Bridging Gaps in Mental Health Service Delivery At the Community Level

Presented to the Wellness Coalition – June 29, 2016

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Objectives:

• Participants will be Provided a Perspective of the Legal and Ethical Issues Contributing to the Closing of Institutions for Persons Suffering from Mental Illness

• Participants will Review/Understand the Responsivity Principle for MI and Dual/Multiple - Diagnosed Individuals

• Participants will Understand Evidence-Based Practices for the general population and Promising MH Treatment Practices with improved or show promise for improved results

• Participants will learn Strategies/Techniques that are EBP ‘s and Those Which are Showing Promise for the MI Client

• Participants will Identify Key Issues for Stakeholders and Policymakers- for Programs Targeting the Mentally Ill
Do mentally ill persons require specific facilities to treat effectively? and if so, what facilities are most effective with this population?
Does the Diagnosis Matter?

Cartoon by Gary Larson
The Decline of Institutionalized MH Treatment

Historical Timeline -
Sourced from AL Dept. of Mental Health Website - http://www.mh.alabama.gov/BryceHospitalProject/history.html

• 1852: Alabama Insane Hospital established by the Alabama Legislature on a 326-acre tract adjacent to the University of Alabama.

• 1860: Peter Bryce, 26, elected first superintendent. During his tenure, Bryce abolishes straitjackets and restraints and insists on treating patients with dignity and respect.

• 1861: The immense hospital, built on the model developed by Thomas Kirkbride and Samuel Sloan, opens. It features running water, flush toilets, gas lighting and is the first building in Tuscaloosa to have gas lights and central steam heat.

• 1865: From the hospital's dome, observers watch Union troops burn the University of Alabama.

• 1900: The state Legislature renames the hospital for Bryce, who died in 1892.

• 1949: A report finds the state's two mental hospitals, Bryce and Searcy near Mobile, have an average daily patient population of 5,732 with 10 full-time staff physicians, the largest patient load of any state in the nation at the time.
Institutional Decline (continued)

• 1970: A class-action lawsuit in federal court, *Wyatt v. Stickney*, alleges that persons involuntarily committed to Bryce were not being treated. At the time, Alabama is 50th out of the 50 states in spending for the care of people with mental illness or intellectual disability in public institutions, allotting 50 cents per day per patient.

• 1971: U.S. District Court Judge Frank Johnson rules persons committed for treatment have a constitutional right to receive treatment.

• 1972: Johnson issues minimum standards for mental health and intellectual disability facilities.

• 1995: U.S. District Court Judge Myron Thompson releases several mental health facilities from supervision under the Wyatt case and finds the department in compliance with about a third of the mental illness and intellectual disability standards.

• 2003: Thompson terminates *Wyatt v. Stickney* case after 33 years.

• 2013: AL Legislature reduced ADMH funding and ADMH follows through on announced plans to close several MH Hospitals.
The Sprawling Brice Hospital – Days Past
The New Brice Hospital – (Today)
One of the Most Modern Institutions of its Kind
The name of Ricky Wyatt is synonymous with Bryce Hospital and the landmark *Wyatt v. Stickney* lawsuit that ultimately led to the de-institutionalization movement in American mental health treatment.

Before that lawsuit and its administration by federal district judge Frank Minis Johnson, patients lived in “warehouse” conditions in cavernous mental health hospitals. As a result of it we have now moved toward a more community-based treatment model.

The once-obscure Alabama lawsuit became federal law, and with it came a genuine sea-change for hundreds of thousands of Americans with a mental illness.

Source: AL. Dept. od Mental Health Website (http://www.mh.alabama.gov/BryceHospitalProject/history.html)
Definitions:
Actuarial-

- **adjective**
- **Relating to calculation of risk**: relating to the statistical calculation of risk .... **relating to actuaries**: relating to actuaries and their work
Evidence-based practice-

• Refers to the use of research and scientific studies as a base for determining the best practices in a field. The movement began in the 1990s with a focus on the medical profession. It has since crossed the line to other professions, including education. The basic premise of the movement is to provide transparency and to assure the public that techniques and procedures will provide the best possible interventions or treatments.

• http://www.ehow.com/about_5048440_definition-evidence-based-practice.html#ixzz26MPQqnT2
Fidelity-

• noun

• **loyalty**: loyalty to an allegiance, promise, or vow... **factual accuracy**: accuracy in reporting facts or details...

• **Synonyms**: loyalty, faithfulness, reliability, trustworthiness, dependability, devotion, commitment, conformity

• *(Encarta® World English Dictionary-North American Edition)*
The Responsivity Principle for MI and Dual-Diagnosed Individuals

Essentially, the practice of Responsivity is to place the right person in the right program for the right dose (frequency, duration and intensity) required to achieve the desired outcome.

