BOONE COUNTY JUDICIAL AND LAW ENFORCEMENT TASK FORCE

Meeting Minutes – August 13, 2014

Present: Warren Brewer, Kay Evans, Nicole Galloway, Jared Vessel, Taylor Major, David Thomas, Lisa Thomas, Judge Deborah Daniels, Mary Epping, Rockne Corbin, Janet Thompson, Christy Blakemore and Rusty Antel

The meeting opened at 4:30 PM. The jail population has declined somewhat since the levels in June and July 2014, where we were averaging 30 persons housed out in other facilities. The number housed in other facilities was down to 19 as of the August 14, 2014 snapshot.

Warren Brewer gave a presentation on the history of mental health issues at the jail. The expansion of the jail from 134 beds to 210 beds was completed in 1998 which coincides with the growth of the mental health issues in the jail. Currently, the jail provides 40 hours per week of counseling services and seven hours of psychiatric services, all overseen by the physician who serves as jail medical director. The problem dates back to the deinstitutionalization of the mental health system in the 1960s. There is currently a severe shortage of mental health treatment beds The jail sees approximately 50-60 inmate clients per month and approximately 25% of the jail population has contact with the mental health treatment staff at the jail.

There are several documents which will be posted on the website pertaining to the meeting topic, as follows:

1. Outline of Warren's presentation from August 13
2. AP Article – US Jails Struggle With Role as Makeshift Asylum
3. Opinion Piece – How We Shaft the Mentally Ill – Tom Dart, Cook County IL sheriff
4. St. Louis Post-Dispatch article – Shortage of Psychiatrists, Funding Issues Create Crisis in Mental Health Care
5. Article – States' Decision on Expanding Medicaid Will Impact Inpatient Psychiatric Care

The next meeting will be on Wednesday November 12 at 4:30 PM at the Government Center. Any suggestions as to the meeting topic will be greatly appreciated.

Rusty Antel - Chair

Boone County Sheriff's Department
Presentation on Mental Health Process
Boone County Jail
August 13, 2014

I. Problem defined Estelle v. Gamble 429 U.S. 97, 103, (1976) 8th Amendment protection against cruel and unusual punishment (Texas DOC inmate injured loading cotton bales misdiagnosed give pain pills instead of x-ray or further tests.)

II. Mental Health Care is governed by the same constitutional standard of deliberate indifference as is medical care.

III. Elements of an adequate mental health care system

A. Systematic program for screening and evaluating prisoners in order to identify those who require mental health treatment
B. Treatment must entail more than segregation and close supervision of the prisoner patients
C. Treatment requires the participation of trained mental health professionals who must be employed in sufficient numbers to identify and treat in a individualized manner
D. Accurate, complete, and confidential records of the mental health process must be maintained.
E. Prescription and administration of behavior-altering medications must be supervised and endure periodic evaluation.
F. A basic program for the identification, treatment and supervision of prisoners with self-injurious behavior

Historical: From Deinstutionalization to trans-institutionalization.

In the early 60's, states embarked on an initiative to reduce and close their publicly operated mental health hospitals. Advocated of deinstutionalzation envisioned that the mentally ill would live more independently with treatment provided by community mental health programs. The Federal Government did not provide sufficient ongoing funding for these community programs to meet the growing demand. States reduced budgets for hospitals but provided no increase in funds for community based treatment facilities.

This policy prompted the Surgeon General of the United States to issue a report titled "Mental Health: A report of the Surgeon General" which stated **"Even more than other areas of health and medicine, the mental health field is plagued by disparities in the availability of and access to its services."** Many of the individuals released into the community were ultimately incarcerated thereby creating a "trans-institutionalization" of their condition.

2009 report by Treatment Advocacy Center reveals that for every 20 public psychiatric bed that existed in the US in 1955 there was only 1 such bed in 1995. In 1955 there were 340 beds available for every 100,000 persons; by 2005 there were only 17 beds per 100,000 persons in the US.

Consequences of Bed Shortage:

1. Homelessness: 2005 studies in Massachusetts and Ohio found that average of over 30% of those released from mental health hospitals become homeless within 6 months.
2. Jails and Prisons become Psychiatric Hospitals for violent offenders: 3 largest de facto psychiatric institutions in the US are LA county jail, Cook County jail and New York's Riker Island jail.

3. Hospital ER overflow ER's are often used as waiting rooms for people in need of a psychiatric bed.
4. Violent Crime: Between 5 to 10% of seriously mentally ill persons who are not receiving treatment will commit a violent act each year.

Missouri Bed Shortage:

2009 DMH conveyed Mid-Mo to UMC hospital. Mid Mo was operating 46 beds at the time of transfer down from 69 beds in 2007. Since transfer length of stay has decreased from 12-15 days to six days. Adult intake is pronounced at 250 to 270 a month. In October of 2011 99 patients were diverted due to lack of bed space.

