W.
National Council for Behavioral Health

Sarah Jones, M.D. Candidate
Thomas Scattergood Behavioral Health Foundation

Rick Kellar, M.B.A.
Peg's Foundation

Jennifer Mathis, J.D.
Bazelon Center for Mental Health Law

Amanda Mauri, M.P.H.
Thomas Scattergood Behavioral Health Foundation

Brian McGregor, Ph.D.
Satcher Health Leadership Institute at Morehouse School of Medicine

Mark R. Munetz, M.D.
Northeast Ohio Medical University

Sandra Newman, Ph.D.
John Hopkins Bloomberg School of Public Health

Joseph Pyle, M.A.
Thomas Scattergood Behavioral Health Foundation

Dominic Sisti, Ph.D.
Scattergood Program for Applied Ethics in Behavioral Health Care
Perelman Schoo of Medicine, University of Pennsylvania

Lloyd I. Sederer, M.D.
New York State Office of Mental Health, Mailman School of Public Health at Columbia University

Andrew Sperling, J.D.
National Alliance for Mental Illness

Hyong Un, M.D.
Aetna

Kate Williams, J.D.
Thomas Scattergood Behavioral Health Foundation

Glenda L. Wrenn, M.D., M.S.H.P.
Satcher Health Leadership Institute at Morehouse School of Medicine

Julia Zur, Ph.D.
Kaiser Family Foundation

Titles in the Paper Series

Editors Howard Goldman, M.D., Ph.D. and Constance Gartner, M.S.W.

America's Opioid Epidemic Lloyd I. Sederer, MD

Behavioral Health and the Individual Health Insurance Market: Preserving Key Elements of Reform Richard R. Frank, Ph.D. and Sherry A. Glied, Ph.D., M.A.

Coordinated Specialty Care for First-Episode Psychosis: An Example of Financing for Specialty Programs Lisa B. Dixon, M.D., M.P.H.

Fentanyl and the Evolving Opioid Epidemic: What Strategies Should Policymakers Consider? Colleen L. Barry, Ph.D., M.P.P.

Improving Outcomes for People with Serious Mental Illness and Co-Occurring Substance Use Disorders in Contact with the Criminal Justice System Glenda L. Wrenn, M.D., M.S.H.P., Brian McGregor, Ph.D., and Mark R. Munetz, M.D.

Medicaid's Institutions for Mental Diseases (IMD) Exclusion Rule: A Policy Debate Jennifer Mathis, J.D., Dominic A. Sisti, Ph.D. and Aaron Glickman, B.A.

Suicide Is a Significant Health Problem Michael F. Hogan, Ph.D.

The Current Medicaid Policy Debate and Implications for Behavioral Healthcare in the United States Rachel Garfield, Ph.D., M.H.S. and Julia Zur, Ph.D.

Find the papers online at http://www.thinkbiggerdogood.org

Bringing Treatment Parity to Jail Inmates with Schizophrenia

Mark R. Munetz, M.D.
Professor and Margaret Clark Morgan Endowed Chair
in Psychiatry, Northeast Ohio Medical University
mmunetz@neomed.edu

Erik Messamore, M.D., Ph.D.
Associate Professor of Psychiatry and Medical Director,
Best Practices in Schizophrenia Treatment (BeST) Center,
Northeast Ohio Medical University
emessamore@neomed.edu

Sara E. Dugan, Pharm.D., B.C.P.P., B.C.P.S.
Associate Professor, Department of Pharmacy Practice
and Psychiatry, Northeast Ohio Medical University
sdugan@neomed.edu

1 In Jail with Schizophrenia: The Problem

Individuals with serious mental illness (SMI), such as schizophrenia-spectrum, bipolar, or recurrent depressive disorders, are overrepresented in the criminal justice system. Of the 11 million individuals cycling through the U.S. jail system annually, more than 2 million have SMI (1). Compared with individuals without mental illness, those with SMI spend more time in jail awaiting adjudication, serve a longer sentence if found guilty, are at an increased risk of returning to jail after release, and are more likely to be arrested for the same behavior. Ensuring necessary treatment for such inmates would reduce individual, family, and societal burden of these disorders.

