CONSTRUCTING A COMPREHENSIVE AND COMPETENT CRIMINAL JUSTICE/MENTAL HEALTH/SUBSTANCE ABUSE TREATMENT SYSTEM:

Strategies for Planning, Leadership, Financing, and Service Development

EXECUTIVE SUMMARY & TABLE OF KEY RECOMMENDATIONS

EXECUTIVE SUMMARY

200 years ago, people with severe and disabling mental illnesses in the United States were often confined under cruel and inhumane conditions in jails. This was largely due to the fact that no alternative system of competent mental health treatment existed. During the 1800's, a movement known as *moral* treatment emerged that sought to hospitalize and treat individuals with mental illnesses rather than simply incarcerating them. The first state psychiatric hospitals were opened in the United States during the 1800's, and were intended to serve as more appropriate and compassionate alternatives to the neglect and abuse associated with incarceration. Unfortunately, overcrowding at these institutions, inadequate staff, and lack of effective treatment programs eventually resulted in facilities being able to provide little more than custodial care. Furthermore, physical and mental abuses became common and the widespread use of physical restraints such as straight-jackets and chains deprived patients of their dignity and freedom. The asylums intended to be humane refuges for the suffering had instead turned into houses of horrors.

By the mid-1900's, more than a half million people were housed in state psychiatric hospitals across the United States. The system was stretched beyond its limits and states desperately needed some alternative to addressing this costly and ever-expanding crisis. Around this same time, the first effective medications for treating symptoms of psychosis were being developed, lending further support to the emerging belief that people with serious mental illnesses could be treated more effectively and humanely in the community. This period marked the beginning of the *community mental health movement*.

In 1963, Congress passed the Community Mental Health Centers Act which was intended to create a network of community-based mental health providers that would replace failing and costly state hospitals, and integrate people with mental illnesses back into their home communities with comprehensive treatment and services. In what would be his last public bill signing, President Kennedy signed a $3 billion authorization to support this movement from institutional to community-based treatment. Tragically, following President Kennedy's assassination and the escalation of the Vietnam War, not one penny of this authorization was ever appropriated.

As more light was shed on the horrific treatment people received in state psychiatric hospitals, along with the hope offered by the availability of new and effective medications, a flurry of federal lawsuits were filed against states which ultimately resulted in the *deinstitutionalization* of public mental health care. Unfortunately, there was no organized or adequate network of community mental health centers to receive and absorb these newly displaced individuals.

The fact that a comprehensive network of community mental health services was never established following deinstitutionalization has resulted in a fragmented continuum of care that has failed to adequately integrate services, providers, or systems; leaving enormous gaps in treatment and disparities in access to care. Furthermore, the community mental health system that was developed was not designed to serve the needs of individuals who experience the most chronic and severe manifestations of mental illness.

Lack of strategic funding and programming, and adherence to treatment guidelines that do not necessarily reflect current best practices have affected certain segments of the population in particularly devastating ways. For many individuals unable to access care in the community, the only options to receive treatment is by accessing care through the some of the most costly and inefficient points of entry into the healthcare delivery system including emergency rooms, acute crisis services, and ultimately the juvenile and criminal justice systems.

There are two ironies in this chronology that have resulted in the fundamental failure to achieve the goals of the community mental health movement and allowed history to repeat itself in costly and unnecessary ways. First, despite enormous scientific advances, treatment for severe and persistent mental illnesses was never deinstitutionalized, but rather was transinstituionalized from state psychiatric hospitals to jails and prisons. Second, because no comprehensive and competent community mental health treatment system was ever developed, jails and prisons once again function as de facto mental health institutions for people with severe and disabling mental illnesses. In two centuries, we have come full circle, and today our jails are once again psychiatric warehouses.

On any given day in Florida, there are approximately 16,000 prison inmates, 15,000 local jail detainees, and 40,000 individuals under correctional supervision in the community who experience serious mental illness (SMI). Annually, as many as 125,000 people with mental illnesses requiring immediate treatment are arrested and booked into Florida jails. The vast majority of these individuals are charged with minor misdemeanor and low level felony offenses that are a direct result of their psychiatric illnesses. People with SMI who come in contact with the criminal justice system are typically poor, uninsured, homeless, members of minority groups, and experience co-occurring substance use disorders. Approximately 25 percent of the homeless population in Florida has an SMI and over 50 percent of these individuals have spent time in a jail or prison.

A 2006 report by the National Association of State Mental Health Program Directors (NASMHPD) Research Institute reported that the State of Florida ranked 12th in the nation in spending for forensic mental health services. Today, this estimate is likely to be considerably higher as this ranking did not take into account the state's investment earlier this year of more than $16 million in emergency funding allocated by the Legislative Budget Commission and the addition of $48 million in annual funding to add 300 desperately needed treatment beds to the overflowing forensic system. Individuals ordered into forensic commitment are now the fastest growing segment of the publicly funded mental health marketplace in Florida. Between 1999 and 2007, forensic commitments increased by 72 percent, including an unprecedented 16 percent increase between 2005 and 2006.

