



Asking Why

Reasserting the Role of Community Mental Health

**A Report on the Performance Improvement Project in Five States
September 2011**

Judge David L.
BAZELON CENTER
for Mental Health Law
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Asking Why

Reasserting the Role of Community Mental Health

Across the United States, the Bazelon Center is partnering with community mental health systems in five sites to focus on a too-common scenario, the reliance on police to intervene in preventable mental health emergencies. The initiative is called the Performance Improvement Project (PIP). Its goal is to reassert the intended role of community mental health programs in addressing problems that affect the quality of life of local citizens. As its initial focus, the project is working with community mental health agencies to take responsibility for meeting the needs of consumers who are at risk of involvement with police as a result of mental health crises.

For various reasons, most public mental health systems today take a reactive stance toward psychiatric crises. Mental health treatment is most accessible—and most expensive—during an emergency. When individuals are regarded as dangerous to themselves or others, they consume huge amounts of resources in a very short time: police calls, hospitalization and jail beds—all high-cost interventions. Then, once the crisis passes, these individuals too often find the less intensive resources and treatment they need are out of reach, even though such support can lower the chance of recurring crises.

The Performance Improvement Project takes a different approach to crises among people with serious mental illnesses. It is designed to empower community mental health to address the diverse factors that place people with serious mental illnesses at risk of crisis and bring them into contact with law enforcement. The project enables a community to take more cost-effective, less harmful proactive approaches in responding to the needs of citizens who have serious mental illnesses.

Drawing on the example of recent reforms in the use of psychiatric seclusion and restraint, the project redefines police involvement in mental health crises as a symptom of system failure and challenges the service system to address the root causes of such a failure. Seclusion and restraint were a common response to psychiatric crises, entrenched in mental health practice until a conceptual shift led to the near abandonment of these practices. When it was made clear that their use reflected not a routinely needed service, but a routine service failure, the mental health community shifted to preventive approaches.

The Performance Improvement Project is designed to empower community mental health to address the diverse factors that place people with serious mental illnesses into contact with law enforcement.

By failing to provide early intervention and adequate ongoing treatment and supports, a mental health system's routine operation perpetuates the crisis cycle that places people at risk of police intervention.^a This scenario is sustained by policy and reimbursement priorities that favor emergency services, that treat early intervention and prevention as expendable, and that do not recognize the untapped abilities of community mental health to provide innovative solutions.

The PIP goes beyond calls for closer collaboration between mental health and criminal justice agencies or better mental health care in jails. In five sites—Austin, Travis County, Texas; Detroit, Wayne County, Michigan; Pittsburgh, Allegheny County, Pennsylvania; Portland, Multnomah County, Oregon; and Westchester County, New York—it aims to spur a culture change within mental health systems. The goal is for local community mental health agencies to take ownership of problems, such as police encounters, that have resulted from the failure to meet their consumers' basic needs.

What community mental health was supposed to be & why it hasn't turned out this way

When pointing toward change, it's useful to take a quick look back to see how the nation's mental health services system arrived at its present state. The community mental health movement was envisioned by President John F. Kennedy in 1963 as "a wholly new emphasis and approach to care for the mentally ill."^b Launched in 1965, the initiative responded to a combination of concerns: the need to protect the civil rights of people with mental disabilities, publicity about inhumane conditions inside institutions, the development of new forms of psychotherapy and medication, and fiscal expediency. State budgets could not support the costs of huge institutions housing thousands of individuals, sometimes for decades on end. In contrast to the grim prospect of life on a custodial "back ward" of a state hospital, the community mental health movement was meant to herald a new era of innovation and hope.

Even in the absence of a detailed blueprint, there was a spirit of optimism that the nascent community mental health system would emerge as an altogether new model of support for people with serious mental illnesses. But the urgency of moving people from deplorable living conditions, combined with states' fiscal constraints and federal pressure for speed, trumped planning.

To get the ball rolling and lend weight and credence to the idea that mental health services should be provided in the community, the federal government provided seed money to establish a few dozen community mental health centers over eight years. Yet

states were given neither the time nor the funds to develop rational plans that would guide the development of a comprehensive community mental health system to meet the needs of their citizens.^c Nationwide, community mental health stumbled out of the gate. And before it could gain its footing, new requirements, programs and regulations piled on.

Although excellent programs were developed in some communities and massive state hospitals downsized virtually everywhere, the hope for coherent, adequately resourced community service systems was never realized.

At the end of its first decade, the community mental health movement could point to a system, but not a well-designed system. “We know,” reported President Carter’s Mental Health Commission in 1978, “that people are usually better off when care is provided in settings that are near families, friends and supportive social networks, yet we still channel the bulk of our mental health dollars to nursing homes and state hospitals.”^e

More than 30 years later, such trans-institutionalization persists, a result of stagnant planning, perverse funding incentives, unintended effects of regulation and stop-gap measures. Too many people with mental illnesses are in nursing homes, jails, and other settings that needlessly segregate people from the mainstream.

The potential for recovery is ignored

The earlier efforts to design community mental health often referred to the “chronicity” of mental illness and presumed a lifetime of dependency. Today, as reported by the Surgeon General of the United States^f and a commission convened by President George Bush,^g there is ample evidence that recovery from mental illness is possible. But, shamefully, we are still not delivering services and supports that can enable people with mental illnesses to realize their potential and to live, work, learn and participate fully in their communities.