Schizophrenia is prominent among SMIs and is a leading cause of disability, reducing life expectancy by 15 to 20 years, primarily from preventable conditions (2). Half of people with schizophrenia will attempt suicide, and one in ten will die from suicide. Approximately 1.1% of the population has schizophrenia or a schizophrenia-spectrum disorder, and these disorders are estimated to cost the U.S. economy $155 billion annually (3).

This paper outlines the medically necessary care and treatment of schizophrenia, with a specific focus on medication treatment for individuals with schizophrenia in jail. It also explores the impediments that jail administrators may encounter when attempting to fulfill their legally mandated duty to treat incarcerated persons with schizophrenia-spectrum disorders. We argue that a few modifications to health care policy can significantly improve the lives of people with schizophrenia in the justice system and likely reduce recidivism.

2 A Closer Look at the Situation

Schizophrenia Is Treatable, and Recovery Is Possible

Schizophrenia is an illness of persistent psychosis. A longer duration of untreated psychosis correlates with greater lifetime disability, and psychotic relapse increases the risk of poor response to formerly effective medications (4, 5). These observations underscore the imperative for timely recognition and immediate treatment of schizophrenia to achieve remission of acute episodes and prevent psychotic relapse. Treatment of schizophrenia is more than a medical necessity; treatment of mental disorders is recognized by the United Nations as a fundamental human right (6).

Treatment of schizophrenia is more than a medical necessity; treatment of mental disorders is recognized by the United Nations as a fundamental human right.

In the United States, incarcerated individuals constitute the only class of citizens to whom a right to medically necessary treatment has been affirmed. This includes treatment of people with schizophrenia (7). The constitutional standard is for treatment that is "above the level of cruel and unusual punishment." We assert that inadequate treatment of schizophrenia can expose affected individuals to substantial risks of potentially disturbing delusions, threatening hallucinations, self-harm, and suicide and may well fall within the definition of cruel and unusual punishment. More important, we aim for a higher, more humane standard. Medically necessary treatment calls for a combination of antipsychotic medication and psychosocial interventions. Unfortunately, many patients lack access to these interventions. This paper focuses primarily on medication treatment and related policies.

Antipsychotic medications are a central component of successful schizophrenia treatment, and minimal standards for their use should follow the principles of effectiveness (ability to provide meaningful relief of symptoms), tolerability (minimization of adverse effects), and continuity of effective treatment. Clinical response to antipsychotic medications is favorable, especially if treatment is offered within the first year of illness. When an effective antipsychotic is identified, ensuring continuation of therapy is essential to prevent the numerous adverse effects of psychotic relapse. Use of long-acting injectable (LAI) antipsychotic formulations may assist with providing weeks' or months' worth of medication with one injection. LAIs have been reported to achieve longer durations of sustained recovery and improved adherence rates while also demonstrating superiority to oral antipsychotics in delaying time to incarceration (8, 9).

Although following these treatment principles will resolve psychotic symptoms in most patients, about 30% of those with schizophrenia fail to respond adequately to standard antipsychotic treatment, and their illness may be deemed "treatment resistant." For these individuals, clozapine must be considered. Clozapine is the only medication with FDA-recognized effectiveness in treatment-resistant schizophrenia. Clozapine is also unique in being recognized by the FDA as reducing the risk of recurrent suicidal behavior among individuals with schizophrenia or schizoaffective disorder. Clozapine responders are at risk of psychotic relapse, catatonia, or delirium if clozapine is discontinued (10). Clozapine is an irreplaceable and indispensable medication in the treatment of schizophrenia-spectrum disorders but is unfortunately underutilized generally and may have especially limited availability in correctional facilities (11).