Suggestions as to making the system work:

1. Holding state governors and mental health officials responsible for the shortage of beds.
2. Utilizing Programs of Assertive Community Treatment (PACT) these alternatives to hospitalization have good track records for success.
3. Modifying federal and state regulation s to allow more flexibility in the utilization of alternative to psychiatric hospitalization.
4. Making the Public aware of the severe shortage in public psychiatric beds and the corresponding increase in homelessness, number of mentally ill persons in jails and prisons, mentally ill persons in ER waiting rooms, and increase in violence by mentally ill persons in need of treatment.

5. All those jails that have mental health services supported or supervised by licensed psychiatric personnel to "force medicate" those who consistently "go off their" meds in the same manner and guidelines as mental health treatment facilities.

U.S. jails struggle with role as makeshift asylum

Cook County jail has more than 106,000 inmates, and like many jails across the country is struggling to deal with a rising number of inmates suffering from serious mental illnesses. ¦ Charles Rex Arbogast/ The Associated Press
BY Adam Geller/The Associated Press

CHICAGO — The numbers, posted daily on the Cook County sheriff's website, would be alarming at an urgent care clinic, let alone a jail: On a Wednesday, 36 percent of all new arrivals report having a mental illness. On a Friday, it's 54 percent.

But inside the razor wire framing the 96-acre compound, the faces and voices of the newly arrested confirm its accidental role as Chicago's treatment center of last resort for people with serious mental illnesses. It's a job thrust on many of the nation's 3,300 local jails, and like them, it is awash in a tide of bookings and releases that make it particularly unsuited for the task.

Peering through the chain link of an intake area holding pen, a 33-year-old man wrapped in a navy varsity jacket leans toward clinical social worker Elli Petacque Montgomery, his bulging eyes a clue that something's not right.

"They say I got bipolar, that's all," he says.

"OK, are you taking your meds?" she asks.

"When I can get them."

Two pens over, a white-haired man with a cane huddles on a bench, booked in on a narcotics charge. He tells Montgomery he is haunted by visions of people he killed in the Vietnam War, and heroin eases the post-traumatic stress.

"I'm down here every day," says Montgomery, deputy director of the sheriff's office of mental health policy. "Every morning I hear this."

The Cook County Jail, with more than 10,600 inmates, is one of the country's largest single-site jails. But it is not unique. From big cities to rural counties, jails have seen a rise in the number of inmates with serious mental illnesses, most of them arrested for nonviolent crimes.

Unlike prisons — where inmates serve extended sentences — jails hold those trying to make bail while awaiting trial, or serving shorter terms. U.S. jails hold about 731,000 people, less than half the 1.57 million in state and federal prisons. But last year, jails booked in 11.7 million people — more than 19 times the number of new inmates arriving at prisons.

The revolving door greatly complicates the task of screening for mental illness, managing medications, providing care and ensuring inmate safety.

"Jails are churning people," says Henry J. Steadman, a former New York state mental health official and longtime consultant to government agencies across the country on how courts and correctional facilities deal with people with mental illnesses. "You can do things in prison, in terms of treatment and getting to know people, that is very difficult to do in a jail because of that constant movement."

Experts have pointed to rising numbers of inmates with mental illnesses since the 1970s, not long after states began closing psychiatric hospitals without following through on promises to create and sustain comprehensive community treatment programs.

But as the number of those with serious mental illnesses has climbed or surpassed 20 percent in some jails, many have struggled to keep up, sometimes putting inmates in jeopardy.

The Associated Press has reported that at least nine of the 11 suicides in New York City jails over the past five years came after operators failed to follow safeguards designed to prevent self-harm by inmates. In one case, a mentally ill man hanged himself from a pipe on his third attempt after orders to put him on 24-hour watch were apparently ignored.

The AP's investigation into the deaths of two mentally ill inmates at the city's Rikers Island jail complex — one who essentially baked to death in a 101-degree cell in February and the other who sexually mutilated himself last fall — have prompted oversight hearings and promises of reform.

"The incredibly high intake rate makes it very difficult (for jailers) to do their job well because they operate in environments that are so chaotic," says Amy Fettig, senior staff counsel at the American Civil Liberties Union's National Prison Project, which has sued a number of jails to demand they provide federally mandated care and improve conditions for inmates with mental illnesses.

"Frankly, local jails have become the new social safety net for individuals with mental illnesses," she says. "The only net that catches them is the criminal justice system."

"The complex mixing of dynamics"

By 9 a.m. the guards, public defenders and counselors who constitute the Cook County Jail's welcoming committee can see their work before them — 87 men and 19 women arrested in the city overnight, with more from the suburbs to follow. All must be processed in two hours, before they are marched through tunnels to face a judge who will hear a seconds-long synopsis of each case and set bond.

