Elements of an Effective Mental Health System

Many of the recommendations contained in this report are predicated on the availability of effective mental health services in the community. Police, judges, jailers, community corrections officials, and others who refer a person with mental illness to community-based mental health services expect the delivery of certain services and outcomes. A well-functioning mental health system will reduce the number of people with mental illness who come into contact with the criminal justice system. Policy statements and recommendations in this chapter are intended to point the way toward an effective mental health service system.

Mental health systems in many states across the country have undertaken examinations of the services they offer, their funding mechanisms, and the administrative systems needed to manage them effectively. Systems have looked at overarching issues such as the legislative mandate for the state to provide services or the population to be targeted for these services. They have also looked at the details of reimbursement and relationships with other functions within state government. Legislative commissions have put some state systems under the microscope of examination and in at least one state, California, a state-funded independent oversight agency has recently studied the quality and availability of mental health services.[1]

It would not be surprising if different states taking different approaches came up with highly varied recommendations for improvements to the mental health system. However, as much as details may vary, there is remarkable consistency in elements recommended by state commissions and those described by the U.S. Surgeon General's 1999 report on mental health.[2] For a comprehensive examination of the way mental health services are provided in this country, the Surgeon General's re-

1. Little Hoover Commission, *Being There: Making a Commitment to Mental Health*, Sacramento, CA, November, 2000.

2. Office of the Surgeon General, *Mental Health: A Report of the Surgeon General*, Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999.

port is the single best resource available. State policymakers considering improvements in their state-based systems should make themselves familiar with the contents of the report and consider adapting many of its recommendations to fit the needs uncovered by their efforts.

It is at the community level, however, that mental health services are delivered, and it is there that policies prove to be effective or not. Policymakers and partners seeking change in community responses must be aware of the structure of the community mental health system in the towns and cities where they live. They should focus not just on what exists, but most intently on what a community mental health system could look like if all pieces were in place. Mental health experts in this country know what works and what doesn't. They agree for the most part on services that should be available in community mental health systems. Yet, for a variety of reasons, our public mental health system has been unable to implement much of what we know. The following policy statements argue for and enumerate practices and approaches shown to be effective.

Finally, it is important to consider the role played by funding in determining the scope and depth of the public mental health system. While this report does not provide sufficient analysis to develop recommendations specific to funding issues, readers must bear in mind the funding ramifications inherent in many of the steps recommended herein.

At a minimum, it is important for those who use this report to consider three funding issues as they contemplate implementation of its recommendations. First, are there sufficient funds available to the system for it to meet the expectations of its various constituents? Second, are funds allocated appropriately to ensure the system's priorities are met? And third, is there a mechanism to determine whether allocated funds are achieving the outcomes appropriators think they are purchasing?

As funding for public mental health services has evolved, it has become an extremely complex system. Each funding stream brings with it conditions and constraints that determine for whom and for what services it can be used.

Funding for Mental Health Services

Readers of this report and virtually everything written on this nation's public mental health system understand that funding for services involves an exceptionally complicated mix of local, state, and federal monies. To provide the full spectrum of services envisioned in this report, a local provider agency must weave together funds derived from sources that may have different guidelines, fiscal years, and stated purposes. Some funding comes to agencies on a per capita basis, some on a "fee for service" or reimbursement basis. Some services are paid for regardless of who accesses them, while most require clients to qualify for programs by demonstrated poverty or disability.

Local support – In many communities, local tax levies provide a source of operating support for community mental health agencies. Levels of community support can vary widely. Many agencies serve several towns and therefore may draw support from each of them. It is not at all unknown, however, for one town to provide substantial support, while its neighbor contributes meagerly to the agency.

County support – A number of states have developed mental health systems that are financed and managed at the county level. In many of these states, this has been a conscious process of devolution. Again, there is considerable variation among states that have developed county-based systems. Typically, state general funds are provided to counties in block grants based on formulas that may include population, anticipated need, and historic contribution. As with federal block grants to states, however, the idea is to promote local control.