Barriers to Getting the Right Treatment

Up to 85% of individuals with schizophrenia may experience meaningful symptom reduction if appropriate medication treatment is instituted. This figure is based on commonly cited estimates of 30% prevalence of treatment resistance combined with a clozapine success rate of at least 50% in the subset with treatment-resistant illness (12). However, this degree of success is difficult to fully realize. Only half of all individuals with SMI in the United States who require ongoing mental health treatment are connected to adequate care (13). Access to comprehensive treatment is inconsistent throughout the country (14). Pervasive stigma discourages individuals and their families from seeking care (15). Public health campaigns to promote awareness of psychosis symptoms and to encourage recently affected individuals to seek treatment are lacking. As symptoms progress, affected individuals may be more likely to drop out of school or work, detach from their families, and become impoverished and/or homeless. Lacking insight and/or resources, many are arrested for petty offenses, landing them in jails (16).

Jail-Specific Considerations

Individuals with schizophrenia-spectrum disorders who are incarcerated may have diminished resources to make bail and diminished capacity to successfully exit the justice system. Jails are not designed to be therapeutic environments, and people with SMI often become more symptomatic in the jail setting. Once jailed, individuals who had been in treatment become disconnected from their mental health system, because the jail is often not considered part of the community's local mental health system. Most inmates with SMI do not receive medication in jail (17–20). Furthermore, medications that are available in jails often differ from those that would be prescribed in the community.

Although treatment in jails is constitutionally mandated, this is essentially an unfunded mandate. The burden of paying for health services in jails falls on the jail administrator, typically a county sheriff (18). Many community jails contract with independent correctional medical providers who are under pressure to minimize costs (19, 21). A common cost-containment strategy is to impose a restricted formulary. These formulary restrictions may result in effective medications being discontinued or not restarted and in treatment being replaced with a potentially less effective medication (19, 21). When jail formularies omit clozapine, patients whose illness had been successfully treated with clozapine will be placed at substantial risk of psychotic relapse because there are no equivalent substitutions for clozapine. Meanwhile, individuals with new cases of treatment-resistant schizophrenia will be denied

access to the only medication approved for this pernicious variant of schizophrenia. Such formulary omissions risk extending the duration of inadequately treated psychotic symptoms, causing distress to the individuals and management problems for the jail. Similarly, LAI antipsychotics are often stopped on jail entry and rarely started in jail settings.

The disruption of ongoing treatment in jails or the failure to initiate effective treatment is due in part to health care financing. Medicaid is the major health insurer for jail inmates, especially after Medicaid expansion under the Affordable Care Act. But jails cannot bill Medicaid. This is the result of what is known as the Medicaid Inmate Exclusion. At the time of its enactment in 1965, Medicaid law excluded people residing in institutions that had historically been the responsibility of the states. The Medicaid Inmate Exclusion was intended to ensure that the states continued to bear responsibility for health care in prisons. However, both the nature of the correctional population and the nature of health care have changed substantially since 1965. Growth in jail and prison populations has far outpaced U.S. population growth. The U.S. jail population in 1960 was 119,671 and rose to 731,200 in 2013 (21, 22). Adjusted for U.S. population growth, this represents a 348% increase. Over the same time, the cost of health care more than tripled as a share of overall GDP (23).

Year	
1960	2013
U.S. Jail Population	
119,671	731,200

Modern day realities that could not have been anticipated in 1965 have created financial burdens that risk widespread substandard care and missed opportunities to effectively reduce the personal and social burden of schizophrenia.

3 Disrupting the Revolving Door: Recommended Solutions

Consider the Jail Part of the Community

In many communities, the jail is not considered part of the local treatment system. This must change. To improve outcomes for individuals with SMI, community mental health systems need to include jail inmates among their target populations. For individuals connected to treatment, including the jail as part of the community's treatment continuum can ensure continuity of effective care. For inmates who had disconnected from previous treatment, jail can offer the opportunity to reconnect with services. For individuals yet to engage in treatment, including those experiencing their first episode of psychosis, jails can be a resource for case finding and engagement in initial treatment.