The fault lies with a system in continuing disarray: “[F]or too many Americans with mental illnesses, the mental health services and supports that they need remain fragmented, disconnected and often inadequate, frustrating the opportunity for recovery. Today’s mental health care system is a patchwork relic—the result of disjointed reforms and policies.”^h

One significant factor—one that PIP targets—is the disconnect between policy decisions at various levels and the consumers and community mental health providers who know first-hand what services and supports make a difference.

“We know that services should be tailored to the needs of people in different communities and circumstances, but we do not provide the choices that make this possible... Social and human services were to have been integrated with more formal mental health care, resulting in a complete range of services.” President Carter’s Mental Health Commission, 1978.^d

Money problems, then and now

Even coherent service delivery systems cannot deliver good outcomes if not adequately resourced. At no time has community mental health received enough funding to meet the needs of low-income uninsured people with serious psychiatric problems. In 2006, real state spending on mental health (adjusted for inflation and population) was just 12% of what states spent in 1955.ⁱ Furthermore, whereas funding levels decades ago largely reflected a model of long-term custodial care, today's approaches have the potential to promote recovery, employment and self-sufficiency. In other words, rather than anticipating increasing and even lifelong dependency among people assigned to fixed service "slots," today's state-of-the-art services are flexibly provided in support of individuals' recovery. For many, success can result from an elastic service approach with low levels of routine assistance and the ready availability of more intensive help as needed. So from a purely business perspective, appropriate funding of today's community mental health models could generate a substantial return on investment.

States have increased their investment in responding to the *consequences* of unmet mental health needs in the community: jails, prisons, emergency care, homeless services and inpatient psychiatric hospitalization.

The reality, to everyone's detriment, is that neither social nor fiscal arguments have led to rational public policy that regularly produces good outcomes. In 1981, federal block grants to states effectively supplanted a comprehensive initiative enacted only a year earlier to promote, define and *fund* community mental health nationally.^j Community mental health has had to compete for a share of public revenues with programs that benefit more favored populations, always coming up short. And notwithstanding mission statements that are now ubiquitous in public mental health, at no time has community mental health received enough funding to make recovery the norm for people with serious mental illnesses. Instead, states have increased their investment in responding to the *consequences* of unmet mental health needs in the community: jails and prisons, emergency care, homeless services and inpatient psychiatric hospitalization.

Today, we see increased demand for community mental health services during a sustained period of budget-cutting. Since 2007, state budgets for mental health services have been cut by \$2.2 billion.^k During that time, demand for community mental health services increased by 56%.^l In fiscal year 2010, for example, Michigan cut \$40 billion from its budget, forcing the Detroit (Wayne County) community mental health agency to cut more than \$20 million midyear. As one result, Detroit's only downtown warming center was open only 12 hours a day rather than 24, a multi-service program that served homeless people was terminated, and 11 employees were laid off.^m

Notwithstanding these deep-seated and daunting challenges, community mental health programs nationwide are today an essential part of the social safety net. Albeit not established on the broad scale needed or intended, they have been incubators of innovative and successful programs that benefit people with serious mental illnesses. In many, sometimes small ways, the core values of the community mental health movement persist.

Pockets of innovation

Within community mental health, innovators have devised approaches that work around systemic problems such as funding silos, reimbursement structures that favor restrictive treatment, and program requirements that prevent the tailoring of services to individual needs and choices. In virtually every state over the past few years, initiatives have demonstrated positive and often cost-saving outcomes for people who have serious mental illnesses. But too often, these exist as isolated models or demonstration projects that end once special funding dries up. As a result, their successes seldom drive public-policy change.

Among the too few examples of enduring innovation in community mental health is the Housing First model, pioneered by Pathways to Housing in New York City for people with serious mental illnesses (some with substance-use disorders) who lack permanent housing.⁹ In contrast to congregate residential models, such as group homes, that were state-of-the-art decades ago, Housing First promotes personal responsibility and “investment” in one’s own home.

People live in their own apartments and must adhere to the same kinds of requirements as all other tenants. Unlike congregate settings that house people with mental illnesses, there are no “facility rules.” Individuals make their own choices, including whether to receive services. Maximum community integration is achieved when the supportive housing is scattered throughout the community, avoiding the stigma attached to “special” buildings or mental health ghettos. The program includes case management and access to a range of flexible, voluntary services that assist people in being good tenants and members of their communities.

The Housing First model has been adopted across the U.S. and abroad. SAMHSA recognizes Housing First as an evidence-based intervention and its tenets are embedded in programs funded by the U.S. Department of Housing and Urban Development (HUD).

Also expanding across the country is community mental health systems’ use of peer support services. One of the early adopters was Georgia’s mental health system, which since 2001 has employed certified peer specialists to serve on assertive community treatment (ACT) teams and to provide support and education to consumers of mental health services. Peer specialists assist consumers in writing recovery plans and teach advocacy skills. They promote personal responsibility and empowerment in self-directed recovery. Services provided by peer specialists are covered by Medicaid. To date, 614 peer specialists have been trained and certified in Georgia. To people with mental illnesses, their families and their communities, these peer specialists transmit a message of hope, social responsibility and first-hand know-how.

Self-Directed Care

Oregon is one of a handful of states to offer consumers the option of self-directed care. In Portland, individuals who have a serious mental illness, who are covered by Medicaid and who want to develop their own individualized plan for recovery, may take charge of their treatment and their lives. Consumers who choose the self-directed care option collaborate on a care plan and develop an annual budget with a peer recovery mentor. The plan and the budget specify activities, treatment and other services that the individual believes will further his or her recovery that year. A portion of the person’s Medicaid benefits is used to pay for activities that support recovery.