State support – State general revenue funds are traditionally the largest funding source for mental health services. For a variety of reasons, however, the share of state funds has been falling for close to a decade, whether measured as the percentage of state budgets or as the portion of the total mental health budget in a given state. At the same time, the amount of state funding needed to provide the required "match" for federal Medicaid funds has continued to rise, as states have increased their reliance on Medicaid for many services. In a typical state, for example, general revenue funds for mental health services may have made up approximately 32 percent of the overall public mental health budget in 1996. By 2001, that portion had decreased to 19.5 percent. By contrast, the state Medicaid match had risen from 20 percent to 29 percent of the overall budget over the same period.

Federal support – Each state receives a share of the Mental Health Block Grant, which is administered through the Center for Mental Health Services within the Substance Abuse and Mental Health Services Administration. These Block Grant funds typically comprise approximately 1.5 percent to 3 percent of a state mental health system's budget. States also receive Substance Abuse Block Grants, which make up a higher proportion of the budget for substance abuse services. Even in systems where mental health and substance abuse services are administered together, however, the two Block Grant programs are subject to rules that prevent their blending.

Federal entitlement programs provide the largest sources of funds for the public mental health system. As already noted, the program that has the largest impact on the system is Medicaid. To be eligible for Medicaid, most adults with mental illness must qualify for Supplemental Security Income (SSI).

Medicaid funding poses a great problem for states. While the federal program does provide funding for some services used by people with mental illness, it also comes with many restrictions. To begin with, many people who need public mental health services do not qualify for Medicaid, which was created to address the medical needs of needy and disabled persons. Secondly, only certain services are eligible for Medicaid reimbursement. Since these are services based on medical needs, many state Medicaid authorities do not allow reimbursement for important rehabilitative services required by people with mental illness. Thirdly, Medicaid has never allowed for hospitalization of adults aged 21 to 64 in large psychiatric institutions, although it pays for costs in institutions used by people with developmental disabilities, for example. With fewer people than ever in institutions, this exclusion for "institutions for mental diseases" – IMDs – may not seem to be a great problem. However, Medicaid pays out large amounts for services to developmentally disabled people receiving services in the community, on the theory that the community services are preventing more costly institution-based services. Mental health services do not qualify for such "waivers" since there are no savings to be realized by diverting adults with mental illness from noncovered institutional care.

Support also comes through programs administered by other agencies in the federal government. Housing programs, for example, are funded through the Department of Housing and Urban Development (HUD), vocational rehabilitation programs are administered by the Department of Education, and so forth. In addition, qualifying veterans receive mental health services through programs operated by the Veterans Health Administration of the Department of Veterans Affairs. In most states, these programs are operated independently of the state-administered public mental health system. It is often the case that if an individual receives services through a VA program, he or she may not be deemed eligible for non-VA services.

35 Evidence-Based Practices

POLICY STATEMENT #35

Promote the use of evidence-based practices and promising approaches in mental health treatment, services, administration, and funding.

In recent years, enormous advances have been made in treatments available for persons with mental illness. New medications have emerged; new services, supports, and interventions have proven effective. Researchers have conducted studies and collected data—they have developed an "evidence base"—which demonstrate the effectiveness and applicability of some of these treatments and approaches. Gradually, a body of research literature is growing to support the choice of particular interventions in certain situations. While some researchers might argue over the standards by which an intervention or treatment approach is judged to be evidence-based, there is general agreement that the term and designation imply that a given practice has withstood rigorous scientific examination.

The public mental health system must take steps to ensure that practice keeps pace with research. By ensuring that what is done meshes with what is known, mental health policy makers and providers can reduce the numbers of homeless individuals on the streets, the numbers of individuals with mental illness whose behavior or crimes attract the attention of police officers, and the numbers of attempted and completed suicides by people who have not received effective treatment for their mental illness.

RECOMMENDATIONS FOR IMPLEMENTATION

a Implement evidence-based practices into the public mental health system.

Dr. Robert Drake, a national leader in the move toward evidence-based practices, characterizes evidence-based practices as standardized treatments and services subjected to controlled research involving objective outcome measures and more than one research group. Evidence-based practices are built on scientific principles, and while they are supported by certain values and as-

sumptions they are not themselves values; rather, they are specific interventions and treatment models that have been shown to improve client functioning and the course of severe mental illness.[3]

"When it comes to suicide and mental illness, the gap between what we know and what we do is lethal."

