Mental Health, Criminal Justice and Hospitals

March 30, 2015 Webinar
WE BELIEVE IN HEALTHCARE THAT CARES
BAPTIST HEALTH SOUTH FLORIDA

- 6 hospitals in Miami-Dade and Monroe counties with 1,700 beds
- Over 235,000 emergency visits and 70,000 admissions per year
- 35 urgent care and outpatient/diagnostic centers are visited by 275,000 patients per year

Over 2,500 physicians and 16,000 employees
Introduction: *What is the Problem?*

About the Issue: *What Factors Contribute to the Problem?*

Possible Solution: Technology and Community Collaboration
De-institutionalization = Trans-institutionalization

- Psychiatric Hospitals to Jails and ER’s
1955 - 560,000 people in State Psychiatric Hospitals in the United States
1955 - 5,000 people with SMI’s in custody
Today, less than 40,000 Psychiatric Beds
Last year approx. 1.5 million people with mental illnesses were arrested.
90% Decrease in Psychiatric Beds = 400% Increase number of people with SMI’s in Jails/Prisons
De-Institutionalization

- 90% Decrease in Psychiatric Beds = 400% Increase number of people with SMI’s in Jails/Prisons

- 500,000 people with SMI’s in Jail/Prison

- 850,000 people with SMI’s on Probation or Community Control
An Expanding Population under Correctional Supervision

7 MILLION AND COUNTING

Led by probation, the correctional population has tripled in 25 years.

- Probation: 4,293,163
- Parole: 824,365
- Prison: 1,512,576
- Jail: 780,581

NOTE: Due to offenders with dual status, the sum of these four correctional categories slightly overstates the total correctional population.

Pew Center on the States (2009)
WHO’S UNDER CORRECTIONAL CONTROL?

Correctional control rates vary drastically across demographic lines.

TOTAL 1 IN 31

WOMEN 1 IN 89

MEN 1 IN 18

WHITE 1 IN 45

HISPANIC 1 IN 27

BLACK 1 IN 11


Pew Center on the States (2009)
SMI and Co-Occurring Substance Use Disorders (CODs)

Prevalence of SMI and CODs in Jail Populations

General Population

- Serious Mental Illness: 5%
- No Serious Mental Illness: 95%

Jail Population

- Serious Mental Illness: 17%
- No Serious Mental Illness: 83%
- COD: 72%
- No COD: 28%
Alcohol and Drug Use Disorders: Household vs. Jail vs. State Prison

- Alcohol use disorder (Includes alcohol abuse and dependence)
- Drug use disorder (Includes drug abuse and dependence)

<table>
<thead>
<tr>
<th></th>
<th>Household</th>
<th>Jail</th>
<th>State Prison</th>
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<tbody>
<tr>
<td>Alcohol use disorder</td>
<td>8%</td>
<td>54%</td>
<td>53%</td>
</tr>
<tr>
<td>Drug use disorder</td>
<td>2%</td>
<td>47%</td>
<td>44%</td>
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</tbody>
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Abrams & Teplin (2010)
Costs of Criminal Justice Involvement for Individuals with SMI/COD

- Housing instability and homelessness
- Non-adherence with medications and treatment
- Difficulty managing finances
- Increased vulnerability to physical illnesses—HIV infection and hepatitis
- Higher service utilization and costs
- Increased vulnerability to relapse and re-hospitalization
- More vulnerability to re-incarceration
Impact on Hospitals

Nearly 12 million visits made to U.S. hospital emergency departments involved people with a mental disorder, substance abuse problem, or both. This accounts for one in eight of the 95 million visits to emergency departments by adults that year.

Agency for Healthcare Research and Quality (AHRQ).
Impact on Hospitals

- Of these visits, about two-thirds involved patients with a mental disorder, one quarter was for patients with a substance abuse problem, and the rest involved patients dealing with both a mental disorder and substance abuse.

- Mental health and/or substance abuse-related visits were 2½ times more likely to result in hospital admission than visits not involving mental disorders and/or substance abuse. Nearly 41 percent of mental disorder and/or substance abuse-related visits resulted in hospitalization.
Impact on Hospitals

- The average length of stay for a patient with MHSA was significantly longer than for a patient without MHSA (7.1 days to 4.6 days)

- The rate of discharges Against Medical Advice (AMA) is significantly higher for MHSA discharges than all other discharges - 19 per 1000 for MH and 107 per 1000 for SA versus 8 per 1000.
Impact on Hospitals

- While the average cost for MHSA hospital stay was lower than all stays without a major operating room procedure, the average cost of a hospital stay for an individual with schizophrenia was higher ($7,500 to $6,700).