At a white laminate counter, Marianne Kelly, a substance abuse and mental health counselor, stands alongside two interns, calling up inmates one by one. Quarters are close, but the unending drone of ventilation ducts overhead and the hum of the body scanning machine drown out nearby conversation.

Kelly gently questions Jeremy, a 21-year-old wearing a black Marilyn Monroe T-shirt, arrested for simple possession. He tells her he's been taking medication for bipolar disorder since childhood. Except when he doesn't — a lapse he blames on a family member.

"I just get mad at the person who tells me to take my medicine because they tell me I'm retarded," he says. (The Associated Press agreed to a request by jail officials to use only first names in identifying inmates who have not yet been tried.)

Kelly explains that a judge will likely send Jeremy home today and urges him to reconcile with his family and resume medication. But there's no way to know what will happen or whether Jeremy, like so many here, will substitute illegal drugs for prescriptions.

"The mental health issues are causing the substance abuse. The substance abuse is causing their criminal behavior," Kelly says. "It's not about good or evil, or right or wrong. It's the complex mixing of dynamics."

Jails across country are failing to assist mentally ill

On this morning, 40 percent of the people booked into Chicago's jail tell a counselor they are mentally ill. Other facilities around the country report similar rates, with nearly half of those diagnosed with a serious disorder. Cook County estimates around 30 percent of inmates have a serious mental illness.

But when Sheriff Thomas J. Dart, a former prosecutor and state legislator, took over running the jail in 2006, a DOS-based computer system (since replaced) was incapable of analyzing the inmate population. A Justice Department investigation in 2007 and 2008 found multiple problems, including a failure to provide adequate mental health care, putting the department on notice.

Federal law protects the rights of people in jails and other institutions, requiring facilities to provide mental health and other care and ensure safety. But in temporary holding facilities, dealing with serious, long-term mental illnesses has required operators to rethink what they do.

"You're given a court order by a judge to hold this person in the jail until you're told not to," Dart says. "You're not supposed to do anything other than feed him, give them a bed, make sure they don't harm anyone else or themselves. ... You're not in there trying to cure people."

Across the country, many jails are dealing with similar dynamics, with sometimes disturbing results.

- In June, federal officials cited "deplorable" conditions for mentally ill inmates in the Los Angeles County jails as partly to blame for 15 suicides in 30 months. The L.A. system, the largest in the country with 19,000 inmates, has been under federal supervision since 2002, but still fails to adequately supervise inmates with mental illnesses or provide care for "prisoners with clearly demonstrated needs," the Justice Department concluded.
- In Florida, Justice officials last year issued a scathing report about conditions at the Escambia County Jail in Pensacola, noting that it employed a single, part-time psychiatrist for 1,314 inmates. Records showed many inmates who requested care were never seen by a mental health professional. When inmates refused to take medications, the jail merely removed them from its list of those with a mental illness. The county has since taken over operation of the jail from the sheriff in an effort to address the issues.
- In Columbus, Nebraska — seat of a county of 33,000 — the Platte County Detention Center saw six inmates attempt suicide in the first few months of this year, equaling all attempts in the previous 10 years combined. Jon Zavadil, who retired June 1 after 21 yearsas the county sheriff, says that is a direct symptom of the influx at a jail that, early this year, had about 80 percent of all inmates medicated for some type of mental illness.

  Zavadil recalled that when he was a deputy on patrol in the 1980s, he and fellow officers were rarely called to take someone with a mental illness into emergency protective custody. Now, that happens in Platte County about two to three times a week, he says. In February, one of the jail's inmates was declared mentally unfit to stand trial. But he stayed in the jail until April, waiting for one of the state's few psychiatric beds to open up, Zavadil says.

  "Every county jail in the state has the same problem," says Zavadil, who blames Nebraska lawmakers for voting to close two of the state's three public psychiatric hospitals over the past decade. "I don't really know what the real answer is. Somebody's going to have to throw some money at this."

For many mentally ill, jail is primary care provider

The fresh white walls and computer-equipped nursing station on the second floor of Cermak Health Services give it the appearance of a hospital. The uniformed guards watching the patients, some behind locked doors, make clear that's not the case.

Cermak is the Chicago jail's infirmary, and this floor is the landing place for inmates with the most pressing mental health needs. Many arrive knowing doctors' names, a sign not just that they've been here before, but that for many, the jail is their primary care provider, says Dr. Kenya Key, the chief psychologist.

At midday, art therapist Eric Spruth joins three patients around a small table in a room decorated with inmate drawings, encouraging them to express their thoughts in letters home while listening to the Jimi Hendrix ballad "Little Wing."

Cermak also offers individual therapy. But Dr. Jack Raba, the infirmary's interim site administrator, points out that housing an inmate here costs up to $50,000 a year, money he says would be better spent on care that would help keep people with mental illnesses out of jail. Yet in 2012, Chicago closed six of its 12 outpatient mental health clinics.

