Full Circle In Less Than 200 Years

- Nearly 200 years ago, mentally ill individuals were typically incarcerated in either jails or prisons. Years later, they were transferred into mental hospitals. We then closed down those mental hospitals, effectively reverting to forcing these individuals back into jails and prisons. (Treatment Advocacy Center and National Sheriffs Association, 2010)
    - Prior to the 1960s, nearly 600,000 adults with mental health issues were housed in state-funded mental hospitals. A desire to deinstitutionalize the mentally ill led to a substantial drop in the number of people housed in public psychiatric hospitals—down to nearly 70,000—by the 1990s. Severe cuts to state funding for mental health treatment facilities have only contributed to this decrease in the hospitalization of the mentally ill.
    - Now, roughly 1.3 million mentally ill individuals are incarcerated in federal and state prisons, as well as in local jails.

A Repetitive Cycle

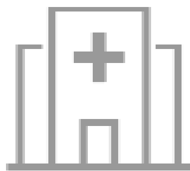
- Large numbers of people with serious mental illnesses are cycling through the criminal justice system, often resulting in tragic outcomes for these individuals and their families.
    - Too often, people with serious mental illnesses are incarcerated, often for minor offenses, who would be better served in the community. Though jails have a constitutional mandate to treat the mental illnesses of individuals under their supervision, they are ill-equipped to meet the needs of those with serious mental illnesses. (Council of State Governments, 2009)
- The incarceration of individuals with mental illness impacts the communities at large by the ineffective use of funds designated for law enforcement, court, and corrections; missed opportunities to link people to effective treatment; and failure to improve public safety. (Council of State Governments, 2009)
    - According to the Department of Justice, the cost in the mid-1990's to American taxpayers was a staggering $15 billion per year to house individuals with psychiatric disorders in jails and prisons ($50,000 per person annually; 300,000 incarcerated individuals with mental illness).

A Large, Vulnerable Portion of Our Populations

- People with mental illnesses in parole and probation populations are thought to be represented at three to four times those in the general population. A study conducted by numerous health and law enforcement officials in 2010 reported that roughly ten times more mentally ill individuals were in prisons and jails throughout the country than in hospitals and the general population. Thus, the nation's jail and prisons have become, *de facto,* our largest psychiatric hospitals.
- Now, more severely mentally ill individuals are in the Los Angeles County Jail, Chicago's Cook County Jail, or New York's Riker's Island Jail than in any single psychiatric hospital in the nation.

(The Costs of Correctional Mental Health Ade Ilesanmi | January 28, 2015 | Wellness)

THE ANNUAL COST OF UNTREATED MENTAL ILLNESS



EMERGENCY ROOM CARE

$38.5 billion [1]

INCARCERATION

$37 billion [2,3]

MEDICAL COMORBIDITIES

$132.6 - $351 billion, est.[4]

LOST PRODUCTIVITY

$193.2 billion [5]

Source: https://valant.com/the-cost-of-untreated-mental-illness/ last updated 3/28/17

[1] "E.R. Costs for Mentally Ill Soar, and Hospitals Seek Better Way", last modified December 25, 2013, http://www.nytimes.com/.
[2] "Guilty of mental illness", last modified April 27, 2015, http://chicagoreporter.com/.
[3] "A shocking number of mentally ill Americans end up in prison instead of treatment", last modified April 30, 2015, https://www.washingtonpost.com/.
[4] Steven Melek and Doug Norris, Chronic Conditions and Comorbid Psychological Disorders, 2008.
[5] "Mental Disorders Cost Society Billions in Unearned Income", last modified May 7, 2008, https://www.nimh.nih.gov/.

Serious Mental Illness (SMI) Among U.S. Adults

- While mental disorders are common in the United States, their burden of illness is particularly concentrated among those who experience disability due to serious mental illness (SMI).
- The data presented here are from the National Survey on Drug Use and Health (NSDUH), which defines SMI as:
  - A mental, behavioral, or emotional disorder (excluding developmental and substance use disorders);
  - Diagnosable currently or within the past year;
  - Of sufficient duration to meet diagnostic criteria specified within the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV); and,
  - Resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities.
- In 2015, there were an estimated 9.8 million adults aged 18 or older in the United States with SMI within the past year. This number represented 4.0% of all U.S. adults.

