Missouri Association of Counties
Policing, Justice & Mental Health Steering Committee

History and Context:

In February, 1963, in President Kennedy's Special Message to Congress on Mental Illness and Mental Retardation, he stated, "I am proposing a new approach to mental illness and to mental retardation. This approach is designed, in large measure, to use Federal resources to stimulate State, local and private action. When carried out, reliance on the cold mercy of custodial isolation will be supplanted by the open warmth of community concern and capability. Emphasis on prevention, treatment and rehabilitation will be substituted for a desultory interest in confining patients in an institution to wither away."

The Community Mental Health Act of 1963 resulted from President Kennedy's speech. Before that Act was promulgated, many Americans with disabilities were sent to asylums, or what the President called "custodial isolation." Their purpose was to uphold community standards by keeping individuals living with mental illness out of sight, warehoused in institutions where care and housing standards varied from state to state, with virtually no federal oversight.

The 1963 Community Mental Health Act promoted, at its core, comprehensive community mental health centers in every jurisdiction in every state, utilizing available federal funding to develop these centers in ways that best met local needs. The Act also focused on improving care in state institutions, increasing research on mental illness, and increasing training for professionals and staff.

The new focus on deinstitutionalization codified in the 1963 Act arose out of various factors, including states' efforts to strengthen their commitment laws. Additional and perhaps more important factors included the development and more widespread use of medications that helped individuals to live outside of an institutional setting and speeded recovery for those individuals admitted to those settings; the 1963 Act itself; changes in Medicaid laws which denied financial coverage for inpatient services for persons 21-65 years of age, which in turn incentivized States to use community-based services instead where possible; advances in the treatment of epilepsy, neurosyphilis, developmental and intellectual disabilities, and geriatric dementia, conditions that had accounted for large percentages of the psychiatric inpatient populations before;

managed care, establishing strict medical necessity criteria for insurance reimbursement of the costs of hospitalization, and federal disability laws like the Civil Rights of Institutionalized Persons Act of 1980 and regulations that implemented the SCOTUS decision in *Olmstead v. L.C.*, 527 U.S. 581 (1999) (the decision based on the ADA and which suggests that states use community alternatives to inpatient care).

In 2008, when the 1963 Act was updated with the Mental Health Parity and Addiction Equity Act, promoters of that Act, including President Kennedy's nephew, Representative Patrick Kennedy, acknowledged that, while those affected by mental illness, addiction, or intellectual or developmental disabilities were energized by the initial promise of the Act, "the execution of the vision was flawed, [and the] fragmented implementation of the promise [the Act} held out allowed too many people to fall through the cracks. Too many people failed to receive the help they needed. Too many became homeless or were bypassed by our society."

Here in Missouri, the promise of community mental health treatment was begun as, over time, many of the in-patient treatment facilities in which individuals with behavioral health challenges were housed were closed and individuals, families, and caretakers or guardians were directed toward community mental health centers for resources of all sorts. The federal funding upon which the 1963 Act and all subsequent iterations depended was directed from the federal Department of Health and Human Services to the state Department of Mental Health (DMH). From there, funding has been distributed to local jurisdictions primarily on a regional basis through state-designated mental health care providers. Decisions as to how and where services will be provided locally are made by the designated providers and state-level agency personnel.

Despite good intentions and concomitant allocation of resources intended to provide appropriate community-based care for individuals with behavioral health challenges and to maintain public safety, the system has not functioned as either envisioned or intended. As one writer has noted, "…the medicines along were never quite as effective as promised—at least not for everyone—and the comprehensive community-based care system that was envisioned to meet the complex needs of persons with severe, disabling disorders such as schizophrenia never fully materialized." The term "frequent flyer" often became attached to individuals who, unable or incapable of adhering to available treatment, cycled through clinical deterioration, emergency short-term

psychiatric admission, and often involvement with the criminal justice system, that involvement related in some fashion to the individual's untreated psychiatric problems.

Across the country, and in every county in Missouri, a substantial number of individuals with serious mental illness (and often with co-occurring substance use issues) who face seemingly insurmountable barriers to accessing community behavioral health care and who may also to unable or unwilling to voluntarily comply with available treatment, are caught in a cycle of treatment; a period of doing well; stopping or being cut off from treatment; clinical deterioration, and subsequent involvement in the criminal justice system or the civil/probate system. When appropriate and well-resourced services are interjected into the system, it is possible to break the cyclical nature of these individuals' experiences, thus reducing the burden on Public Administrators, law enforcement, the courts, prosecution services, public defender systems, ancillary court services, and the emergency room portal into the health care system.

