Request For Information – Charity Hospital

Submitted by:
Healing Minds NOLA

Janet Hays
2206 Soniat St.
New Orleans, LA 70115
(504) 274 6091

Healing Minds NOLA

2206 Soniat Street
New Orleans, LA 70115
E-Mail: HealingMindsNOLA@Gmail.com
Phone: 504-274-6091

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Mark E. Bradley
Project Manager
Office of Facility Planning and Control
1450 Poydras Street, Suite 1130
New Orleans, LA 70112

Dear Mr. Bradley:

I respectfully submit this document to illustrate that the highest and best adaptive reuse for the Charity Hospital Building is as a one stop shop mental healthcare and research facility.

In this proposal, I will show how to use a million square feet of space to address a critical need along with contingency plans for funding. *Note: the proposed facility is not meant to replace already existing services such as primary care and behavioral health clinics or supportive community housing for people with mental illness, the idea is to use the million square feet to eliminate the gaps when outpatient support is inadequate.*

I am also expressing the popular sentiment that, because of it's cultural importance and because Charity Hospital is a State owned Building, the Orleans Parish Community have a roll to play in deciding It's future. While the Federal Government mandated three meetings be held to receive comments from residents of the Parish under Section 106 of the National Historic Preservation Act, consulting parties were notified of only one meeting. [Documents available upon request].

It is rare for a City to have the opportunity to reuse a million square feet of available space right within the medical corridor and just two blocks away from two new hospitals slated to come on line this year and next. To pair this opportunity with the economic and humanitarian crisis of untreated mental illness would present multiple wins for patients, the community at large, businesses, and Universities.

Sincerely,

Janet Hays
Mental Health Advocate

SCOPE

The scope of the project involves restoring the Charity Hospital building for the purposes of providing long-term inpatient psychiatric beds, affordable housing for low income residents, spaces for mental health and neurological research, diversionary programs, a mental health court and space for a nexus of organizations that deal with systemic challenges of mental illness, homelessness and the lack of work force development and business ownership opportunities for an underserved and/or under resourced population.

Placing organizations in close physical proximity to one another would allow for communication to formulate better policy that drives a long-term strategic master plan. Louisiana needs a road map in order to combine and streamline mental health services and facilities that function efficiently to produce cost savings and compassionate and humane care for individuals afflicted with behavioral and physical mental illnesses.

This proposal involves dividing the Building into four parts. The illustration below (Figure A) does not represent actual spatial considerations. It is being provided for visual context only.

Figure A: Conceptual Space Allocation

RESEARCH

There is revived interest in mental health and neurological research. In the aging population alone, there is research happening around Alzheimer's disease and dementia, anxiety, depression and suicide, and behavioral health & substance abuse. There is also a critical need for more geropsychologists who could be trained at the proposed facility[(1)].

Other categories of mental health research for both youth and adult include, PTSD, Brain Trauma, environmental [impacts of lead] - and more that can be found on the National Institute of Mental Health website [(2)].

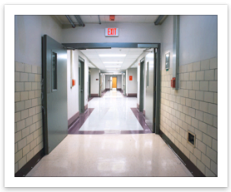
This portion of the project is perfect to anchor the BioDistrict that has, until now, has had difficulty in fulfilling It's mission to foster research in Orleans Parish and build manufacturing and production off of discovery.

Renewed interest in mental health research is also reflected in H.R. 2646 – The Helping Families in Mental Health Crisis Act - proposed bipartisan legislation reintroduced this year by Tim Murphy (R-PA) and Rep. Eddie Bernice Johnson (D-TX). The Bill provides for including increased funding for mental health research such as $40 million annually for four years specifically for NIMH to start studying violence to self and others plus the Brain Initiative.

Note: The Helping Families in Mental Health Crisis Act of 2015 (HR 2646) is a congressional Bill that has been reintroduced this year, Senators Cassidy and Chris Murphy are writing the companion Bill in the Senate.
NAMI came out with a statement of support of HR 2646. There is a groundswell of interest happening around the country these days to explore solutions to incarceration and the epidemic of untreated mental illness[(3)].
***Other provisions in the Bill – **including increased funding for inpatient services -** are found in Appendix A.

The East Wing of the Building could be easily renovated to include laboratories given renovations that were completed as noted below in Figure B.

Figure B: Pre-Katrina Laboratory Renovations


Hallway Old_New.JPG


Lab2.JPG


Lab5.JPG


Lab5[1].JPG


Lab8.JPG


Nurses Station 1.JPG


Nurses Station 2.JPG


Nurses Station 4.JPG


Lab6.JPG

LONG-TERM INPATIENT CARE

With the loss of 128 long-term inpatient psychiatric beds when Charity Hospital was shuttered after Katrina, finding care for people suffering with mental illness - especially serious mental illness [SMI] such as schizophrenia, bipolar disease and severe chronic depression - has become a law enforcement problem with unsustainable costs. The result is that counties around the country are looking for alternatives.

The Restoration Center in San Antonio, TX [the brainchild of Leon Evans] has become a national model and has saved the State of Texas $50 million over the past 5 years.
"EVANS: Even here in Texas, which is very conservative, you know, we learned some time ago that nonviolent mentally ill offenders shouldn't be in prison. They don't make good prisoners because they're listening to voices; it's hard for them to obey the rules. So they get no good time. Their behaviors agitate the other prisoners that make it dangerous for everybody. And they're taking space up for violent offenders. [(4)]
Another Model the nation is looking to is the Miami-Dade Mental Health Diversion Facility [The Brain Child of Judge Steven Leifman]
"Since 2006 the courts have been working with stakeholders from Miami-Dade County on a capital improvement project to develop a first of its kind mental health diversion and treatment facility which will expand the capacity to divert individuals from the county jail into a seamless continuum of comprehensive community-based treatment programs that leverage local, state, and federal resources. This project, which is funded under the Building Better Communities General Obligation Bond Program, was established to build on the successful work of the CMHP with the goal of creating an effective and cost efficient alternative treatment setting to which individuals awaiting trial may be diverted.

The diversion facility will be housed in a former state forensic hospital that has been leased to Miami-Dade County and is in the process of being renovated to include programs operated by community based treatment and social services providers. Services offered will include crisis stabilization, short-term residential treatment, day treatment and day activities programs, intensive case management, outpatient behavioral health and primary care treatment services, and vocational rehabilitation/supportive employment services. The proposed plan for the facility includes space for the courts and for social service agencies such housing providers, legal services, and immigration services that will address the comprehensive needs of individuals served.