This principle takes into consideration the individuals amenability to engage in the process and other factors regarding the client’s ability to engage including ability to read, cognitive ability, access to the treatment/program referral, etc.
EBP’s for the general population and Promising MH Treatment Practices with improved or potential improved results...

Those Programs and practices that have been demonstrated and replicated and have been shown to reduce significant episodes of crisis for the general population.

• Adherence to the risk-needs-responsivity model. A set of principles designed to maximize the effectiveness of community-based treatment/interventions
• Cognitive-behavioral treatment interventions, which involve a type of therapy that addresses irrational thoughts and beliefs.
• For MI patients with Dual-Disorders, drug treatment in the community (Least Restrictive – Natural Environments)
Strategies/Techniques Showing Promise

Using Proven Clinical Models For Mentally Ill Clients
Established EBP’s for this Population include the Following Practices:

1. Firm but Fair Relationships
2. Problem Solving Strategies, and
3. Boundary Spanning
“Firm but fair” relationships-

Relationships between case managers and the clients they serve that are characterized by caring, fairness, trust, and an authoritative (not authoritarian) style.

These types of relationships have shown to reduce a MH client’s frequency of crisis episodes, ER visits, Commitments, etc.
Problem-solving strategies -

• Strategies and positive pressures to encourage compliance with the elements of the Case Plan, which involves case managers working with the clients on their caseload(s) to identify obstacles to compliance (medication, therapy sessions, etc.), resolve the problems, and agree on/with compliance plans.

• Using these strategies and avoiding threats or other negative pressures reduces client’s risk of the need for a crisis response.
Boundary-spanning

A skills model, in which other stakeholders actively coordinate and work on teams with treatment and service providers. Use of these skills increases client’s use of services.

Also described as a Co-managed model of case management with a team approach which includes “Staffing” cases and sometimes “Behavioral Contracting”
Evidence-Based Mental Health Treatment Practices with demonstrated improved clinical outcomes

- Assertive Community Treatment (ACT), a service delivery model in which a multidisciplinary team of mental health professionals provide individualized treatment

- Illness self-management and recovery, in which people learn skills to monitor and control their own well-being

- Integrated mental health and substance use/abuse services, in which specific treatment strategies and therapeutic techniques are combined to address mental illness and substance use disorders in a single contact or series of contacts over time.

(continued)…
Improved Clinical Outcomes (continued)

- Supported employment, in which people with mental illness are employed in competitive, integrated work settings with follow-along supports.

- Psychopharmacology, in which medications are used to treat mental illness

- Family psychoeducation, in which people with mental illness and their families learn about mental illness, symptom management techniques, and stress reduction.

Example: N.A.M.I. and Mental Health America
Two Promising Mental Health Treatment Practices which **may** produce improved clinical outcomes

- Supported housing such as “Housing First,” in which people with mental illness gain quick access to housing in addition to case management and other supports.

- Trauma interventions, in which people with mental illness and extensive histories of trauma (especially among women), including physical and sexual abuse, receive targeted interventions.
All of these Practices can and should be Delivered in Communities

Because:

• Less Confining and more Humane Environment
• Uses Natural Community Concept
• Capitalizes on Local Family/Social Support
• Facilitates Community Collaboration/Networking
• Appropriately Engages Community Leaders to “Work the Issue”
• Less Stigma with Community Commitment
• Engages the Total Social Services Network
Key Issues for Stakeholders and Policymakers

The present body of research informing potential stakeholders and policymakers has established that the following issues should be fully addressed and provided for to assure an effective and positive outcome. In this case, a reduction in critical incident responses and/or hospital referrals and jail placements for those with Mental Illness.
POLICY CONSIDERATIONS:

- Referral, Screening, Assessment and Intake (Who performs this? Where and when?)
- Cross Agency Collaboration (Who or What is needed to keep this consistent?)
- Program Implementation (Timeline, responsible persons, program data and evaluation)
- Performance-Based Contracting and Funding (Outcomes based incentives or other compensation)
- Organizational Culture and Leadership (Usually Takes years to Accomplish and Foster)
Community Advocates in a Role to Cause Effective and Lasting Change

Bridging the Gap
Now we Know
The What and the Where

Alabama to Close Most Mental Hospitals
Feb 17, 2012 8:35 AM CST

Where do we go from here?
One Local Example:

The Brainchild of Envision 2020 –

Formed the -

Healthy Minds Network

Selected a Local Demonstration Project to Address the Problem of the “Revolving-Door” of Offenders with MI being rearrested for low-level offenses (Most common “solution” for MI Offenders with very limited community options).
Post-Incarceration Case Management Program (PICM)

Background of the PICM Program:

• In 2014, the **Healthy Minds Network** created a demonstration project – Post Incarceration Mental Health Case Management (PICM) to identify individuals in State Prison being released on Community Corrections supervision, as well as offenders from the Montgomery Municipal Jail, Montgomery County Jail and Federal Prisons (those detainees being released), either under supervision or directly to the community, who have continuing (post incarceration) mental healthcare needs.