Stepping Up Goals Based on Four Key Measures

1 Reduce

The number of people with SMI booked Into jail

2 Shorten

The average length of stay for people SMI in jails

3 Increase

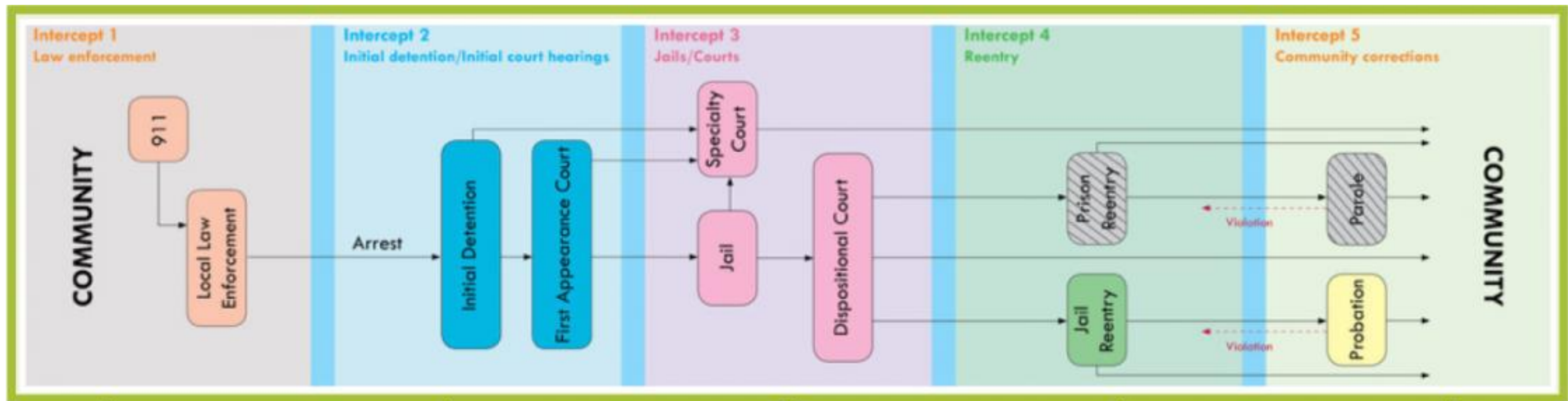
The percentage of connection to care for people with SMI in jail

4 Lower

Rates of recidivism

Checklist to Establish Baseline Data:

- ✓ System-wide definition of recidivism
- ✓ Electronically collected data
- ✓ Baseline data on the general population in the jail
- ✓ Routine reports generated by a county agency, state agency, or outside contractor



INTERCEPT 1: Train law enforcement officers in CIT, establish mobile crisis outreach teams

INTERCEPT 2: Screen for mental illnesses, link to comprehensive services

INTERCEPT 3: Establish a mental health court, provide jail-based mental health services

INTERCEPT 4: Create reentry treatment plans, coordinate transition with community providers

INTERCEPT 5: Maintain a continuity of care, utilize graduated responses

Source: NACo The Stepping Up Initiative: Reducing Mental Illness in Rural Jails

Keeping mentally ill out of jail and in treatment—model shown to work in breakthrough study

June 1, 2017 by Christine Roth
Credit: University of Rochester Medical Center

People with severe mental illness are more than four times more likely to be arrested than other adults and account for nearly 20% of today's U.S. prison population. Behind bars, they often wait months to receive appropriate treatment, if any, studies show.

To tackle this growing national concern, varied approaches have been tried and tested in cities across the country, but results have been mixed at best.
Now, an intervention born in Rochester, N.Y., has been shown for the first time to reduce the population's criminal convictions, jail time and hospitalizations by roughly 50 percent. Additionally, the model—which hinges on active collaboration and shared problem-solving between mental health and criminal justice systems—has proven to keep mentally ill individuals in treatment twice as long as the study's comparison program.

In a three-year, randomized-control study conducted by clinical researchers at the University of Rochester Medical Center's Department of Psychiatry, the **Rochester Forensic Assertive Community Treatment model (R-FACT)** withstood rigorous examination and now holds promise for cities across the United States. The peer-reviewed study, supported by a grant from the National Institute of Mental Health, was published online today in *Psychiatric Services*, a journal of the American Psychiatric Association.
"Our research suggests that it's possible to prevent criminal recidivism among people with even the most severe mental illnesses and substantial criminal histories." says study principal investigator, J. Steven Lamberti, M.D., a professor of Psychiatry in URMC's Department of Psychiatry. "We found that by combining the expertise of mental health and criminal justice professionals in a certain way, we can promote both individual health and public safety."