The vision for the mental health diversion facility and expansion of the CMHP's diversion programs is to create a centralized, coordinated, and seamless continuum of care for individuals who are diverted from the criminal justice system either pre-booking or post-booking. By housing a comprehensive array of services and supports in one location, it is anticipated that many of the barriers and obstacles to navigating traditional community mental health and social services will be removed, and individuals who are currently recycling through the criminal justice system will be more likely to engage treatment and recovery services. Creation of this facility will also allow for the movement of individuals currently spending extended amounts of time in the county jail into residential treatment programs and supervised outpatient services supported by more sustainable funding sources. It is anticipated that the facility will begin operations in 2016."
***[Full ELEVENTH JUDICIAL CRIMINAL MENTAL HEALTH PROJECT Program Summary is found in Appendix B]

The Baton Rouge Area Foundation is spearheading a proposal to create a Recovery and Empowerment Center.
A 58 page report prepared by economist M. Ray Perryman, founder of The Perryman Group in Waco, Texas for the foundation showed that East Baton Rouge Parish could save $3 million in its first year and $55 million over 10 years in government expenses if it were to open a treatment center diverting mentally ill people from the parish prison system. That report can be found on their website [(5)].

A 2009 NAMI report suggested a minimum of 50 public psychiatric beds per 100,000 residents (which translates into roughly 9.3 beds per 1,000 adults with serious mental illness [SMI]). Note, that was only SMI [i.e. brain diseases - not substance abuse or behavioral health.] It went on to say - "But even this suggested minimum threshold assumes that effective community-based services and assisted outpatient treatment programs are available, which is not the case" [(6)].

In Orleans Parish, the new Louisiana Children's Medical Center Corporation [LCMC] operated replacement hospital for Charity will have just 60 psychiatric beds and the new VA hospital just 20. 80 beds for a growing population of almost 400,000 people is inadequate and incarceration as an alternative is costly.

The West Wing can be renovated to include mental health crisis stabilization beds [Approx. 100], long term stabilization beds [200], medically supported detox beds [Approx. 100], short term adult residential inpatient drug treatment beds [Approx. 200], long term adult residential substance abuse treatment and sober living beds [Approx. 100].

LOW INCOME HOUSING

The upper floors of Charity Hospital were previously offices and call rooms that could easily be converted into efficiency apartments for residents transitioning from long-term care by simply taking out one wall between two rooms.

ADMINISTRATIVE OFFICES, DIVERSIONARY, PREVENTATIVE AND HOLISTIC HEALING PROGRAMS

The Center portion of the building, would house administrative offices and organizations that manage systemic challenges of mental illness, homelessness, workforce development, stigma, etc. Bringing such organizations together in a creative spacial environment enables better communication amongst agencies to allow for streamlining and better efficiency in policy making. Having access in other areas of the building to researchers, families and individuals who are most impacted is also conducive to understanding the mental health needs of the community.

Added to this space would be preventative and holistic therapy programs, diversionary programs such as a 5000 sq/ft kitchen to teach people culinary skills such as what is being built in the Miami-Dade Diversionary Facility. That is just one example of the type of diversion training needed to help transition people with mental illness back into the community.

It is important to recognize that one of the main conditions that causes pre-trail inmates with mental illness to recidivate to hospitals and prisons is the inability to meet their obligations to a Judge to apply for educational programs, seek psychiatric care and/or evaluation, show up for future hearings, etc. The nature of their disease is that mentally ill people often forget, are prone to sleeping all day, and have other obstacles preventing them to comply with what a Judge may ask of them. **A one-stop shop eliminates the physical barrier between the courtroom and the places an inmate needs to get to in order to get care. There is no opportunity for a person to fall through currently existing gaps.**

Of course, meditative and "green" spaces would be built into the facility to make it aesthetically pleasing for residents, patients and workers.

NEED

The need for such a one-stop shop facility cannot be overstated. The withering away of mental health facilities and services over the last few decades has left gaps in the mental health care system resulting in enormous economical and societal costs. One out of every four Americans is afflicted with some sort of mental illness. The epidemic of those left untreated is creating chaos, and families who constantly struggle to find help for their loved ones are emotionally and physically exhausted.

Below are some statistics to illustrate that point.

NATIONAL NEED:

- Approximately one out of five adolescents has a diagnosable mental health disorder, and nearly one third show symptoms of depression. Psychiatric disorders affect 12 percent of children. Children are 3 to 4 times more likely to be abused if they are mentally ill [(7)].
- "For the past 20 years, studies have consistently estimated that between 40 and 50 percent of all individuals with schizophrenia or bipolar disorder are receiving no treatment for their mental illness at any given time. According to disease prevalence estimates of NIMH, this means that approximately 3.0-3.5 million such individuals are receiving no treatment." [(8)]. (
- "A report released by the Treatment Advocacy Center and the National Sheriffs' Association last year, showed that Americans with severe mental illnesses are three times more likely to be in jail or prison than in a psychiatric hospital."[(9)] .
- "According to the Department of Justice (1996 Source Book: Criminal Justice Statistics), it costs American taxpayers 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)." [(10)]

NEED IN GREATER NEW ORLEANS AREA

- Studies show that outpatient care is not adequate to deal with patients that have long-term mental health needs. New Orleans has an acute need for an inpatient psychiatric care facility - especially for uninsured residents. [(11)]
- Those who have insurance can find long term treatment care in private facilities such as the Children's Hospital on State Street. Those without insurance often have no place to have their long-term needs met outside of Orleans Parish Prison. "Dr. Sam Gore, [former] chief psychiatrist for the OPSO [Orleans Parish Sheriffs Office], estimates about 45 percent of inmates at Orleans Parish Prison have mental illness." [(12)] That is consistent with numbers

across the country [13]

- The new Veterans Affairs and University Medical Center Hospitals coming online in the near future will provide 80 long-term inpatient psychiatric beds combined. This is at least 78 beds less than pre-Katrina yet there are indications that today, there is an even a greater need for long-term beds. For instance, many people including youth still suffer from post-Katrina mental illnesses, and the new VA Hospital will be a destination hospital for Veterans with PTSD returning from the wars in Iraq and Afghanistan.

FUNDING:

When speaking about how to pay for such a facility, it is important to remember that we are already paying for it by way of the costs of incarceration, 911 calls, ER visits, homelessness, death, lost hours to businesses when workers must take time off to deal with a crisis, property damage when people in psychosis destroy vehicles and homes, the emotional and physical costs to families in crisis, and the costs of lost business and residents due to the perception of New Orleans being the number one city in the world for incarceration.