In jail, Cermak provides what amounts to urgent care in a setting that is anything but therapeutic.

"Is this the right place to be? Absolutely not," says Raba, who has visited 65 jails and prisons around the country, as an expert witness in correctional health care lawsuits. "It's simply something the jail has to do because they have the patients. They're here."

Number of inmates with serious mental illnesses has increased

It's not like the influx of inmates with serious mental illnesses came as a surprise. Researchers have warned for decades that mental illness was being "criminalized," as police arrested and charged more people for offenses linked to untreated psychoses.

"Nothing's changed," says Linda Teplin, a Northwestern University researcher who authored a widely cited 1984 study on arrest rates among the mentally ill. "We're still talking about the same issues."

In the 1980s, researchers found about 6 percent of jail and prison inmates showed signs of serious mental illness. A survey published in 2009 found 17 percent of jail inmates with serious mental illnesses, and significantly higher rates among women. But individual jails report far greater numbers of mentally ill inmates who stay locked up longer because they often lack the money and family ties that allow others to make bail and are more likely to break jail rules.

The advent of powerful psychotropic drugs for treating mental illnesses, and exposes of conditions inside psychiatric hospitals, led to promises of a new kind of community-based care. Many of those released from the hospitals in the early years "tended to be aware of their illnesses, they had family, had a place to go. They were less severely impaired," says Dr. E. Fuller Torrey, founder of the Treatment Advocacy Center and a strident critic of the mental health care system.

But as hospital closings continued, people with more serious conditions were released. Today, many of those jailed with mental illnesses have grown up in a system full of holes.

"Even what we had when I started doing this work in 1988 was better than what we have now," says Nancy Koenigsberg, legal director for Disability Rights New Mexico, which helped bring suit against her state's Dona Ana County Detention Center in 2010 for mistreatment of inmates with mental illnesses.

The suit led to improvements inside the jail including increases in its mental health staff, she says. But New Mexico cities and counties have continued closing adult day programs, drop-in centers and transitional housing that were supposed to ensure people with serious mental illnesses maintained treatment.

Without it, many people end up on the street, some repeatedly picked up for relatively minor crimes, becoming what jail operators call "frequent flyers."

At the Volusia County Detention Center in Daytona Beach, Florida, administrators compiled a list of offenders who'd been booked into the jail at least 20 times over five years. The 19 worst had been collectively jailed 894 times, mostly for minor offenses. Nearly half had a history of mental illness.

"A lot of their behavior was low level. In fact, the majority were misdemeanor offenses," says Marilyn Chandler Ford, the county's corrections director. "So they cycle through in a fairly short period of time and they never make it to prison."

Funding to facilitate inmates with mental illness is too late for some

The influx has increased pressure on jails to find solutions — but not soon enough for some families.

In Wichita, Kansas, Angela Waldon starts each day by putting on a necklace threaded with a small blue glass vial sealed by a cap bearing a Celtic cross. Then she waits for people to ask about the ashen memento it holds: remains of a brother whose battle with alcoholism and delusional demons led him to the cell at the Sedgwick County Jail where he hanged himself in 2012.

"I want people to see what's become of my brother," Waldon says.

Wichita's jail, with nearly 1,400 inmates, is Kansas' biggest local lockup. On a recent afternoon, 407 of those prisoners had some kind of mental illness. One such inmate has been booked in to the jail 27 times over the last year and a half.

"These folks are going back out in to the community without medication, they re-offend and they're right back in jail," Sheriff Jeff Easter says.

But critics say jail officials long compounded the problem through negligence, allowing for abuse of inmates with mental illnesses by both guards and fellow prisoners, while limiting access to treatment.

In 2008, an inmate diagnosed with paranoid schizophrenia, Edgar Richard Jr., was severely beaten by a deputy after refusing to take medication, breaking his jaw and causing permanent brain damage. In affidavits, two former sheriff's officers alleged mistreatment of inmates and one said he saw signs of a cover-up of the beating. Richard's son, a former jail employee, filed a lawsuit, settled by the county earlier this year for $300,000.

In 2010, the previous sheriff, Robert Hinshaw, repeated a request to county commissioners for money to pay for a new housing unit for inmates with serious mental illnesses. But they again turned him down, citing the expense.

In May 2012, Waldon's brother, Jon Haehn, turned himself in at the jail for violating probation for driving under the influence. Just before, he sat for six hours while a tattoo artist inked the right side of his chest with a wing. Once he got sober, he told another sister, he'd get the other side done. But his family was wary. Months earlier, Haehn had stabbed himself with a pair of pruning shears in the belief there was a demon on his stomach. Waldon says that when he called from jail to report demons in his cell, the family warned officials he might try to harm himself.