Clinicians' attitudes toward justice-involved individuals are less positive than their attitudes toward those without justice involvement (24). This bias is likely based on a failure to appreciate that a significant portion of individuals with SMI are involved with the justice system at some point in their lives, often unbeknownst to the mental health system. Many of the charges pressed against individuals with SMI are for crimes rooted in poverty, homelessness, or hunger. More than 60% of jailed inmates are in preadjudication status, meaning that they have not and may never be convicted of a crime (25). For these reasons, clinicians and mental health care systems need to expect, accept, and address justice involvement among persons in their caseloads, just as clinicians and systems have come to understand that co-occurring substance use disorders are to be expected and addressed in settings serving individuals with SMI.

Many jails offer limited mental health services, usually provided by a contracted medical service. This arrangement is not inherently bad if that provider and the community mental health system understand the importance of working together and are willing to share clinical data and maintain treatment initiated in either setting. A better alternative may be for mental health services in the jail to be provided by the same care system that serves that community. In this way, continuity of care

would be seamless. Treatment would not be interrupted, and there would be fewer challenges with information sharing. Such continuity would facilitate engagement in services and ease the difficult transition from jail back to the community. Regardless of who provides the care, the standards for psychiatric care in the jail should be on par with those prevailing in the community or in local and state psychiatric hospitals. This includes access to medication.

Formularies in Jails Should Match Those of Hospitals and Clinics in the Community

Medication formularies in jails should match the formularies in the corresponding state hospitals, which in turn should match the Medicaid formulary. Continuity of medication from communities to institutions, whether they are hospitals or jails, would improve outcomes. It is remarkably shortsighted to destabilize people who have been successfully treated with LAIs or clozapine. It is imprudent to miss opportunities to start these effective treatments for individuals who are literally a "captive audience."

The Medicaid Inmate Exclusion Should Be Eliminated

We join the call to eliminate the Medicaid Inmate Exclusion (18). Although it may continue to make sense to exclude inmates of state prisons from the Medicaid program during extended incarcerations, it is counterproductive to maintain this exclusion for local jail inmates. The Medicaid Inmate Exclusion creates an unfunded mandate for local governments to treat jail inmates. It is also a poor policy because it leads to fragmented, suboptimal care. Continuity of care between community and jails is essential to initiating treatment for people with SMI and maintaining them in treatment, which is the best way to help them stay out of jail.

An obvious objection is that if jails could bill Medicaid, an incentive might be created to incarcerate people with mental illness (and other health conditions) and would take away motivations to divert people from the criminal justice system. It will require vigilance to ensure that this unintended consequence is not the outcome. If mental health and criminal justice personnel work as a unified team to ensure that individuals are getting the best treatment possible, there is no reason to assume that the system will be gamed. Our collaborative efforts to divert people with mental illness from the justice system must continue unabated (26).

4 Implementation Strategies

The Stepping Up Initiative, now adopted by 447 counties across the country, has gotten county sheriffs and mental health administrators talking, instead of fighting or finger pointing, and beginning to problem solve together (27). Working together is a critical first step. In Ohio, the Buckeye State Sheriffs' Association worked with the Ohio Department of Mental Health and Addiction Services (OMHAS) to address the rising cost of psychiatric medications in jails. Despite their restricted formularies, Ohio jails spend over $4 million dollars annually on psychiatric medication. In state fiscal year 2018, OMHAS provided $2 million to the county mental health boards to distribute to the county jails to help defray these costs. Some local county boards added to the state contribution by using local tax savings that resulted from Medicaid expansion.

Seemingly most unfair is excluding Medicaid coverage for persons in jail pretrial, who are still presumed innocent. It is encouraging that there is a bill before Congress, H.R. 165, "Restoring the Partnership for County Health Care Costs Act of 2017," that would remove limitations on Medicaid and other federal health benefits to pretrial inmates. Advocacy to eliminate the Medicaid Inmate Exclusion for pretrial inmates seems like a politically sensible first step.