The National Association of Counties Executive Director reports that the 3069 counties across the Country - with a 500 billion dollar/yr budget - each year spend over 70 billion dollars on justice and public safety and 70 billion dollars on healthcare for citizens - often times, healthcare in Americas jails. About 8 1/2 million people a year become inmates in jails and there are about 11 1/2 million visits - indicating that large numbers of people are paying more than one visit. A polling of their members to ask what percentage of people in jails had severe mental illness resulted in 25% saying they estimated over 60% of people currently in their jails met that criteria. [14]

***Information regarding other costs mentioned above to be provided upon request.

Potential funding possibilities include:

- Securing a building sponsor such as a pharmaceutical company whose corporate mission involves mental health. A lease would be negotiated in exchange for building naming rights and possible lease-back arrangements for laboratory and administrative space;
- Ancillary building(s) developer negotiations for development rights to those structures provided funding for the charity hospital site is provided for mental health needs;
- Passing a millage to pay back a bonding authority;
- Tax credits where applicable;
- Philanthropic Money;
- Public Private Partnerships.
- These are a few of the funding possibilities for the hospital site others can be negotiated where applicable.

STIGMA

"Until we eliminate the reality of increased violence, efforts to eliminate stigma via P.R. campaigns will be doomed to failure. The on-going headlines about "Psychotic killers on rampage" will continue to tar all consumers, even those who have never been involved in acts of violence. The fear of violence will continue to cause communities to reject the very residential and community based treatment facilities that can prevent violence. The problem is not that newspapers report on violence, the problem is, the violence does exist. The question becomes what to do about it. Some would have us continue to deny it is a problem in spite of overwhelming evidence. Others would have us attack the media for reporting on it. I think it is time AMI advocates take steps to reduce acts of violence by people with NBD. The reduction in stigma will inevitably follow." [15]

"Stigma was eradicated years and years ago in many people who suffer from no-fault biological diseases. For example, stigma used to exist in men with prostate cancer and women with breast cancer. It also existed in people with no illness at all: gays, lesbians, the left handed, and other historically marginalized populations. [16]

But over time all these groups found a cure. They simply decided there was no stigma to having cancer, being gay, lesbian, or lefty. It was not a 'mark of shame' or "token of disgrace'.

They killed stigma and recognized what they were really suffering from was prejudice and discrimination."

CONCLUSION:

Inpatient care and outpatient care are not mutually exclusive. What is needed is a middle path.

This Charity Hospital proposal does not replace already existing services such as supportive independent living communities and primary and outpatient clinics but, rather, it serves to enhance and weave together with these services to provide wraparound care thereby preventing recidivism to hospitals or prisons and jails.

The Charity project will also provide supplementary long-term psychiatric beds to the region when the VA and UMC hospitals are saturated. In terms of commercial real estate, it makes sense to reuse Big Charity for its originally intended purpose: i.e. medical use. The million square foot buildings location in the medical corridor complements the biomedical industry that focuses on mental health research. Also, its cultural importance must not be underestimated.

The 2005 shuttering of Charity Hospital during a time of great trauma in New Orleans left a deep wound on those who were born there and who saw It as their medical home. Reusing the old hospital for a public purpose that meets critical health needs of our community would do much to heal that wound, as well as to restore trust between residents and decision makers thereby helping to inspire community engagement.

A sign-on letter in support of the renovation will be provided.

References

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(4) http://www.npr.org/2014/08/20/341826070/mental-health-treatment-system-saves-san-antonio-millions

(5) http://braf.org/index.cfm/page/52

(6) http://www2.nami.org/Content/NavigationMenu/Grading_the_States_2009/Findings/NAMI_GTS09_Findings.pdf

(7) http://www.hhs.gov/ash/oah/adolescent-health-topics/mental-health/home.html

(8) http://www.treatmentadvocacycenter.org/resources/assistedoutpatienttreatment/aboutaot/159

(9) http://www.treatmentadvocacycenter.org/index.php?option=com_content&id=1538&Itemid=68

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(11) http://www2.nami.org/ContentManagement/ContentDisplay.cfm?ContentFileID=126233

(12) http://www.bestofneworleans.com/gambit/new-orleans-mental-health-crisis/Content?oid=1972425

(13) https://stepuptogether.org/updates/mental-illness-is-no-crime

(14) http://csgjusticecenter.org/mental-health/posts/law-enforcement-health-advocates-and-members-of-congress-push-to-reduce-the-number-of-people-with-mental-illness-in-jails/

(15) http://schizophrenia.com/family/stigma.html

(16) http://www.opednews.com/articles/There-s-No-Stigma-to-Menta-by-DJ-Jaffe-110416-261.html

Appendix A

Helping Families In Mental Health Crisis Act 2015, HR 2646

MENTAL ILLNESS POLICY ORG.
UNBIASED INFORMATION FOR POLICYMAKERS + MEDIA
50 EAST 129 ST., PH7 NEW YORK, NY 10035
OFFICE@MENTALILLNESSPOLICY.ORG MENTALILLNESSPOLICY.ORG

HELPING FAMILIES IN MENTAL HEALTH CRISIS ACT 2015
HR 2646

On June 4, 2015, Rep. Tim Murphy (R. PA) and Rep. Eddie Bernice Johnson (D. TX) introduced the Helping Families in Mental Health Crisis Act of 2015 ("HFMHCA", HR 2646) which updates the 2013 version which did not pass (HR3717). Following is a summary of the provisions related to serious mental illness.

SAMHSA Replaced by an Assistant Secretary of Mental Health and Substance Use Disorders
Background: The Substance Abuse and Mental Health Services Administration (SAMHSA) has failed to focus it's efforts on serious mental illness, use science to develop policy, hire employees with medical expertise, or focus on reducing important metrics like rates of homelessness, arrest, incarceration, suicide, violence or hospitalization in people with mental illness. It primarily focuses on 'wellness' for the highest functioning and embraces pop-psychology.

The Helping Families in Mental Health Crisis Act replaces SAMHSA and it's administrator with Assistant Secretary for Mental Health and Substance Use Treatment who must be a licensed Psychiatrist or Clinical Psychologist. This raises the profile of mental health in the government org chart and ensures that the lead policy official for mental health policy knows something about mental illness. The Assistant Secretary will administer responsibilities formerly administered by SAMHSA.

The Helping Families in Mental Health Crisis Act requires the Asst. Sec to focus on important metrics like **r**ates of suicide and attempts, emergency psychiatric hospitalizations, emergency room boarding; arrests, incarcerations, victimization, and homelessness. The bill dramatically tightens the definition of evidence to be used in determining the efficacy of programs. It establishes a coordinating committee to advise the secretary that includes significant representation from criminal justice.

Mental Health Block Grant Applicants Required to Address Serious Mental Illness
Background: Mental Health Block Grants (MHBGs) are roughly $500 million in federal funds allocated to SAMHSA to distribute as "block grants' to the states. Both SAMHSA and the Block Grants are supposed to serve people with Serious Mental Illness, but SAMHSA gives guidance to the states to divert the money from people with serious mental illness.