KAY REDFIELD JAMISON
Researcher, Author

Source: *Night Falls Fast: Understanding Suicide*, Knopf, 1999

Among the evidence-based practices experts believe should be available in the public mental health system are: appropriate use of all available psychotropic medications; assertive community treatment; supported employment; family psychoeducation; illness self-management; and integrated treatment for co-occurring mental illness and substance abuse disorders. This is by no means an immutable list. In fact, it is expected that these currently identified practices represent just the leading edge of a much larger body of evidence-based practices that will result in more reliable standards for mental health services. Promising practices exist in a variety of areas, including rehabilitative services, supported housing, and case management, among others. Properly implemented, existing evidence-based practices have been shown to improve outcomes for both the client and the system. There is every reason to believe that if they were implemented more broadly, fewer people with mental illness would become involved in the criminal justice system.

Studies show, for example, that people who are prescribed the newer, "atypical" antipsychotic medications experience fewer debilitating side effects than do clients taking the older classes of medications, with the result that they are more likely to adhere to their treatment regimens and thus to see the course of their illness improve. Yet the schizophrenia PORT study shows that the newer medications are seriously underutilized, especially in African-American and other minority populations, resulting in higher noncompliance with treatment and the familiar consequences of untreated mental illness.[4] The evidence shows that mental health service providers should make the newer medications routinely available to those who would benefit from them.

The Assertive Community Treatment (ACT) model (also known as Program of Assertive Community Treatment, or PACT) has been the subject of more than a quarter century of research showing its effectiveness with clients who do not respond to less comprehensive approaches. Since its inception in Madison, Wisconsin, in the 1970s, the ACT model has demonstrated that a mobile, multidisciplinary team approach, with services available twenty-four hours a day, significantly improves outcomes for persons with hard-to-treat mental illnesses. In some sites, persons with histories of criminal justice involvement or deemed to be at risk of criminal justice involvement have been identified as priority clients of ACT programs.

Despite the abundance of research that demonstrates ACT's effectiveness, providers and systems have until recently been reluctant to make the changes necessary to implement the program. Research is less clear on the factors that

3. Robert E. Drake, presentation at National Corrections Conference on Mental Illness, July 18 - 20, 2001, Boston, MA.

4. A. F. Lehman and D.M. Steinwachs, "Translating Research into Practice: The Schizophrenia Patient Outcomes Research Team (PORT) Treatment Recommendations," *Schizophrenia Bulletin* 24, 1998, pp. 1 -10.

may have impeded implementation of ACT, but many providers note that it is difficult to change staff habits, program configurations, and patterns for state funding and federal reimbursement. In this way, the story of ACT is illustrative of some of the hurdles to be overcome by all evidence-based practices. So, too, is the recent upturn in ACT implementation, which stems from increased advocacy for the program at both the federal and grassroots levels, as well as clarification of reimbursement rules under Medicaid and other funding streams.

It is important to note that evidence-based practices are not all treatment interventions. Supported employment, family psychoeducation, and illness self-management are better seen as support techniques that ultimately allow a client to develop his or her self-reliance and personal strengths. Each in its own way can be a critical element in a person's recovery and ability to function, but none of these practices can be seen as direct treatment.

The U.S. Surgeon General and others have made efforts to gather and disseminate information about evidence-based practices, but it is apparent that a huge gap remains between knowledge and practice, between what is known through research and what is actually implemented in many public mental health systems across the country. A particular challenge for public mental health stakeholders is to ensure that evidence-based practices become more broadly available and more seamlessly integrated into existing systems of care.

The Surgeon General's 1999 report on mental health makes this challenge particularly clear. "Exciting new research-based advances are emerging that will enhance the delivery of treatments and services in areas crucial to consumers and families—employment, housing, and diversion of people with mental disorders out of the criminal justice systems. Yet a gap persists in the broad introduction and application of these advances in services delivery to local communities, and many people with mental illness are being denied the most up-to-date and advanced forms of treatment."[5]

Example: New York State Office of Mental Health

The departments of mental health in Illinois, Maryland, New York, Ohio, and Virginia, among other states, have held or plan to convene conferences on evidence-based practices. The most ambitious of these was held in New York by the Office of Mental Health for the clear purpose of acquainting county-level policymakers and local service providers with national best-practice trends. The New York conference was the first step in a projected series of initiatives designed to make adherence to best practices a top priority in the New York public mental health system.