5 Conclusions

Treatment of schizophrenia-spectrum disorders is a medical necessity that can burden jails. Financial limitations from the Medicaid Inmate Exclusion and discontinuity of care between jails and community agencies are two major impediments to adequate care. There is no insurmountable reason why community mental health and criminal justice systems cannot work together in advocacy to eliminate obstacles to ensuring the provision of high-quality care. Addressing these barriers will increase access to treatment for individuals with SMI and will reduce their recidivism. This will benefit both patients and the overall community.

There is no insurmountable reason why community mental health and criminal justice systems cannot work together in advocacy to eliminate obstacles to ensuring the provision of high-quality care.

References

1/ Steadman HJ, Osher FC, Robbins PC, et al.: *Prevalence of serious mental illness among jail inmates.* Psychiatr Serv 60:761–765, 2009. Available at https://bit.ly/2KsJO9X

2/ Rössler W, Salize HJ, van Os J, et al.: *Size of burden of schizophrenia and psychotic disorders.* Eur Neuropsychopharmacol 15:399–409, 2005. Available at https://bit.ly/2Ku9saW

3/ Cloutier M, Aigbogun MS, Guerin A, et al.: *The economic burden of schizophrenia in the United States in 2013.* J Clin Psychiatry 77:764–771, 2016. Available at https://bit.ly/2KvzcDL

4/ Pentillä M, Jääskeläinen E, Hirvonen N, et al.: *Duration of untreated psychosis as predictor of long-term outcome in schizophrenia: systematic review and meta-analysis.* Br J Psychiatry 205:88–94, 2014. Available at https://bit.ly/2MzGK9g

5/ Emsley R, Chiliza B, Asmal L, et al.: *The nature of relapse in schizophrenia.* BMC Psychiatry 13:50, 2013. Available at https://bit.ly/2KwzvkV

6/ United Nations General Assembly Resolution 46/119: *The Protection of Persons with Mental Illness and the Improvement of Mental Health Care* (A/RES/46/119), Dec 17, 1991. Available at https://bit.ly/2cRYiyo

7/ Estelle v. Gamble, 429 U.S. 97 (1976). Available at https://bit.ly/1HdtCAE

8/ Marcus SC, Zummo J, Pettit AR, et al.: *Antipsychotic adherence and rehospitalization in schizophrenia patients receiving oral versus long-acting injectable antipsychotics following hospital discharge.* J Manag Care Spec Pharm 21:754–768, 2015. Available at https://bit.ly/2KihFmx

9/ Alphs L, Benson C, Cheshire-Kinney K, et al.: *Real-world outcomes of paliperidone palmitate compared to daily oral antipsychotic therapy in schizophrenia: a randomized, open-label, review board-blinded 15-month study.* J Clin Psychiatry 76:554–561, 2015. Available at https://bit.ly/2IC1s67

10/ Modak A, Åhlin A: *The treatment of clozapine-withdrawal delirium with electroconvulsive therapy.* Case Rep Psychiatry Article ID 1783545, 2017. Available at https://bit.ly/2IDYTAf

11/ Kelly DL, Wehring HJ, Vyas G: *Current status of clozapine in the United States.* Shanghai Arch Psychiatry 24:110–113, 2012. Available at https://bit.ly/2KxjueF

12/ Lally J, Gaughran F, Timms P, et al.: *Treatment-resistant schizophrenia: current insights on the pharmacogenomics of antipsychotics.* Pharmgenomics Pers Med 9:117–129, 2016. Available at https://bit.ly/2N9ZWeM

13/ Kreyenbuhl J, Nossel IR, Dixon LB: *Disengagement from mental health treatment among individuals with schizophrenia and strategies for facilitating connections to care: a review of the literature.* Schizophr Bull 35:696–703, 2009. Available at https://bit.ly/2KwGw5q

14/ Rowan K, McAlpine D, Blewett L: *Access and cost barriers to mental health care by insurance status, 1999 to 2010.* Health Aff (Millwood) 32:1723–1730, 2013. Available at https://bit.ly/2NaR6h1