How the Performance Improvement Project works

The disconnect between providers of mental health services—who, along with the people they serve, are best situated to understand unmet needs—and the policies and regulations that determine those services has contributed to gaps, oversights and counterproductive requirements. PIP relies on local data analyses to identify trends and subgroups that are vulnerable to poor outcomes, and to examine the underlying causes. These may include resources that are available but not used to full advantage and misdirected public policies that constrain community mental health from demonstrating its true capacities.

“Most performance improvement measures tend to operate in isolation from one another... Frequently data-collection efforts are particular to specific care settings—such as hospitals or ambulatory care organization—or to particular payers, whether public or private... Since data are collected and used in fragmented ways, they rarely provide a picture of the overall quality or performance...or how well patients fare, or the state of the public’s health at large.” *Hospital Care at the Crossroads, The Joint Commission.*^p

The project builds on existing performance improvement programs and uses root-cause analyses to identify underlying systemic problems. The PIP will not only enhance programs as they stand alone, but it will also empower and support mental health systems toward the broader goal of sustainable, effective and prevention-oriented programs in community mental health.

Reframing encounters between people with serious mental illnesses and criminal justice systems as *failures* in human service programs shifts accountability back to mental health and related human service agencies. The PIP promises to show how community mental health and related agencies can take ownership of problems that stem from the failure to meet their consumers’ basic needs and, ultimately, how local community mental health entities can actively re-shape guiding policies and regulations.

Beyond working to improve outcomes for people with serious mental illnesses and their communities, the project offers community mental health organizations the opportunity to once again assume the role that was embedded in the original community mental health movement—that of a leader in efforts to strengthen the community by identifying and addressing problems that threaten the common good.

Leadership and opportunity

Assuming ownership of problems attributed to inadequate mental health services and related supports (in this instance, crises culminating in police encounters) requires leadership and some measure of political risk-taking. The five community mental health entities chosen by the Bazelon Center to participate in the project have exhibited strong leadership locally. Each has a history of innovation and each had previously demonstrated interest in trying to improve services and reach people who are most in need of community

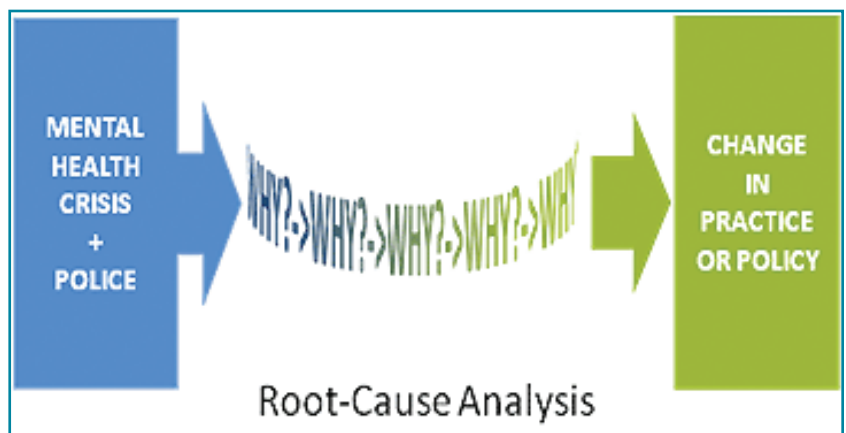
mental health care. These five communities achieved progress in the face of the substantial political, policy and fiscal challenges that confront community mental health nationwide. With a clear view of the community mental health mission, they took ownership of the problem in an environment where responsibility is diffuse.

Although the PIP was adapted to conform to the local terrain, four elements for success are found at each site:

- An initial survey of sources of data—within and beyond mental health organizations—that might be brought to bear on the project;
- Establishment of a steering committee comprising a wide range of stakeholders to guide the project;
- An examination of non-violent mental health emergencies that routinely elicit police involvement;
- Expansion of community mental health’s customary role by leading a collaborative, cross-agency examination of how the community tolerates preventable emergencies involving people with serious mental illnesses and how it ultimately responds.

Identifying the root causes of crises

To understand the multiple clinical and systemic factors that put people with serious mental illnesses at risk of crises culminating in police intervention, each site examined selected real-life cases using root-cause analysis. Root-cause analysis is a category of methods and is ubiquitous in health care quality-improvement programs. While the specifics vary according to which model of root-cause analysis is chosen, essentially all models entail asking a sequential series of “why” questions, beginning with a negative outcome and working backward. The series of questions and answers tracks back to underlying policies and practices that cause the sequences of events leading to crises.



For example, a root-cause analysis of an instance in which an individual with a serious mental illness is arrested for stealing a soda might ask why he stole a soda. The answer to that question tracks to his lack of money to purchase snacks (why?), his lack of employment (why?), his lack of skills that would allow him to enter the workforce (why?), the lack of access to job training (why?), the fact that he is now on a one-year wait list for supportive employment (why?), and so on.

In health care, root-cause analysis typically is applied to a catastrophic incident (sometimes termed a “sentinel event”), such as a suicide or a medical error leading to serious physical injury. Most encounters between police and people with serious

mental illnesses do not result in physical harm, and more often than not go unnoticed. Yet their psychological impact, affirmation of negative stereotypes, cost to public systems and future consequences (for instance, problems in gaining employment or housing) can be substantial. Accordingly, the project frames police interventions in mental health crises as reflecting “sentinel” system failures that merit attention through root-cause analyses.

Considered as a single incident, a petty theft that leads to a police encounter seems insignificant. But given that in a year such incidents may occur hundreds of times in a community and thousands of times nationwide, aggregate data from analyses can make a powerful argument about the true cost of misguided policies, off-the-mark regulations and difficult funding choices. Ultimately, using root-cause techniques, the PIP aims to compile real-world data that community mental health organizations can use to make the *business case* for changes in practice and public policies that will dramatically reduce many mental health crises and the resulting use of police.

