NATIONAL ASSOCIATION of COUNTIES NACo

BEHAVIORAL HEALTH CONDITIONS REACH CRISIS LEVELS:

Counties Urge Stronger Intergovernmental Partnerships and Outcomes

EXECUTIVE SUMMARY

Our nation's counties are facing an acute escalation of the mental and behavioral health crisis.

A recent NACo survey revealed that behavioral health conditions increased:

- **75 percent** of counties reported an increase in the last year.
- **89 percent** of counties reported an increase compared to five years ago.

COUNTY POLICY PRIORITIES:

Invest and align local crisis response systems.

Tulare County, Calif.: Clinicians are carrying 100+ caseloads, making it impossible to see individuals as often as needed.

Youth behavioral health needs are at the forefront of the crisis.

Two-thirds (67 percent) of survey respondents report that youth behavioral health conditions are **"definitely a problem"** or **"very prevalent and/or severe."**

Pierce County, Wash. reported increased violence among youth, including murders, suicides and substance use. A survey of 10th graders showed that 18 percent did not feel safe at school.

Limited access to services inhibits county residents from receiving the help they need.

In identifying the primary barriers to providing or expanding access to behavioral health services:

- **74 percent** of counties cited financial costs.
- **71 percent** cited lack of direct service providers.

COUNTY POLICY PRIORITIES:

Enforce mental health parity to ensure equal health care coverage of treatment for mental illness and addiction.

Roscommon County, Mich.: Current providers are overloaded, so it takes 2-3 months for a mental health care appointment, and there is a waitlist for beds.

The crisis is exacerbated by a lack of behavioral health workers throughout counties.

- Nearly **three-quarters (72 percent)** of survey respondents consider the shortage of behavioral health workers in their county to be **"definitely a problem"** or **"a severe problem."**
- **Eighty-nine (89) percent** of counties are designated as wholly within a mental health professional shortage area according to the Rural Health Information Hub.

COUNTY POLICY PRIORITIES:

Strengthen the mental health workforce.

Macon County, N.C. faces high burnout and turnover rates for behavioral health workers due to low pay, a high cost of living and high patient loads, so few workers stay in the field for very long.

While counties work to respond, the financial and human cost of behavioral health is compounding across all county systems.

- **80 percent** of counties indicated that they incurred associated costs in the legal system (courts and jails).
- **77 percent** of counties indicated associated costs in law enforcement.
- **54 percent** of counties indicated associated costs in the health system and hospitals.

COUNTY POLICY PRIORITIES:

Amend exclusionary policies under Medicaid for improved access to care for individuals living with mental illness and/or substance use disorder in the most appropriate setting.

Barry County, Mo. has no place other than the county jail to place residents in need of behavioral health services.

---

*Counties are integral to the local behavioral health system of care, investing **$163 billion** each year in community health, hospitals and social services, as well as **$107 billion** in justice and public safety systems. In at least 33 states, counties may provide traditional behavioral health services, but county leaders in every state are confronting the need to innovate when it comes to mental health, whether in county courts, jails, juvenile justice systems, hospitals, parks, libraries, housing and homelessness services or other service areas – from services for youth, to elderly and veterans.*

Despite the severity of the crisis and its strain on our resources, counties across the nation are:

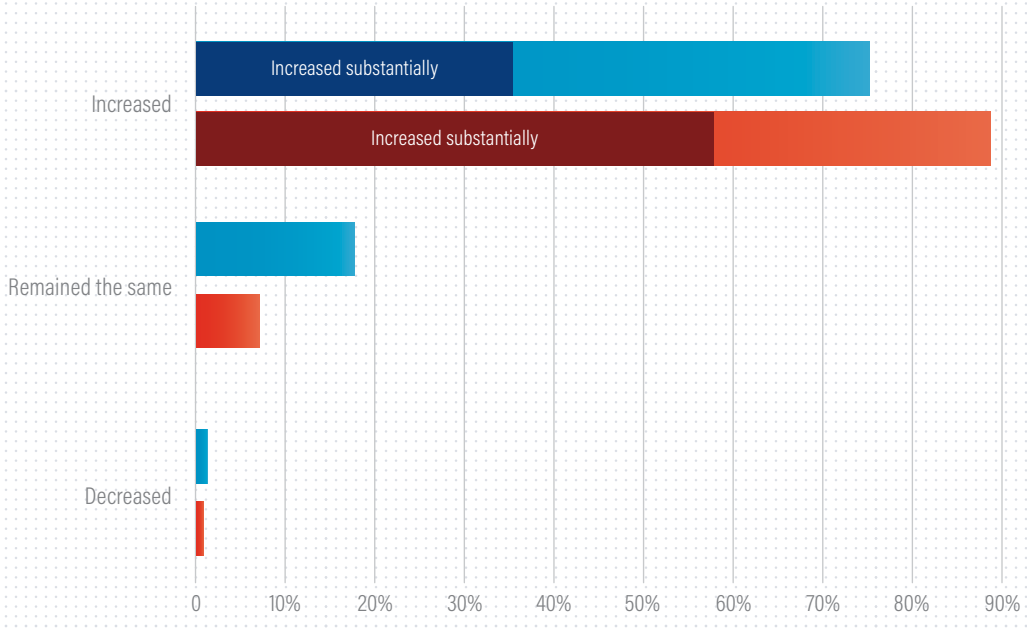
1. ***Expanding direct or indirect behavioral health service systems to care for our residents, and***
2. ***Advocating for federal and intergovernmental policies that support our goal of serving residents and addressing the mental and behavioral health crisis.***

Our Nation's Counties are Facing an Acute Escalation of the Mental and Behavioral Health Crisis

In a recent survey conducted by NACo, respondents reported that over the past year, 75 percent of respondents estimated that the incidence of behavioral health conditions in their counties increased over the past year – and about half of these counties (35 percent of all respondents) reported "substantial increases". Over the past five years, 89 percent of responding counties estimated increases in the incidence of behavioral health conditions, with the large majority of these counties (58 percent of all respondents) saying they "increased substantially."[1]

What this increase looks like on the ground differs for each county. In Arizona, rural **Cochise County** has difficulty attracting psychiatrists and other mental health professionals to the area, so this increase has put strain on an already overtaxed system and overwhelmed local hospitals, outpatient providers and law enforcement officers. **Curry County** (N.M.), **Hunterdon County** (N.J.) and **Stevens County** (Minn.) also emphasized the difficulty of increasing caseloads paired with a lack of resources and staffing. In **Johnson County** (Iowa) the challenge is with a lack of treatment and hospital beds for the most severely ill, despite increases in mental illnesses.

Behavioral Health Conditions Increased in 75 Percent of Responding Counties Over the Past Year and in 89 Percent of Responding Counties Over the Past Five Years



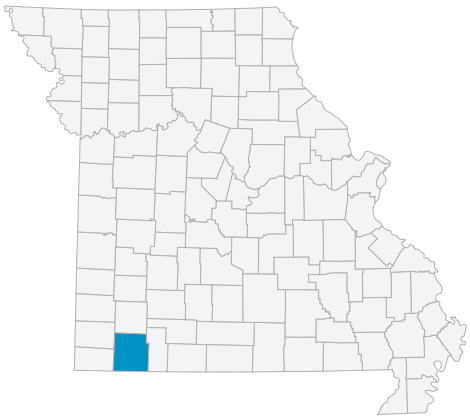
QUESTION:

In the past year / in the past five (5) years, has the incidence of behavioral health conditions in your county increased, decreased or remained the same? (n=220, 219)

PAST YEAR
PAST 5 YEARS

TULARE COUNTY, CALIF.:

Clinicians are carrying 100+ caseloads, making it impossible to see individuals as often as needed.



BARRY COUNTY (MO.):

Caseloads expanded tremendously since 2021, and the county expects caseloads to triple by 2026 due to the ongoing crisis.

In **Tulare County** (Calif.), clinicians are carrying 100+ caseloads, making it impossible to see individuals as often as needed, and the two managed care plans in the county have neither the capacity nor the infrastructure to take any clients with mild or moderate behavioral health issues. In **Barry County** (Mo.), caseloads expanded tremendously since 2021, and the county expects caseloads to triple by 2026 due to the ongoing crisis. Residential facilities in **Texas County** (Mo.) are at maximum capacity, and various substance use recovery meetings are growing, too.

Respondents often drew the connection between mental illness and substance use disorder. **Kidd County** (N.D.) has heard from residents that some are using drugs and alcohol in response to societal changes, like increased prices or workloads. **Matin County** (Ky.) struggles with a lack of facilities that can address dual issues of addiction and mental health. **Jefferson County** (Neb.) has seen behavioral health service needs increase due to alcohol and methamphetamine use, and the two providers in the county consistently experience a high volume of caseloads as well as extended wait times for assistance. For **Cavalier County** (N.D.), excessive alcohol use and mental health services have been top concerns over the past 10 years. The county had a Behavioral and Mental Health Task Force, but the challenges remain persistent: providers in the county report long waiting lists; schools report large increases in student mental and behavioral health needs; and the justice system reports few cases without a behavioral health component.

Behavioral health impacts all facets of county government's services and operations.

Along with substance use disorder, many respondents saw a strong connection between behavioral health and homelessness. In Whitfield County (Ga.), many of the county's homeless residents are suffering from either mental health or substance use challenges, and the caseloads for both types of issues have "definitely increased." Harlan County (Ky.) reported that the behavioral health crisis is causing an increase in the county's homeless population, causing a strain on the community food kitchen and shelter. St. Francois County (Mo.), too, has seen an increase of transient homelessness alongside an increase in crime. And for Clark County (Wash.), behavioral health conditions are becoming more visible as the county focuses on helping its growing number of homeless residents. The county reported finding a strong connection between homelessness, substance use disorder and behavioral health issues. Carroll County (Ga.), Montgomery County (Ill.), Macon County (N.C.) and Cass County (N.D.) all also included homelessness as a key aspect of the behavioral health crisis that they are trying to address in their respective communities.