The Helping Families in Mental Health Crisis Act requires states applying for block grants to "include a separate description of case management services and provide for activities leading to reduction of rates of suicides, suicide attempts, substance abuse, emergency hospitalizations, incarceration, crimes, arrest, victimization, homelessness, joblessness, medication" and other important outcomes.

Assisted Outpatient Treatment Programs Receive Modest Funding
Background: Assisted Outpatient Treatment (AOT) allows judges to order a small group of seriously mentally ill who already accumulated multiple episodes of arrest, violence and hospitalization as a result of failing to comply with treatment to stay in mandated and monitored treatment while in the community. This has reduced their incarceration, arrest, homelessness and hospitalization by 70% each and saved money for taxpayers by reducing the use of expensive jails and hospitals. In 2013 Rep Murphy inserted a provision in the 2014 Protecting Access to Medicare Act (a/k/a "SGR" or

"DocFix") that provided $15 million annually for AOT.

The Helping Families in Mental Health Crisis Act of 2015 ups the amount provided to states for AOT by $5 million to $20 million annually and extends the grants through 2018. (20% to existing programs and 80% to new programs.) Further, states with an AOT law on their books will receive a 2 percent increase in their block grant funding. (Roughly $10 million annually split between them)

The Helping Families in Mental Health Crisis Act requires the Asst. Sec to measure outcomes in states with AOT which will help strengthen the evidence for it. Relatedly, states with a need for treatment standard will also receive a 2 percent increase in their block grant funding (about $10 million nationally).

HIPAA/FERPA Regulations Slightly Modified to Allow Helpful Disclosures to Caregivers
Background: Parents who provide case management, housing, income support and other services out of love to their children, are prohibited by HIPAA and FERPA from getting information about diagnosis, medications and next appointments of loved ones. Therefore they can't make sure prescriptions are filled, transportation to appointments arranged and help facilitate compliance. Doctors and mental health programs also falsely claim that HIPAA prevents them from receiving information from family members.

The Helping Families in Mental Health Crisis Act allows an entity normally required to maintain patient confidentiality to share some limited information with "caregivers". HIPPA disclosure is limited to information about the diagnoses, treatment plans, appointment scheduling, medications, and medication related instructions, but does not include any personal psychotherapy notes. The Helping Families in Mental Health Crisis Act does not put a limit on which FERPA-protected information may be disclosed.

The Helping Families in Mental Health Crisis Act defines "caregivers" as "an immediate family member; someone who assumes primary responsibility for providing a basic need of such individual; a personal representative; someone who can establish a longstanding involvement and is responsible with the individual."

The Helping Families in Mental Health Crisis Act provides that HIPAA protected information may be disclosed only if the patient is over 18 and has "serious mental Illness" diagnosed by a doctor that results in functional impairment of the individual that "substantially interferes with or limits one or more major life activities of the individual." HIPAA protected information for people without serious mental illness may not be disclosed. FERPA protected information can be disclosed without those limitations.

Disclosure of information can only be made if all the following conditions are met for HIPAA protected information or the first condition only is met for FERPA protected information.

- Such disclosure is necessary to protect the health, safety, or welfare of the individual or general public.
- The information to be disclosed will be beneficial to the treatment of the individual if that individual has a co-occurring acute or chronic medical illness.
- The information to be disclosed is necessary for the continuity of treatment of the medical condition or mental illness of the individual.
- The absence of such information or treatment will contribute to a worsening prognosis or an acute medical condition.
- The individual by nature of the severe mental illness has or has had a diminished capacity to fully understand or follow a treatment plan for their medical condition or may become gravely

disabled in absence of treatment.

The Helping Families in Mental Health Crisis Act makes it clear that healthcare providers may "listen to information or review medical history provided by family members or other caregivers who may have concerns about the health and well-being of the patient, so the health care provider can factor that information into the patient's care."

IMD Exclusion Slightly Ameliorated to End Discrimination Against Seriously Mentally Ill who Need Hospital Care

Background: IMD's are "Institutes for Mental Disease" colloquially known as state psychiatric hospitals. Likewise any facility, like an adult homes with more than 50% mentally ill are also IMDs. The IMD provision of Medicaid prevents states from getting reimbursed for people 18-64 who need long-term care in these IMDs. That is why states lock the front door of hospitals, open the back, and kick patients out of the hospitals and into the community where Medicaid will pick up 50% of the cost of care. Many of these individuals cannot live in the community and end up in jail or homeless. Rep. Eddie Bernice Johnson (D. TX), and a former head of psychiatric nursing at a VA hospital has been a stellar proponent of eliminating the IMD Exclusion and helping people with the most serious mental illnesses.

The Helping Families in Mental Health Crisis Act allows states to get Medicaid reimbursement for care of adults in IMDs where the facility-wide average length of stay is less than 30 days. It also provides language preventing residential facilities from being declared IMDs. (CK)

PROTECTION AND ADVOCAY (P&A, PAIMI, Disability Rights) Returned to Original Mission of Protecting Mentally Ill from Abuse and Neglect

Background: The Protection and Advocacy for Individuals with Mental Illness (PAIMI/P&A) program was set up by Congress with the noble purpose to establish 50 state organizations to protect institutionalized individuals from neglect and abuse. (These frequently go by name of "Disability Rights [Name of State]). The programs moved beyond that purpose and used other language in the legislation to take on the mission of stopping treatment for the seriously ill, lobbying for laws to close hospitals, kicking people out of adult homes and opposing AOT. Many a state mental health director who has tried to improve care, and families of the seriously ill who have tried to facilitate it have found these federally funded lawyers opposing them.

The Helping Families in Mental Health Crisis Act returns PAIMI to it's original mission of protecting patients against "abuse and neglect." Outside the legislation "abuse" and "neglect" are defined.

42 USC § 10802:

(1) The term "abuse" means any act or failure to act by an employee of a facility rendering care or treatment which was performed, or which was failed to be performed, knowingly, recklessly, or intentionally, and which caused, or may have caused, injury or death to an individual with mental illness, and includes acts such as—
(A) the rape or sexual assault of an individual with mental illness;
(B) the striking of an individual with mental illness;
(C) the use of excessive force when placing an individual with mental illness in bodily restraints; and
(D) the use of bodily or chemical restraints on an individual with mental illness which is not in compliance with Federal and State laws and regulations.

(5) The term "neglect" means a negligent act or omission by any individual responsible for providing services in a facility rendering care or treatment which caused or may have caused injury or death to a [1] individual with mental illness or which placed a [1] individual with mental illness at risk of injury or death, and includes an act or omission such as the failure to establish or carry out an appropriate individual program plan or treatment plan for a [1] individual with mental illness, the failure to provide adequate nutrition, clothing, or health care to a [1] individual with mental illness, or the failure to provide a safe environment for a [1] individual with mental illness, including the failure to maintain adequate numbers of appropriately trained staff.