Missouri Association of Counties & the Steering Committee Model:

The Missouri Association of Counties (MAC) Policing/Justice/Mental Health Steering Committee is comprised of representatives from the entities, agencies, and jurisdictions who have seen and been impacted by a system that, despite good intentions of all involved, has demonstrated the flaws that have been noted by politicians and researchers since the advent of community-based treatment. Judges, Prosecutors, Public Defenders, Public Administrators, Sheriffs, Court Administrators, representatives of the National Alliance on Mental Illness (NAMI), Juvenile Officers, County Commissioners, and representatives of the developmental disability community have joined together to wrestle with this issue, which presents across all of these systems.

At a recent meeting of the Steering Committee, members acknowledged that, because of the scarcity of appropriate and accessible resources, each of these systems had sought to move the individual with behavioral health challenges into another system, believing, perhaps wistfully, that "other" system would have the resources to appropriately address the individual's issues and needs. For instance, when an individual has presented in the criminal justice system with serious mental illness and judges, prosecutors, court administrators, and defense counsel cannot identify an existing or available appropriate placement, the possibility of transferring the individual, and thus the placement issue, to

the Probate Court and the Public Administrator, has been seen as a viable response. The collaboration of all of these entities in both the MAC Steering Committee and the work within the National Association of Counties (NACo) "Stepping Up Initiative," has allowed the entities to understand that transferring the individual simply means transferring the problem—from one under or un-resourced system to another. Similar transfers, from one of the above-referenced systems to nursing homes, or other similar situations, have come to light because of the ongoing collaboration among the system representatives.

This has led to frank discussion of where we are and how we got here, including a granular unpacking of information from each system—how and why individuals with serious mental illness and substance use issues enter each system; what resources are available to address the individual's behavioral health issues; who or what controls the resources and how they are or can be utilized; and perhaps most importantly, how we, as a State, and as representatives of our various agencies and interest groups, can fulfill the promises made to communities, and individuals living with mental illness and their families, in 1963 and beyond.

The following are excerpts from reports of stakeholder groups from the Steering Committee, detailing how issues involving mental health present in their particular areas of practice and potential solutions suggested to address those issues.

Public Administrators:

In 2020, the Missouri Association of Public Administrators (MAPA) funded a Missouri Public Guardianship Report that provided the current status of Missouri's public guardianship system and opportunities for improvement.

Over 11,000 individuals in Missouri have been appointed to Public Administrators. The primary diagnosis for 80% of those individuals (some 8,800 individuals) is a diagnosis served by the Missouri Department of Mental Health (DMH). These diagnoses include mental illness (22%), developmental disability (18%), intellectual disability (14%), behavioral health issues (11%), substance use disorder (4%), or co-occurring conditions. (11%). A key finding in the report is that "Missouri's public guardianship system is serving younger individuals with more complex issues than ever before," consistent with the

national trend. The study noted the ongoing lack of appropriate services and placements for Missourians battling mental illness and substance use disorders.

The study also noted that the numbers of forensic referrals for public guardianship continue to rise. Community-based oversight for wards who have a history of violent behavior is extremely limited. Placement options are also limited and can be highly inappropriate, including the housing of violent individuals within a geriatric population in, for example, a nursing home. The study cautions that the establishment of guardianship does not, of itself, stop violent or dangerous behavior and should not be considered a complete solution, since it must be accompanied by sufficient additional and appropriate supportive services and resources.

The MAC Steering Committee Public Administrator members noted the lack of consistency across the State in how agencies (state and federal) operate and how resources are allocated. The members also noted that increased, ongoing communication between a Public Administrator and care providers would greatly assist in the identification of issues before they reach crisis proportions. Transparent, accountable, conflict-free, and timely identification of resources combined with an evidence-based decision-making process will result in better outcomes for the individuals, their families, and the communities at large.