- Hospital stays for MHSA were more commonly uninsured or insured by Medicaid.

- The aggregate costs of hospitalizations for schizophrenia was $2.7 billion dollars, depression and bi-polar disorders was $2.1 billion dollars, alcohol $1.3 billion dollars and drug related disorders $1.1 billion dollars for a total cost of $7.1 billion dollars.
The Problem: Overrepresentation of Persons with Behavioral Disorders. Why?

- Arrested at disproportionately higher rates
  - Co-occurrence of substance use disorders
  - Homelessness
- Stay longer in jail and prison
- Limited access to health care
- Low utilization of EBPs
- High recidivism rates
- More criminogenic risk factors
What Accounts for the Problem? Limited Access to Health Care

- Poor health status
- Poor health access
Additional Challenges Due to Stigma

“Crazy”

“Drug-addicted”

“Criminal”

- Bias
- Distrust
- Prejudice
- Fear
- Avoidance
- Distress
- Anger
- Stereotyping

- Reduced Access:
  - Housing
  - Employment
  - Treatment
  - Other services

- Perception of violence
- Discrimination

Challenges in Accessing Mental Health Care

- **Structural barriers to accessing care**
  - Fragmentation of the mental health care system
  - Paucity of funds and resources across communities

- **Quality and availability of care**
  - Short supply of services
  - Contingent on timing, personal resources, program eligibility criteria

- **Willingness of mental health service providers to participate in court-based initiatives varies**
  - Self-perceived lack of competence
  - Stigma
SOLUTION – Advanced Technology

ODH IN MIAMI
Otsuka Digital Health -

Provider-Delivered Behavioral Health Care

INTAKE  CARE MANAGEMENT  DISCHARGE

Shared information Across Providers

Improved Care Coordination
Stakeholders in behavior healthcare

- Consumers and Families/Caregivers
- Providers/Hospitals
- Court and Jails
- SFBHN – Managing Entity
Consumers and families/Caregivers

- Beginning coordination of care across the provider network, more than an episode of care

- View in ODH all service appointments and attendance across providers

- Use provider service schedule to schedule transportation

- BENEFITS: significantly increases consumer participation with minimal involvement
Providers

- Increased visibility to their consumers participation in services
- Less likely for a consumer to "drop thru the cracks" through automation of scheduling and tracking consumers – reduces overall cost of care
- Automation of mundane tasks
- View across the provider network of the consumers and their family's participation in services
- BENEFITs – insight into consumers ability to participate
Courts, jails and hospitals

- Ability to quickly determine current state of consumers current and past behavior history

- Quickly determine and begin appropriate services for the consumer using the built in referral process

- Reduce incarceration and hospitalization by diverting consumer to a provider for services
Begins transition of SFBHN from participating in care to monitoring quality of care using metrics and analytics for high risk/high utilizers.

Provides the data foundation to create treatment protocol(s) for specific behavior diagnosis for age/gender based.

BENEFITS: begins codifying coordination of care using ODH as the information data store using consumer and provider information to identify best treatment protocols and standardize best treatment practice.
Connecting to Mental Health Care Services in Your Community

- Be familiar with the services that are available in your community
  - Establish community partnerships with key stakeholders
  - Invite community providers to meeting to share expectations (client and system level)
- Be familiar with the quality and effectiveness of services individuals under court supervision receive
  - Maintain communication with treatment providers and other court-based staff
- Monitor outcomes
Wrap Up

- As the field moves toward population health management, integration and access to an appropriate continuum of behavioral health services becomes even more critical.
- There is no single model for behavioral health that is appropriate for every hospital.
- Rather, each hospital has to develop its own plan in light of community needs, existing community resources, and hospital resources & capabilities.
- The unavoidable reality is that every hospital treats patients with behavioral health disorders, even when an acute care community hospital has no organized behavioral health service or clinicians.
- Integration of physical and behavioral medicine is KEY to bending the cost curve and improving outcomes. Research has shown that people with chronic medical and comorbid behavioral health conditions have medical expenses 2-3 times as high as those who don’t have comorbid behavioral health conditions.
- To achieve AHA’s Vision of a society of healthy communities where all individuals reach their highest potential for health, we must work together in community partnerships to increase access and coverage to behavioral health services.
Takeaways

- Including behavioral health needs in your community needs assessment
- Review your organization’s behavioral health plan in light of identified community needs
- Encourage and actively participate in developing a community wide plan for behavioral health including coordinating this initiative with community agencies
- Work with community agencies and the judicial system to ensure that all patients are treated in the most appropriate setting
- Become an advocate for better funding for behavioral health….