Example: NASMHPD Research Institute

The National Association of State Mental Health Program Directors (NASMHPD) Research Institute is joining with the New Hampshire Dartmouth Psychiatric Research Center and the Medical University of South Carolina to develop methods for the dis-

Replicating Evidence-Based Practices Successfully

Researchers point out that the history of ACT implementation also raises another of the complex questions in the promotion of evidence-based practices. There are communities in which providers claim to be operating ACT teams. On examination, however, it is evident that the model has been incompletely applied, raising serious concerns about its ability to live up to expectations based on research documenting the complete model. For example, the original ACT standards call for a psychiatrist to participate as a full member of the treatment team, not just as a consultant. Some agencies, however, see an opportunity to save money by restricting participation of the psychiatrist. Inevitably, this changes the nature of the team and, thus, potentially erodes reliability of "ACT" in that community. Researchers remind us that an evidence-based practice cannot succeed if its local implementation does not maintain fidelity to the original model. Worse, when a practice such as ACT is corrupted and improperly applied, results can be very different from those intended.

5. Office of the Surgeon General, *Mental Health: A Report of the Surgeon General*.

6. The NASMHPD Research Institute (NRI) has recently launched a center for evidence-based practices, performance measurement, and quality improvement. The full range of the center's activities is still under development.

semination of evidence-based practices. This effort, which various government and foundation sources support, is intended to provide hands-on assistance with replication of proven interventions. At the same time, research is under way to determine those factors that improve acceptance and implementation of proven models. This work has tremendous implications for the future of effective mental health services.[6]

b Incorporate recent findings, best practices, and promising practices into existing approaches at the agency level.

Identification and implementation of evidence-based practices should not prevent innovation or the development of new practices. Many practices employed in the public mental health system have not yet been well researched. This does not mean that they aren't effective; in many cases, they simply have not attracted the attention of researchers or they do not easily conform to traditional research methodologies. Researchers, providers, and practitioners should be encouraged to continue to develop new methods to serve people with mental illness who enter the system. Incentives for this activity should include an emphasis on outcomes in funding and contracting structures used for community services. Reliance on performance measures that emphasize recovery and improvement in a person's quality of life can lead to development of practices geared towards these outcomes. Providers should incorporate innovative approaches and methods expected to achieve good outcomes, paired with appropriate evaluation methods, into the practices employed by their agencies.

c Promote and support research in the government, academic, and private sectors into the causes and treatment of mental illness.

Research into effective medications and services is vitally important to the mental health field. Medical and rehabilitative advances of the past quarter century have changed our society's understanding of what is possible for someone with mental illness to achieve. Yet most researchers and practitioners agree that much remains unknown about mental illness and its treatment. As the Surgeon General's report on mental health notes, the nation must continue to invest in research at all levels to continue the trends benefiting many people today.[7]

The federal government sets much of the nation's agenda in basic, clinical, and services research. The research agenda is broadly encompassing; it should not overlook concerns of those people with mental illness who have contact with the criminal justice system. Practitioners and policymakers at the community level should be familiar with the research process and should promote

See the NRI Web site at: *http://nri.rdmc.org/* for more details. NRI also presents an annual conference that has evolved into a leading venue for services researchers and practitioners to meet and exchange information.

7. Office of the Surgeon General, *Mental Health: A Report of the Surgeon General*, pp. 453-54.

continued support of federal agencies, such as the National Institute of Mental Health and the Substance Abuse and Mental Health Services Administration.

At the same time, the government should ensure that its policies and relationships with academic research centers and with industry promote research expected to benefit the same core group of disabled individuals. Close attention should be paid to provision of incentives that will ensure continuation of the progress this field has experienced in recent decades.

The research community also has an obligation to guard the safety of any human subjects involved in its programs. Mental health service providers must work with researchers to ensure that clients who participate in research understand the potential risks and benefits of the programs in which they take part.

d Employ effective mechanisms to disseminate research findings and promote promising practices and evidence-based practices to practitioners in the field.

Researchers and policymakers have noted the unfortunate truth that practice in the field too frequently fails to reflect what is known about the most effective practices available. This wide gap between what is known and what is in fact done results in lost lives, failed systems, and wasted resources.

Policymakers should ensure that practitioners employ effective mechanisms for knowledge dissemination of findings regarding promising practices and evidence-based practices in the systems they oversee. These mechanisms might include conferences, professional journals, academic partnerships, and regular in-service training opportunities. Contracts should include bonuses or other incentives for the use of evidence-based practices as well as for training and other dissemination practices.