Judges:

While all judges in Missouri hear cases with behavioral health implications, those on the front lines of these situations are often the Associate Circuit Court judges, who have either a large probate or a large criminal docket, and are the first judicial officer to have contact with these individuals. For the criminal court docket, the number of individuals with behavioral health issues is "staggering," with the situation often involving either an individual who is charged with a crime and the individual's competency to proceed is in question or the individual is charged with a relatively minor offense, such as trespassing, that likely would not have occurred had the individual not been in behavioral health crisis.

The competency question should be capable of resolution given the court's power to enter an order under Section 552.020 RSMo. However, despite judges across the state issuing orders first, for evaluation, and later, for commitment to the custody of the Department of Mental Health, those orders seem to be

considered suggestions rather than orders. Judges routinely acknowledge that DMH regularly request multiple extensions of time—3 to 6 to 12 months—to evaluate an individual and similar or even longer time frames for removal from the county jail to a treatment bed. Judges identify as the common denominator at the Associate Circuit Court level the lack of viable crisis intervention options that are readily accessible to individuals with behavioral health issues. Housing and keeping individuals in mental health crisis in the jail adds to the already bloated over-crowding of the jail, and if they are not connected and kept connected with services, they will be part of the revolving door at the jail and courthouse.

Judges who hear probate cases, in which a Guardianship and/or Conservatorship have been requested, report the same drastic increase in caseload as have the Public Administrators. Individuals who face behavioral health challenges and who lack the ability to care for themselves or make decisions relating to that care, petition the court for establishment of the Guardianship and/or Conservatorship. Lacking family willing and able to assist, and often lacking personal resources, it is the psychiatric hospital or entity that makes the request. The Public Administrator then faces the same challenges noted elsewhere in this report—what facility might have a bed and, if so, does the facility have the personnel trained to care for these individuals? Judges also report that, if a poor option for a facility exists, the individual may return to the court on a criminal charge—for example, if the individual is inappropriately placed in a nursing home and ultimately assaults a staff member or another resident.

Prosecutors:

Because of the prevalence of court-involved individuals with behavioral health challenges, the nature of the work of prosecutors and law enforcement agencies has changed dramatically over time. As resources and statutory options for treatment of those individuals have become more limited, prosecutors have seen many of the same individuals cycle through the system, presenting time after time with no resolution to pre-existing conditions. When DMH fails to timely abide by a court order for evaluation or placement, or when defense counsel elects to forego a mental health evaluation, knowing that it will take longer to schedule the evaluation than the individual may be detained, and then the individual may be released to the community without treatment and without a treatment plan, law enforcement and the prosecutor are often among the first to see the individual—charged again, detained again, tried again.

While much of the direct burden has fallen on law enforcement, prosecutors have also attempted to find ways to address issues and relieve caseload challenges by allocating already limited resources to identify appropriate outcomes in specific cases. Prosecutors encourage the development and funding of real access to behavioral health treatment and substance abuse treatment in every jurisdiction, with tele-mental health services augmenting in person services where broadband capacity exists and is affordable. Treatment courts, including but not limited to mental health court, are effective and should not be limited solely to post-adjudication or misdemeanor cases. Advocates, peer specialists, and other navigator-based programs, are critically important supports to the success of individuals living with behavioral health issues. Creation and funding of support service programs for both juveniles and adults within the court system will help to ensure success of those individuals and will relieve pressures on the Prosecutor's Office.

Recognition of the existence of these problems will be the first step to their resolution. Without recognition and then adequate funding and training, they will continue to play an outsize role in communities across Missouri. Our community mental health crisis cannot be allowed to continue to consume so many resources for such marginal results.

Juvenile Officers:

The Missouri Juvenile and Family Division publishes annual reports that present general population data about Missouri court-involved youth; summary statistics about state, law and abuse/neglect referrals; risk and needs characteristics of the juvenile offender population, and more. The 2021 Report includes substantial information about the prevalence of behavioral health challenges presented in a large percentage of court-involved youth. The following information is gleaned from that Report: In 2020, approximately 624,000 youth, aged 10-17, were court-involved, with that number projected to increase by 2.5% annually. During 2021, 47% of youth were referred to the system by law enforcement; 23% by the Children's Division, and 18% by schools. Of those referrals, 36% were for abuse or neglect; 33% for delinquency, and 29% were for status offenses. During 2021, 63.5% of total referrals were of youth aged 13-18. Of the referrals disposed of in 2021, the risk level presented was in the moderate range for 61%, with 21% presenting a low risk level, and 17% presenting a high risk level. Among the most

significant needs factors identified across that population were mental health (37.3%) and parental mental health (22.5%).