15/ Clement S, Schauman O, Graham T, et al.: *What is the impact of mental health-related stigma on help-seeking? A systematic review of quantitative and qualitative studies.* Psychol Med 45:11–27, 2015. Available at https://bit.ly/2Nbb0s1

16/ Ramsay Wan C, Broussard B, Haggard P, et al.: *Criminal justice settings as possible sites for early detection of psychotic disorders and reducing treatment delay.* Psychiatr Serv 65:758–764, 2014. Available at https://bit.ly/2KsKc8n

17/ Bronson J, Berzofsky M: *Special Report: Indicators of Mental Health Problems Reported by Prisoners and Jail Inmates, 2011–2012.* Washington, D.C., U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, 2017. Available at https://bit.ly/2rVBTcF

18/ Medicaid Coverage and County Jails: Understanding Challenges and Opportunities for Improving Health Outcomes for Justice-Involved Individuals. Washington, D.C., National Association of Counties, Feb 2017. Available at https://bit.ly/2Ne60TM

19/ Casendino A: *Convicts without care: how the privatization of healthcare in the U.S. prison system fails to protect inmates' health* [blog post]. Berkeley Political Review, Jan 28, 2017. Available at https://bit.ly/2sb4Cde

20/ Wilper AP, Woolhandler S, Boyd JW, et al.: *The health and health care of U.S. prisoners: results of a nationwide survey.* Am J Public Health 99:666–672, 2009. Available at https://bit.ly/2yRDAfe

21/ *Pharmaceuticals in State Prisons: How Departments of Corrections Purchase, Use, and Monitor Prescription Drugs.* Washington, D.C., Pew Charitable Trusts, Dec 2017. Available at https://bit.ly/2My0HgA

22/ Glaze LE, Kaeble D: *Correctional populations in the United States, 2013.* Washington, D.C., U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, Dec 2014. Available at https://bit.ly/2MzZaXy

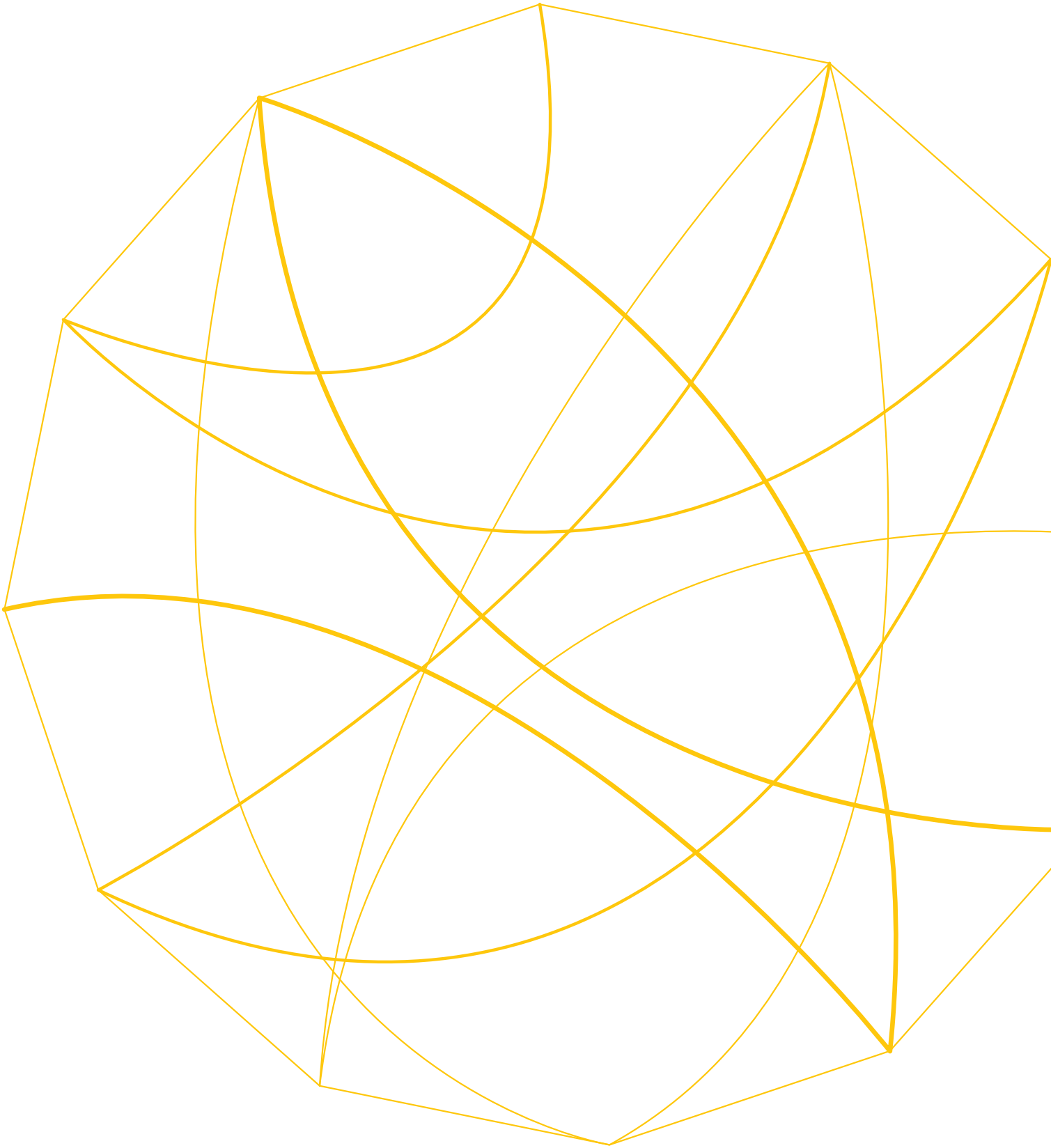
23/ Catlin AC, Cowan CA: *History of healthcare spending in the United States, 1960–2013.* Baltimore, Centers for Medicare and Medicaid Services, 2015. Available at https://go.cms.gov/2aCAqfi