What’s old is new again

Leadership in public mental health goes beyond providing services. Taking “ownership” of a problem that affects not just individuals with serious mental illnesses, but the community as a whole, and advocating for reforms is consistent with the principles behind the community mental health movement. Sadly, leadership, advocacy and, to a large extent, innovation quickly fell by the wayside as community mental health became more medicalized, shaped more by reimbursement requirements and geared more toward late-stage crisis interventions.

The prospect of community mental health assuming leadership and taking on a pressing local problem (such as routine involvement with the police) is new again. For this reason, during the project’s first phase, sites have spent a good deal of time forging relationships and understanding the various perspectives about how and why people with serious mental illnesses so often come into contact with police and how community mental health can fulfill a leadership role in providing remedies.

The five project sites are diverse geographically, demographically and in the way they are configured. They use different models of health care financing and employ different approaches to service delivery. Structural arrangements include mental health services operated by county authorities and nonprofit community mental health programs that provide services via contracts with the county. Their experiences through the PIP represent a cross-section of what is happening in community mental health across the country, of

The Business Case

Funding mental health services is a cost-effective alternative to the cycle of people with mental illnesses ending up in emergency rooms or jails. The Wayne County, Michigan, Sheriff acknowledged the high percentage of people in jail who have some form of mental health problem, noting that it costs the county \$31,000 per year to incarcerate a person.⁴ In contrast, the annual cost of case management is \$2,165 per person and Assertive Community Treatment (ACT) costs \$9,029 per person.

⁴ Michigan would save an estimated \$5 to \$8 million annually if fewer individuals with serious mental illnesses were in jail or prison.⁵

the on-the-ground challenges and opportunities for assuming a leadership role in their communities, and, most important, of the enduring spirit of innovation that is embedded in their roots. What follows are accounts of a few of each site's accomplishments to date, in the context of the essential principles of effective community mental health systems: consultation, informed social activism, targeted outreach, open access by the community and community engagement.

Consultation

Cascadia Behavioral Healthcare, Portland, Oregon

Consultation, one of the five original essential activities of community mental health centers, was abandoned long ago by most such centers in favor of services aimed at more immediate crises. But it is a cornerstone of the PIP in Portland, Oregon, led by Cascadia Behavioral Healthcare.

In its first year, Portland's PIP, established under the local name of "Safer PDX," has focused on building relationships, collaboration and service. Safer PDX has successfully engaged leadership of the City of Portland's Police Bureau, Multnomah County administrators, elected officials, community mental health advocacy leaders and community mental health providers in a collaborative examination of how mental health crises typically develop and how the community handles them.

Agencies and organizations with a stake in community mental health—including advocates, health care providers, payers, elected officials, public safety leaders and consumers—came together to focus on the pervasive involvement of police in mental health interventions. Through this collaboration, Safer PDX has demonstrated that root-cause analysis and adjunctive quantitative and qualitative outcome measures can be performed across the criminal justice and mental health interface to identify factors underlying unnecessary police encounters during mental health crisis.

As part of its initial work on the project, Cascadia examined the various systems whose processes culminate in police interventions with people who have serious mental illnesses. They identified four key emergency access points, any one of which can be the initial point of contact when a mental health crisis arises: the Portland Police Bureau, 911 emergency dispatch, the county's mental health crisis call center, and Cascadia's own mobile crisis unit. To better understand how these programs function to either initiate or divert police involvement in mental health crises, the PIP launched a program of cross-agency consultations. Those consultations became the basis for improving coordination and paved the way for a collaborative examination of standard procedures.

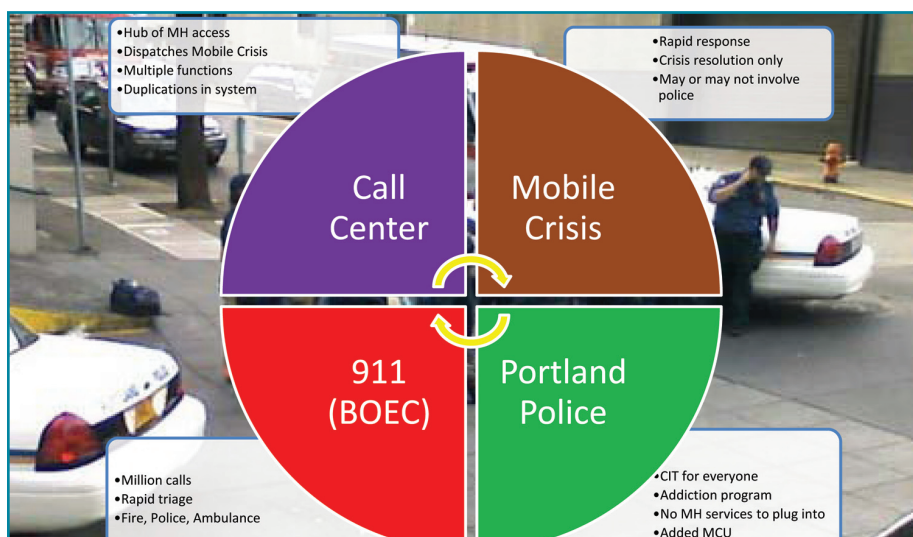
Data to Spur System Change

Cross-system analyses by Safer PDX found that in Portland, over a five-year period, 40 people with serious mental illnesses had a total of 461 contacts with police and were seen by a mental health crisis team on 776 occasions.