County Policy Priority: Invest and align local crisis response systems

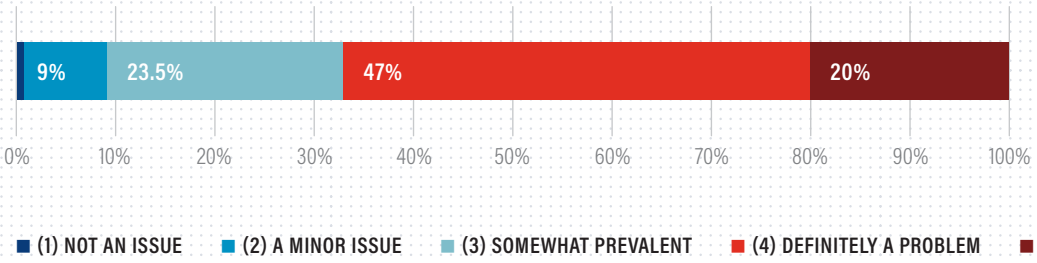
Counties are committed to enhancing the intergovernmental partnership for the development and modernization of local crisis response systems and infrastructure. We are working to develop and support new models of servicing individuals in crisis that are tailored to fit the unique needs of our communities which include the development of tiered and co-response models, integrative care, wraparound service and referral systems and 24/7 call centers that support the recently implemented 988 National Suicide Prevention Lifeline. The long-term success of these efforts is dependent on a strong intergovernmental partnership, where all levels of government are invested in aligning systems for better outcomes for individuals in crisis.

> **Fifty-eight (58) percent** of county respondents highlighted **"Fully Implement Services Across the Life Cycle"** as a federal policy priority that could provide the greatest opportunity for their county to serve residents.

See Appendix III for specific policy recommendations.

Youth Behavioral Health Needs are at the Forefront of the Crisis

Two-thirds (67 percent) of survey respondents report that youth behavioral health conditions are "definitely a problem" or "very prevalent and/or severe"



QUESTION:

To what extent are behavioral health conditions prevalent among the youth in your county? (n=157)

(1) NOT AN ISSUE
(2) A MINOR ISSUE
(3) SOMEWHAT PREVALENT
(4) DEFINITELY A PROBLEM
(5) VERY PREVALENT AND/OR SEVERE

For some counties, such as **Alexander County** (N.C.), **Forest County** (Wis.) and **Burlington County** (N.J.), the biggest needs are for the county's youth, who are experiencing increased mental health and substance use issues. For these younger residents, challenges with suicidal thoughts, depression and anxiety can lead to substance use, alongside prescription medications. Two-thirds (67 percent) of survey respondents consider youth behavioral health conditions to be "definitely a problem" or "very prevalent and/or severe." Another quarter (24 percent) of respondents see youth behavioral health conditions as "somewhat prevalent" – leaving less than 10 percent of respondents that consider youth behavioral health conditions as "a minor issue" or "not an issue." These responses illustrate that the behavioral health needs of young residents are a high priority for county leaders.

Hunterdon County (N.J.) has seen an increased number of suicides and hospitalizations among young people, but lacks inpatient pediatric beds for behavioral health as well as providers for younger

PIERCE COUNTY, WASH.:

has seen increased violence among youth, including murders, suicides and substance use. A survey of 10th graders showed that:

***18 percent** did not feel safe at school*

***13 percent** said they were bullied at school*

***13 percent** said they were bullied online*

***11 percent** said these feelings about being unsafe led them to miss school*

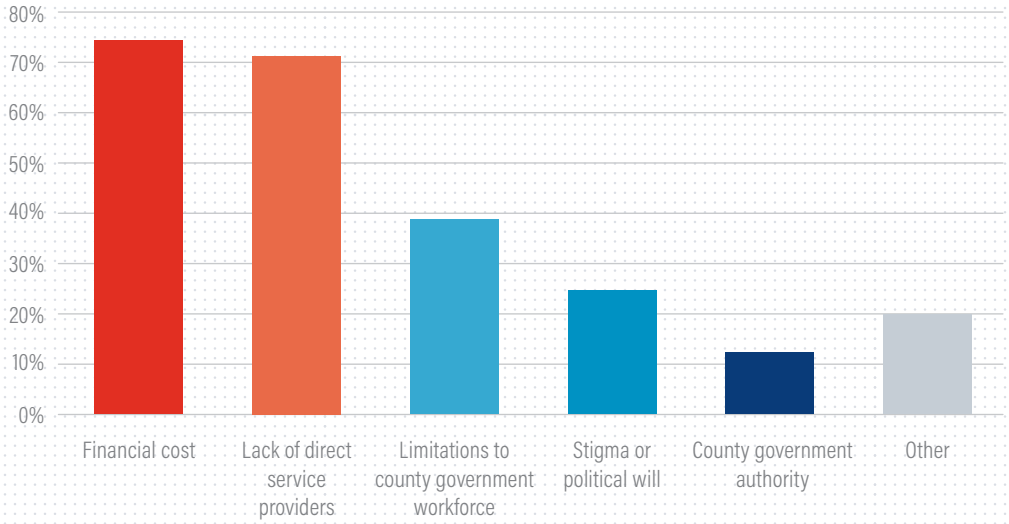
children under 12. In **Forest and Warren counties** (Pa.), more youth who are not familiar with county services have needed inpatient admissions, and some families still struggle even after taking advantage of all the services the county has to offer. **Snohomish County** (Wash.) has been facing violence among the adolescent population, adding pressure to county services. And **Elko County** (Nev.), too, reported an increase in both youth suicides and in juvenile detention.

Throughout the pandemic, **Tulare County** (Calif.) saw a 168 percent increase in the number of youth experiencing a behavioral health crisis. Thirty (30) percent of those who were hospitalized had never had mental health treatment previously. **Pierce County** (Wash.), has seen increased violence among youth, including murders, suicides and substance use. A survey of 10th graders in the county showed that 18 percent did not feel safe at school, 13 percent said they were bullied in school, 13 percent said they were bullied online and 11 percent said these feelings about being unsafe led them to miss school.

Numerous county respondents reported issues related to the COVID-19 pandemic and home life as impacting children's behavioral health outcomes, such as domestic violence, abuse at home, parental substance use and other parental behavioral health issues. **Macon County** (N.C.) especially saw this increase throughout the pandemic as children stayed in homes for extended periods of time with parents who had behavioral health issues. For **Palm Beach County** (Fla.), the entire home life is impacting youth, especially those growing up in poverty who may lack basic necessities. In response, **Jefferson County** (Neb.), implemented a program with a whole family approach, bringing family members together to provide supports that address trauma from substance use disorders or behavioral health issues.

Limited Access to Services is Inhibiting County Residents from Receiving the Help They Need

Financial Costs and a Lack of Direct Services Providers are the Top Barriers to Providing Behavioral Health Services, per nearly three-quarters of respondents

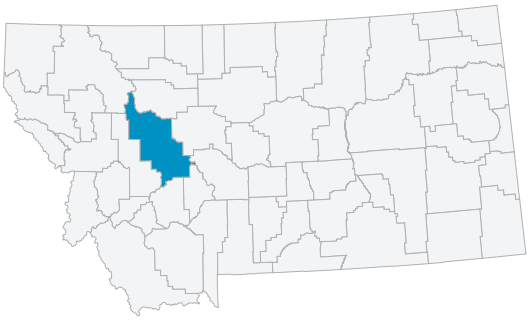


QUESTION:

What are the primary barriers to implementing new or improving current programs and services that address behavioral health conditions in your county? (n=194)

To help increase residents' access to behavioral health care, nearly two-thirds (61 percent) of responding counties indicated that their county provides behavioral health services to residents, most commonly through either a specific county department or agency (58 percent) and/or by contracting these services to an outside organization (53 percent). Most (60 percent) of these counties which provide behavioral health services have at least one full-time staff member dedicated exclusively to coordinating or directing the provision of these services to residents.

Counties provide a wide range of services, from mobile crisis units to children and adult mental health assessments and diversion services. Yet, numerous challenges inhibit or delay service delivery. Nearly three-quarters of county respondents identified financial costs (74 percent) and a lack of direct service providers (71 percent) as the top barriers



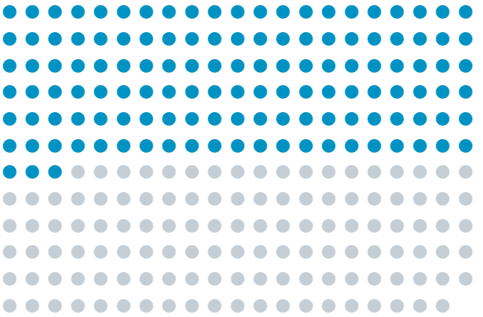
LEWIS AND CLARK COUNTY, MONT.:

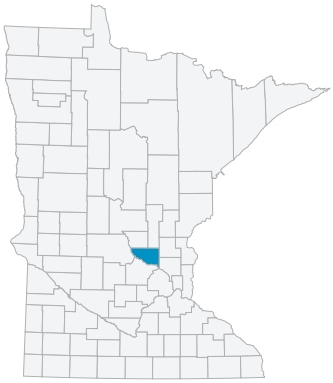
initiated mobile crisis response teams and helped fund a local center that connects residents to behavioral health services.

to implementing new or improving current programs and services that address behavioral health conditions. Over one third (39 percent) of respondents cited limitations to the county government workforce and one quarter (25 percent) included stigma or political will as primary barriers. And a few respondents (12 percent) even mentioned that county government authority as enumerated under state law is a primary barrier.

