Healthcare Council

Thursday, February 15, 2007
4:15 PM
212 Knott

This is a Joint Meeting with the Safety & Security Council

Marco Rubio
Speaker

Aaron Bean
Chair

Joint Meeting
Healthcare Council and Safety and Security Council
February 15, 2007
4:15 p .m.
212 Knott Building

Opening Remarks by Chairman Bean and Chairman Dean

Overview of the Current Situation
- Department of Children and Families
  - Secretary Bob Butterworth
  - Ken deCerchio, Assistant Secretary for Substance Abuse and Mental Health
- Dr. Tom Blomberg, Dean, College of Criminology and Criminal Justice

Panel Discussion
- Donna Wyche, Manager, Office of Mental Health and Homelessness, Orange County Florida
- Lisa Fonteyn, 19th Circuit Public Defender Office
- Judge Mark A. Speiser, 17th Circuit Court, Ft. Lauderdale

Department of Corrections Issues and Ideas
- Dr. Laura Bedard, Deputy Secretary
- Dean Aufderhide, Director of Mental Health Services

Closing Remarks by Chairman Bean and Chairman Dean

Presentation by Thomas G. Blomberg

Dean and Sheldon L. Messinger Professor of Criminology, College of Criminology and Criminal Justice, Florida State University

Presentation to the Florida House of Representatives: Safety & Security Council and Healthcare Council

Thomas G. Blomberg, Dean and Sheldon L. Messinger Professor of Criminology

Jails and the Mentally Ill

February 15, 2007

COLLEGE OF CRIMINOLOGY AND CRIMINAL JUSTICE

Research Brought to Life.

Factual Assumptions

- Given anticipated future increases in arrests and jail populations and the nature of society with its associated challenges for its members, the problem of confronting mentally ill inmates in jail will not decline but continue to increase.
- Mental illness is a developmental disease that can be effectively treated in many instances, but if left untreated will worsen, and there is a strong relationship between mental illness and crime.
- Each year 600,000 inmates are released from prison nationally including 36,000 in Florida and re-enter our communities. An alarming number of these releasees suffer from various forms of mental illness that have not, as a whole, been effectively treated during their incarceration (Irwin 2005, "Super Predators").
- Community service centers that are able to provide comprehensive prevention and treatment services are a fundamental component if we are to begin to confront the escalating problem of mental illness and crime.
- Ultimately, effective policy for mentally ill offenders will require a systemic approach that is held to strict and ongoing quality assurance and diagnostic evaluation requirements.

Background

- Beginning in the 60's and continuing today, the U.S. began the implementation of a major reform movement involving the deinstitutionalization of the mentally ill from jails, prisons and mental hospitals (Lurigo & Swartz, 2000).
- The movement was fueled by an emerging belief that various negative consequences were associated with incarcerating and institutionalizing the mentally ill as well as other less serious offenders (Labeling and Stigma vs. Effective Treatment).
- An associated series of mental health laws were enacted making it increasingly difficult to involuntarily hospitalize all but the most dangerous and clearly mentally ill (Lurigo & Swartz, 2000).
- A major outcome of the deinstitutionalization movement was that many mentally ill inmates and patients were released back to the community into programs that had limited capacities and that were largely ill equipped. Responses to the releasees needs often relied upon medication as the main treatment approach which, in turn, contributed to subsequent homelessness, further criminal involvement and multiple returns to jail (Scull, 1984).

Background

- Beginning in 1980, after more than a decade of experience with the deinstitutionalization movement, the U.S. began an unprecedented effort to "get tough" on all criminal offenders.
- For jails and prisons, the get tough on crime movement resulted in an exploding population of inmates that was further complicated by the demand for differentiated processing of mentally ill inmates, that has now culminated in a national crisis on how to deal with mentally ill offenders.
- Ultimately, two factors that often bring about change in corrections were at odds with each other: namely litigation and limited resources. Mental health services reform is one of the most frequently litigated areas. Yet, funding pressures, cutbacks, and increasing numbers of inmates made the implementation of effective reform difficult at best.