The Helping Families in Mental Health Crisis Act requires those who get PAIMI contracts to agree to refrain from "lobbying or retaining a lobbyist for the purpose of influencing a Federal, State, or local governmental entity or officer; and "counseling an individual with a serious mental illness who lacks insight into their condition on refusing medical treatment or acting against the wishes of such individual's caregiver." Importantly, it also adds a grievance process so state mental health directors, family members and consumers who feel PAIMIs are violating their mission and impeding care can be reported to a third party for investigation.

Eliminates Discrimination in Medicare Against Mentally Ill who Need Long-term Care
Background: Medicare discriminates against those with serious mental illness by imposing a 190 day lifetime cap on inpatient psychiatric hospitalizations.

The Helping Families in Mental Health Crisis Act eliminates the 190 day lifetime cap on inpatient psychiatric hospitalization in Medicare.

Requires Medicaid to Allow Two Services Within Same Day
Background: There is a proscription against Medicaid paying for two services in the same day for certain individuals. So those who go to a clinic can't see their primary physician and psychiatrist on same day, a particularly bothersome provision in rural areas where people have to travel.

The Helping Families in Mental Health Crisis Act allows payment for two services received in a single day.

Bans Medicaid Programs from Discriminating Against Medications Used to Treat Serious Mental Illness
Background: Many treating authorities are trying to move people off expensive treatments and on to less expensive ones without regard to their efficacy.

The Helping Families in Mental Health Crisis Act protects the most seriously ill. For "major depression, bipolar (manic-depressive) disorder, panic disorder, obsessive-compulsive disorder, schizophrenia, and schizoaffective disorder, a State shall not exclude from coverage or otherwise restrict access to such drugs other than pursuant to a prior authorization program" The bill also requires managed care organizations to cover all mental illness medications.

Strengthens Hospital Discharge Procedures
Background: For many seriously mentally ill, the crack is the system. Hospital responsibility ends at discharge, and community programs have no responsibility for patients who don't show up.

The Helping Families in Mental Health Crisis Act attempts to make the crack smaller, by requiring (medicare reimbursed?) hospitals to prepare discharge plans and facilitate connection with outpatient treatment for patients they are discharging.

National Institute Of Mental Health
Background: Extensive research shows that most mentally ill seriously mental illn are not violent, but that seriously mentally ill who are not in treatment are as a group more violent than others. Historically, the mental health industry has refused to admit this for fear of causing stigma.

The Helping Families in Mental Health Crisis Act provides $40 million annually for four years specifically for NIMH to start studying violence to self and others plus the Brain Initiative.

Increases Minority Mental Health Workforce
Authorizes fellowships to increase the number of culturally competent behavioral health professionals

Creates Suicide Prevention Technical Assistance Center to Focus on those at High Risk for Suicide.
Background: Most investments in suicide prevention are made based on politics rather science. For example, programs aimed at preventing suicide in children are expanded, even though children are the least likely age group to commit suicide.

The Helping Families in Mental Health Crisis Act **will provide grants for "**prevention of suicide among all ages, particularly among groups that are at high risk for suicide."

Establishes Interagency Serious Mental illness Coordinating Agency
Background: The federal government has dramatically expanded its mental health efforts by decalring things such as bad grades, bad marriages, lack of jobs, bullying and cyberbullying as mental illnesses and diverting funds to them. Government should help those who need help the most, not least.

The Helping Families in Mental Health Crisis Act establishes this committee to refocus efforts on the most seriously ill. In addition to those responsible for mental health policy, the Attorney General is on it. Other mandatory members include a judge, a law enforcement officer, and a corrections officials.

Other Provisions

Reports on Best Practices to Train and Certify Peer Support Specialists
Background: "Peer Support" is a program that pays people with mental illness or substance abuse to guide others with it. Peer support has been shown to be a useful program to address substance abuse. For mental illness, there is solid evidence that those paid like it. According to those paid to provide it, those who receive it feel more hopeful. No independent studies show meaningful improvements in important outcomes like homelessness, arrest, incarceration and suicide. No independent studies compare peer support with non-peer support. And no independent studies of peer support report on the effect on those serious mental illness. There is clear evidence the money SAMHSA historically distributed for peer support goes to organizations that lobby against treatments that help the most seriously ill like the availability of hospitals, AOT and the 2013 version of the Helping Families in Mental Health Crisis Act (HR 3717). I.e, Peer support for mental illness has generally had a negative systemic impact even if those who receive it do receive some benefit.

The Helping Families in Mental Health Crisis Act requires the Assistant Secretary to prepare a biennial report on best practices for "training and certifying peer support and establishing and operating programs using peer-support". It defines a peer support specialist as someone who has "been an active participant in mental health or substance use treatment for at least the preceding 2 years" and "uses his or her recovery from mental illness or substance abuse plus skills learned in formal training, …to work …with individuals with a serious mental illness or a substance use disorder, in consultation with and under the supervision of a licensed mental health or substance use treatment professional."

Appendix B

Eleventh Judicial Criminal Mental Health Project

ELEVENTH JUDICIAL CRIMINAL MENTAL HEALTH PROJECT
Program Summary

The Eleventh Judicial Circuit Criminal Mental Health Project (CMHP) was established in 2000 to divert individuals with serious mental illnesses (SMI; e.g., schizophrenia, bipolar disorder, major depression) or co-occurring serious mental illnesses and substance use disorders away from the criminal justice system and into comprehensive community-based treatment and support services. The CMHP provides an effective, cost-efficient solution to a community problem and works by eliminating gaps in services, and by forging productive and innovative relationships among all stakeholders who have an interest in the welfare and safety of one of our community's most vulnerable populations.

Short-term benefits include reduced numbers of defendants with SMI in the county jail, as well as more efficient and effective access to housing, treatment, and wraparound services for the individuals re-entering the community. This decreases the likelihood that individuals will re-offend and reappear in the criminal justice system, and increases the likelihood of successful mental health recovery. The long term benefits include: reduced demand for costly acute care services in jails, prisons, forensic mental health treatment facilities, emergency rooms, and other crisis settings; decreased crime and improved public safety; improved public health; decreased injuries to law enforcement officers and people with mental illnesses; and decreased rates of chronic homelessness. Most importantly, the CMHP is helping to close the revolving door which results in the devastation of families and the community, the breakdown of the criminal justice system, and wasteful government spending.

Impact to the Community

Everyday, in every community in the United States, law enforcement agencies, courts, and correctional institutions are witness to a parade of misery brought on by untreated or under-treated mental illnesses. Last year, roughly 2.2 million admissions to local jails in the United States involved people with SMI. Roughly, three-quarters of these individuals also experience co-occurring substance use disorders which increase their likelihood of becoming involved in the justice system. On any given day, there are 750,000 people with mental illnesses incarcerated in jails and prisons across the Unites States and 1.25 million people with mental illnesses are on probation in the community.