Example: Ohio Department of Mental Health; Illinois Office of Mental Health

Some state public mental health systems are accepting the challenge and taking steps to bridge the gap between research and practice. For example, the Ohio Department of Mental Health has established "coordinating centers of excellence" responsible for disseminating evidence-based or promising practices across the state. Eight of these centers are planned with the hope that they can promote local initiative and raise statewide quality measures. In Illinois, funding from the state Office of Mental Health has helped to establish the Illinois Staff Training Institute for Psychiatric Rehabilitation at the University of Chicago.

36 Integration of Services

POLICY STATEMENT #36

Initiate and maintain partnerships between mental health and other relevant systems to promote access to the full range of services and supports, to ensure continuity of care, and to reduce duplication of services.

People with serious mental illness generally have service needs that extend well beyond core mental health treatments such as medication and counseling. This is especially true of people with co-occurring mental illness and substance abuse disorders (see Policy Statement 37: Co-Occurring Disorders) but applies equally to any person with mental illness who has concerns related to health care or other disabilities. In many cases, these needs are best met by agencies or providers who can combine specific expertise in other areas with these or other traditional mental health services. It is certainly easier for clients to access services through providers able to link acute clinical services with necessary support services such as housing assistance, vocational rehabilitation, and educational services—and consumers cite ease of access as an important reason for sticking with or abandoning treatment. Similarly, when they are served by a single agency or by a well-coordinated partnership, consumers usually feel they are treated with greater respect. They are not asked for the same information again and again, and they may even be spared filling out quite so many forms.

From a clinical standpoint, provision of coordinated services simply makes sense. Even when a client sees different clinicians in the same agency, it is more likely that charts and records are consistent and there is agreement on treatment goals. Coordinated care, a value expressed by many health care providers, is much more achievable when all related services are provided by the same agency.

RECOMMENDATIONS FOR IMPLEMENTATION

a Promote services and systems integration for co-occurrence of mental illness and other chronic conditions.

While the disorders thought of most frequently as co-occurring are mental illness and a substance abuse disorder, these are by no means the only disorders to overlap. Mental illness can also coincide with developmental disability

(mental retardation), traumatic brain injury, HIV, diabetes, or any disabling condition or chronic illness. In each instance, it is now understood, the person with co-occurring conditions meets with greater success if his or her needs are considered as a whole and the disorders are treated in an integrated manner. The goal of integrated treatment is to combine treatments for more than one disorder at the level of clinical intervention. Ideally, the individual with co-occurring disorders should find services to be delivered seamlessly, "with a consistent approach, philosophy, and set of recommendations."[8]

"The organization of services for adults with severe mental disorders is the linchpin of effective treatment. Since many mental disorders are best treated by a constellation of medical and psychosocial services, it is not just the services in isolation, but the delivery system as a whole, that dictates the outcome of treatment."

Source: *Mental Health: A Report of the Surgeon General*, p. 285

Example: **Fountain House, New York City (NY)**

Fountain House, in New York City, is the founding site and leading example of the clubhouse model of rehabilitation. Its program has been replicated in communities worldwide. It provides education, housing, employment programs, and social opportunities for its members. While clubhouses such as Fountain House do not directly provide clinical treatment services, they generally have strong links with appropriate agencies to ensure that members who need treatment are able to receive it. In operation since 1948, Fountain House itself is able to meet the needs of members who are elderly or disabled by illness or disability. Ten percent of its members, for instance, are deaf or hearing-impaired. Approximately half of its members have histories of substance or alcohol abuse. And one in five are elderly. Like other successful and long-standing models, Fountain House appears to meet the needs of its clients by accepting them as they present themselves and working with them from that point forward.

b Integrate primary health care and mental health care services.

People with mental illness are at greater risk for health problems than is the general public. Smoking and poor nutrition are more prevalent among people with mental illness. Because of poverty or disorganization associated with their illness, people with mental illness are also less likely to visit primary health care providers on a regular basis. As a result, people with mental illness are in poorer health than the general population, and they rarely benefit from early intervention for health problems. When they do receive treatment for health problems, their conditions may already be in advanced states, so the treatment itself is typically more involved and more costly.