Current Problem

- According to the U.S. Department of Justice, in 2006, 64% of the country's jailed inmates self-reported some kind of mental health problem.
- In 2001 there were five times more mentally ill in jails and prisons (300,000) than in psychiatric hospitals (60,000), (Leifman, 2001).
- Miami-Dade has the largest percentage of seriously mentally ill people of any urban area in the country, two to three times the national average, (Bennet, 2006).
- In addition to adult inmates, on any given day in Florida there are between 60 to 70 juveniles who are determined to be incompetent (DCF,2007)

Current Problem (Cont.)

- As recent as December 2006, there were 307 mentally ill inmates in Florida jails awaiting an opening in one of the state's 1,416 secure psychiatric beds.
  - 72% of these inmates had waited longer than the statutory time limit of 15 days.
- Judges throughout the state have been considering ways to force the Florida Department of Children and Families (DCF) to comply with the 15 day limit for mentally ill offenders to be held in jail.
- DCF has been seeking a **short-term solution** to the bed shortage; however, each new bed costs more than $100,000 per year.
  - 24 new secure beds will be added in 2007 and 233 additional beds have been requested for 2008 resulting in a secure psychiatric bed capacity of 1,673.

Current Problem (Cont.)

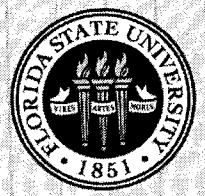
Year	Jail Population	Estimated Mentally Ill (16%)	Commitments to Psychiatric Beds*	Actual Secure Psychiatric Beds **
2004	55,956	8,953	1,248	NA
2005	57,559	9,209	1,276	NA
2006	63,537	10,166	1,483	1,416
2007	67,446	10,791	1,525	1,440
2008	71,595	11,455	1,618	1,673
2009	76,000	12,160	1,718	1,673

*Projections are based on the average ratio of psychiatric commitments to total jail populations from 2004 to 2006 (2.26%).**24 new secure psychiatric beds were requested for this year and 233 beds have been approved for next year (DCF, 2007). According to DCF's 2007 projections, the Department will need 1,958 beds by 2008-2009. Please note that these projections are approximate and should be updated as more specific data become available.

Policy Responses and Best Practices
A Sequential Approach

Immediate

- **Compliance with the law, per current initiatives, to add additional secure psychiatric beds and community placements.**
  - **Avoid the program magnet phenomenon likely to accompany the availability of new beds through accountable implementation (McGee, 1973).**



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Policy Responses and Best Practices
A Sequential Approach (Cont.)

Immediate

- Review existing laws and procedures relating to mental health services within the criminal justice system such as:
  - The forecasting of offenders with mental illness including those found to be incompetent to stand trial is not currently included in the Criminal Justice Estimating Conference forecasts therefore impeding responsible and proactive policy responses
  - Mental health screening in jails
- Cross train criminal justice and mental health personnel such as judges, law enforcement, and intake personnel (Hartstone; Teplin; Jemelka; Drovskin, 1990)
- Implement quality assurance and diagnostic evaluation of all immediate measures

Policy Responses and Best Practices
A Sequential Approach

Intermediate

- Consider state and private provider partnerships in developing and operating community service centers with the state assuming responsibility for quality assurance and diagnostic evaluation
  - Similar to healthcare services in jails involving the private sector. Center services should include community residential placements, case management and follow-up to deal with a range of mental health problems and needs.
- Designate police officers specifically trained on how to deal with the mentally ill and the use of community service centers as an alternative to jail where appropriate
- Designate mental health positions in jails
- Encourage pre release Medicaid enrollment for inmates with diagnosed mental illness to facilitate access to community treatment upon release (Sentencing project, 2002)
- Develop crisis intervention teams within the jails (Hartstone, 1999)
- Implement quality assurance and diagnostic evaluation of all intermediate measures

Policy Responses and Best Practices
A Sequential Approach

Long-Term

- Jail diversion programs for the mentally ill:
  - Electronic monitoring
  - Mental health courts
  - Community based case management and treatment
  - Integrating community service centers with the criminal justice community and private healthcare providers
- Develop other appropriate prevention programs that target at-risk populations such as the homeless and substance abusers (Continuum of Care)
- Implement quality assurance and diagnostic evaluation of all long-term measures

Recommendations

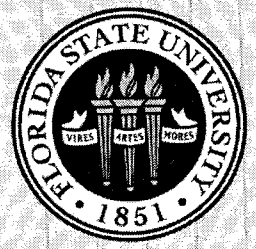
Systemic Approach that includes:

1. Expand secure psychiatric beds and community placements for mentally ill offenders.
2. Implement community-based service centers (establish linkages between jails, mental health services, and private sector).
3. Expand policing resources (mental health training and liaisons).
4. Refine admissions and booking procedures (screening and diversion).
5. Expand jail-based services (training correctional officers, crisis intervention teams, mental health units).
6. The State must hold all components accountable and maintain a rigorous quality assurance and ongoing diagnostic evaluation system.