Collaboration is a key focus for counties seeking to overcome the challenges. **Cochise County** (Ariz.) is working to improve coordination of care and better use existing resources across existing entities, as well as on better data analytics for these services. **Miami-Dade County** (Fla.) has focused on bringing the behavioral health community together, including providers, advocates and community-based organizations. **Sherburne County** (Minn.) created a mental health action team comprised of representatives from health and human services, community corrections, law enforcement, mental health providers and the local jail. **Montgomery County** (Ohio) also created a mental health task force to coordinate the full continuum of care, facilitate communication between providers and share data across entities. And in **New Mexico**, six counties and three cities are partnering on a regional behavioral health facility.

51 PERCENT (129 COUNTIES) of the 254 largest counties have already budgeted over **$1.1 BILLION** of ARPA dollars to invest in mental health, substance abuse and addiction.[2]





SHERBURNE COUNTY, MINN:

created a mental health action team comprised of representatives from health and human services, community corrections, law enforcement, mental health providers and the local jail.

Forsyth County (N.C.) is collaborating across various systems to improve service delivery to residents. Within one county-owned building there is an open access outpatient provider a 24/7 behavioral health urgent care center and a primary care facility operated by two major hospital systems. These providers all meet regularly with the county and emergency management staff to discuss challenges and plan out the county's response.

Funding from the American Rescue Plan Act's (ARPA) State and Local Fiscal Recovery Fund has also proved beneficial for many counties facing an unprecedented need. Of the 254 largest counties, 51 percent (129 counties) already budgeted over $1.1 billion to invest in mental health, substance abuse and addiction.[2] **Clayton County** (Ga), for example, supplemented its behavioral health funding with ARPA dollars. **Dakota County** (Minn.) also found ARPA dollars critical in responding to the increased need.

Counties are also tapping into opioid settlement funds. **Shoshone County** (Idaho) is working with its regional health district to use opioid settlement funds for education and outreach. **Barnstable County** (Mass.) is using both ARPA and opioid settlement funds to improve its behavioral health services in response to multiple assessments the county conducted to ascertain the need.

Many counties are working to expand their services and facilities in response to an increased need among residents. **Kent County** (Mich.) is working on a new crisis center, while **Dickinson County** (Kan.) is developing a drug court. **Lewis and Clark County** (Mont.) initiated mobile crisis response teams and helped fund a local center that connects residents to behavioral health services. In **Arizona**, counties are working to change a state law that impedes the ability of rural counties to provide behavioral health services, though they have faced significant resistance.

Some responding counties have programs aimed at reducing the stigma of behavioral health issues. **Bremer County** (Idaho) implemented a program of weekly messages aimed to break the stigma of mental health issues among county employees. And **Dakota County** (Minn.) is working with local advocacy organizations to reduce the stigma and advocate for various policy changes.

County Policy Priority: Enforce mental health parity

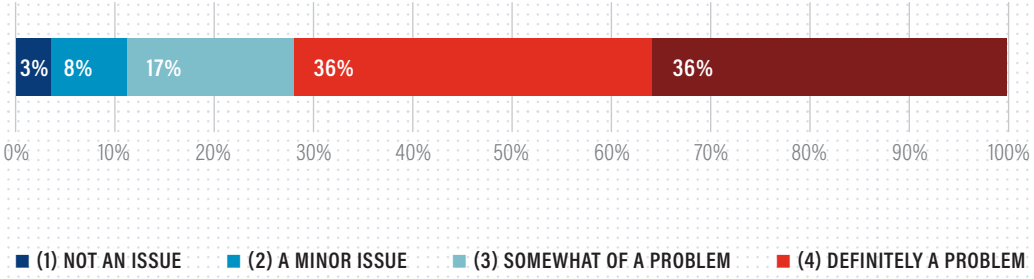
Counties demand that the federal government enforce policies that ensure equal coverage of treatment for mental illness and addiction. The Mental Health Parity and Addiction Equity Act (P.L. 110-343) is a federal parity law that was enacted in 2008, and required comprehensive standards for equitable coverage of mental health and substance use disorder treatment and coverage of physical treatment. Strengthening behavioral health parity protections and enforcing existing protections is a critical component of improving coordination and integration of primary care and behavioral health care in the health care delivery system, and better addressing the behavioral and mental health needs of our community more broadly.

> Nearly **two-thirds (63 percent)** of county respondents highlighted **"Fully Implement and Expand Mental Health Parity"** as a federal policy priority that could provide the greatest opportunity for their county to serve residents.

See Appendix III for specific policy recommendations.

The Crisis is Exacerbated by a Lack of Behavioral Health Workers Throughout Counties

Nearly Three-Quarters (72 Percent) of Survey Respondents Consider the Shortage of Behavioral Health Workers in Their County To Be "Definitely a Problem" or "a Severe Problem"



QUESTION:

To what extent is a shortage of behavioral health workers a problem for your county? (n=161)

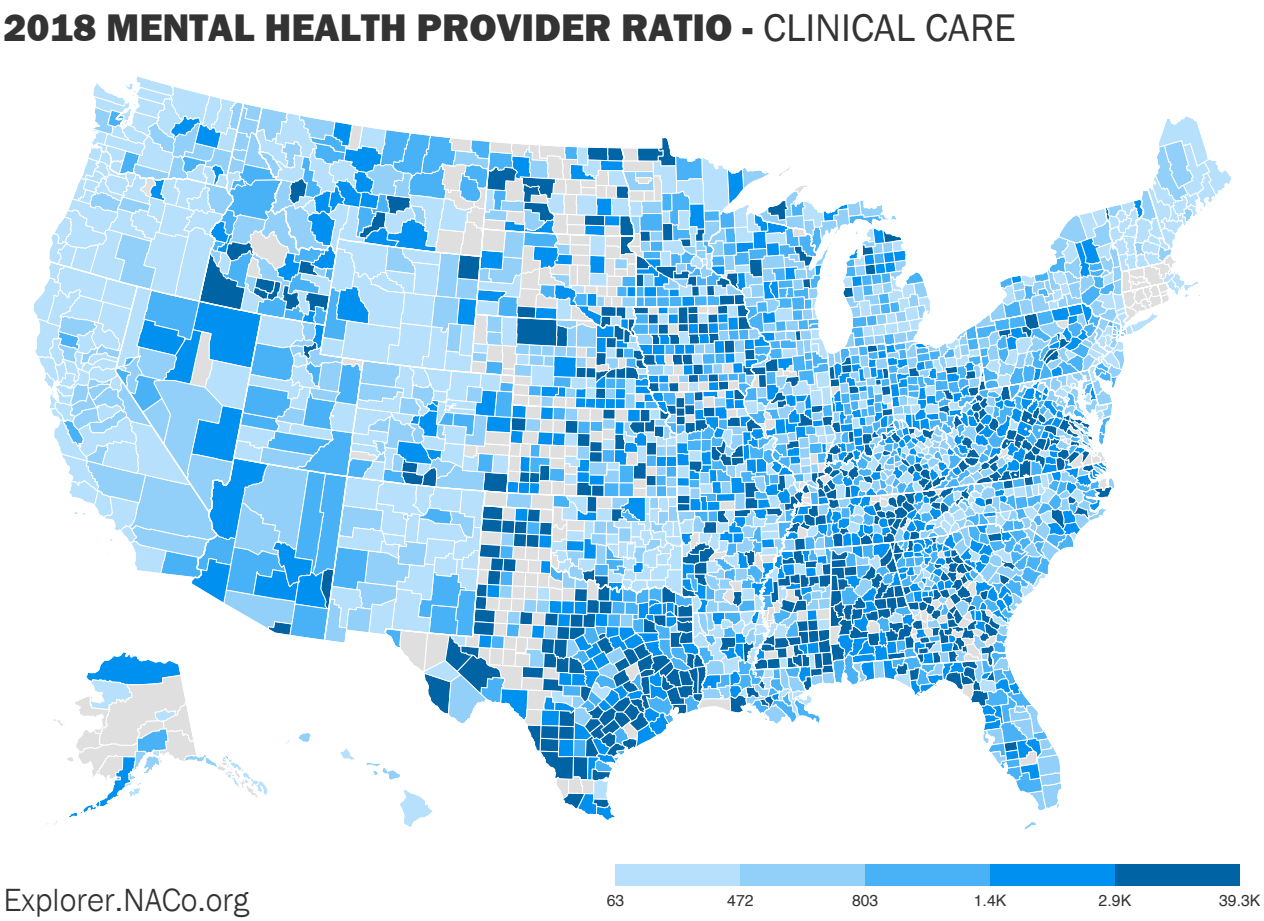
Nearly three-quarters (72 percent) of survey respondents consider the shortage of behavioral health workers in their county to be "definitely a problem" or "a severe problem". Another 17 percent consider this issue to be "somewhat of a problem." Thus, only 11 percent of respondents are not too concerned about the behavioral health workforce, considering it "a minor issue" or "not an issue." **McLean County** (Ill.), with a population of 171,000, has over 100 open positions for behavioral health workers. And **Lee County** (Iowa) has written multiple RFPs for service without receiving applications. **Marathon County** (Wis.) is part of a multi-county behavioral health entity with crisis, inpatient and outpatient services, but consistent vacancies have impacted their ability to deliver services.

MCLEAN COUNTY, ILL.:

with a population of 171,000, has over 100 open positions for behavioral health workers.

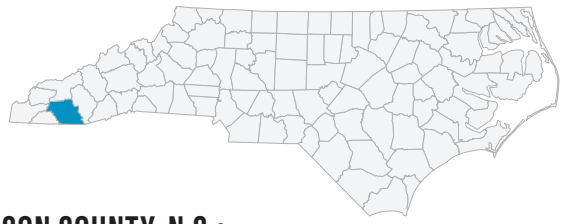
The survey results confirm what national data also reveals: throughout the nation, there is a severe shortage of mental health workers. In over 1,150 counties across the U.S., there is only one provider of mental health for every 1,000 residents. Over half of these counties (597 counties) have only one mental health provider for every 2,000 residents.[3] At the national level, only 28 percent of the need for mental health care is met: 7,871 psychiatrists are needed to close the gap.[4] All in all, 89 percent of counties (2,734 counties) are designated as being wholly within a mental health professional shortage area, representing approximately half (48 percent) of all county residents in the U.S.[5]

Half of the U.S. Population Lives in a County Designated as a Mental Health Professional Shortage Area.