To put this in a more acute perspective, the State of Florida currently spends roughly a quarter of a billion dollars annually to treat roughly 1,700 individuals under forensic commitment; most of whom are receiving services to restore competency so that they can stand trial on criminal charges and, in many cases, be sentenced to serve time in state prison. Furthermore, the treatment provided in Florida's forensic hospitals is funded entirely by state general revenue dollars, as Federal law prohibits Medicaid from providing payment for psychiatric services rendered in such institutional settings. As a result, the state is investing enormous sums of

taxpayer dollars into costly, back-end services that may render a person competent to stand trial, but will do nothing to provide the kind of treatment needed to facilitate eventual community re-entry and reintegration.

While expenditures in the area of forensic mental health services place Florida near the top of list nationally, the level of expenditures on front-end community-based services intended to promote recovery, resiliency, and adaptive life in the community place the state near dead last. According to the NASMHPD Research Institute, the State of Florida ranks 48th nationally in overall per capita public mental health spending. Difficult to navigate and inefficient points of entry have resulted in barriers to accessing preventative, routine, and competent care. Last year alone, more than half of all adults with SMI and about a third of all children with severe emotional disturbances (SED) in need of treatment in the Florida's public mental health system had no access to care. Furthermore, despite recent research which has lead to the identification and development of increasingly effective, evidence-based interventions for serious mental illnesses, such treatments have yet to be adequately implemented by many service providers in the public mental health system. Consequently, increasing numbers of people experiencing acute episodes of mental illness are becoming involved in the justice systems.

Roughly 150,000 children and adolescents, under the age of 18, are referred to Florida's Department of Juvenile Justice (DJJ) every year. Many of these youth have been impacted by poverty, violence, substance abuse, and academic disadvantage. Over 70 percent have at least one mental health disorder, with females experiencing higher rates of disorders (81%) than males (67%). Of youth diagnosed with a mental health disorder, 79 percent meet criteria for at least one other co-morbid psychiatric diagnosis, the majority of whom (approximately 60 percent) are diagnosed with a co-occurring substance use disorder.

The problems currently facing Florida's mental health and, consequently, criminal justice systems relate to the fact that the community mental health infrastructure was developed at a time when most people with severe and disabling forms of mental illnesses resided in state hospitals. As such, the community mental health system was designed around individuals with more moderate treatment needs, and not around the needs of individuals who experience acute and chronic mental illnesses. People who would have been hospitalized 40 years ago because of the degree to which mental illness has impaired their ability to function are now forced to seek services from an inappropriate, fragmented, and unwelcoming system of community-based care.

The justice system was never intended to serve as the safety net for the public mental health system and is ill-equipped to do so. Florida's jails and prisons have been forced to house an increasing number of individuals who are unable to access critically needed and competent care in the community. The consequences of the failure to design and implement an appropriate system of community-based care for people who experience the most severe forms of mental illnesses have been:

- Substantial and disproportionate cost shifts from considerably less expensive, front end services in the public mental health system to much more expensive, back-end services in the juvenile justice, criminal justice, and forensic mental health systems
- Compromised public safety

- Increased arrest, incarceration, and criminalization of people with mental illnesses
- Increased police shootings of people with mental illnesses
- Increased police injuries
- Increased rates of chronic homelessness

To effectively and efficiently address the most pressing needs currently facing the mental health system in Florida, it is recommended that the state invest in a redesigned and transformed system of care oriented around ensuring adequate access to appropriate prevention and treatment services in the community, minimizing unnecessary involvement of people with mental illnesses in the criminal justice system, and developing collaborative cross-systems relationships that will facilitate continuous, integrated service delivery across levels of care and treatment settings.

In this report, recommendations are made for the development of a comprehensive and competent mental health system which will prevent individuals from entering the justice system to begin with and will respond to individuals who do become involved in the justice system quickly and effectively to link them to appropriate services and prevent recidivism. By designing an appropriate and responsive system of care for individuals with serious mental illnesses, severe emotional disturbances, and/or co-occurring substance use disorders, people who otherwise would continue to recycle through the justice system will be served more effectively and efficiently. Public safety will be improved and the rate of individuals accessing more costly services in forensic mental health and criminal justice systems will be reduced.

Under this redesigned system of care, which will serve both adults with SMI and children with SED there will be 1) programs incorporating best-practices to support adaptive functioning in the community and prevent individuals with SMI/SED from inappropriately entering the justice and forensic mental health systems, 2) mechanisms to quickly identify and appropriately respond to individuals with SMI/SED who do become inappropriately involved in the justice system, 3) programs to stabilize these individuals and link them to recovery-oriented, community-based services that are responsive to their unique needs; and 4) financing strategies which redirect cost savings from the forensic mental health system and establish new Medicaid funding programs.