Co-investigator, Robert L. Weisman, D.O., professor of Psychiatry and forensic psychiatrist on the URMC study team, notes that R-FACT "promotes patient engagement in treatment and community tenure through collaboration with criminal justice partners. Such efforts will likely have large beneficial downstream effects for this population."
With the continued support of his Psychiatry Department chair and senior author Eric Caine, MD, and an equally dedicated team of colleagues, Lamberti has relentlessly devoted nearly 25 years to finding a way to keep mentally ill individuals from languishing in prisons—a trend that coincides with the downsizing of U.S. psychiatric hospitals in the 1980s.The Rochester Psychiatric Center (RPC), for example, once housed as many as 3,000 patients, but serves only about 100 today.

For many years, Lamberti believed the solution to the high rate of incarceration among the mentally ill (often involving the same individuals with repeated incarcerations in Rochester's Monroe County Jail) was simply to provide better mental health treatment With county funding in 1995, he assembled what was then considered the "gold standard" of community mental health treatment—an assertive community treatment (ACT) team composed of culturally diverse psychiatric clinicians, social workers, and s case managers who made "house calls" across the Rochester area.

Many other American cities, he would learn, developed similar outreach programs—which were later shown in studies to be effective at reducing hospitalizations, but not criminal involvement. In fact, to Lamberti's dismay, ACT teams' close monitoring of offenders and timelier reporting of criminal infractions to the justice system actually resulted in higher recidivism rates.

It was a talk given by a criminologist at a national conference that caused Lamberti to channel his energies in a new direction. His attention turned toward understanding the multiple and unique "criminogenic risk factors" of mentally ill individuals, such as antisocial personality, criminal thinking, social support for crime, and substance

abuse—coupled with psychiatric issues like psychosis, paranoia, cognitive impairment and trauma—and how this combination makes people more vulnerable and less responsive to standard correctional intervention.

"If we want to fix the problem, we have to understand it," says Lamberti. "People with severe mental illness have much higher rates of criminogenic risk factors, along with other issues that affect how they relate to others. The key to preventing recidivism is to engage these individuals in specific interventions that target the things driving their involvement with the criminal justice system."
But engaging individuals in treatment—especially those resistant or fearful of it—is the hardest part, says Lamberti.

After several years of research, trial-and error, multiple studies and focus groups, what evolved under Lamberti's direction was the Rochester FACT prototype which uses legal leverage to engage individuals in mental health treatment that systematically targets their criminogenic risk factors.

Getting judges, lawyers, probation officers, and other criminal justice professionals to "buy-in" to the program is key, Lamberti says.

"Legal leverage isn't about making threats to force compliance, or simply reporting infractions," says Lamberti. "It's about the appropriate, respectful use of legal authority to guide people toward engagement. It also requires getting mental health and criminal justice professionals to problem-solve together, and to consider therapeutic alternatives to punishment. Our clients are men and women who feel demoralized and discouraged, they are at their very lowest point, and they need more rewards than sanctions."

Rochester City Court judge (7th Judicial District) Hon. Jack Elliott, one of two judges who participated in the study, says the key elements that made the program work were the intensive level of communication between him and the R-FACT team members, the program's comprehensive approach, and the fact that individuals could be seen immediately by a mental health provider upon court recommendation.

"Prior to that, so many people had to wait six weeks or more for an appointment," says Elliott, who now presides over the Monroe County Mental Health Court and the Rochester Drug Treatment Court. "That's what they were used to. But with FACT, they're in treatment within a week. The treatment provider was always there in court and they had a feeling that someone was actually looking out for them. I would meet with the treatment team before and after the court appearance and get straight information about how each person was doing. If they were doing well, I could reinforce that, give them praise, and if they were screwing up, I could really address them in a very factual way. I could hone in on it. But the big thing was getting them immediate access to the right treatment."