He committed suicide days later.

In August 2012, Easter beat incumbent Hinshaw in a campaign that centered largely on treatment of jail inmates. Months later, commissioners approved Easter's request for the mental health unit. It opened in February, housing 49 inmates; it is always full.

The unit costs $740,000 a year to operate, a large part of it to pay deputies who stand guard in pairs around the clock. The county recently signed a new contract with its jail health care contractor, paying $390,000 more to bolster a psychiatrist's time at the jail from four hours a week to 12, adding a new case manager and mental health nurse, and adding hours for a physician's assistant and social worker. Easter says he's working with the local mental health agency to have a staffer work with inmates so they can resume Medicaid and Medicare coverage after release, to maintain needed medications.

Larry Wall, the lawyer representing the family of the inmate beaten at the jail, says they settled just before trial largely because of the changes underway. But he is skeptical of the county's dedication to providing better care.

The new mental health unit was approved "shortly before the trial was to occur and it doesn't take a rocket scientist to figure out why they did it at that time," Wall says. "I would be naive to say that I believe the culture has changed, and I'm not a naive person."

For inmates with mental illness, treatment is an uphill battle

The pale beige bricks of Cook County Jail's Division 2, Dorm 2 make it all but anonymous in a compound of buildings with barred windows. Upstairs, though, talk among inmates in a long chamber with 48 bunks bolted to the floor makes it clear that this is not just another cell block.

Montgomery, the clinical social worker, says she recognizes faces from jobs years ago supervising programs for children and adolescents with mental illnesses. Dorm 2 has a total of 464 bunks, most of them reserved for inmates with mental illnesses. They're always full.

In the best scenario, the jail can offer an island of stability for those inmates, Dart says. Maybe judges will consider the information about mental illnesses gathered by social workers when setting bond or at trial. In the next few months, Dart plans to convert a building that once housed

a boot camp into a transition center that will help those with mental illnesses ease back into life outside the jail.

But William, a 62-year-old inmate who says he's been jailed nine or 10 times for theft to support a drug habit, doubts that will end the cycle. Too many judges dismiss mental illness as a factor in crimes, says the inmate, diagnosed with depression, anxiety and symptoms of bipolar disorder. And outside jail, treatment is increasingly hard to get.

"You come back to the streets and all the facilities are closed with maybe one or two that are still open and they have an overload. And sometimes they get you and sometimes they don't," he says. "Once we leave here, we're back on doom street."

How we shaft the mentally ill

By Tom Dart

For more than 50 years, the Tinley Park Mental Health Center served as the treatment facility for up to 1,900 mentally ill patients annually. These days, the patients have been left to fend for themselves as the building lies vacant — a stark and eerie reminder of everything that is wrong with Illinois' mental health system.

Since the 1960s, the number of beds in Illinois' state-run psychiatric hospitals has decreased to fewer than 1,500 from 35,000, according to the National Alliance on Mental Illness. The latest closures in 2012, including the Tinley Park center, coincided with Chicago shuttering half of its 12 mental health clinics. For decades, we were told that government was not turning its back on the mentally ill. Rather, these institutions would be replaced through "reinvesting in community care" — a more humane and cost-effective means of treating those patients.

Those of us within the mental health and law enforcement communities know the truth — the "reinvestments" never come to fruition. When these institutions close, the seriously ill patients end up on their own, often on the street with no support system to keep them stable or medicated. Inevitably, they suffer psychotic states and commit petty crimes that land them within the unyielding grip of the criminal justice system — caught in a revolving door between jail and the streets.

Indeed, mental illness has been effectively criminalized in Illinois. The same society that deemed the old mental asylums as abhorrent has witnessed the evolution of jails and prisons into the new asylums. Currently, the largest mental health hospital in Illinois is not even a hospital — it's Cook County Jail, which I oversee as sheriff. My office's conservative estimate is that one-third of the 10,000 inmates in custody suffer from serious mental illnesses.

This crisis is hardly isolated to Chicago or Cook County. This ongoing nightmare is spreading throughout the nation. According to the Treatment Advocacy Center, jails and prisons serve as the largest mental health institutions in 44 states. Additionally, 10 times as many mentally ill individuals are currently incarcerated as are residing in state hospitals. According to NAMI, states collectively cut $4.35 billion in mental health spending between 2009 to 2012. Illinois ranks as the third worst offender, following a 31.7 percent reduction in its mental health budget, according to NAMI. These cuts have had tangible effects on real people.

Who are these mentally ill men and women? Contrary to popular belief, they are not dangerous criminals. Yes, we have some violent mentally ill inmates in the Cook County Jail, but they are the exceptions. The vast majority of these inmates are charged with low-level crimes of survival: prostitution, trespassing, disorderly conduct. Many are facing drug charges — for those unable to get medication to make the voices in their heads go away, heroin is often the next best solution. They are, for the most part, good people who suffer from an illness beyond their control and simply need their government to have its priorities straight.