The organizational consultations significantly improved understanding of cross-system and cross-agency challenges, defined differences in primary mission and capacity, and established potential collaborative improvements. The use of root-cause analysis in Portland and Multnomah County increased understanding of both common and unique factors for unnecessary police contact with community members with mental illnesses.

Issues uncovered by root-cause analyses include not receiving the right services at the right time and the use of police to transport individuals who are not dangerous but are

requesting services. The project examined 40 recent episodes that were representative of mental health crises triggering local police involvement. Rigorous analysis made it clear that an issue as fundamental as sharing information might have prevented police involvement; this was a finding in 78% of the cases examined. The use of police to provide secure transportation to a hospital or other location was a factor in 40% of the cases.



As illustrated in the graphic, Cascadia provided organizational consultations to Portland's four points of emergency contact. They found that the dispositions of mental health emergencies depended partly on which point of contact took the call. Soon afterward, the four points of initial emergency contact began exploring how to rely on one another's strengths to support and improve daily operations.

During the next year of the project, a team comprising a mental health clinician and a police officer will serve as the "thought laboratory." In addition to providing person-centered outreach and collaborative problem-solving, the team will select cases that illustrate the causes of unnecessary police contact and submit them for root cause analysis.

Safer PDX has significantly improved understanding of the interface of crisis mental health and public safety and is beginning to improve local performance. The project is establishing the technical skills, evidence-based methods and definition of program and policy tools that are necessary to establish a working model for other communities to eliminate unnecessary police contact.

Through the PIP, Cascadia demonstrated that it is both possible and informative to combine quality-management data from health care and public safety settings. Portland found that difficulties in sharing data between agencies about a person in mental health crisis had caused unnecessary police contacts. Cascadia therefore made data-sharing a

priority during the first year of the project. Using data from different settings, community stakeholders in Portland began to examine patterns of service use, disconnection from services, crisis calls and police involvement with people experiencing a mental health crisis. Portland is now considering whether coordination between its 911 call center and its mental health crisis call center can reduce police involvement in mental health emergencies. Portland is also considering how to help callers reconnect with community based mental health services.

Informed social activism

Neighborhood Service Organization, Detroit, Michigan

The history of community mental health in Detroit-Wayne County is distinguished by its deep and broad roots in the larger community and its legacy of collaboration across organizations, agencies and departments. A comprehensive array of services is provided by a cluster of well-developed, long-lived nonprofit organizations. These organizations are closely tied to the community by the individuals they serve, by the families of those served, by employees and their families, and by their boards of directors and their own connections to institutions that have deep roots in the community. Several have been going strong for 40 years or longer.

Neighborhood Service Organization (NSO), founded in 1955, is one such organization with a strong community presence; it is the lead agency for the PIP in Detroit. NSO provides services to vulnerable individuals, including people with serious mental illnesses, homeless citizens, youth at risk and seniors. Community development and community activism are two tools that NSO has used to create housing and provide innovative services.

However, Michigan's once thriving economy has been in decline for decades and the recent recession has resulted in particularly steep reductions to mental health services statewide. From 2004 to 2009, the number of people statewide served by community mental health programs such as NSO increased by 25%, from 187,058 to 233,654.¹ During that time, four years of successive budget cuts took a toll on the operations of hospitals, jails and law enforcement. Nonetheless, in 2010, additional state budget cuts resulted in an 18% reduction in Wayne County's community mental health budget.²

Drawing on a real-world understanding of the challenges faced by Detroiters with serious mental illnesses and its history of activism, Sheilah Clay, CEO of Neighborhood Service Organization, provided compelling testimony in Washington DC at a congressional briefing hosted by Senator Debbie Stabenow (D-MI). She explained:

"Michigan's statewide mental health budget reduction for the 2009/10 fiscal year was \$40 million in state general funds. Of that \$40 million, Detroit-Wayne County consumers

Housing Is Key.

A Wayne County judge noted that one of the primary problems facing the repeat offenders he sees at the county's mental health specialty court is homelessness and the lack of stable housing options. He asked, "How can we expect they get regular mental health treatment when they need housing?"³



had to bear \$20.7 million or nearly 52 percent of this total. This disproportionate funding reduction has occurred during the past three years despite the high volume of consumers and the severity of illness present in this county. Many of the innovative, best-practice programs which had proven positive outcomes have been closed or significantly reduced.”^v

“The public mental health system was designed to provide crucial services to uninsured children and adults with serious mental illnesses and emotional disturbances such as schizophrenia, bipolar disorder and major depression. The unemployment rate in Michigan has significantly increased the number of uninsured citizens who need to access the public mental health system, but what will they find when they come to our door?” Sheilah Clay, February 16, 2011 testimony.

By bringing local problems to the attention of Congress, Ms. Clay reminded us that leadership, activism and advocacy on behalf of the well being of the community is as relevant today as it was 50 years ago. Community mental health is uniquely positioned to inform legislators and policymakers about the impact their decisions have on people’s lives and what is possible in effective community mental health.

Reductions in Detroit-Wayne County’s mental health programs have had widespread consequences in the community. Both the county sheriff and Detroit’s police chief reported that mental health funding cuts negatively affected public safety and law enforcement operations and drove jail overcrowding.^w For example, almost two thirds of Detroit’s 120,000 ambulance runs are for non-emergency calls, such as substance abuse and mental health-related issues, making ambulances less available for true emergencies.^x In a single downtown district, calls involving mental health crises consumed roughly 50 hours per week, or the equivalent of 1.3 officers. The volume of mental health crisis calls diverts officers from patrols and fighting crime.