Source: *University of Wisconsin Population Health Institute analysis of CMS, National Provider Identification file 2017 data.*

When there are not enough behavioral health workers to meet the needs of residents, county government workers often pick up the slack, including law enforcement, court and other public safety workers and human services employees. Yet, recruiting and retaining employees is a key challenge for the behavioral health sector. In **Missoula County** (Mont.), all of the behavioral health providers are now hiring workers, to the point that many providers are looking to hire remote workers. The county jail also has difficulty filling behavioral health positions – further challenged by the low pay of the positions and the high cost of housing in the area. **Macon County** (N.C.) faces similar problems of low pay for behavioral health workers and a high cost of living. When high patient



MACON COUNTY, N.C.:

faces high burnout and turnover rates for behavioral health workers due to low pay, a high cost of living and high patient loads, so few workers stay in the field for very long.

loads are added, burnout and turnover rates are high, too, so few workers stay in the field for very long. Moreover, the pipeline of workers for the county is slowing down, as nearby higher education institutions pare down their behavioral health programs. **Ste. Genevieve County** (Mo.) has a Community Counseling Center with retention challenges. And **Pierce County** (Wash.) has funding available for behavioral health programs and services, but cannot find case managers, social workers, nurses and therapists.

Tulare County (Calif.) summarized the challenge of recruiting and retaining behavioral health workers: "Working in behavioral health, especially with the severely mentally ill, is a very difficult job. The behaviors that clinicians are trying to treat can be very difficult. With high caseloads, documentation requirements and many options to work in other areas in the field, it is hard to keep clinicians long term. Many come in as interns and once they receive their supervision hours and pass the licensing exam, move into private practice or into another area of clinical practice."

For some counties, like **Putnam and Marshall counties** (Ill.) the difficulty is in providing services to low-income residents, especially those with little or no health insurance. In **Broomfield City and County** (Colo.), there are enough private therapists, but many people have high-deductible insurance and so avoid using them. **Bradford County** (Pa.) sees the primary cause for the behavioral health worker shortage as systemic, related to stringent requirements for insurance payments that cause delays in providing services, coupled with regulations that make it difficult for behavioral health providers to serve residents.

ROSCOMMON COUNTY, MICH.:

Current providers are overloaded, so it takes 2-3 months for a mental health care appointment, there is a waitlist for beds and a quarter of those in jail are waiting for medication.

The shortage of behavioral health workers that counties are facing drastically impacts service availability for residents. In many rural counties, residents must drive long distances to find any behavioral health services (e.g., **Henry County**, Ind.). Residents of rural **Rooks County** (Kan.) have access to only one mental health clinic, which is 40 miles away. For those living in **Randolph County** (Ala.), the only option they have is to look for care outside of the county, and even outside of the state.

Other counties are facing the challenge of long wait times due to a lack of behavioral health workers. The mental health facility in **Jasper County** (Iowa) has a long waiting list due to the shortage of workers. The county could use five more providers, but low wages and a high burnout rate make recruitment difficult. **Roscommon County** (Mich.) has a similar challenge, where current providers are overloaded, so it takes 2-3 months for a mental health care appointment, there is a waitlist for beds and a quarter of those in jail are waiting for medication. **Atchinson County** (Mo.), too, has issues with long wait times for behavioral health services, or simply that no provider is available to help at times.

County Policy Priority: Strengthen the mental health workforce

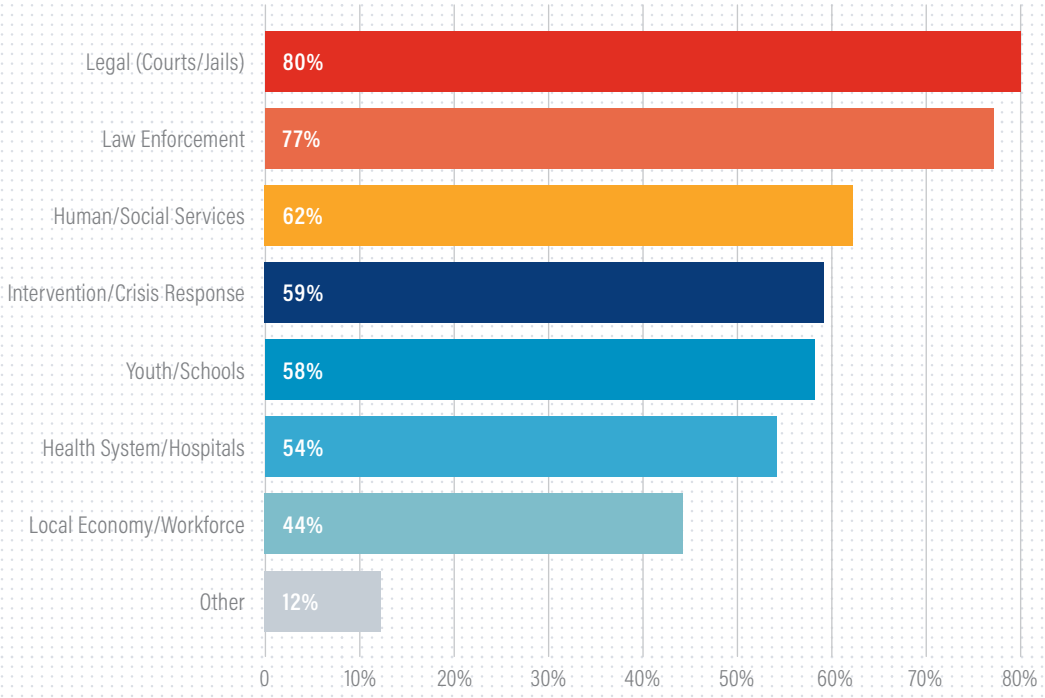
Counties need direct and flexible resources and incentives to support the recruitment, training and retention of a sufficient behavioral health workforce. We rely on our federal partners to supplement investments made in the mental health workforce through the enhancement of existing programs that promote workforce recruitment and retention. New financial incentives for integrated care may result in an increase of individuals pursuing jobs in the behavioral health care field and increase access to these critical services.

> **Sixty-one (61) percent** of county respondents highlighted **"Develop and Expand the Workforce"** as a top federal policy priority that could provide the greatest opportunity for their county to serve residents.

See Appendix III for specific policy recommendations.

While Counties Work to Respond, the Financial and Human Cost of Behavioral Health is Compounding Across All County Systems

Eighty (80) Percent of Responding Counties Indicated That They Incurred Associated Costs in the Legal System (Courts And Jails) and 77 Percent in Law Enforcement



QUESTION:

In which areas does your county incur indirect costs associated with behavioral health conditions? (n=198)

When faced with the growing need for services and a lack of workers, county respondents discussed the need to utilize other service systems for residents with behavioral health needs, including public health and hospital systems as well as, unfortunately, local courts and jails. **Barry County,** (Mo.) for example, lamented that their low-resourced local government has no place other than the county jail to place residents in need of behavioral health services. Counties are incurring a plethora of associated costs in various service areas to respond to residents' behavioral health needs, whether or not we provide traditional behavioral health services. "Associated costs" refer to costs to provide government services to residents with behavioral health conditions that fall outside of the scope of direct, traditional behavioral health services – from, e.g., increased jail costs due to the incarceration of individuals with behavioral health conditions to increased hospital costs due to physical illnesses connected to behavioral health.

The justice and public safety system is the most common county function that absorbs the indirect costs of an inadequate behavioral health service system. Eighty (80) percent of responding counties indicated that they incur various associated costs associated with behavioral health conditions in the

legal system (courts and jails). Another 77 percent of county respondents saw their law enforcement departments incurring associated costs. In **Harlan County** (Ky.), behavioral health issues have overloaded the court system, thus also tying up the sheriff's department with transporting individuals and participating in court proceedings. **Montgomery County** (Ohio) estimates that behavioral health issues comprise 20 percent of all jail, court and social services operations.

In **Clayton County** (Ga.), where the nearest facility in the neighboring county is often overbooked, there is too heavy a burden being placed on local hospital and law enforcement services, since individuals experiencing a mental health crisis are brought to the emergency room or the jail. In **Cass County** (N.D.), the hospital is too full to treat many individuals with severe mental illnesses, so they end up sitting untreated in the jail or interacting often with law enforcement. **Burt County** (Neb.) and **Dallas County** (Texas), though very different in terms of population size and location, both have residents with behavioral health issues – especially those with severe conditions – waiting in jails for beds to open at behavioral health facilities, thus overcrowding the jails and incurring a substantial financial burden on the counties while also lacking proper treatment.

Another **54 PERCENT** of responding counties **INCURRED ASSOCIATED COSTS** in the health system and hospitals.

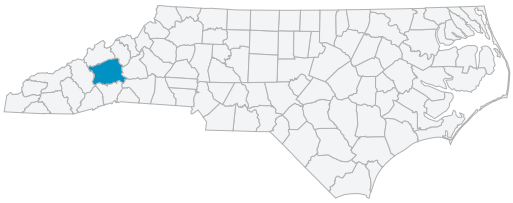
BARRY COUNTY, MO.:

has no place other than the county jail to place residents in need of behavioral health services.

For **Cochise County** (Ariz.), one concern is that many justice, public safety and education workers are not formally trained to address behavioral health challenges. **Lee County** (Fla.) emphasized its need for a short-term crisis center and a better co-response model for emergencies, since law enforcement workers are answering behavioral health calls when they are needed for safety calls, and some individuals end up in jail simply because they are unable to take their medication. And **Pierce County** (Wash.) has seen an increase in its jail population of individuals requiring intense mental health support and medication. Because of the county's lack of funding and workforce, however, lives have been lost on all sides and ultimately, the community is frustrated by the broken system.