Although these national statistics are alarming, the problem is even more acute in Miami-Dade County which is home to the largest percentage of people with SMI of any urban community in the Unites States. Roughly 9.1% of the population in Miami-Dade County (175,000 adults) experiences SMI, yet only 1% of the population (24,000 adults) receives treatment in the public mental health system. As a result, police officers have increasingly become the first, and often only, responders to

people in crisis due to untreated mental illnesses. Too often, these encounters result in the arrest and incarceration of individuals for criminal offenses that are directly related to individuals' psychiatric symptoms or life-health contexts (e.g., homelessness, addiction, poverty).

The Miami-Dade County jail currently serves as the largest psychiatric institution in Florida and contains nearly half as many beds serving inmates with mental illnesses as all state civil and forensic mental health hospitals combined. Of the roughly 114,000 bookings into the jail last year, nearly 20,000 involved people with mental illnesses requiring intensive psychiatric treatment while incarcerated. On any given day, the jail houses approximately 1,400 individuals receiving psychotherapeutic medications, and costs taxpayers roughly $65 million annually, more than $178,000 per day. Additional costs to the county, the state, and taxpayers result from crime and associated threats to public safety; civil actions brought against the county and state resulting from injuries or deaths involving people with mental illnesses; injuries to law enforcement and correctional officers; ballooning court case loads involving defendants with mental illnesses; and uncompensated emergency room and medical care.

On average, people with mental illnesses remain incarcerated eight times longer than people without mental illnesses arrested for the exact same charge, at a cost seven times higher. With little treatment available, many individuals cycle through the system for the majority of their adult lives.

Need for Adequate Community-Based Treatment Services

In 2008, the National Leadership Forum on Behavioral Health/Criminal Justice Services (NLF) was established by the Substance Abuse and Mental Health Services Administration (SAMHSA) to address common barriers to successful diversion from the criminal justice system and community re-entry among individuals with SMI. Forum members consisted of national experts in the fields of public health, public safety, criminal justice, consumer advocacy, and behavioral healthcare service delivery. In September of 2009, the NLF issued a report, *Ending an American Tragedy: Addressing the Needs of Justice-Involved People with Mental Illnesses and Co-Occurring Disorders*,[1] which details the crisis that currently exists, identifies barriers to more effective service delivery, and makes recommendations for immediate action necessary to reverse the tragic and costly trends associated with the inappropriate and unnecessary criminalization of people with mental illnesses.

Among the most pervasive findings from the NLF report is that communities lack accessible, high quality services targeting the unique needs of individuals with the most severe forms of mental illnesses who are involved in or at risk of becoming involved in the justice system. Services that do exist tend to be "inadequately funded, antiquated, and fragmented." (p.2) Inefficiencies in service delivery are compounded by poor coordination and redundancies across the criminal justice and mental health systems.

The NLF identifies and recommends an array of core services that comprise what is referred to as an *Essential System of Care.* These evidence-based practices, designed around the needs and experiences of individuals involved in the criminal justice system, include:

- Forensic intensive case management

[1] NLF report is available at: http://gainscenter.samhsa.gov/pdfs/nlf/AmericanTragedy.pdf

- Supportive housing
- Peer support
- Accessible and appropriate medication management
- Integrated dual diagnosis treatment for co-occurring substance use disorders
- Supported employment
- Assertive Community Treatment (ACT)/Forensic Assertive Community Treatment (FACT)
- Cognitive Behavioral Treatment (CBT) targeted to risk factors

In addition to these core elements there are

- Proper diagnosis and treatment planning
- Treatment for histories of physical, sexual, and emotional trauma
- Dynamic and ongoing assessment of individual risks and needs
- Primary medical care examination and treatment
- Provision of meaningful day activities
- Provision of transportation assistance
- Assistance with access to entitlement benefits and other means of economic self-sufficiency

Eleventh Judicial Circuit Criminal Mental Health Project

The Eleventh Judicial Circuit Criminal Mental Health Project (CMHP) was established nearly 15 years ago to divert nonviolent misdemeanant defendants with SMI, or co-occurring SMI and substance use disorders, from the criminal justice system into community-based treatment and support services. Since that time the program has expanded to serve defendants that have been arrested for less serious felonies and other charges as determined appropriate. The program operates two components: pre-booking diversion consisting of Crisis Intervention Team (CIT) training for law enforcement officers and post-booking diversion serving individuals booked into the jail and awaiting adjudication. All participants are provided with individualized transition planning including linkages to community-based treatment and support services.

The CMHP's success and effectiveness depends on the commitment of stakeholders throughout the community. Such cross-system collaboration is essential for the transition from the criminal justice system to the community mental health system. Program operations rely on collaboration among community stakeholders including: the State Attorney's Office, the Public Defender's Office, the Miami-Dade County Department of Corrections and Rehabilitation, the Florida Department of Children and Families, the Social Security Administration, public and private community mental health providers, Jackson Memorial Hospital-Public Health Trust, law enforcement agencies, family members, and mental health consumers.

Pre-Booking Jail Diversion Program

The CMHP has embraced and promoted the Crisis Intervention Team (CIT) training model developed in Memphis, Tennessee in the late 1980's. Known as the *Memphis Model*, the purpose of CIT training is to set a standard of excellence for law enforcement officers with respect to treatment of individuals with mental illnesses. CIT officers perform regular duty assignment as patrol officers, but are also trained to respond to calls involving mental health crisis. Officers receive 40 hours of specialized training in psychiatric diagnoses, suicide intervention, substance abuse issues, behavioral de-escalation techniques, the role of the family in the care of a person with mental illness, mental health and substance abuse laws, and local resources for those in crisis.

The training is designed to educate and prepare officers to recognize the signs and symptoms of mental illnesses, and to respond more effectively and appropriately to individuals in crisis. Because police officers are often first responders to mental health emergencies, it is essential that they know how mental illnesses can impact the behaviors and perceptions of individuals. CIT officers are skilled at de-escalating crises involving people with mental illnesses, while bringing an element of understanding and compassion to these difficult situations. When appropriate, individuals in crisis are assisted in accessing treatment facilities in lieu of being arrested and taken to jail.

The pre-booking diversion program has demonstrated excellent results. To date, the CMHP has provided CIT training, free of charge, to roughly 4,000 law enforcement officers from all 36 local municipalities in Miami-Dade County, as well as Miami-Dade Public Schools and the Department of Corrections and Rehabilitation. Countywide, CIT officers respond to 16,000 mental health crisis calls per year. Last year alone, CIT officers from the Miami-Dade Police Department and City of Miami Police Department responded to more than 10,000 calls, resulting in over 1,200 diversions to crisis units and just 9 arrests. Over the past four years, these two agencies have responded to nearly 38,000 mental health crisis calls resulting in almost 9,000 diversions to crisis units and just 85 arrests.