The fact is that doing right by the mentally ill will help address our state budget problems. Incarcerating just one seriously mentally ill inmate costs two to three times the rate of the average inmate, taking into account medications and enhanced security to protect against self-harm. For a fraction of that cost, we can empower new community health centers and establish comprehensive discharge planning. It's humane and fiscally prudent.

Here's just one example. I recently met Joseph, a 54-year-old inmate who has spent most of his adult life battling schizophrenia while shuffling in and out of prisons, nearly always for petty theft. A patient at Tinley Park Mental Health Center, he established quality relationships with the staff and had a stable medication schedule. When the center abruptly closed, he felt broken. No community-based alternative was ever provided for him. Within months, he reverted to self-medication and landed in jail for stealing a $248 handbag from Bloomingdale's while in a psychotic state. "I've been falling through the cracks a long time," he told me.

Joseph recently received a one-year sentence. That $248 purse will cost Illinois taxpayers in excess of $16,000, the annual price to house a prisoner in the state facility where Joseph now resides.

Joseph and tens of thousands like him in our state deserve a fair shot at leading productive and fulfilling lives. Instead, they are falling through the cracks of broken promises. Any further talk of "reinvesting" in mental health should be accompanied by concrete plans and budgets. It's time to help the most vulnerable among us.

Tom Dart is the sheriff of Cook County.

ST. LOUIS POST-DISPATCH

Shortage of psychiatrists, funding issues create crisis in mental health care

JANUARY 18, 2014 11:30 PM • BY BLYTHE BERNHARD BBERNHARD@POST-DISPATCH.COM 314-340-8129

Suzanne Falvey of north St. Louis County said it took years of red tape and frustration to find the right support for her 22-year-old son who as a teenager developed schizoaffective disorder, which can cause severe mood swings, aggressive behavior and paranoia.

Even though the Falvey family had good insurance, their initial wait to see a child psychiatrist was six months. Once they got in, the psychiatrists rotated every few months so the family had to repeat the medical history and try to re-establish a rapport each time.

"Many people who have family members with mental illness go to wherever there's an opening or to whoever will take them," Falvey said. "When you're needing help and you're reaching for someone to help you out of the water, you don't have a lot of time to check out what the hand looks like or if they can pull you up."

The mental health care system is strained by the number of people who need help and a shortage of psychiatrists to meet those needs. The situation has reached a crisis point, experts say, pointing to some alarming figures:

- The federal government designates 104 out of 114 Missouri counties and most of St. Louis city as mental health shortage areas. There is no licensed psychiatrist in 72 Missouri counties.
- A majority of psychiatrists don't accept Medicaid, and a growing number refuse all health insurance plans.
- The average wait to see a psychiatrist in the St. Louis area is estimated at 10 to 30 days and can reach six months for children and teens.
- There are 1,174 psychiatric hospital beds in the state, down from 2,600 in 1990.
- Many people with mental illness end up in county jails when they fail to find treatment elsewhere. The jails are not equipped to treat mental illness, and officers are overwhelmed by the effort to find more appropriate facilities. Recently the only deputy in Clark County, Mo., transported a mentally ill patient 325 miles to Nevada, Mo., which had the closest open bed, according to Keith Schafer, director of the Missouri Department of Mental Health.

"It's creating huge problems for individuals, for families, for emergency rooms and certainly for law enforcement officials," Schafer said.

After several run-ins with the police and multiple trips to area emergency rooms, the Falvey family found the right balance of inpatient and outpatient care for their son at Mercy Hospital St. Louis in Creve Coeur.

"They worked very hard with us to get the right fine-tuning to get him stable and to maintain his stability," Falvey said. "It took years and it took a competent psychiatrist with the right kind of heart and mind."

That Mercy Kids psychiatrist, Dr. Duru Sakhrani, said the country's mental health care system is not adequately developed for patients who require faster and earlier attention.

"If we as a society develop mental health treatment that would be equal to the way we treat diabetes and asthma, it will serve our patients a whole lot more," Sakhrani said.

Mercy recently opened a 13-bed psychiatric unit in its children's hospital. It is nearly always full with children as young as 6 who stay three to five days for group and individual therapy for acute needs. But most patients don't need that level of care, and access to community clinics can take months. To help address the shortage, Mercy offers outpatient care and is set to launch telepsychiatry services so its in-house psychiatrists can communicate electronically with rural patients.

The first symptoms of mental illness often strike young adults in their 20s and 30s, who are disproportionately uninsured and lack resources for treatment.

"As people think about tragedies like (Newtown) Connecticut and other horrible events around the nation involving young people, leaving them untreated can be horribly damaging to the young person as well as dangerous to the community," Schafer said. "The vast majority of those individuals will never be dangerous to somebody else, but their health will deteriorate, their function will deteriorate, and if we intervened earlier we could prevent most of those problems."