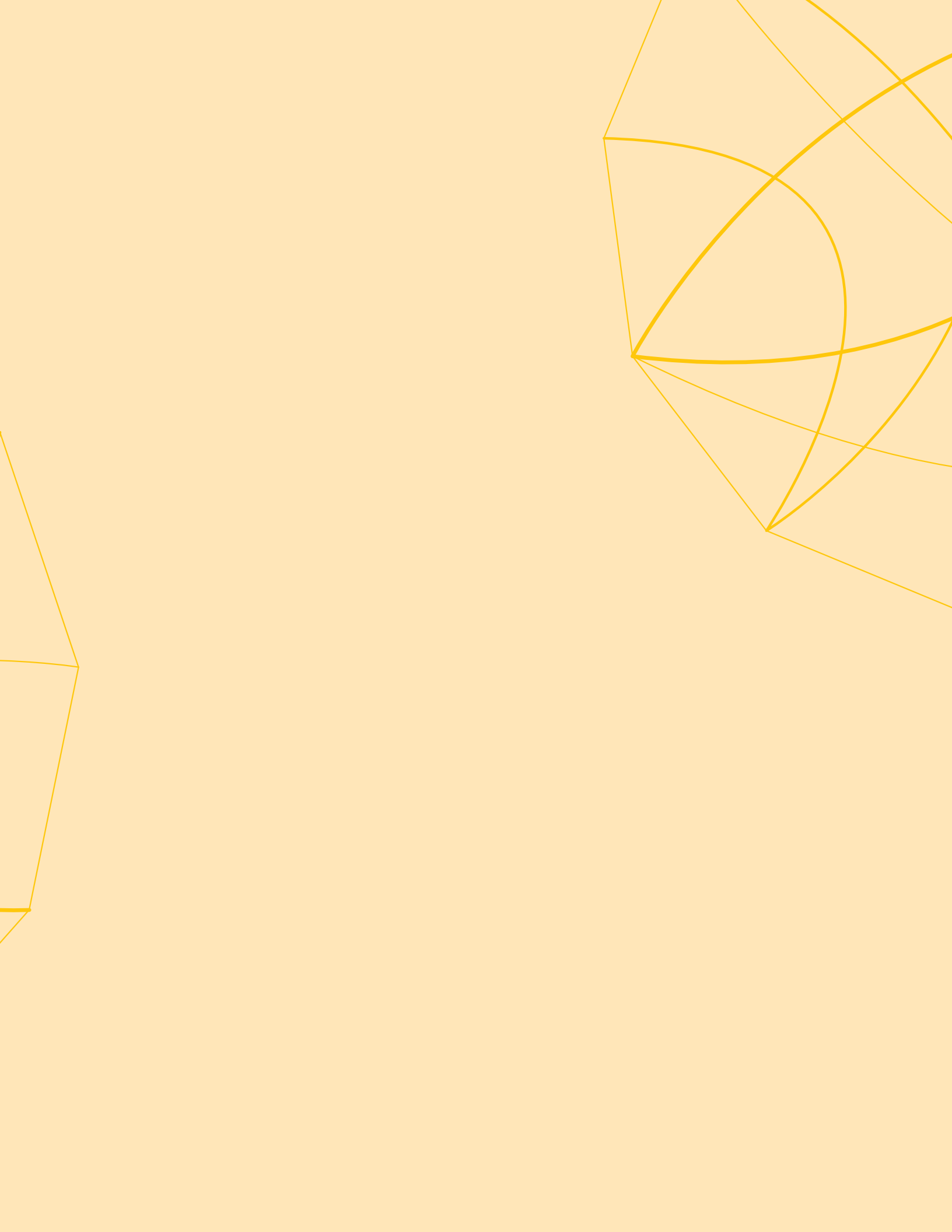
24/ Sachini N, Bandara MS, Daumit GL, et al.: *Mental health providers' attitudes about criminal justice involved clients with serious mental illness.* Psychiatr Serv 69:472–475, 2018. Available at https://bit.ly/2MxBIKo