As a result of CIT, the average daily census in the county jail system has dropped from 7,800 to 4,800 inmates, and the county has closed one entire jail facility at a cost-savings to taxpayers of $12 million per year. There has also been a dramatic reduction in fatal shootings and injuries of people with mental illnesses by police officers. From 1999 through 2005 there were nineteen persons with mental illness that died as the result of altercations with law enforcement officers in Miami-Dade County. Since 2005, this figure has dropped significantly.

Post-Booking Jail Diversion Program

The CMHP was originally established in 2000 to divert nonviolent misdemeanant defendants with SMI and possible co-occurring substance use disorders, from the criminal justice system into community-based treatment and support services. In 2008, the program was expanded to serve defendants that have been arrested for less serious felonies and other charges as determined appropriate. Post-booking jail diversion programs operated by the CMHP serve approximately 500 individuals with serious mental illnesses annually. Over the past decade, these programs have facilitated roughly 4,000 diversions of defendants with mental illnesses from the county jail into community-based treatment and support services.

Misdemeanor Jail Diversion Program: All defendants booked into the jail are screened for signs and symptoms of mental illnesses by correctional officers. Individuals charged with misdemeanors who meet program admission criteria are transferred from the jail to a community-based crisis stabilization unit within 24 to 48 hours of booking. Upon stabilization, legal charges may be dismissed or modified in accordance with treatment engagement. Individuals who agree to services are assisted with linkages to a comprehensive array of community-based treatment, support, and housing services that are essential for successful community re-entry and recovery outcomes. Program participants are monitored by CMHP for up to one year following community re-entry to ensure ongoing linkage to necessary supports and services. The vast majority of participants (75-80%) in the misdemeanor diversion program are homeless at the time of arrest and tend to be among the most severely psychiatrically impaired individuals served by the CMHP. The misdemeanor diversion program receives approximately 300 referrals annually. Recidivism rates among program participants has decreased from roughly 75 percent to 20 percent annually.

Felony Jail Diversion Program: Participants in the felony jail diversion program are referred to the CMHP through a number of sources including the Public Defender's Office, the State Attorney's Office, private attorneys, judges, corrections health services, and family members. All participants must meet diagnostic and legal criteria[2] as well as eligibility to apply for entitlement benefits such as Supplemental Security Income (SSI), Social Security Disability Insurance (SSDI), and Medicaid. At the time a person is accepted into the felony jail diversion program, the state attorney's office informs the court of the plea the defendant will be offered contingent upon successful program completion. Similar to the misdemeanor program, legal charges may be dismissed or modified based on treatment engagement. All program participants are assisted in accessing community based services and supports, and their progress is monitored and reported back to the court by CMHP staff. Individuals participating in the felony jail diversion program demonstrate reductions in jail bookings and jail days of more than 75 percent, with those who successfully complete the program demonstrating a recidivism rate of just 6 percent. Since 2008, the felony jail program alone is estimated to have saved the county over 15,000 jail days, more than 35 years.

Forensic Hospital Diversion Program

Since August 2009, the CMHP has overseen the implementation of a state funded pilot project to demonstrate the feasibility of establishing a program to divert individuals with mental illnesses committed to the Florida Department of Children and Families from placement in state forensic hospitals to placement in community-based treatment and forensic services. Participants include individuals charged with 2nd and 3rd degree felonies who do not have significant histories of violent felony offenses and are not likely to face incarceration if convicted of their alleged offenses. Participants are adjudicated incompetent to proceed to trial or not guilty by reason of insanity. The community-based treatment provider operating services for the pilot project is responsible for providing a full array of residential treatment and community re-entry services including crisis stabilization, competency restoration, development of community living skills, assistance with community re-entry, and community monitoring to ensure ongoing treatment following discharge.

[2] Legal criteria specify a current most serious charge of a third degree felony, with not more than three prior felony convictions.

The treatment provider also assists individuals in accessing entitlement benefits and other means of economic self-sufficiency to ensure ongoing and timely access to services and supports after re-entering the community. Unlike individuals admitted to state hospitals, individuals served by MD-FAC are not returned to jail upon restoration of competency, thereby decreasing burdens on the jail and eliminating the possibility that a person may decompensate while in jail and require readmission to a state hospital. To date, the pilot project has demonstrated more cost effective delivery of forensic mental health services, reduced burdens on the county jail in terms of housing and transporting defendants with forensic mental health needs, and more effective community re-entry and monitoring of individuals who, historically, have been at high risk for recidivism to the justice system and other acute care settings. Individuals admitted to the MD-FAC program are identified as ready for discharge from forensic commitment an average of 52 days (35%) sooner than individuals who complete competency restoration services in forensic treatment facilities, and spend an average of 31 fewer days (18%) under forensic commitment. The average cost to provide services in the MD-FAC program is roughly 32% less expensive than services provided in state forensic treatment facilities.

Access to Entitlement Benefits

Stakeholders in the criminal justice and behavioral health communities consistently identify lack of access to public entitlement benefits such as Supplemental Security Income (SSI), Social Security Disability Insurance (SSDI), and Medicaid as among the most significant and persistent barriers to successful community re-integration and recovery for individuals who experience serious mental illnesses and co-occurring substance use disorders. The majority of individuals served by the CMHP are not receiving any entitlement benefits at the time of program entry. As a result, many do not have the necessary resources to access adequate housing, treatment, or support services in the community.

In order to address this barrier and maximize limited resources, the CMHP developed an innovative plan to improve the ability to transition individuals from the criminal justice system to the community. Toward this goal, all participants in the program who are eligible to apply for Social Security benefits are provided with assistance utilizing a best practice model referred to as *SOAR (SSI/SSDI, Outreach, Access and Recovery)*. This is an approach that was developed as a federal technical assistance initiative to expedite access to social security entitlement benefits for individuals with mental illnesses who are homeless. Access to entitlement benefits is an essential element in successful recovery and community reintegration for many justice system involved individuals with serious mental illnesses. The immediate gains of obtaining SSI and/or SSDI for these people are clear: it provides a steady income and health care coverage which enables individuals to access basic needs including housing, food, medical care, and psychiatric treatment. This significantly reduces recidivism to the criminal justice system, prevents homelessness, and is an essential element in the process of recovery.