Elliott, who was a public defender for several years before becoming a city court judge, says it will take a high level of trust and understanding between mental health and criminal justice systems for the program to be transplanted elsewhere successfully. Lamberti and his colleagues worked diligently with the Rochester court system for several years to develop that level of rapport.

"We have a totally different lingo," Elliott says. "It took some time for them to get used to how the court system works, and vice versa. Mental health is very touchy-feely, and this is a court and you have to be accountable. I take a different tone in here. Which is why I think it works. Steve calls it therapeutic jurisprudence. It does come down to the judge in many cases. I don't think what I do is all that special. Treat people decently, give them a chance, find humor when I can and try to be understanding. You have to get a judge who's willing to do that. But with this type of work, I feel like you can really make a difference in changing people's lives."

Columbia Homelessness Outreach Team (CHOT)

Organization	Program	Contact	Telephone	Availability	Eligibility/Services
Phoenix Health Programs 90 E Leslie Lane	Street Outreach Program	Yolanda Day	Cell: 573-673-2361 Phoenix front desk: 573-875-8880	Mon-Fri 8AM-5PM	-Linking with housing and emergency assistance -Provides assistance in securing housing -Detox -Substance abuse treatment -Outreach Services
Burrell 3401 Berrywood Drive, Suite 101	Emergency Room Enhancement (ERE) Program	Carisa Kessler	573-777-8455 24-hour crisis hotline 1-800-395-2132	Mon-Fri 8AM-5PM	-Uninsured individuals -Provides assistance in securing housing, no direct housing program -Provides linkage to services -Willing to engage in case management
	Community Mental Health Liaison	Anna White	573-777-8300	Mon-Fri 8AM-5PM	-Available for consultation/referral assistance/trainings
New Horizons 1408 Hathman Place	PATH Program	Katie McBride	573-443-0405	Mon-Fri 8AM-4:30PM	-Serious Mental Illness, no insurance required -Homeless or at-risk of being homeless -Provides assistance in securing housing, no direct housing program -Willing to engage in case management -Outreach Services
VA 800 Hospital Drive	Homeless Veteran Program	Katie Burnham Wilkins	Homeless Triage Team (M-F, 8-4PM): 573-814-6000 x56486 Or present as a walk in to the Green Team Clinic (2nd floor)	Mon-Fri 8AM-4:30PM	Served in the military -Enrollment in VA healthcare -Emergency, transitional and permanent housing programs -Employment programs -Legal programs -Peer support programs -Referral to VA services: mental health, substance abuse, primary care, etc.
Rainbow House	Homeless Youth Program	Mark Kirchhoff	Office: 573-474-6600 x3202 Cell: 573-818-8288	Mon-Fri 8AM-5PM	-Transitional Living Program for youth 16-21 -Outreach services for youth 25 and under

Turning Point 702 Wilkes Blvd. Suite 301 Columbia, MO 65201	Drop In Center	Marcus Reynolds Tasca Tolson	573-214-4077	Mon-Fri 8AM-12/noon	-Physical mailing address -Important document storage -Internet access -Telephone access -Referrals for haircuts -Showers and laundry facilities -Sock exchange -Cell phone charging -Employment and housing information -Location to meet case worker -Temporary storage of up to two bags for up to ninety days -Encouragement and support in life's most difficult times

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Panelists made every effort to answer attendee questions; however, time did not allow for all questions to be answered. Questions that were left unanswered at the panel were recorded and answers are currently being compiled. When answers are available for all recorded questions, they will be added to the website. A link to the recording of the panel discussion will also be added to the website when available.

To listen to a recording of the panel discussion, please click on the following links:

Part 1: Introduction and overview
Impacts on system resources
17:38
https://audioboom.com/posts/6107714-boone-county-s-mental-health-crisis-and-the-need-for-solutions-part-1

Part 2: De-institutionalization and lack of access to health care: Trading one problem for another
"Joe's Life"
12:48
https://audioboom.com/posts/6107702-boone-county-s-mental-health-crisis-and-the-need-for-solutions-part-2

Part 3: What agencies are doing now
38:00
https://audioboom.com/posts/6107699-boone-county-s-mental-health-crisis-and-the-need-for-solutions-part-3

Part 4: New collaborative initiatives
Why should we care and next steps
21:14
https://audioboom.com/posts/6107696-boone-county-s-mental-health-crisis-and-the-need-for-solutions-part-4