To launch its project, NSO convened a group of Detroiters who faced these problems daily and used their collective expertise to identify a few of the most influential factors. They confined their examination to the city’s Midtown area, for many decades regarded

as Detroit's skid row but now undergoing revitalization. The area includes the campus of Wayne State University and is the focus neighborhood for the local PIP initiative.

NSO contracted with the University's School of Social Work to conduct a qualitative study of factors placing individuals with serious mental illnesses at risk of involvement with the police. The effort included consultations with residents of the area who have experienced multiple mental health crises that led to police involvement, police officers assigned to the central district, staff of Henry Ford Hospital and Detroit Receiving Hospital, people who work in the area, the Detroit Wayne County Community Mental Health Agency, and staff of organizations that provide mental health and housing services in the area. The results were surprising.

There was consensus that police were called for mental health and substance abuse crises because there was no one else to call. Prior to mid-year budget reductions in 2010, NSO had an outreach team that engaged homeless adults on Detroit's streets, moving them out of abandoned buildings and from under freeway bridges and doorways into treatment and eventually housing. During its six months of operation that year, the team had 2,000 encounters with individuals living on the streets and was successful in getting more than 1,300 people into either mental health or substance abuse treatment. When the program was eliminated, the burden fell squarely—and inappropriately—on police.

After years of reductions, the community mental health system is struggling to shoulder the burden. Both consumers and providers of mental health services report that the services that are most available sometimes do not fit the needs of the intended beneficiaries. Far too often, mental health consumers who are homeless or at risk of homelessness are left with no treatment options between inpatient hospitalization and outpatient counseling, supplemented by occasional medication adjustments. Many of these individuals are not offered treatment designed to meet their needs, even though they may be on a clear course toward crisis.

The PIP uncovered problems related to the use of psychotropic medication. Interruptions in a person's medication regimen sometimes led to crises. Providers of mental health services attributed non-compliance with medication to personal choice. However, users of psychotropic medication reported that non-compliance was often a result of severe but unaddressed side effects, such as blurred vision or gastric distress. Lack of a secure place for people to keep their medication and the difficulty of taking it on a fixed schedule with meals, both associated with homelessness or precarious housing conditions, were obstacles. The group also identified a systems problem: When discharged from a crisis center, where a typical stay was 1-2 days, a person was given enough medication to last several days and a follow-up appointment. The follow-up appointment, however, was typically 1-2 weeks in the future. The arrangement ensured a lapse in medication and often increased the likelihood of another crisis.

Not surprisingly, like other communities, Detroit reported that an insufficient supply of suitable housing and integrated treatment programs for people with serious mental

illnesses and addictions contributed to the high number of emergencies that elicited police involvement. These findings are serving as the starting point for NSO and the collaborative group it has formed to pursue policy reforms. Like many other communities in the U.S., Detroit's challenge is to find ways to improve local practices while bringing to light the effects that funding and policy decisions have had on community mental health.

Targeted outreach

Westchester County Department of Community Mental Health, New York

A traditional role of community mental health, too often eroded by funding cuts, was reaching out to people with mental illnesses who are at risk of negative outcomes. In that

tradition, Westchester County's Department of Community Mental Health—the lead agency for the PIP—developed a two-tiered approach to reducing the number of mental health emergencies that lead to police intervention. Both Police Mental Health Outreach Teams and Care Coordination are resounding successes.

Police Mental Health Outreach Teams are Westchester's expansion of the Crisis Intervention Team (CIT) model that has been adopted by many police departments throughout the United States. Clinicians are embedded in local police departments and dispatched with a uniformed officer in response to 911 calls. As part of the police response, the Outreach Team refers people in crisis to service providers that can meet their needs. A few days after the police call, people who experienced a crisis receive a personal visit to be sure that they are linked with services. This model has had significant success in reducing contact with law enforcement. Of people who received a referral and a follow-up visit, 88% did not have another police-involved emergency within the next six months. Based on its demonstrated impact, other communities within the county and within the PIP program nationally are considering this approach.

Through the PIP, Westchester County is using root-cause analysis to explore how and why people become heavily reliant on emergency services and how effective engagement can bring about dramatic improvements. Recognizing that a small group of people need a different type of intervention, Westchester County developed its Care Coordination Program. This program focuses on people who have had multiple contacts with law enforcement, high use of emergency rooms, chronic

Partnerships In Recovery

Rob has an extensive psychiatric history from his early teens. It includes treatment for bipolar disorder and substance use, multiple contacts with police and the justice system, homelessness and many psychiatric hospitalizations. Today Rob is no longer on the social margins. He is actively engaged in his own recovery. Working with a Westchester care coordinator, he was able to move from paying rent for use of the back seat of a car to having his own apartment. With the support of his recovery mentor, he adopted a pet for companionship. For months now, he has been living successfully, without justice system encounters. Rob has a full life; he has used self-determination funding to transport his musical equipment to New York City to perform at festivals and parties. And he has developed a relationship with a woman who has similar interests. While once emblematic of the struggling "ex-mental patient," Rob is now enriching his community.

hospitalizations and chronic homelessness. Care Coordination supplements intensive case management with a person-centered approach. Individuals enrolled in Care Coordination work with a recovery mentor and have access to “self-determination funding”—flexible funds that they can spend on services or activities that support their recovery. Availability of these funds also supports their engagement in services and personal recovery—for example, to purchase clothing or for career training.