Court-involved youth referred to detention more and more frequently present with substance abuse, mental health or developmental disabilities. As with the adult population, the average length of detention for this population is increasing exponentially, in part because of the lack of adequate placement facilities. Further, while needs assessments reveal what appropriate resources should be mobilized for individuals, the lack of those resources has become endemic. Finally, because the law allows for the suspension of payment for such services after 30 days in custody, too often those services cannot be provided since no funding stream exists for providing them. Juvenile court staff note that a factor compounding the problems in providing services to detained youth is the suspension of Medicaid and other benefits to youth detained more than 30 days.

Juvenile court officials and staff recommend systemic change among state agencies and community-based providers to improve care for youth in detention. Areas of focus, including collaborative, accessible, affordable and evidence-based strategies, interventions and services, not solely for youth but the entire family unit, are vital for this population. Even if adults in the family lack control of a youth's behavior, adults in the home environment often benefit from learning new skills to increase the influence they may have.

Court Administrators:

Court administrators in Missouri have engaged in and often helped lead processes to address the over-representation of individuals with mental health and substance abuse issues in the court system, on both the civil and criminal sides. However, they uniformly express frustration at the impact of delays by other entities on the court itself. They frequently cite the situation that, under Section 552.020 RSMo, once a judge orders a mental evaluation be performed, the evaluation is to be completed and filed with the court within 60 days. They note that the Department of Mental Health (DMH) never completes its obligation within the 60 day period and that it often takes four to five months after the court has issued its order to DMH before the results are filed with the court. They note that, during those months in which the detainee continues to sit in the jail, they are often held in isolation because of their mental illness and, as a result, they continue to spiral downwards. The delays caused by DMH directly affect the case status, since, once a person's competency is

placed in question, the case cannot proceed. If the detainee is evaluated and the judge finds that the individual is incompetent to proceed, the judge will then order the individual into the custody of DMH but, as noted elsewhere in this report, that individual is likely to wait 9-12 months before finally being transported to a DMH facility. The backlog created by these delays adversely impact the administration of justice generally, increasing caseloads for judges, prosecutors, and defense counsel, and leading to worse results for the individuals involved.

Court administrators witness the direct impact of the failure or inability of entities such as DMH to comply with their statutory obligations on court-involved individuals with behavioral health issues; on the court system; on prosecutors, on defense counsel, and on ancillary court services. They encourage an evaluation of the current allocation of resources to understand how the system can meet its obligation to both litigants and the community.

Law Enforcement:
Sheriffs are unique in that they wear two hats—one the enforcement hat, the other the detention hat. Across the state and the nation on the enforcement side, they have witnessed and experienced the effects of our collective failure to provide adequate resources in the community to address substance abuse and mental health concerns. Without sufficient personnel and other resources to link to individuals in crisis, housing insecurity, lack of employment, and other factors often lead to court involvement and thereafter detention. Once individuals are court-involved, unless they are linked to other resources, it is extremely rare that they can extract themselves from those systems.

Law enforcement officials statewide have acknowledged that sheriffs, who not only are tasked with ensuring community safety through the "road officer" side of their work but with maintaining county detention facilities, are running the largest mental health facilities—those self-same detention facilities—in their jurisdictions. Not only do officers have to develop skills (through CIT training or Mental Health First Aid training) to de-escalate situations involving individuals in behavioral health crisis, but detention staff and other detainees in the jails are exposed to difficult behaviors that require additional resources and personnel, which in turn limits the resources that otherwise would be directed to traditional law enforcement activities. Most if not all county jails are experiencing serious staffing issues. Maintaining the safety of those detained, those who work in the facility, and the community itself must be of paramount concern. While Sheriffs across the state are housing individuals

with serious behavioral health issues and provide as many resources as possible to those detainees, housing these individuals in what is, in essence, a concrete box, is not in the best interest of either the individual or the facility. An individual who enters the facility with the charge of a minor offense may well decompensate and then engage in more aggressive behavior, endangering himself, another detainee, or a member of the law or detention staff, or damaging jail property. The individual who entered the facility with a misdemeanor charge now faces felony charges and still has untreated behavioral health issues.