Although respondents most often identified associated costs in the justice and public safety space, over half of responding counties indicated that they incur associated costs in intervention and crisis response (59 percent); youth and schools (58 percent); health systems and hospitals (54 percent); and human and social services (62 percent). Nearly half (44 percent) of responding counties also reported incurring associated costs in their local economies or workforces.

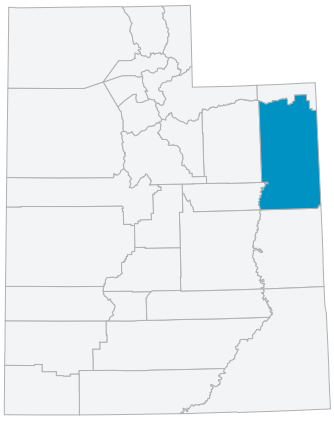
Shoshone County (Idaho) sees behavioral health challenges impacting its local economy and workforce. Being a resource-rich county, many jobs that drive the economy are dangerous, so hiring a worker with mental or substance use issues is a risk that companies simply cannot afford to take. And residents that do find a job may struggle to be reliable, whether because of inconsistent transportation, episodes of severe depression and anxiety, intoxication or time in jail. **Buncombe County** (N.C.) is struggling with the cost of providing childcare services for over 300 children in custody due to mental health issues. The county has also seen the number of protective services calls for adults increase dramatically over the past five years, with many asking for guardianship.



BUNCOMB COUNTY, N.C.:

is struggling with the cost of providing childcare services for over 300 children in custody due to mental health issues and with a dramatic increase in the number of protective services calls for adults, with many asking for guardianship.

Uintah County (Utah) summarized the various associated costs of the behavioral health crisis and how the crisis impacts all facets of their government's services and operations. First, law enforcement officers are spending over one third of their calls for service on mental health issues. Second, mental health employees are responding to the hospitals, correctional institutions and in-office services daily, without enough certified or trained employees and without enough beds for those who need more intensive care. It currently takes over 3-4 hours to process a request and up to 10 days to find an in-house placement bed. Third, there is a lack of trained clinicians to work in the schools as well as provide coverage in the community with an outreach program. Fourth and finally, Uintah County reported that their local economy and workforce simply needs employees, but a subset of the workforce is relying on public assistance programs and pooling resources rather than trying to gain employment.



UINTAH COUNTY, UTAH:

Law enforcement officers are spending over one third of their calls for service on mental health issues.

County Policy Priority: Amend exclusionary policies under Medicaid

Counties see a strong need to amend the Medicaid Inmate Exclusion Policy (MIEP) for improved care continuity of individuals living with mental illness and/or substance use disorder. Amending the MIEP to allow individuals who are detained pre-trial to retain access to Medicaid and other federal health benefits can better help break the cycle of recidivism exacerbated by untreated physical and mental illnesses and substance use disorders.

> **Over half (56 percent)** of county respondents highlighted **"Enhance Medicaid Flexibility"** as a top federal policy priority that could provide the greatest opportunity for their county to serve residents.

Counties also see a need to modernize the Institutions for Mental Diseases (IMD) exclusion to reduce barriers to the provision of comprehensive behavioral health treatment and increase access to short-term residential treatment when clinically appropriate. The federal Medicaid statute prohibits federal reimbursement for care provided in psychiatric or other residential treatment facilities with more than 16 beds, defined as Institutions for Mental Diseases (IMDs). Modernizing the Medicaid IMD exclusion would greatly expand the treatment capacity of county-operated hospitals and behavioral health facilities while also promoting equitable access to treatment options for our most vulnerable residents.

> **Nearly half (49 percent)** of county respondents highlighted **"Ease Medicaid's Institutes of Mental Disease (IMD) Exclusion"** as a top federal policy priority that could provide the greatest opportunity for their county to serve residents.

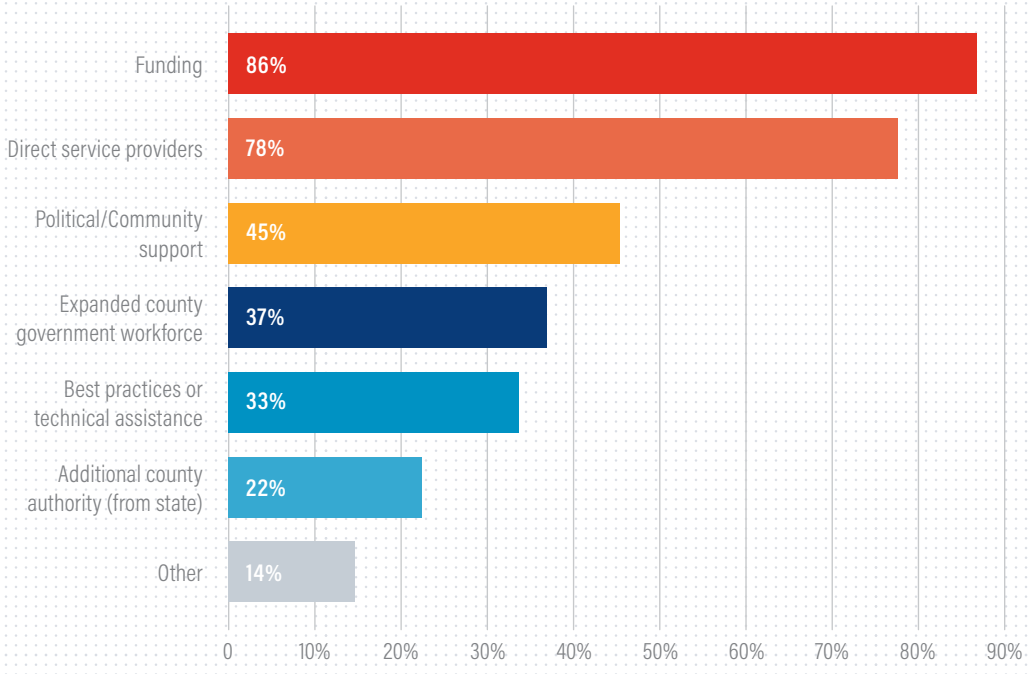
See Appendix III for specific policy recommendation

Counties Persevere in Expanding Behavioral Health Services Despite Severity of Crisis And Strain on Resources

> *Looking ahead, counties need **funding** and **direct service providers** to adequately respond to the behavioral health crisis in collaboration with the federal government.*

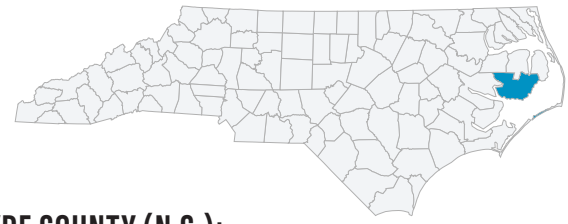
As counties evaluate the growing need and their current behavioral health systems, the need for more resources is apparent in counties of all sizes and demographics. About four-fifths of county respondents indicated their need for additional funding (86 percent) and more direct service providers (78 percent) to adequately respond to the crisis. Nearly half (45 percent) of respondents also mentioned their county's need for more political or community support. And one third of responding counties indicated their need for an expanded government workforce (37 percent) and for technical assistance or best practices (33 percent). Over one fifth (22 percent) of respondents also mentioned the need for additional county authority from the state.

Four-Fifths of County Respondents Indicated Their Need for Additional Funding and/or More Direct Service Providers to Adequately Respond to the Crisis.



QUESTION:

What resources does your county need to adequately respond to current and future behavioral health challenges? (n=188)



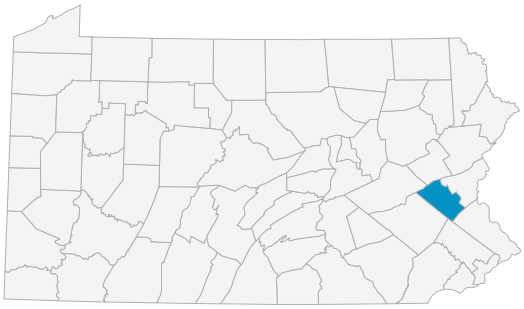
HYDE COUNTY (N.C.):

"We are a very rural, poor county of less than 5,000 people. ***We are limited in funding and staff to provide all the services that we truly need.*** *Everyone seems to be doing multiple jobs just to keep us afloat..."*

Moving forward, many county respondents are planning to expand their behavioral health services in a variety of ways. Numerous counties would like to focus on mobile crisis teams or crisis centers (e.g., Alameda County, Calif.; Clayton County, Ga.; Lee County, Iowa; Yates, N.Y.; Kidder County, N.D.; Waukesha County, Wis.). **Uintah County** (Utah) would like to add a treatment program with licensed, experienced clinicians, but needs both funding and political support from the community. **Missoula County** (Mont.) is currently building a crisis receiving center and looking for additional funding for their Mobile Support Team. **Tulare County** (Calif.) is preparing to implement a Care Court to serve residents with a severe mental illness at risk of homelessness. The county is also developing a team to serve individuals coming out of or being diverted from the criminal justice system.

Other counties, too, are looking for solutions to divert individuals who need behavioral health care from the justice system. **Rockdale County** (Ga.) is working on a diversion center and increasing supports for those entering recovery or returning to the community from hospitalization or incarceration. **El Paso County** (Texas) is hoping to add services to prevent recidivism, more mental health court services and more resources for juveniles. And **Lehigh County** (Pa.) is working on a sequential intercept model to prevent incarceration, to provide creative housing options and supportive employment as well as to support residents with peers and community treatment options when higher levels of service are unavailable.