Presentation to the Florida House of Representatives: Safety & Security Council and Healthcare Council

Questions

For More Information, Contact The Center for Criminology and Public Policy Research
850– 414 – 8355
www.criminolgycenter.fsu.edu



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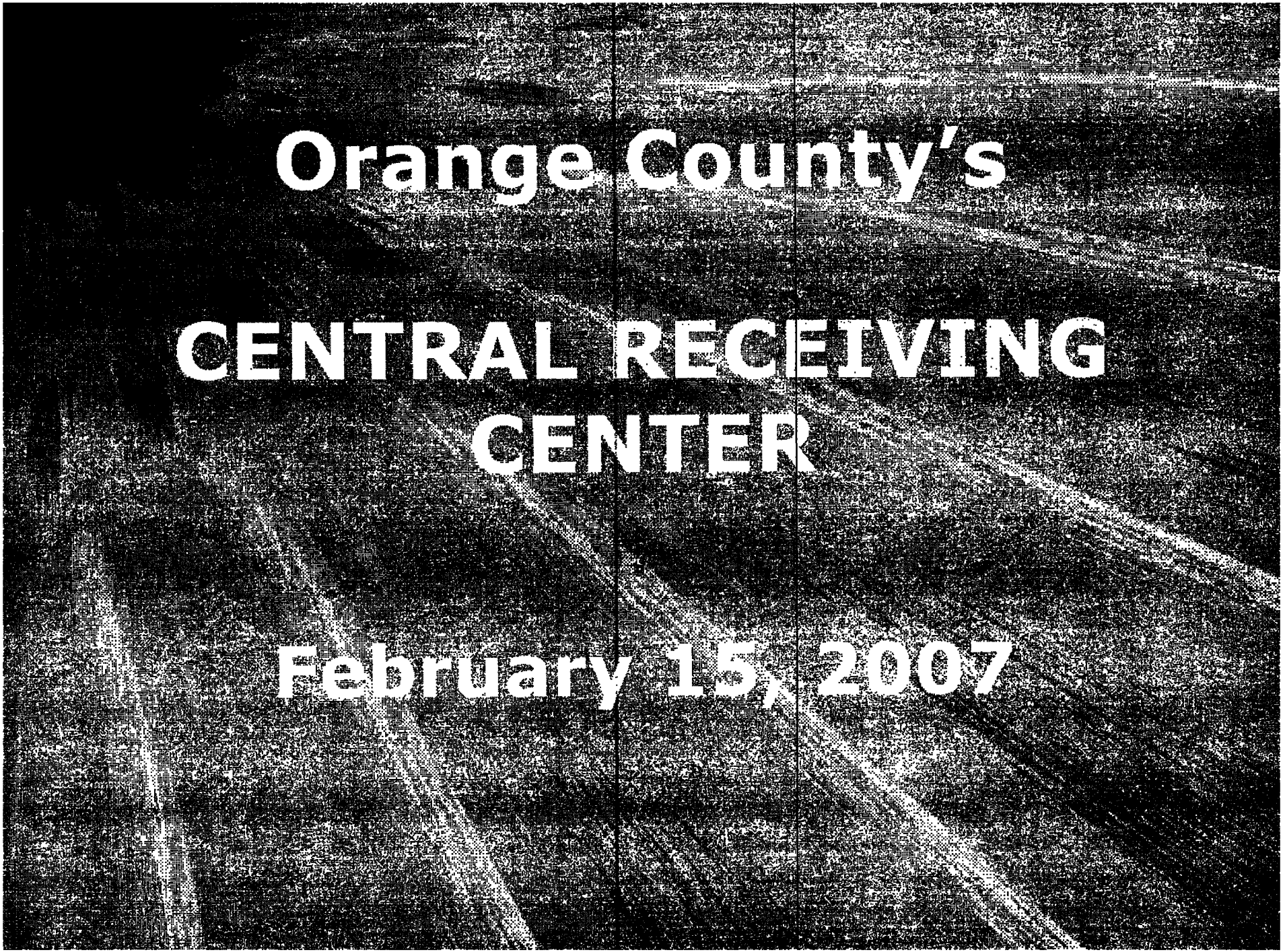
Presentation by Donna Wyche