25/ Minton TD, Zeng Z: *Jail Inmates in 2015.* Washington, D.C., U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, 2016. Available at https://bit.ly/2tGqufu

26/ Munetz MR, Bonfine N: *From boundary spanning to deep partnerships.* Psychiatr Serv 66:901, 2015. Available at https://bit.ly/2Ncc27t

27/ Stepping Up Initiative. New York, Council of State Governments, Justice Center, 2018. Available at https://bit.ly/2ICPFV0





How to use this paper to "Think Bigger" and "Do Good"

1 / **Send the paper to your local, state, and federal policy- and decision-makers**

2 / **Share the paper with mental health and substance use advocates and providers**

3 / **Endorse the paper on social media outlets**

4 / **Link to the paper on your organization's website or blog**

5 / **Use the paper in group or classroom presentations**

6 / **Reference the paper in your materials, and cite it as follows: "Bringing Treatment Parity to Jail Inmates with Schizophrenia." Scattergood Foundation, Philadelphia, PA (Summer 2018) www.thinkbiggerdogood.org**

SCATTERGOOD

THINK|DO|SUPPORT

The Scattergood Foundation believes major disruption is needed to build a stronger, more effective, compassionate, and inclusive health care system — one that improves well-being and quality of life as much as it treats illness and disease. At the Foundation, we THINK, DO, and SUPPORT in order to establish a new paradigm for behavioral health, which values the unique spark and basic dignity in every human.

www.scattergoodfoundation.org

Peg's FOUNDATION

Peg's Foundation believes in relevant and innovative, and at times disruptive ideas to improve access to care and treatment for the seriously mentally ill. We strive to promote the implementation of a stronger, more effective, compassionate, and inclusive health care system for all. Our Founder, Peg Morgan, guided us to "Think Bigger", and to understand recovery from mental illness is the expectation, and mental wellness is integral to a healthy life.

www.pegsfoundation.org