Westchester County found that nine of ten people who experienced multiple mental health crises that elicited police involvement, like Rob, had received mental health treatment or other human services in the past, but had become disconnected from both natural and professional supports. Among individuals who have been “high-end” users of services, the Care Coordination program reduced Medicaid and jail costs by 65-67% and cut state hospital costs by 22% over a two-year period. These individuals had experienced unusually high numbers of crises, such as emergency room visits, lengthy hospital stays or detention in a jail.

Community engagement

Austin-Travis County Integral Care, Texas

The key to improving the mental health of a community is engagement, a core value of the community mental health movement. Engagement means involving the full community, including people with mental illnesses, their families, government entities, faith-based organizations, for-profit and nonprofit corporations and the public in social change. In the aftermath of a police shooting of a person with a serious mental illness, Austin set out to become a national model of a “mentally healthy community,” examining all the challenges individuals with behavioral health disorders face daily.²

Describing the features and trends of a mentally healthy community was the first step. In a groundbreaking community-based collaborative process, Austin combed national and international research for behavioral health community indicators to document progress toward that ultimate goal. The preliminary data allow Austin-Travis County to formulate questions not only about the mental health system, but about other systems that interface with it. Austin recognized that a key component of community progress was that all service systems “own” the answers. The Mental Health Task Force, supported by five local funders in addition to the Bazelon Center, is spearheading the indicator

Data to Spur System Change

Some important findings in Austin:

- ◆ Individuals with frequent readmissions to psychiatric hospitals are low users of community mental health clinics, but high users of emergency rooms
- ◆ Homeless men with mood disorders and co-occurring substance use disorders have the highest cross-system utilization
- ◆ There is surprisingly little overlap between EMS, law enforcement, hospitalization and jail high-utilization lists
- ◆ 162 unique individuals with severe and persistent mental illnesses were booked more than four times into the Travis County Jail during the study period
- ◆ Only 19% of individuals presenting to emergency rooms with primary substance use diagnoses were open to community mental health treatment or alternatives at the time.

improvement initiative, a model for system change. The task force, whose leadership overlaps with that of the PIP, tracks data across multiple service systems, including community mental health, hospitals, law enforcement, incarceration settings, emergency rooms, community clinics, courts and emergency medical services.^{aa}

To date, Austin has reviewed more than 445 cases across these data sets, analyzing both individual intervention strategies and service system level changes that will improve outcomes. Austin has discovered and proven that data development, in conjunction with strong community collaboration are the keys to system change for individuals with behavioral health disorders.

Open access

Allegheny County Office of Behavioral Health, Pennsylvania

From the beginning, community mental health was meant to be a resource for the entire community rather than focusing narrowly on services to people who live with severe mental illnesses. In Allegheny County, services are accessible to anyone who needs them. Allegheny County's Office of Behavioral Health (OBH) is the home of the PIP. The project has local support from the Staunton Farm Foundation and is being carried out in cooperation with the University of Pittsburgh's Graduate School of Public Health.

As in communities nationwide, Pittsburgh police are a presence in the lives of many people with serious mental illnesses and, often, those with co-occurring substance use disorders. OBH has established a project steering committee that includes leadership from mental health, police, public housing, advocacy and consumer groups, and the county's emergency service systems. Reflecting the core values of the initiative, these representatives have endorsed the assumption that a behavioral health crisis that involves law enforcement has the potential to be dangerous and traumatic for everyone and does not promote recovery.

The project's goal is to promote the behavioral health system's ability to be dynamic in ways that support at-risk individuals in achieving and maintaining productive and rewarding lives, making available the supports and services needed to prevent, interrupt or deter the behavioral health crises that now lead to police intervention. The OBH hypothesis is that criminal justice involvement is decreased by:

- ◆ establishing relationships and maintaining engagement in routine mental health services;
- ◆ addressing co-occurring disorders through access to integrated treatment; AND
- ◆ ensuring that flexible funds are readily available for consumers to purchase goods and services that can assist in recovery.

Allegheny County's innovative crisis support network, *re:solve*, is testing the OBH hypothesis. *re:solve* Crisis Network is a component of Western Psychiatric Institute and Clinic, funded through a contract with OBH. In July 2008, it began operations as a full-service crisis response for county residents, providing crisis support regardless of age, ability to pay or whether residents have previously used behavioral health or other supportive services.

Designed to provide support "before a crisis becomes a crisis," *re:solve* Crisis Network provides a 24/7 telephone line staffed by trained counselors, face-to-face mobile crisis response and a walk-in center with limited overnight-stay capacity—all designed to de-escalate a situation, make people feel more comfortable in their situation, provide respite and, when possible, divert individuals from arrest. The *re:solve* Crisis Network provides help to residents when they are just feeling lonely and need to talk or when there is a sense of overwhelming depression or suicidal ideation.

Allegheny County's Office of Behavioral Health convened a sweeping array of stakeholders, bringing different world views, goals and methods to the PIP. The committee includes representatives from the police bureau, hospital-based emergency services, community service programs, emergency medical services, housing and transitional services, Christian counseling services, consumer and family organizations, and public health. Together, these stakeholders engaged in a collaborative examination of how they respond to people who have serious mental illnesses, frequent involvement with police and heavy use of emergency services.

Given its emphasis on early intervention in crises, Pittsburgh's project *re:solve* is congruent with the aims of the PIP. It also has enormous potential to clarify the root causes of crises that lead to police encounters and to the high cost of preventable crisis care. Through the PIP, Allegheny County hopes to determine whether engaging people who have co-occurring mental and substance use disorders with personal contact and the availability of flexible funds promotes engagement, recovery and reduced involvement by the criminal justice system. Assuming that this will be demonstrated to be an effective strategy, the next task will be to identify the policy and structural changes needed to embed this in practice.