Manager of the Office of Mental Health and Homelessness for Orange County Florida


Orange County's
CENTRAL RECEIVING CENTER
February 15, 2007

Central Receiving Center

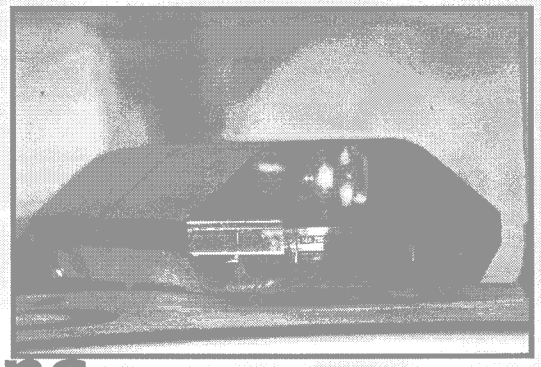
- Service Integration
- One-Stop Shop
- Medical Clearance
- Mental Health/Substance Abuse Assessment
- Resource management
- Streamlined process

Central Receiving Center

- **Why Have a CRC?**
  - Supported by the Jail Oversight Commission and the Community Review Panel for Lakeside Alternatives
  - Many Jail inmates have mental health and/or substance use disorders
  - Future trends support the integration of systems

Central Receiving Center

- One-Stop Shop for Law Enforcement:
  - Saves law enforcement 2-4 hours
  - Saves at least 800 man-hours per-month
  - Time saved equals 9600+ hours per-year or 4.6 positions
  - Central hub for data collection



Central Receiving Center

- Seamless System of Care:
  - Medical triage
  - Substance abuse and mental health assessments (Baker Act/Marchman evaluations)
  - Treatment assigned to appropriate community resources
  - Better decisions with scarce resources

Central Receiving Center

- Collaborative Effort:
  - Orange County Government
  - Department of Children & Families
  - Criminal Justice System Stakeholders
  - Local community hospitals
  - Local community service providers
  - Consumers and Families

Central Receiving Center

- Crisis Intervention Team (CIT):
  - Trains law enforcement to make better decisions in the field
  - Orange County Corrections Officers trained
  - Individuals kept in civil Vs. criminal system when possible

Central Receiving Center

- Future Phases:
  - Specialized intensive case management
  - Transitional and Supportive housing for homeless- Phase 2 CRC