Further exacerbating these situations is that, when a court has determined that an individual is not competent to stand trial and orders the individual into the custody of the Department of Mental Health (DMH), that individual typically remains in county jail for months—8 to 12 months is commonplace—awaiting an "open bed." During the third quarter of 2022, approximately 200 detainees state-wide are in that situation. Significant for Sheriffs statewide, the cost during that period for maintaining these individuals rests not with DMH but with the local Sheriff and the County generally.

Conclusions:

Individuals with mental health challenges and substance use issues can be found in every system that touches the justice system, from law enforcement to community-based placement options. Although substantial resources have been earmarked by both the federal and state governments to address the needs of these individuals, many fall through the cracks, not receiving appropriate and timely services that would support their success and the safety of the community that surrounds them.

That a better model for current delivery of services can exist has been highlighted by the participation in this Steering Committee of Christina Devine, General Counsel for Boone County Family Resources, a "Senate Bill 40" organization designed to serve individuals with developmental disabilities, made possible by enabling legislation passed by Missouri's legislature in 1969. Before that time, individuals with developmental disabilities experienced the same kinds of problems—lack of resources, mis-directed resources—as individuals with behavioral health issues. The state legislature promulgated this legislation so that special tax levies could create funding pathways in

Missouri counties to provide individuals with developmental disabilities assistance with residential needs, employment, and related services.

In 1976, Boone County voters approved the ballot initiative to establish "Boone County Group Homes" (later changed to "Boone County Family Resources") and the political subdivision began serving eight individuals in residential services in 1977. The structure and oversight of the Senate Bill 40 Board has allowed flexibility in services and supports to Boone County residents for 46 years, enabling BCFR to meet changing needs as they are identified, including targeted case management services through a contractual arrangement established with the Department of Mental Health.

Counsel Devine has noted that, in 1994, in a letter to then-Lt. Gov. Roger Wilson, Nancy Allman, former President of Missouri Association of County Developmental Disabilities Services (MACDDS), wrote that "local empowerment" was taking place in Pettis and Boone Counties through the Senate Bill 40 Boards. "This empowerment is allowing the local county tax boards to expand their services, which serve more people and match additional federal dollars to expand even more services for people with disabilities. This presents tremendous opportunity for the consumer, their families, and the Missouri taxpayer…. Greater autonomy has been in place since 1989 in Boone County, which has seen services grow from ninety-nine individuals to almost five-hundred persons in 1994. Boone County is vaporizing waiting lists, and local needs are being met." That kind of service continues today across the state in Senate Bill 40 Boards. In 2021, BCFR provided supports and services to 2,026 individuals locally, supporting almost 40 individuals in residential apartments. It offers services with over 75 providers, and Medicaid Waiver services for eligible persons served. Its success is partly due to its ability to adapt to meet changing needs, while maintaining focus on its mission of assisting individuals with developmental disabilities to thrive in the community, connect with others, and achieve personal goals. Its structure not only provides oversight to the County in addressing proper expenditure of funds, but also maintains a focus not on profits but on providing effective, tailored services within the community in the most efficient way possible.

Since individuals with developmental disabilities may also have behavioral health challenges, BCFR and other Senate Bill 40 Boards have experienced the same issues as the other stakeholder groups contributing to this report. Counsel Devine confirmed that BCFR has noted the same concerning lack of local resources and services when its staff works with individuals having a dual

diagnosis of developmental disability and one or more mental health diagnoses. Specifically, staff has noted the following: 1. Decreased availability of residential placement for individuals with behavioral health issues; 2. Crisis intervention services are often completely unavailable to families seeking assistance for loved ones; 3. If crisis intervention services are available, releases are made without transition to a community plan of action; 4. Individuals with behavioral health concerns may face criminal charges due to escalation of their behaviors during treatment for psychiatric or psychological concerns; 5. Individuals with behavioral health concerns often are re-admitted to crisis programs after they are returned to community placements without adequate resources for their behavioral health issues; 6. Safety and other challenges exist—both to the individual and to other residents and staff—when individuals with behavioral health issues are housed in various settings.