Some mental health providers have explored integration of primary health care and mental health care as a way to improve general health among people with mental illness. A recent study has demonstrated the benefits of this approach.[9] Subjects in the study were enrolled in a Veterans Affairs (VA) mental health clinic, where some were randomized to receive primary care through an integrated care initiative located in the mental health clinic, while others received medical care through the general medicine clinic. Those who received

8. Robert E. Drake et al., "Implementing Dual Diagnosis Services for Clients with Severe Mental Illness," *Psychiatric Services* 52:4, April 2001, pp. 469-76.

9. Benjamin G. Druss et al., "Integrated Medical Care for Patients with Serious Psychiatric Illness," *Archives of General Psychiatry* 58:9, September 2001, pp. 861-68.

primary care through the integrated care clinic had significantly better outcomes than those with mental illness who received primary and mental health care in separate settings. Policymakers and providers should consider adopting this approach to improve the general health of people with mental illness and to lower the incidence of emergency interventions in that population.

c Develop blended funding strategies to sustain comprehensive, integrated services.

Funding is the major challenge faced by advocates and managers who wish to start or maintain integrated or comprehensive service programs. Those who have managed to start programs and operate them successfully do have experience that can be useful to others in the field. According to a report by the GAINS Center, there are several strategies that increase the likelihood of success.[10]

Programs focusing on integrating several types of services in order to provide comprehensive treatment should identify a mix of funding sources that, in a sense, reflects the blending of services. Reaching out to different funding sources may appear to be more difficult than traditional mental health funding, which usually relies on categorical funding streams. Approached creatively, however, adopting a mix of services can also expand the range of funding possibilities. Approaching the development of services in this manner may also help providers to better understand what they are looking for in services as well as in funding and where the service deficiencies lie for the target population.

d Adjust licensing and other regulatory functions to encourage development and operation of comprehensive, integrated services.

Funding is by no means the only issue keeping systems from supporting more effective services. Key providers in a given community, perhaps competing for funding, may operate with different philosophies, undermining opportunities for cross-training, effective communication, or service coordination. At the same time, conflicting or confusing licensing regulations can thwart one agency's efforts to provide integrated services.

To achieve widespread service integration, policymakers will need to coordinate or consolidate regulatory and reporting mechanisms. The purpose is to make creative and effective integrated service models available for people who have mental illness and a variety of other needs.

10. National GAINS Center, *Courage to Change*, December 1999, pp. 17-22.

Example: Assertive Community Treatment

The Assertive Community Treatment model (known as ACT or PACT) was developed in Madison, Wisconsin, in the 1970s. Six states (Delaware, Indiana, Michigan, Rhode Island, Texas, Wisconsin) currently have statewide ACT programs. Nineteen states have at least one or more ACT pilot programs in their state. It is a service-delivery model that provides comprehensive, locally based treatment to people with serious and persistent mental illness. Unlike many other community-based programs, ACT is not a linkage or brokerage case-management program that connects individuals to mental health, housing, or rehabilitation agencies or services. Rather, it provides highly individualized services directly to consumers. ACT recipients receive the multidisciplinary, round-the-clock staffing of a psychiatric unit, delivered in the "real world" settings of their homes, local coffee shops, or other places they may frequent. To have the competencies and skills to meet a client's multiple treatment, rehabilitation, and support needs, ACT team members are trained in psychiatry, social work, nursing, substance abuse, and vocational rehabilitation. Recently, ACT teams have placed a greater emphasis on inclusion of consumers as treatment team members, either in the traditional professional positions or as peer counselors able to communicate more effectively with a team's clients. The ACT team provides these necessary services 24 hours a day, seven days a week, 365 days a year. To make ACT programs more accessible, states have adopted funding strategies approved by Medicaid for this purpose. As part of their contracting process, states monitor ACT programs for compliance with certain agreed-upon practice standards.

Example: Village Integrated Service Agency, Long Beach (CA)

The Village Integrated Service Agency in Long Beach was initially developed through state legislation (1989) that attempted to remove administrative and funding barriers from the delivery of comprehensive, individualized mental health services. The three basic elements of Village's program design are collaborative case-management teams, case-rated funding, and a psychosocial rehabilitation/recovery philosophy. As in the ACT model, services at the Village are primarily delivered to the client wherever he or she is: at home, on the job, in the supermarket. Teams of clinicians work with each client and bring complementary skills to the process. Case-rated funding is an important principle because it is focused on outcomes rather than on delivery of units of service. The overarching recovery philosophy imbues staff and clients with a willingness to seek the rewards that come with higher risks, knowing that support will be available when needed. The Village offers a clear, single point of responsibility for everyone it serves and provides coverage 24 hours a day, seven days a week.