Data to Spur System Change

Pittsburgh's preliminary review found that 70% of people with behavioral health issues and past criminal justice involvement had a co-occurring mental health and substance use disorder.

Conclusion: The Good News and the Bad

Notwithstanding its ambitious beginning, community mental health nationwide has had a rocky history. Too commonly, the role of community mental health has been relegated to that of a safety net for crises that could—and should—be averted. The initial work of the five PIP sites affirms that innovation and commitment remain alive within community mental health and that there is broad support for local organizations to assert a leadership role on behalf of the people they serve. Nevertheless, decades of struggle under what may be regarded as a *siege environment* have created an array of obstacles that hamper today's efforts to reduce the routine presence of the police in the lives of people with serious mental illnesses, including those with co-occurring substance use disorders.

The project's findings to date across the sites point to some tentative conclusions.

First, the bad news:

- ◆ Downward economic trends have affected every state's mental health programs.
- ◆ Community mental health competes for resources with other state, county and municipal agencies.
- ◆ The people served by community mental health continue to be regarded as a social burden, not as individuals who, with appropriate supports, can recover and contribute to the community.
- ◆ Policymaking too often suggests that supports for these individuals are not regarded as a good—or politically attractive—investment of public funds.
- ◆ Providers of mental health services compete for contracts with one another, often in a climate where it is safest to “not rock the boat.”
- ◆ In a siege environment, survival needs push aside critical self-examination and innovation.
- ◆ Meeting immediate needs, such as improving crisis services, is typically afforded higher priority than improving routine services.
- ◆ Playing a role in late-stage crises underscores the importance of community mental health, while preventing crises offers a more abstract argument for enhancing community mental health.
- ◆ A narrow focus on improving crisis services undercuts a community's ability to examine and improve routine services. Handling crises is an immediate and compelling challenge for providers. It is a given that good, coordinated crises response is fundamental to any community mental health system. Yet, the PIP sites

found that it was short-sighted to improve crisis response without also building an adequate system of the routine services and supports that can reduce the frequency or intensity of crises.

- ◆ Asking questions requires strong leadership, but turnover in leadership is part of the climate. During the first 18 months of the project, elections and appointments resulted in significant changes in leadership at three of the five sites.

The good news:

- ◆ Local community mental health programs can assert a leadership role in addressing factors that place the people they serve needlessly at risk.
- ◆ Community mental health can make a strong social and “business” case for a more active role in promoting services that work, even—or, perhaps, *particularly*—in today’s challenging fiscal climate.
- ◆ Local community mental health organizations can form and lead innovative collaborations of officials and stakeholders representing diverse systems
- ◆ The media are interested in issues connected with community mental health. Media coverage can help build public support for community mental health services.
- ◆ Identifying systems problems is risky but rewarding work.
- ◆ Mental health services have become more responsive to consumers’ needs. There has been steady improvement in the range and quality of specialty services offered by publicly funded mental health agencies. The next step is to span the systems gaps so that community mental health can serve people with complex needs.

Although launched more than four decades ago by a federal initiative, community mental health today is designed and operated by the communities it serves. Throughout its history, community mental health has demonstrated flexibility and resourcefulness by continually adapting its services to address the changing needs of our communities.

The original impetus, abandoning the practice of confining people to hospitals for years on end, belied the wide scope and fluid nature of the community mental health mission. Advances in the science of human behavior have made it possible to intervene early to head off more serious problems, to tailor interventions to needs, and to enable people to recover from serious mental illnesses.

Money has been a constant problem. As simple funding methods (e.g., state dollars to institutions) were supplanted by complex models of health care finance (e.g., Medicaid, Medicare and private insurance), community mental health learned to make the most of available funding to meet the needs of the community by weaving funds from different sources together. Today, community mental health confronts what may be the worst funding crisis in its history. Most communities are being forced to reduce spending due to a general economic downturn. Some have already made successive annual cuts in mental

health funding. Yet, as the examples in these pages show, even in the face of adversity, community mental health continues to carry out its mission.

Stifled by chronic underfunding and buried by layers of accumulated regulations and requirements, the foundations of community mental health are still intact. During the early phases of this project, these five communities have shown that community mental health has held to its core values. Adversity spurred the PIP participants to return to the traditional roles of the community mental health movement: consultation, outreach, social activism, community engagement and intervening before a crisis occurs. As community mental health reclaims its traditional roles and responsibilities, it will encounter jolts and bumps, some anticipated, others not. The Performance Improvement Project is beginning to show how community mental health, even in this time of great stress, can forge ahead in its 50-year quest for system reform.

Notes

- a During the past several years, the Bazelon Center has participated in various activities that have exposed underlying flaws in how mental health services are delivered in the U.S. and the consequences for at-risk individuals. In 2001, the Center published *Disintegrating Systems: The State of States' Public Mental Health Systems* and, the following year, *A New Vision of Public Mental Health*, outlining in the form of a model law some of the steps needed to turn the system around. The Center also contributed to federal government analyses of the problems, including the Surgeon General's 1999 Report on Mental Health and the recommendations of the 2002-2003 New Freedom Commission on Mental Health. Drawing on findings that poor mental health outcomes are sustained by a dysfunctional service delivery structure, these analyses culminated in federal "transformation" grants to states seeking to break down bureaucratic silos and promote cross-agency coordination. The Bazelon Center is currently supporting these efforts through technical assistance to state mental health authorities and by producing publications addressing such factors as states' legal obligations to people with serious mental illnesses and funding options for community services. For example, *Recovery in the Community and Get it Together: How to Integrate Physical and Mental Healthcare for People with Mental Disorders*.
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