• The case manager works directly with his/her clients to meet their needs for: housing, food, job placement (according to each client’s ability to work), SSI and Medicaid applications, appointments at the Mental Health Authority, psychotropic medications and personal hygiene (haircuts).
Year One: Results

• Of the 40 consumers who participated in the program in the first year, there were only 2 re-arrests reported and 1 re-incarceration, which is a recidivism rate of 3%. The average recidivism rate for the first year after release is for the MH offender was 56.7% until PICM.

• Average daily savings of keeping 40 consumers out of jail = $2,288.40

• Average annual savings of keeping 40 consumers out of jail = $795,266
Proposed Second Year Program Expansion

• Add 1 new case manager per quarter until a 300-400 client capacity is reached
• Investment per case manager = $40,000 (potential to become self-sufficient after full case load)
• Time to full case load (30-40 clients) = 6-12 months
• Average annual savings from 5 case managers keeping 40 consumers out of jail = $3,976,330
• After 3-4 years, 400 client capacity = $7,952,660
• For 2016 – Received funding for 3 more Case Managers
Current Challenges:

• Timely Access to MH Services- (Emergent, Acute, and Routine)
• Access to Affordable Medications
• Adequate Housing
• Custody as Solution of Last Resort
• Training for LE and First Responders
• Need Facility for Crisis Stabilization/Intervention

➤ Funding Sources
   a. Federal – SAMHSA, Medicaid, Grants
   b. State – Dept. Mental Health
   c. County/Municipal – Support for MH Authority & Others
   d. Local Initiatives – United Way, NAMI, Wings, MHA, etc.
Sequential Intercept Mapping:
Policy Research Associates, Inc., Delmar, NY 12054 training@prainc.com
A national leader in mental health services research

Creating a Local Cross-Systems Map

• Funded by a Grant from SAMHSA
• This 1-day workshop develops a map that illustrates how people with mental illness come in contact with and flow through the criminal justice system
• It brings together key stakeholders to tap into local expertise ..
• A local map is created using ..the Sequential Intercept Model developed through the CMHS National GAINS Center at PRA
• Opportunities and resources are ..identified for diverting people to treatment
• Gaps in services are summarized ..
Sequential Intercept Mapping: (continued)

**Priorities for Change -**

- Uses examples of successful systems integration, promising programs, and emergent collaborations from around the U.S.
- Participants determine areas where immediate steps will effect a more cohesive, integrated approach to service delivery
- A local set of priorities for change is established..
Sequential Intercept Mapping: (Continued

**Additional Benefits ...**

- This workshop facilitates cross-system communication..
- The Sequential Intercept Mapping exercise facilitates cross-system collaboration and helps identify underused resources.
- This collaboration improves the early identification of people with co-occurring disorders coming into contact with the criminal justice system, increases effective service linkage, reduces the likelihood of recycling through the criminal justice system, enhances community safety, and improves quality of life.
Montgomery’s Very Own Sequential Intercept Map

Depicting Flow of MI Offenders Through the CJ System
Priorities for Change as Determined by Mapping Participants

• Housing for people with behavioral health needs- 17 votes  
  Funding needed to pay for background checks
• Create a crisis center/Montgomery mental health resource guide, including detox) to get people out of emergency rooms and jails- 15 votes
• More Intercept 1 diversion options for law enforcement 9 votes  
  Such as mobile mental health unit/crisis teams with peers/case managers with 24/7 coverage
• Data sharing system for stakeholders across the criminal justice/behavioral health continuum- 9 votes
• Additional Case Managers at all Intercepts to link people to services- 6 votes
• Access/resources to get necessary medications- 4 votes
• Intercept 2 diversion: First Arraignment Service and Support Team (FASST) 3 votes
• Adding key stakeholders to Task Force (Labor Department, Social Services, veterans groups, Legal Aid, etc.)- 3 votes
• Crisis Intervention Training (CIT) for all law enforcement- 3 votes
• Having a veteran “pod” inside the jail- 2 votes
• Specialized caseloads for community supervision/probation- 2 votes
• Shorten length of stay at Cross Bridge; treatment orders to discharge from Cross Bridge without having to be committed- 1 vote
• Alabama listing of prisons and veterans in custody- 1 vote
The U.S. Department of Justice's Bureau of Justice Assistance (BJA) is seeking applications for the Justice and Mental Health Collaboration Program, which supports innovative cross-system collaboration for individuals with mental illnesses or co-occurring mental health and substance use disorders who come into contact with the justice system. BJA will prioritize applications from law enforcement agencies that demonstrate a collaborative project with mental health partners to plan, implement, or expand strategies that are tailored to the needs of people with mental disorders. This grant program demonstrates a commitment by BJA to support counties engaged in systems-reform planning that is in line with the goals of the Stepping Up Initiative.

Deadline: May 17, 2016
Thank You!

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