Recent budget cuts to mental health and the Legislature's decision against expanding Medicaid funding have placed further strains on the system. CoxHealth Systems in Springfield, Mo., has abandoned plans to expand behavioral health services. BJC Behavioral Health in St. Louis has added 400 clients in the last year without increasing staff. It won't accept new Medicaid patients until another patient is discharged from its services.

"There's a shortage of psychiatrists, especially in rural areas," said Kim Gladstone, vice president of BJC Behavioral Health. "(But) there is not a shortage of case managers and community support workers; there's a shortage of money to pay for them. If you just open the doors but you don't increase the funding for the actual care to meet that need, then you become unbalanced."

SSM Health Care, the private hospital system with the most mental health beds in the St. Louis region, has 10 to 15 patients every day waiting for a bed. On weekends the waiting list can jump higher than 30.

"Unfortunately we have to hold people in our emergency departments," said Dan Body, vice president of SSM Behavioral Health Services. "Absent the Medicaid expansion, we still have 25 percent of adult psychiatric patients uninsured. We're not receiving the same amount of federal dollars, and we don't have the funding source. It leaves us in a vulnerable spot."

NEW COLLABORATIONS

Some new collaborations are allowing hospitals and community health centers to patch together consistent treatment programs for people with mental illness. The community centers send liaisons to hospitals to talk about follow-up care with patients when they are discharged. Since last fall, additional funding has allowed liaisons to also visit mental health patients in the state's emergency rooms. In November, BJC started same-day access to behavioral health care in its downtown clinic. The state, BJC and SSM partnered in 2012 to open the St. Louis Regional Psychiatric Stabilization Center in the former Metropolitan Psychiatric Center on Delmar Boulevard, which closed in 2010 following state budget cuts of $7 million.

The average daily census at the stabilization center is now 20, said CEO John Eiler.

"We're full at least a couple days out of every week, and most patients that we see come to us from other hospitals' emergency rooms when their beds are all full," Eiler said.

Some of Missouri's psychiatrists are already leaving for neighboring states, including Illinois, Arkansas and Iowa that accepted federal funds to enroll more people in Medicaid. The Veterans Health Administration has also been actively recruiting psychiatrists from private practices to help treat an increase in depression and post-traumatic stress disorder among veterans, the state mental health director said. The VA offers higher salaries than the reimbursements offered through the state.

"For me it's an opportunity to work with veterans, plus the opportunity to have more structure in my work hours," said Dr. William Irvin Jr. who is closing his psychiatry practice based in Richmond Heights and moving to the VA.

WORSENING SHORTAGE

The national shortage of psychiatrists is only expected to get worse. More than half of psychiatrists are older than 55, unlike other higher-paying specialties like cardiology or orthopedics. In 2011, there were 16 psychiatry residency programs in the U.S. that did not fill their open spots, according to the National Institute of Mental Health.

The problem is less acute in St. Louis, where psychiatry training programs at Washington University and St. Louis University graduate 24 resident physicians every year. At BJC Behavioral Health, 17 of 20 staff psychiatrists trained at one of the local schools.

"They spend four or five years training after medical school, and they put down roots," said Dr. Mark Johnson, medical director at BJC Behavioral Health. "We do take patients in, we do see new patients, we are treating as much as we can."

Rochelle Brooks of St. Louis was hospitalized at Barnes-Jewish last August after a suicide attempt. Brooks, 34, had symptoms of depression since she was a teen but was reluctant to acknowledge her problems. While in the hospital, a representative from the nonprofit Independence Center visited Brooks to help her transition to outpatient support. The center offers employment, housing and treatment opportunities for people with mental illnesses.

"I'm doing wonderful now. I'm on the right combination of medicines, and they keep me busy," said Brooks of the center she attends five days a week. "It gives you a purpose, and that's all that some people need."

Mental health resources

Behavioral Health Response St. Louis crisis hotline: 314-469-6644 or 800-811-4760

United Way hotline 211 for referrals to various social services

List of community mental health centers:
dmh.mo.gov/mentalillness/org/county.htm

States' Decision on Expanding Medicaid Will Impact Inpatient Psychiatric Care

Mark Moran

The percentage of a hospital's indigent patients is likely to be much higher on psychiatric wards; thus diminished DSH payments next year will disproportionately affect psychiatric care in states that don't expand Medicaid rolls.

States that opt not to expand their Medicaid rolls when that option becomes available next year under the Affordable Care Act may be courting disaster.

That's because beginning next year at the same time the Medicaid expansion becomes an option, the federal government will begin to reduce—ultimately by 50 percent—what are known as Disproportionate Share Hospital (DSH) payments that general hospitals receive for care of the uninsured.