Coordination of care is on the minds of many county respondents. **Cochise County** (Ariz.) is hoping to develop an assessment hub that can serve as a single point of entry and help residents navigate finding the right provider. **Jefferson County** (Neb.) would like to develop a community resource center with certified peer support specialists that could help residents navigate the range of government services – from behavioral health and treatment facilities to housing, food insecurity, child care and other needs. **Douglas County** (Ga.) is expanding its co-responder and diversion programs, focusing especially on supporting youth who are suffering from severe



LEHIGH COUNTY, PA.:

is working on a sequential intercept model to prevent incarceration; to provide creative housing options and supportive employment; and to support residents with peers and community treatment options.

emotional disturbances. **Snohomish County** (Wash.) is also increasing its co-response partnerships with law enforcement. **Dakota County** (Minn.) is identifying funding that can supplant ARPA dollars currently being used to expand its mental health crisis continuum, as well as strengthening the partnership between the offices of social services, community corrections, courts and the jail and sheriff. Nearby **Sherburne County** (Minn.) is working collaboratively with its mental health action team and criminal justice partners to address behavioral health concerns in a cost-efficient and evidence-based manner. And **Forsyth County** (N.C.) is developing an expanded one stop location for individuals with behavioral health issues, and the county has the goal of expanding its full continuum of services so that children do not need to be placed out of state.

WORCESTER COUNTY, MD.:

is gradually funding and adding mental health professionals to their schools, with the goal of having trained, certified mental health staff in every school.

To involve the whole family early on, **Sweet Grass County** (Mont.) has parenting classes starting with kindergartens, as well as in-person behavioral health providers in the schools. **Duchesne County** (Utah) also mentioned strengthening the family as a key priority for the county in addressing behavioral health needs. And in Maryland, where county governments are heavily involved in public education, **Worcester County** is gradually funding and adding mental health professionals to their schools, with the goal of having trained, certified mental health staff in every school.

Additional funding and support from the community are essential to all of these initiatives. Thus, some county respondents mentioned a focus on reducing stigma through various educational campaigns, such as **Lee County** (Iowa), **Buncombe and Pasquotank counties** (N.C.) and **Cavalier County** (N.D.). **Broomfield City and County** (Colo.) included "Reducing Stigma" as one of the three goals within its Behavioral Health Improvement Plan, alongside "Increasing Access to Care" and "Increasing Connectedness in the Community." **Oldham County** (Ky.) is engaging residents directly by teaching a Mental Health First Aid course with public transportation travel vouchers to attend classes, meetings or therapy. Finally, **Morrow County** (Ohio) is hoping to look outside traditional government partners toward those who are more connected with residents personally, such as church leaders, nonprofits or other non-governmental programs or entities.

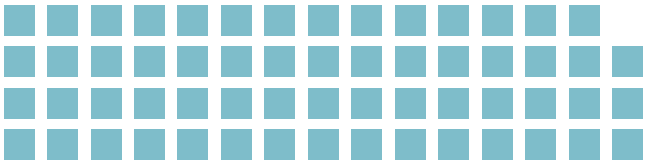
With support from residents, as well as a concerted, coordinated, intergovernmental effort, county leaders can make an impact in the behavioral health crisis and provide critical services to residents in need.

Appendix I: America's County Officials Care About Behavioral and Mental Health

Each year, counties invest $163 BILLION in community health, hospitals and human services, including:

MORE THAN $41 BILLION

for the provision of community and public health services (other than hospital care), including mental health and substance abuse programs



- Counties plan and operate community-based services for persons with mental illnesses and substance use conditions through **750 behavioral health authorities** and community providers.[8]
- Counties support more than **900 hospitals** that provide inpatient medical care and specialized care.[9]

MORE THAN $59 BILLION

in operating county-owned hospital facilities, including those operated by public universities and for the provision of inpatient medical and specialized care

Each year, counties invest* $107 BILLION *in justice and public safety systems, including:

MORE THAN $29 BILLION *to operate correctional facilities, including **91 percent** of local jails.*[6]

- In far too many instances, county **jails and other public safety services are used as the frontline treatment providers** for our most vulnerable residents living with mental illnesses and substance use disorders.
- **64 percent** of incarcerated people have a mental illness[10], and more than **1 in 9 adults** with a co-occurring mental illness and substance use disorder are arrested annually[11], making county jails one of the largest providers of behavioral and mental health services.

MORE THAN $21 BILLION

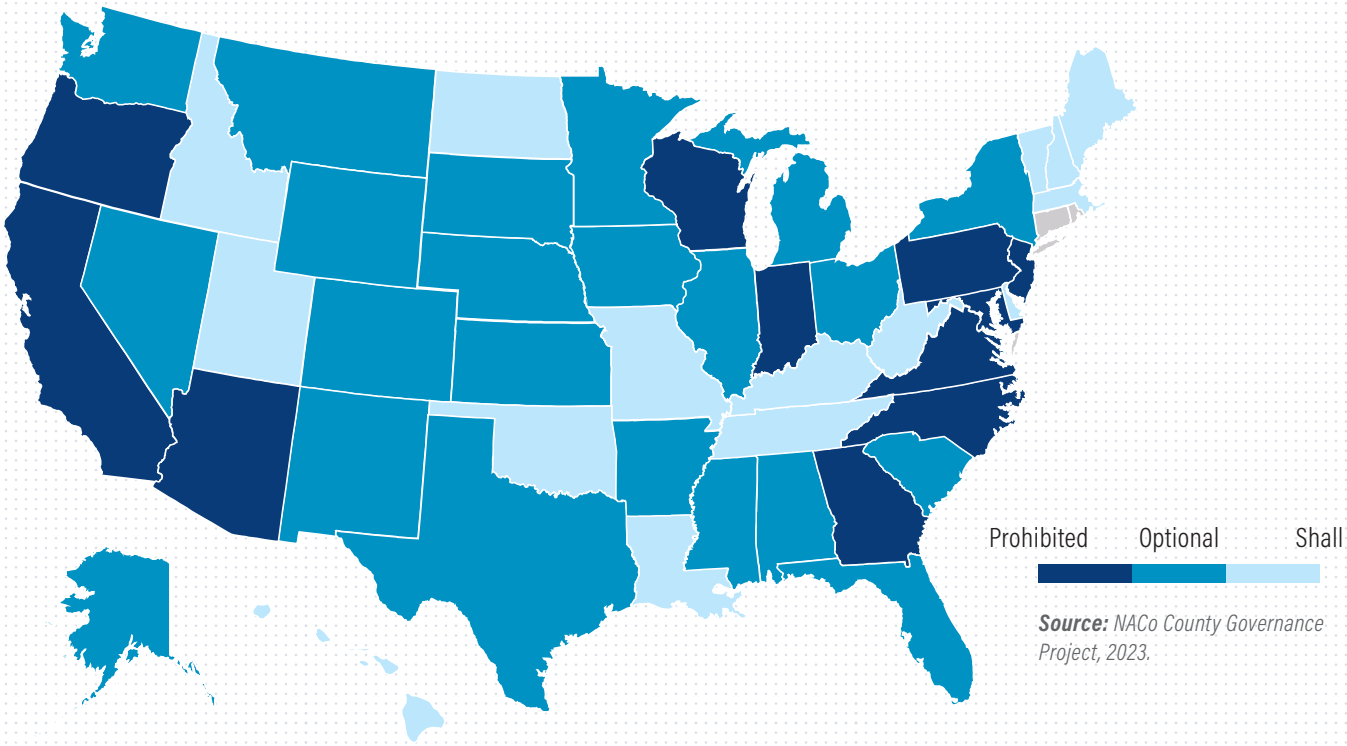
*in county courts and legal services, which process **8 million** individuals each year.*[7]

Source: *NACo Analysis of U.S. Census Bureau – Census of Individual Government: Finance"*

Across at Least 33 States, Counties May Be Involved in Providing Traditional Mental Health Services.

> *Counties in **11 States** are Mandated to Provide Traditional Mental Health Services to Residents.*

County role in providing mental health services, by state



Source: *NACo County Governance Project, 2023.*

Source: *NACo County Governance Project, 2023.*

Counties are permitted by at least 33 states to be involved providing traditional mental health services to residents. In more than half of these states (18 states), counties play a major role in health and human services overall. In fact, of the 20 states in which counties play a major role in health and human services, only two – Louisiana and North Dakota[12] – do not permit counties to provide mental health services. In 15 states, the expectation is that the state or another entity provides mental health services – and in nine of these states, counties play a minimal role in health and human services in general.[13]

There are 11 states which mandate counties to provide mental health services to residents: Arizona (counties under 600,000 in population), California, Georgia, Indiana, Maryland (counties over 80,000 in population), New Jersey, North Carolina, Oregon, Pennsylvania, Virginia and Wisconsin. What these services look like on the ground will differ from state to state, from funding and implementing services directly to appointing community service boards or contracting with other entities.

State-Mandated County Role in Providing Mental Health Services

ARIZONA

Counties with a population under 600,000 must provide behavioral health care for people with severe mental illness. Other counties must maintain intergovernmental agreements with the state department of health services to provide these services.

CALIFORNIA

Counties must establish community mental health services. Each service has a board consisting of 10 to 15 members, appointed by the county board of supervisors

GEORGIA

Counties must appoint members to community service boards that partner with the Georgia Department of Behavioral Health and Developmental Disabilities to provide community based mental health services. These boards are funded by the state and may provide mental health, addictive disease and developmental disability services. Counties may also direct general funds to community boards for mental health services.

INDIANA

Counties must fund the mental health facilities designated in each county. Counties may provide additional funding and services.

MARYLAND

Counties with over 80,000 people must have a local addictions or behavioral health authority. These authorities may function as a unit of county government, a local health department, a quasi-public authority or a private, nonprofit corporation.

NEW JERSEY

Counties must develop plans for community mental health services as well as make recommendations to local agencies, the community mental health board and the state. Counties may also appoint the county mental health board.

NORTH CAROLINA

Counties must provide mental health, public health, developmental disabilities and substance abuse programs. Counties may contract with any governmental agency or other entity to provide health or social services.