Key elements of the proposed plan include:

- Adoption of innovative financing strategies, designed around principles of managed care, that create incentives to prevent individuals from inappropriately entering the justice systems, and to quickly respond to individuals who do become involved in the justice system.
- Establishment of a multi-tiered level of care classification system targeting individuals at highest risk of institutional involvement in the criminal justice, juvenile justice, and state mental health systems to ensure adequate services in times of acute need when at risk of penetration into institutional levels of care and maximizing limited state resources during periods of relatively stable recovery.
- Creation of a statewide system of limited enrollment, Integrated Specialty Care Networks (ISCNs) under a newly authorized Medicaid state plan option targeting Home and

Community Based Services (HCBS) and specifically tailored to serve individuals with SMI/SED who are involved in or at risk of becoming involved in the justice system or other institutional levels of care.

- State certification of local providers and communities for participation in the proposed ISCNs, who demonstrate:
    - The ability to deliver effective, high-quality services across systems of care to individuals at highest risk of becoming involved in the criminal justice system or other institutional levels of care.
    - Ongoing, collaborative relationships with state and local criminal justice and community stakeholders that will facilitate early intervention and continuity of care across systems.
- Implementation of strategies targeting community readiness and individuals at highest risk for institutional involvement.
- Establishment of a partnership between DCF and AHCA to maximize funding streams and opportunities to serve individuals covered under public entitlement benefits (i.e., Medicaid) as well as those not covered.
- Programs to maximize access to federal entitlement benefits by expediting the application process and increasing initial approval rates for individuals prescreened to be eligible for benefits.
- Strategic, phased in implementation over a six year period to ensure adequate infrastructure development and sustainability.
- Strategic reinvestment of general revenue appropriations currently allocated to the state forensic system into community-based services targeting individuals at risk of criminal justice system involvement.
- Establishment of a Statewide Leadership Group to provide administrative oversight and facilitate technical assistance with the development of state and local plans.
- Implementing strategies and promising practices to maximize enrollment in federally supported entitlement benefits such as Medicaid and Supplemental Security Income/Social Security Disability Insurance (SSI/SSDI).
- Expansion of the Criminal Justice/Mental Health/Substance Abuse Reinvestment Grant Program to build local and statewide infrastructures.
- Development of local and statewide collaborations.

TABLE OF KEY RECOMMENDATIONS

Creating a redesigned and transformed system of care will require the provision of community-based services and supports which ensure that people with mental illnesses and/or co-occurring substance use disorders are able to access care that is effective, efficient, safe, and appropriate to individual needs and circumstances. In addition, services and supports must be available in the community when and where they are needed. Services offered should be those that are most likely to contribute to adaptive and productive life in the community, while minimizing unnecessary or inappropriate involvement in the criminal justice system or other institutional settings. While the needs of each community will be different, potentially producing significantly different priorities and objectives, the efforts of each community must be guided by a common vision and current knowledge regarding evidence-based and promising practices. Table 1 lists key recommendations addressed in this report.

Table 1. Key recommendations

Recommendation area:
Phased-in implementation of a redesigned system of care targeting the provision of enhanced services to individuals involved in or at risk of becoming involved in the criminal and juvenile justice systems, with the provision of reasonable start up costs.
Creation of a statewide system of limited enrollment, Integrated Specialty Care Networks (ISCNs) which maximize state funding, along with new Medicaid programs to serve individuals with SMI/SED who are involved in or at risk of becoming involved in the justice system or other institutional levels of care.
Development of financing strategies that creates incentives to prevent individuals from inappropriately entering the justice systems, and to quickly respond to individuals who do become involved in the justice system.
Certification of local providers and communities for participation in ISCNs, who demonstrate the ability, commitment, and readiness to deliver effective, high-quality services, across systems of care to individuals at highest risk of becoming involved in the criminal justice system or other institutional levels of care.
Establishment of a classification system based on risk of institutional involvement in the criminal justice, juvenile justice, and state mental health systems to target enhanced services based on necessary level of care.
Establishment of a partnership between DCF and AHCA to maximize funding streams and opportunities to serve individuals covered under public entitlement benefits (i.e., Medicaid) as well as those not covered.
Implementation of strategies to maximize enrollment in federally supported entitlement benefits such as Medicaid and SSI/SSDI.

Recommendation area:
Establishment of a Statewide Leadership Group to provide administrative oversight and facilitate technical assistance with the development state and local plans.
Development of comprehensive and competent community-based mental health systems based on evidence-based and promising practices.
Development of comprehensive and competent interventions targeting adults involved in or at risk of becoming involved in the criminal justice system based on evidence-based and promising practices.
Development of comprehensive and competent interventions targeting youth involved in or at risk of becoming involved in the criminal or juvenile justice systems based on evidence-based and promising practices.
Recommendations to promote and sustain a more effective, competent, and sustained mental health/substance abuse treatment workforce.
Recommendations for oversight of psychotherapeutic medication prescribing practices in the dependency system and child-protective services.
Recommendations for best practices in screening and assessment in the juvenile justice system.
Recommendations for educating judges and other professionals in the courts.
Recommendations for judicial leadership and the development of community collaborations.