States that do not expand their Medicaid rolls to those earning 133 percent of the federal poverty level will continue to bear the burden of care for the uninsured, but with substantially less federal DSH support. And since a great many of those uninsured are psychiatric patients, the funding shortfall is likely to fall heavily on the care of mentally ill individuals.

Joseph Parks, M.D., medical director of the Missouri Department of Mental Health, is raising alarms about this little-discussed provision in the ACA that he believes could dramatically affect state mental health budgets in ways that will affect patient care. Parks contacted *Psychiatric News* and began raising red flags with colleagues in other states after a study undertaken at the direction of Missouri Gov. Jay Nixon (D) looked at the pros and cons of Medicaid expansion on four Missouri hospitals—CoxHealth-Springfield; St. Joseph Health Center-St. Charles/Wentzville; Truman Medical Center-Lakewood; and Twin Rivers Regional Medical Center-Kennett.

Following are major findings of the report:

- Under the ACA, Missouri hospitals will lose about $250 million in federal reimbursements for the charity care they provide, regardless of whether the state extends eligibility.
- The hospitals included in this study will lose between $1.0 million and $10.6 million in federal indigent care reimbursements annually under the DSH reduction, depending on the hospital's size. Since 24 percent to 58 percent of charity care that these hospitals provide annually occurs on their inpatient psychiatric units, the hospitals will be forced to cut adult acute psychiatric beds as the DSH cuts take effect.

- If community hospital psychiatric beds close, there will be increasing pressure on elected officials to open state acute psychiatric beds. The operating costs for state-operated acute beds would average approximately $850 a day, or about $31 million a year for every 100 beds, not including capital costs.

In an interview with *Psychiatric News*, Parks noted that there will be downstream effects on patients in the community. He said individuals who are seriously mentally ill and in crisis are often involuntarily committed to acute inpatient care for diagnosis and treatment by Missouri's courts.

"The additional loss of acute psychiatric beds will create even greater problems for county sheriffs and city law-enforcement departments that must transport these patients, often for long distances, in search of a psychiatric inpatient bed," he said. "Local law-enforcement officers already stay at the hospital emergency rooms and inpatient units for many hours as these patients are admitted to care. This situation will worsen."

Parks said states that rely heavily on DSH payments will be the most dramatically affected next year if they do not expand their Medicaid rolls to cover the uninsured. The DSH payment reduction will begin next year regardless of a state's decision regarding expansion; in the first years of expansion a state would receive full federal matching funds but be liable for 10 percent of costs by 2020. While a dollar-for-dollar comparison is difficult, in most instances the net effect of expansion would be an increase in funding, while in states that have relied very heavily on DSH payments, the effect of not expanding could be devastating.

Irvin "Sam" Muszynski, J.D., director of APA's Department of Healthcare Systems and Financing, said his analysis of the ACA confirms that the effects Parks has found in Missouri could be felt nationwide in states that opt not to expand Medicaid rolls.

Howard Goldman, M.D., editor of the APA journal *Psychiatric Services* and an expert on mental health parity and Medicaid policy, concurred. "The loss of DSH payments for uninsured patients creates a strong incentive for states to elect to participate in the Medicaid expansion under the ACA," Goldman told *Psychiatric News*. "Failing to expand Medicaid, however, will make it difficult to reduce the reliance on state psychiatric hospitals for uninsured individuals. In many states, uninsured patients will not be admitted to general hospitals and will continue to be admitted to state-operated facilities. States will have to pay for the care with state dollars without the federal participation for Medicaid and without the cost-offset from federal DSH payments for individuals who have no insurance at all."

Joel Miller, senior director of policy and health care reform for the National Association of State Mental Health Program Directors (NASMHPD), went further, saying the reduction in DSH payments

along with other factors affecting mental health funding—such as sequestration and the continuing exclusion from Medicaid payment of Institutions of Mental Disorders—could create a "perfect storm" of a crisis in public mental health.

"We believe it's going to be the worst of all worlds if several states that rely heavily on DSH payments choose not to participate in the Medicaid expansion," Miller told *Psychiatric News*. "States that do not opt into the expansion are really going to be caught in a very tight payment vise as they try to provide care to the uninsured with psychiatric conditions because they are going to be getting little or no compensation from federal agencies."

Miller said the effects will not be confined to inpatient psychiatric beds because many states also use the DSH payments to shore up resources for residential and outpatient services. He said NASMHPD has been alerting policymakers at the federal and state levels to pay attention to what may have major public health consequences.

Parks agreed. "I think we should make sure that the legislators making decisions about Medicaid expansion are fully informed about this potential disaster for access to psychiatric inpatient care and emergency rooms," he told *Psychiatric News*. "I have not seen this particular issue discussed in the individual state dialogues around whether or not to expand Medicaid, but it certainly needs serious consideration." ■