OREGON

Counties must appoint a local planning committee for alcohol and drug prevention and treatment services.

PENNSYLVANIA

Counties must administer mental health and developmental disabilities programs either individually or in groups of two or more counties called "joinders."

VIRGINIA

Counties must establish a community services board to provide emergency services, mental health screenings, case management services and more. The state may provide funds to assist counties in the provision of mental health, developmental and substance abuse services.

WISCONSIN

Counties must provide mental health services, along with alcohol and other drug abuse services.

Source: *NACo County Governance Project, 2023*

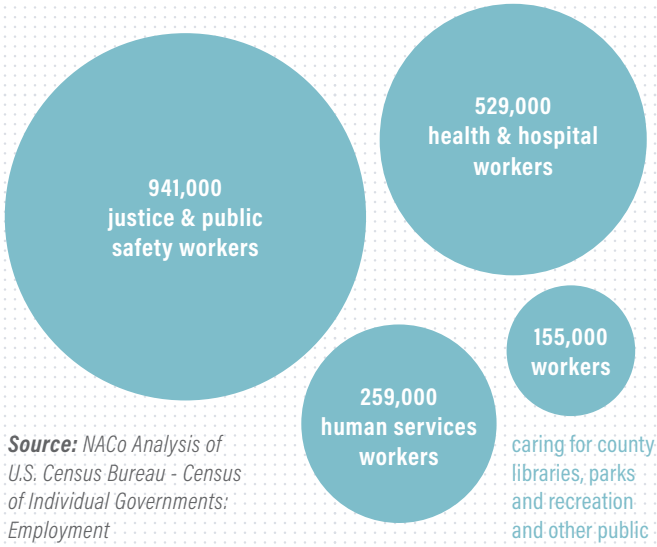
Aside from the 11 states that mandate county-provided mental health services, there are 22 states in which counties are given the option to provide mental health services to residents. In many of these states, the services are not mandated to give counties the flexibility to best respond to the needs of residents. Some states, like **Florida**, allow counties to establish mental health care special districts which, upon voter approval, may levy taxes to fund mental health services. Other states, like **Michigan**, give counties the option to establish a community mental health agency. **Iowa** and **Kansas** are examples of states that permit counties to establish a community mental health center.

In many of these states in which mental health services are optional for counties, the state plays a more prominent role in delivering mental health services, generally alongside counties. For example, in **Montana**, the state licenses mental health facilities; private non-profits and hospitals run community based mental health programs; but county commissioners often serve as the board of directors for the regional community based mental health service providers and may provide space and funding. **Ohio** state statute establishes an alcohol, drug addiction and mental health service district in counties with a population of at least 50,000, and counties may contract with nonprofits to provide mental health services (and levy the necessary taxes to do so). The **Alabama** state department of mental health coordinates with counties and other local governments to provide mental health services, and Alabama counties may construct and establish mental or public health facilities. Counties in **Texas** require state approval to establish a community mental health center, and counties in **South Carolina** with a population over 100,000 also require approval to establish a community mental health services program or clinic.

Within the 15 states that do not permit counties to implement mental health services, these services are most often provided by the state – sometimes at the county level. The **Hawaii** state department of health operates community mental health centers in each of Hawaii's four counties. And the state of **Utah**, too, establishes a local mental health authority and local substance abuse authorities in each county.

Counties employ over 3.6 million workers, many of whom contribute directly or indirectly to the behavioral health system of care. Most directly involved are over 529,000 county health and hospital workers, who may provide direct behavioral or physical health care, as well as another 259,000 human services employees who help connect residents to services. Oftentimes, however, residents may end up involved in the county justice and public safety system, which employes nearly 941,000 workers. Even county parks and recreation, library and other public amenity workers (over 155,000) end up involved in providing services. But issues arise when workers are improperly trained to help with a behavioral health crisis, emphasizing the need for more workers specifically in this field.[14]

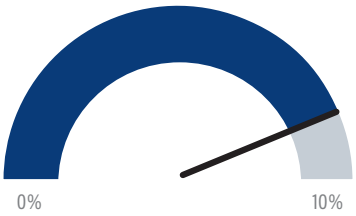
Counties employ over 3.6 million workers, many of whom contribute directly or indirectly to the behavioral health system of care, including:



Source: *NACo Analysis of U.S. Census Bureau - Census of Individual Governments: Employment*

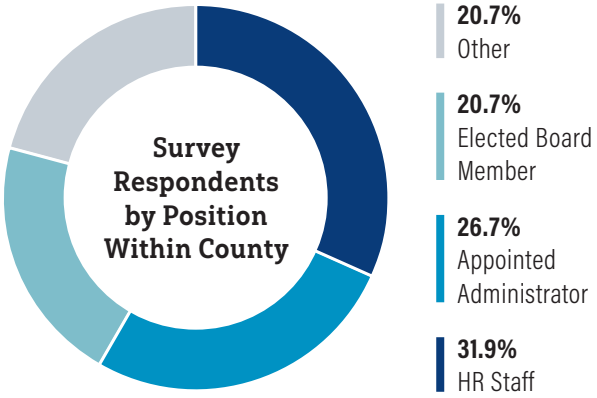
Appendix II: Survey Respondents & Methodology

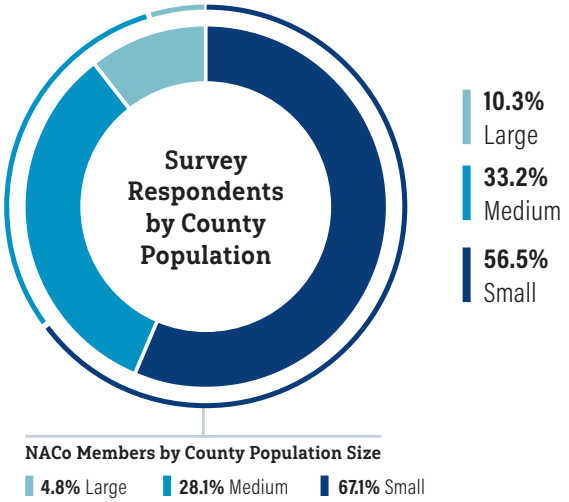
The survey polled 2,622 NACo member counties out of the total 3,069 county governments from March 9 to May 1, and received responses from 251 individuals from 232 different counties, representing a total of 44.5 million residents (14 percent of all county residents in the U.S.). The overall county response rate is 8.8 percent, representing 7.6 percent of all counties. Duplicate answers from a single county were consolidated. One subset of 174 NACo members was randomly selected for targeted outreach via individual emails. Another subset of 505 NACo members was randomly selected for targeted outreach via phone calls.



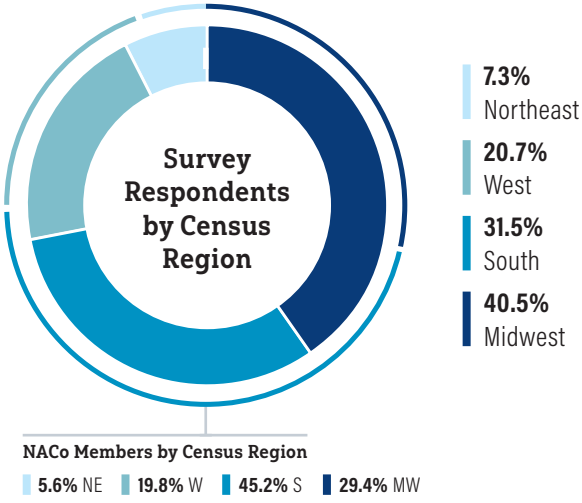
Survey Response Rate: 8.8%

Overall, the survey was fairly representative of NACo's membership and of all county governments in terms of population size and region. Regarding population size, the survey leaned slightly less on small counties (57 percent of survey respondents vs. 67 percent of NACo membership). By region, the survey leaned slightly more on Midwest counties (41 percent of survey respondents vs. 29 percent of NACo membership) and less on the South (31 percent of survey respondents vs. 45 percent of NACo membership).





Approximately one third (32 percent) of respondents worked in the field of health or human services. About one quarter (27 percent) were appointed county administrators, managers or deputy administrators/ managers. One fifth (21 percent) were elected county board members (also known as, commissioners, supervisors, council members, etc.). And the remaining 21 percent of respondents held a different position within the county – including elected county executives, elected row officers and hired staff in a field outside of health or human services.



Appendix III: Policy Recommendations from NACo's Commission on Mental Health and Wellbeing

A nationwide crisis demands an intergovernmental solution. Counties are ready to work across public private and non-profit sectors to blunt this growing crisis through specific federal policy, cross-sector collaboration and enforcement of mental health parity.

1. Invest and align local crisis response systems

Our nation's lack of an effective and widely available mental and behavioral health crisis services system has contributed to tragic outcomes for people in crisis. Not only does this shortage of a crisis services system have real-life negative impacts on our residents, but it also drives up costs for the public sector and taxpayers that have to bear the financial burden when an individual is hospitalized or incarcerated.

Counties are committed to enhancing the intergovernmental partnership for the development and modernization of local crisis response systems and infrastructure. We are working to develop and support new models of servicing individuals in crisis that are tailored to fit the unique needs of our communities which include the development of tiered and co-response models, integrative care, wraparound service and referral systems and 24/7 call centers that support the recently implemented 988 National Suicide Prevention Lifeline. The long-term success of these efforts is dependent on a strong intergovernmental partnership, where all levels of government are invested in aligning systems for better outcomes for individuals in crisis.

- Fifty-eight (58) percent of county respondents highlighted "Fully Implement Services Across the Life Cycle" as a federal policy priority that could provide the greatest opportunity for their county to serve residents.