37 Co-Occurring Disorders

POLICY STATEMENT 37

Promote system and services integration for co-occurring mental health and substance abuse disorders.

In the view of many practitioners and researchers, co-occurrence of mental illness and substance use disorders in individuals is so common as to be the norm rather than the exception. In fact, it is estimated that 75 percent of people with mental illness within the criminal justice system meet criteria for drug and/or alcohol abuse or dependence; some cite figures indicating that up to 90 percent of those behind bars with either mental illness or substance abuse disorders have co-occurring disorders.[11] As a result, increased attention has been given to identification of the most effective models for the provision of services to the "dually diagnosed" population. For the past 15 years, extensive efforts have been made to develop integrated models of care that bring together mental health and substance abuse treatment. Recent evidence from more than a dozen studies shows that comprehensive integrated efforts help persons with dual disorders reduce substance use and sustain mental health recovery. Integrated approaches are also associated with a reduction in hospital utilization, psychiatric symptomatology, and other problematic negative outcomes, including rearrest.[12]

RECOMMENDATIONS FOR IMPLEMENTATION

a Employ an integrated approach to treatment of persons with co-occurring mental illness and substance abuse disorders.

While there is widespread agreement that models featuring integrated services for individuals with co-occurring disorders are far more effective than those delivering services in a fragmented or sequential fashion, access to integrated programs is not available in most localities.

11. Teplin and Abram, "Co-occurring Disorders Among Mentally Ill Jail Detainees," pp. 1036-45; see also Policy Statement 17: Receiving and Intake of Sentenced Inmates.

12. Robert E. Drake et al., *Psychiatric Services*, pp. 469-76.

Barriers to integration exist at policy, program, and clinical levels. The terms "substance abuse disorder" and "mental illness" are often integrated under the phrase "behavioral disorders." Because substance abuse disorders can both mimic and exacerbate psychiatric disorders, the differentiation of what may be contributing to abnormalities in mood, thinking, or behavior is a difficult task requiring sophisticated assessment strategies. It is unfair, and unwise, to put the burden of differential diagnosis on law enforcement, the courts, corrections, or community corrections staff. The responsibility for assessing and responding to the behavioral needs of arrestees, defendants, inmates, and parolees must rest with community behavioral health providers. These providers must offer an integrated behavioral health service package to the criminal justice system if the shared vision of effective treatment and efficient justice is to be achieved.

The essence of integration is that the same clinicians, working in the same setting, provide and coordinate both mental health and substance abuse interventions. For the dually diagnosed individual or the referring agent, the services appear seamless. Clinicians take responsibility for combining the interventions to address the individual's clinical and legal circumstances, and the recommendations are consistent with the best practices of both the mental health and addictions fields. Neither disorder is considered primary, and it is recognized that successful resolution of the symptoms of both the addiction disorder and the nonaddiction psychiatric disorder are interdependent on integrated treatment strategies.

Integration involves modifications of traditional approaches to both mental health and substance abuse treatment. While there are numerous "right" ways to deliver services, and dual diagnosis programs differ from one another in many ways, successful programs incorporate several critical components that make them comprehensive.

Effective integrated programs do more than add a cross-trained staff member or a dual diagnosis group to existing traditional programming. Experts have defined comprehensive programs by the presence of intensive case management models, motivational interventions to advance clinical goals, the involvement of family and natural supports, and a long-term treatment perspective.[13]

Example: Dependency Health Services and Central Washington Comprehensive Mental Health, Yakima (WA)

The Integrated Crisis Stabilization and Detoxification Programs in Yakima are two separate programs that work in close collaboration. Each has learned to offer integrated services to persons with co-occurring substance abuse and mental health diagnoses. The two programs complement each other and offer "seamless" programming.[14] The staffs in the two programs, which share a medical director, together initiate joint clinical interventions. They also collaborate with other agencies, including the hospital (for ambulance response and medical care) and local law enforcement.