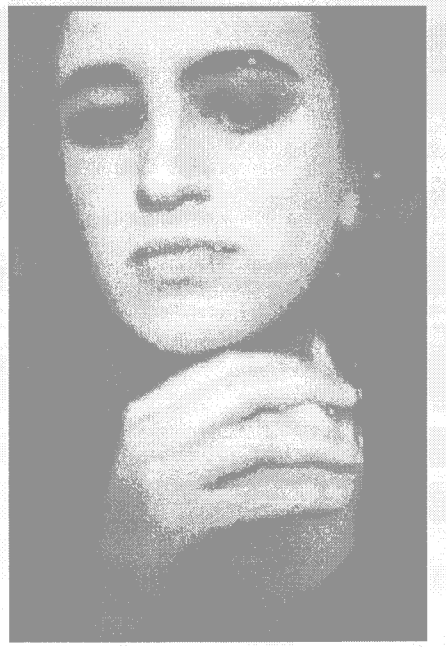
CRC Governing Board

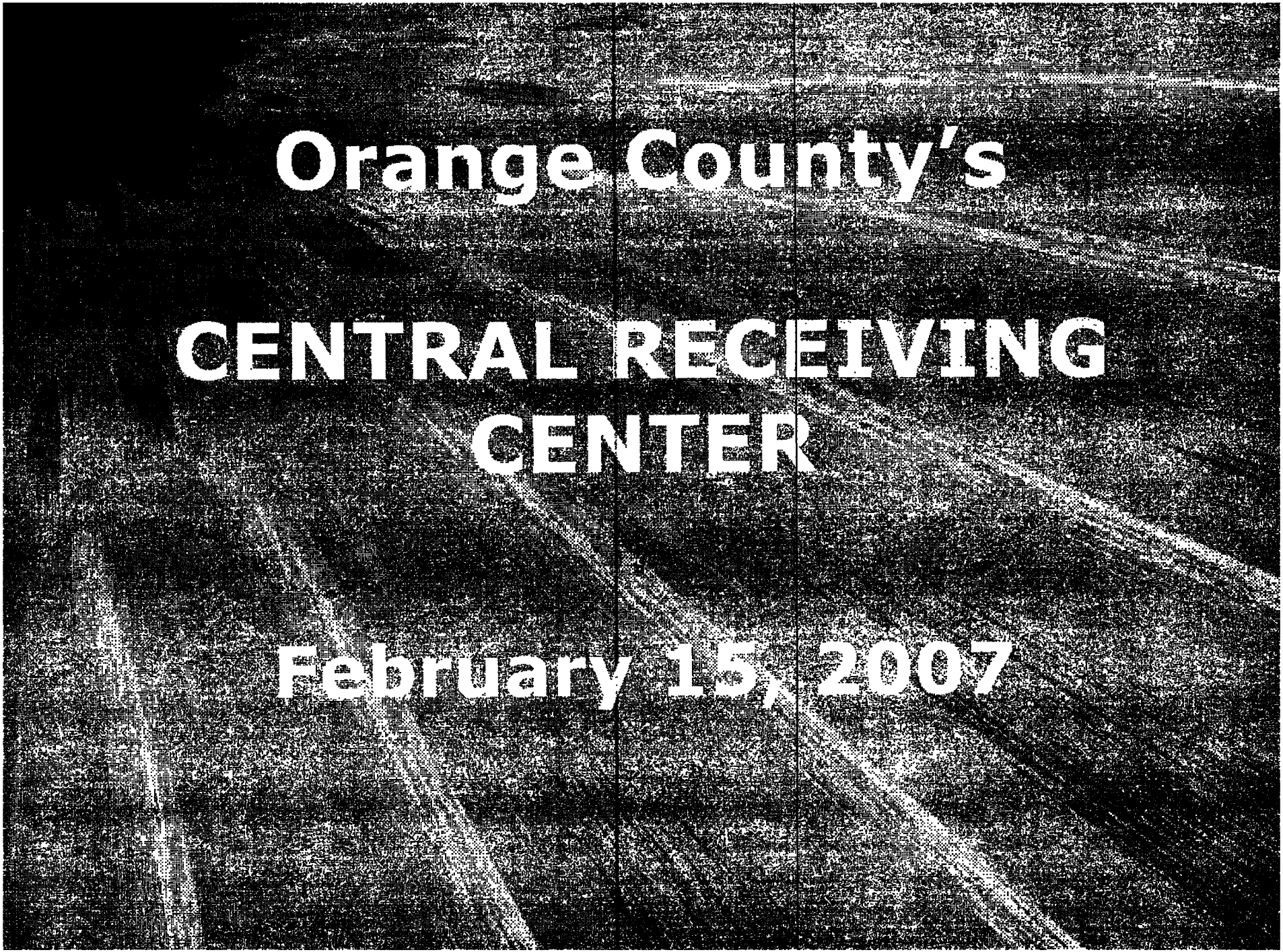
Central Receiving Center

- The Honorable Belvin Perry, Jr.
- The Honorable Lydia Gardner
- The Honorable Kevin Beary
- The Honorable Andy Gardiner
- The Honorable John Mica (Honorary)
- The Honorable Linda Stewart
- The Honorable Robert Wesley
- Mr. Bud Brewer
- Ms. Alana Brenner
- Ms. Carolann Duncan
- Mr. Roger Duryea
- Ms. Linda Bevan
- Mr. Pete Gauntlett
- Mr. Richard Irwin
- Mr. Dick Jacobs
- Mr. Jerry Kassab
- Mr. Michael Mathes
- Ms. Joan Nelson
- Ms. Mary McKinnon
- Mr. Richard Morrison
- Mr. William Vose
- Mrs. Mary I. Johnson
- Mr. Bill Owen

Central Receiving Center

- **Summary: Maximizes Resources and Reduces Duplication:**
  - One assessment
  - Synergies with co-location of services
  - Sharing/cross-training of staff
  - More timely medical clearance

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