The CMHP has developed a strong collaborative relationship with the Social Security Administration in order to expedite and ensure approvals for entitlement benefits in the shortest time frame possible. All CMHP participants are screened for eligibility for federal entitlement benefits, with staff initiating applications as early as possible utilizing the SOAR model. Program data demonstrates that 90% of the individuals are approved on the initial application. By contrast, the national average across all disability groups for approval on initial application is 37%. In

addition, the average time to approval for CMHP participants is 30 days. This is a remarkable achievement compared to the ordinary approval process which typically takes between 9-12 months.

In November 2010, Miami-Dade County was awarded a 3-year, $750,000 grant from the State of Florida to implement a collaborative project between the CMHP and the Miami-Dade Corrections and Rehabilitation Department to expand services to include individuals with SMI re-entering the community after completing jail sentences and to implement a specialized entitlement benefits unit utilizing the SOAR model to expedite access to Social Security and Medicaid benefits for individuals served by the CMHP's programs.

Recovery Peer Specialists

Recovery Peer Specialists are individuals diagnosed with mental illnesses who work as members of the jail diversion team. Due to their life experience they are uniquely qualified to perform the functions of the position. The primary function of the Recovery Peer Specialists is to assist jail diversion program participants with community re-entry and engagement in continuing treatment and services. This is accomplished by working with participants, caregivers, family members, and other sources of support to minimize barriers to treatment engagement, and to model and facilitate the development of adaptive coping skills and behaviors. Recovery Peer Specialists also serve as consultants and faculty to the CMHP's Crisis Intervention Team (CIT) training program.

Bristol-Myer Squibb Foundation Project

The South Florida Behavioral Health Network, which is contracted by the Florida Department of Children and Families to manage the substance abuse and mental health system of care in Miami-Dade and Monroe Counties, was been awarded a 3-year, $1.2 million grant from the Bristol-Myers Squibb Foundation to oversee development and implementation of a first-of-its-kind coordinated system of care demonstration project. The project, which serves as an overlay to both the Misdemeanor and Felony Jail Diversion Programs is designed around recommendations from the National Leadership Forum on Behavioral Health/Criminal Justice Services, targets individuals with severe and persistent mental illnesses who are at highest risk for involvement in the criminal justice system and other institutional settings. A primary goal of the project is to ensure timely and efficient access to a comprehensive array of services based on enhanced, individualized assessment of clinical and criminogenic needs and risk factors. Services, which incorporate criminal justice and trauma informed practices, are delivered by a coordinated network of community-based treatment providers and justice system stakeholders involved in cross-systems and cross-disciplinary treatment planning, service coordination, and information sharing. Project evaluation will include comparisons of behavioral health and criminal justice outcomes among individuals enrolled in the newly created system of care and enhanced services to outcomes among individuals participating in traditional community-based services.

Mental Health Diversion Facility

Since 2006 the courts have been working with stakeholders from Miami-Dade County on a capital improvement project to develop a first of its kind mental health diversion and treatment facility which will expand the capacity to divert individuals from the county jail into a seamless continuum of comprehensive community-based treatment programs that leverage local, state, and federal

resources. This project, which is funded under the *Building Better Communities General Obligation Bond Program*, was established to build on the successful work of the CMHP with the goal of creating an effective and cost efficient alternative treatment setting to which individuals awaiting trial may be diverted.

The diversion facility will be housed in a former state forensic hospital which has been leased to Miami-Dade County and is in the process of being renovated to include programs operated by community based treatment and social services providers. Services offered will include crisis stabilization, short-term residential treatment, day treatment and day activities programs, intensive case management, outpatient behavioral health and primary care treatment services, and vocational rehabilitation/supportive employment services. The proposed plan for the facility includes space for the courts and for social service agencies such housing providers, legal services, and immigration services that will address the comprehensive needs of individuals served.

The vision for the mental health diversion facility and expansion of the CMHP's diversion programs is to create a centralized, coordinated, and seamless continuum of care for individuals who are diverted from the criminal justice system either pre-booking or post-booking. By housing a comprehensive array of services and supports in one location, it is anticipated that many of the barriers and obstacles to navigating traditional community mental health and social services will be removed, and individuals who are currently recycling through the criminal justice system will be more likely to engage treatment and recovery services. Creation of this facility will also allow for the movement of individuals currently spending extended amounts of time in the county jail into residential treatment programs and supervised outpatient services supported by more sustainable funding sources. It is anticipated that the facility will begin operations in 2016.

Typical or Troubled?™ Program

Recently, the CMHP partnered with the American Psychiatric Foundation (APF) and Miami-Dade County Public Schools (MDCPS) to implement the ***Typical or Troubled?***™ School Mental Health Education Program for all public junior high and high schools in the Miami-Dade system. The program will train over 500 teachers, school psychologists, social workers and guidance counselors on early identification of potential mental health problems, will educate and engage parents and will ultimately link students with mental health services when needed.

Typical or Troubled?™ is an educational program that helps school personnel distinguish between typical teenage behavior and evidence of mental health warning signs that would warrant intervention. The program includes culturally sensitive technical assistance for school personnel on best practices and educational materials in English, Spanish and forthcoming in Haitian Creole. To date, the program has been used in over 500 schools and school districts, in urban, suburban and rural areas, and educated more than 40,000 teachers, coaches, administrators, and other school personnel across the country.

This initiative will take a proactive approach to tackle the issue of mental health in schools through partnerships and targeted training that hone in on the identification and effective treatment of mental health problems before those problems manifest through increased truancy, substance abuse, violence or tragedy.

Conclusion

The CMHP has demonstrated substantial gains in the effort to reverse the criminalization of people with mental illnesses. The idea was not to create new services but to merge and blend existing services in a way that was more efficient and continuous across the system. The Project works by eliminating gaps in services and by forging productive and innovative relationships among all stakeholders who have an interest in the welfare and safety of one of our community's most vulnerable populations.

The CMHP offers the promise of hope and recovery for individuals with SMI that have often been misunderstood and discriminated against. Once engaged in treatment and community support services, individuals have the opportunity to achieve successful recovery, community integration, and reduce their recidivism to jail. The CMHP is a national model of excellence and has received numerous recognitions including the *2010 Prudential Davis Productivity Award for implementation of SOAR, 2010 Eli Lilly Reintegration Award for Advocacy, 2008 Center for Mental Health Services/National GAINS Center Impact Award*, the *2007 National Association of Counties Achievement Award*, the *2006 United States Department of Housing & Urban Development's HMIS National Visionary Award*, the *2006 Prudential Financial Davis Productivity Award*, and the *2003 National Association of Counties Distinguished Service Award.*

The CMHP provides an effective and cost-efficient solution to a community problem. Program results demonstrate that individualized transition planning to access necessary community based treatment and services upon release from jail will ensure successful community re-entry and recovery for individuals with mental illnesses, and possible co-occurring substance use disorders that are involved in the criminal justice system.