POLICY RECOMMENDATIONS

- Increase federal coordination on resources and technical assistance to local governments on the development of crisis call centers.
- Enhance funding for existing programs that aid in the development, expansion and sustainment of crisis response infrastructures.
- Expand state and federal support for the expansion of evidence-based crisis response models, including Crisis Intervention Team (CIT) programs and Crisis Assistance Helping Out On The Streets (CAHOOTS).
- Authorize the use of Medicaid financing for regional and local crisis call center operations, crisis stabilization facilities and integrated primary, mental health and crisis response care models such as Community Behavioral Health Centers (CCBHC).

2. Enforce mental health parity

Despite legislative advancements over the last decade, there are still significant disparities in the coverage of mental health and substance use disorders under both public and private health insurance plans, when compared with coverage for medical and surgical benefits. Furthermore, while Medicaid and Managed Care Plans (MCOs) must follow federal parity laws, Medicaid fee for service plans do not, which inhibits many individuals from accessing potentially lifesaving coverage.

Counties demand that the federal government enforce policies that ensure equal coverage of treatment for mental illness and addiction. The Mental Health Parity and Addiction Equity Act (P.L. 110-343) is a federal parity law that was enacted in 2008, and required comprehensive standards for equitable coverage of mental health and substance use disorder treatment and coverage of physical treatment. Strengthening behavioral health parity protections and enforcing existing protections is a critical component of improving coordination and integration of primary care and behavioral health care in the health care delivery system, and better addressing the behavioral and mental health needs of our community more broadly.

- Nearly two-thirds (63 percent) of county respondents highlighted "Fully Implement and Expand Mental Health Parity" as a federal policy priority that could provide the greatest opportunity for their county to serve residents.

POLICY RECOMMENDATION

- Advance federal and state-level legislation that incentivizes and enforces existing parity policy and ensures that laws are uniformly implemented across both public and private insurers providers, and in all 50 states and the District of Columbia.

3. Strengthen the mental health workforce

Counties across the nation are investing in programs and initiatives that both assist with and incentivize the recruitment, training and placement of behavioral health providers that will work within local and under resourced communities. However, despite those efforts, nearly 50 percent of the U.S. population reside in counties that have been designated as having a mental health professional shortage.[15]

Counties need direct and flexible resources and incentives to support the recruitment, training and retention of a sufficient behavioral health workforce. We rely on our federal partners to supplement investments made in the mental health workforce through the enhancement of existing programs that promote workforce recruitment and retention. New financial incentives for integrated care may result in an increase of individuals pursuing jobs in the behavioral health care field and increase access to these critical services.

- Sixty-one (61) percent of county respondents highlighted "Develop and Expand the Workforce" as a top federal policy priority that could provide the greatest opportunity for their county to serve residents.

POLICY RECOMMENDATIONS

- Advance federal policy that takes a comprehensive approach (e.g. loan forgiveness programs, streamlining licensure/credentialing processes, tax incentives, etc.) to creating clear entry pathways for behavioral health professions, particularly in rural and underserved areas.
- Enhance funding authorizations for existing programs, such as the National Health Service Corps, that promote workforce recruitment and retention in local areas.

4. Amend exclusionary policies under Medicaid

The Medicaid Inmate Exclusion Policy (MIEP) is a federal policy outlined under Section 1905(a)(A) of the Social Security Act that revokes federal health benefits for adults and juveniles housed in correctional institutions - making no distinction between individuals who are being detained in jails prior to due process, versus individuals who have been adjudicated and sentenced to time in a jail or prison. Without revision, this policy creates inequitable and unconstitutional disruptions to primary and behavioral health care services for justice-involved populations, thus exacerbating rates of untreated mental illness and substance use disorder in local communities and increasing rates of avoidable, costly jail recidivism.

Counties see a strong need to amend the Medicaid Inmate Exclusion Policy (MIEP) for improved care continuity of individuals living with mental illness and/or substance use disorder. Amending the MIEP to allow individuals who are detained pre-trial to retain access to Medicaid and other federal health benefits can better help break the cycle of recidivism exacerbated by untreated physical and mental illnesses and substance use disorders.

- Over half (56 percent) of county respondents highlighted "Enhance Medicaid Flexibility" as a top federal policy priority that could provide the greatest opportunity for their county to serve residents.

POLICY RECOMMENDATIONS

- Clarify federal policy through the removal of limitations under Medicaid, Medicare, CHIP and the Department of Veterans Affairs on benefits for persons in custody pending disposition of charges.
- Expand the approval of federal and state regulatory measures that would allow Medicaid payment for medical services furnished to any eligible incarcerated individual during the period that proceeds the individual's release.
- Advance federal policy that would allow Medicaid payment for medical and behavioral health services furnished to any eligible incarcerated individual during at least the 30-day period preceding the individual's release.

Federal restrictions on Medicaid reimbursement for inpatient care have created significant barriers to providing clinically necessary inpatient mental health services and contributed to inequities in access to treatment and care for low-income individuals, especially for short-term crisis stabilization.

Counties see a need to modernize the Institutions for Mental Diseases (IMD) exclusion to reduce barriers to the provision of comprehensive behavioral health treatment and increase access to short-term residential treatment when clinically appropriate. The federal Medicaid statute prohibits federal reimbursement for care provided in psychiatric or other residential treatment facilities with more than 16 beds, defined as Institutions for Mental Diseases (IMDs). Modernizing the Medicaid IMD exclusion would greatly expand the treatment capacity of county-operated hospitals and behavioral health facilities while also promoting equitable access to treatment options for our most vulnerable residents.

- Nearly half (49 percent) of county respondents highlighted "Ease Medicaid's Institutes of Mental Disease (IMD) Exclusion" as a top federal policy priority that could provide the greatest opportunity for their county to serve residents.

POLICY RECOMMENDATIONS

- Expand the approval of regulatory measures that waive IMD restrictions for adults with serious mental illness (SMI), children with serious emotional disturbance (SED), and short-term residential stays for the treatment of substance use disorder (SUD).
- Advance regulatory or legislative policy that waives and modernizes IMD restrictions for short-term crisis stabilization facilities, as a critical component of the crisis care continuum.

Endnotes

[1] See Appendix II for notes on the survey methodology, distribution, response rate and county representation. Throughout the brief, all stats, graphs and datapoints are derived from the survey responses unless otherwise cited. All county examples mentioned in this brief are also based on survey responses.

[2] NACo-NLC-Brookings Local Government ARPA Investment Tracker, as of December 2022. See www.NACo.org/resources/featured/arpa-investment-tracker for more information.

[3] University of Wisconsin Population Health Institute analysis of CMS, National Provider Identification file 2017 data.

[4] Kaiser Family Foundation analysis of Bureau of Health Workforce, Health Resources and Services Administration (HRSA), U.S. Department of Health & Human Services, Designated Health Professional Shortage Areas Statistics: Designated HPSA Quarterly Summary, as of September 30, 2022 available at www.kff.org/other/state-indicator/mental-health-care-health-professional-shortage-areas-hpsas/

[5] Rural Health Information Hub analysis of Bureau of Health Workforce, Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services, Designated Health Professional Shortage Areas Statistics: Designated HPSA Quarterly Summary, as of November 2022, available at www.ruralhealthinfo.org/charts/7

[6] NACo analysis of Department of Justice Bureau of Justice Statistics - Annual Survey of Jails.

[7] Ibid.

[8] See NACo and NACBHDD, "Behavioral Health Matters to Counties," available at www.naco.org/sites/default/files/documents/Behavioral%20Health%20Matters_V2_0.pdf

[9] NACo Analysis of Centers for Medicare & Medicaid Services 2016, 2017 cost report.

[10] Bureau of Justice Statistics, U.S. Department of Justice, "Mental Health Problems of Prison and Jail Inmates" (2006), available at: https://bjs.ojp.gov/content/pub/pdf/mhppji.pdf

[11] The Pew Charitable Trusts, "More Than 1 in 9 Adults With Co-Occurring Mental Illness and Substance Use Disorders Are Arrested Annually," (2023), available at: www.pewtrusts.org/en/research-and-analysis/issue-briefs/2023/02/over-1-in-9-people-with-co-occurring-mental-illness-and-substance-use-disorders-arrested-annually

[12] North Dakota permits counties under Home Rule to provide mental health services, though overall, that is a function of the state government.

[13] NACo County Governance Project, 2023. See www.NACo.org/CountyGovData for more information.

[14] NACo Analysis of U.S. Census Bureau - Census of Individual Governments: Employment

[15] Rural Health Information Hub analysis of Bureau of Health Workforce, Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services, Designated Health Professional Shortage Areas Statistics: Designated HPSA Quarterly Summary, as of November 2022, available at www.ruralhealthinfo.org/charts/7

About the National Association of Counties

The National Association of Counties (NACo) strengthens America's counties, serving nearly 40,000 county elected officials and 3.6 million county employees. Founded in 1935, NACo unites county officials to:

- Advocate county priorities in federal policymaking
- Promote exemplary county policies and practices
- Nurture leadership skills and expand knowledge networks
- Optimize county and taxpayer resources and cost savings, and
- Enrich the public understanding of county government.

NACo's Mission

Strengthen America's Counties.

NACo's Vision

Healthy, safe and vibrant counties across America.

About NACo's Commission on Mental Health and Wellbeing

Launched in February 2023, the NACo Commission on Mental Health and Wellbeing brings together county leaders from across the nation to take action to address the ever-growing mental health crisis from the county government perspective.

Through this commission, NACo will elevate the critical role that counties play in providing high-quality, accessible mental health services, showcase county innovations and solutions and outline the intergovernmental and public-private partnerships required to reimagine and strengthen our nation's mental health policies, programs and practices.

Contact

Counties Futures Lab - Research:
Jonathan Harris
Associate Research Director
research@naco.org

Counties Futures Lab - Programs:
Ashley Hunt
Program Manager – Health
ahunt@naco.org

Government Affairs:
Blaire Bryant
Legislative Director – Health | Large Urban County Caucus
bbryant@naco.org

660 North Capitol Street, N.W.
Suite 400 ▪ Washington, D.C. 20001
202.393.6226 ▪ www.NACo.org