Counsel Devine finally noted that all stakeholders on the Steering Committee reference the repeated transfer of individuals with behavioral health issues from one under-resourced system to another. She acknowledges that individuals with developmental disabilities who also have a mental health diagnosis will not thrive in the community without tailored supports and services that will provide a pathway to success. That intentional approach is what has led to the success of the Senate Bill 40 model.
Thus, the model exists. It is one built upon a shift of responsibility, authority, and funding to the local level to assure and increase accessibility accountability, responsiveness to client needs, efficiency, and grassroots, community input to ensure that priorities and planning reflect community ownership.

Specific Suggestions:

The following suggestions have been developed by the MAC Policing, Justice & Mental Health Steering Committee and its member stakeholder representatives as steps that might better inform members of the Missouri legislative and executive branches of government as to steps that will better utilize available resources; lead to better outcomes for the individuals involved and maintain the safety of all Missouri communities.

- Undertake a detailed analysis of resource allocation, contracting decisions, and metrics used to analyze programmatic policies and outcomes addressing mental health and/or substance use issues for all agencies and entities receiving funding from the State of Missouri or from

the federal government, including but not limited to the Department of Mental Health. Key questions to be addressed include transparency of agency decision-making and accountability to the individuals served and the communities in which they live.

- Address the significant deficit in number of beds and placements allocated in settings across the state for individuals requiring either evaluation or long-term care due to behavioral health challenges.
- With due regard to privacy considerations, and utilizing best practices including use of Business Associate Agreements, create and maintain a state-wide data-sharing program for the entities and agencies, including but not limited to law enforcement agencies, the courts, defense counsel, prosecutors, public administrators, health care providers, behavioral health care providers, and other service providers whose work creates interactions with individuals living with mental illness and substance abuse issues. This data-sharing arrangement will allow services and interactions to be more appropriately directed to that individual, given his or her history and current presenting issues.
- Engage with the federal government and participate in the nation-wide expansion of the Excellence in Mental Health Act, which is part of the Bipartisan Safer Communities Act, sponsored by Missouri Senator Roy Blunt and Michigan Senator Debbie Stabenow.
- Develop consistent standards for allocation of resources to Public Administrator clients to ensure consistent quality of service across the state.
- Encourage collaboration and communication between Public Administrators and behavioral health care providers to pro-actively identify needs before crises arise. Establish mechanisms for data sharing such that this communication can occur and be effective.
- Establish a state-wide call line, with on-going funding for personnel and investigative services and referral authority to either regulatory or statutory enforcement agencies, to report issues with DMH and DHSS service providers.
- Develop deliberate, state-wide strategies to connect families and friends of individuals living with a serious mental illness or substance use disorder to take advantage of education, awareness, and supports to increase their potential influence with loved ones living with these illnesses. Increasing general awareness of NAMI and its resources is one such proven strategy.

- Create and maintain in real time a statewide list of vacancies within the DMH-contracted homes and beds in DHSS-licensed facilities and a continuously updated database of complaints against and ratings of those contracted providers.
- Establish state funding for acquiring and staffed additional locally-administered facilities for long-term care of individuals not suitable for low-level community-based housing but not appropriately placed in a criminal justice detention facility.
- Remove from the list of disqualifying criteria for Certified Peer Specialists prior convictions, suspended imposition, or suspended execution of sentence, for the enumerated felonies set forth in Section 630.170.1 & .2 RSMo.
- Advocate on the federal level for suspension of the Federal Medicaid Inmate Exclusion policy, which suspends federal benefits, including but not limited to Medicaid after a detention of 30 days, and enact legislation in Missouri that would continue coverage for detainees (youth and adults).
- Encourage the creation and provide funding for alternative treatment courts, including mental health court, in every jurisdiction in Missouri.
- Explore the use of Assisted Outpatient Treatment (AOT) as an alternative or ancillary approach to providing community mental health treatment in Missouri.
- Advocate for and provide funding for CIT training for all law enforcement officers, including road and detention officers; 911 telecommunicators, and other first responders.
- Provide Community Behavioral Health Liaison personnel including funding for those positions in every county.
- Support recommendations by the National Judicial Task Force to Examine State Courts' Response to Mental Illness.
- Support through funding of peer specialists or other personnel to link individuals returning to the community from either county jail or from a state or federal department of corrections.
- Consider the promulgation of legislation similar to Senate Bill 40, which established the local developmental disabilities model utilized to great success in Missouri.