Intensive Case Management

Intensive case management is often accomplished through the use of multidisciplinary teams that include both mental health and substance abuse specialists who share responsibility for treatment and for training each other. Adhering to the principles of assertive community treatment that are designed for individuals who are difficult to engage in traditional services, intensive case management services perform outreach to the client's home (or street outreach if the client is homeless) and natural support system. Even where there are court-ordered conditions for treatment, noncompliance may be an early feature, due to the disabling effects of co-occurring disorders, and assertive outreach may be required for some individuals. Without such efforts, clients may be expected to drop out of treatment, with ensuing revocation or rearrest.

13. Ibid.

14. James B. Bixler and Brice D. Emery, *Successful Programs for Individuals with Co-Occurring Mental Health and Substance Abuse Disorders: Examples from Five States*, National Association of State Mental Health Program Directors, National Association of State Alcohol and Drug Abuse Directors, August 2000.

b Recognize that relapse is a common feature in the experience of many individuals with co-occurring disorders.

Effective programs accept that recovery from dual disorders is a long-term process. Both mental illnesses and addictive disorders are characterized by periods of higher functioning interrupted by periods with disabling symptoms. Recovery takes place over months and years. Scarce resources should not be diverted from long-term community-based care to high-cost, short, intensive interventions. Relapses are anticipated and contingency plans are made to minimize the duration and severity of the relapse. Close collaboration with community corrections staff is critical to ensure the responses to relapses serve both public safety and clinical goals.

c Integrate mental illness and substance abuse treatment policy, funding, and regulation at the federal, state, and agency levels in order to achieve desired clinical outcomes.

To facilitate service integration, there need to be integrative policies and administrative support at the system level. State, county, and local mental health authorities either promulgate, or are bound by, financing mechanisms and regulations that impede integrative service delivery. In most states, for example, licenses for mental health and substance abuse facilities are handled by two different state agencies with separate regulatory, financial, and oversight procedures. Frontline providers are often caught between doing what is clinically indicated and what is financially reimbursable with the dual diagnosis client suffering the consequences of ineffective care. New interorganizational structures and policies are required to enable the seamless provision of requisite services. These structural changes do not necessarily require more resources, and integration has the potential to be cost efficient.[15]

Advocates and practitioners agree that much can be done at the systems level to remove impediments and ease the provision of integrated mental health and substance abuse services. Supported by the federal Substance Abuse and Mental Health Services Administration (SAMHSA) in June 1998, the National Association of State Mental Health Program Directors (NASMHPD) and the National Association of State Alcohol and Drug Abuse Directors (NASADAD) conducted a formal dialogue intended to explore the issues related to the provision of integrated services. A report on this dialogue was issued by the two organizations in March 1999. In signaling their desire to collaborate in finding solutions, they have initiated a process each hopes will bring movement at both the federal and state levels.[16] More recently, the SAMHSA work plan for 2002

"...dual diagnosis is an expectation, not an exception."

KENNETH MINKOFF
Medical Director, Choate Health Management Care, Assistant Clinical Professor of Psychiatry, Harvard University, MA

Source: "Dual Diagnosis:An Integrated Model for the Treatment of People with Co-occurring Psychiatric and Substance Disorders," Available at: *www.dualdiagnosis.org/library/dual_network/minkoff_summer_01.html*

15. Kenneth Minkoff, "Developing Standards of Care for Individuals with Co-occurring Psychiatric and Substance Use Disorders Psychiatric Services," *Psychiatric Services* 52:5, May 2001, pp. 597-99.

16. National Dialogue on Co-occurring Mental Health and Substance Abuse Disorders, June 16-17, 1998, Washington, D.C., sponsored by the National Association of State Mental Health Program Directors (NASMHPD) and the National

and beyond gives the highest priority to addressing the issues involved in providing services for people with co-occurring disorders.[17]

It is not surprising that financial questions are among the thorniest facing policymakers seeking integration of substance abuse and mental health services. For example, the federal Substance Abuse Block Grant and Mental Health Block Grant are separate funding streams administered in different centers within SAMHSA. They often flow to different agencies in a given state and, in turn, finance quite different providers and services at the community level. Because integration of such federal funding brings with it the possibility of a significant realignment of resources throughout the system, many who would be affected are moving towards integration with great caution.

It should also be noted that the use of illicit drugs—and, more specifically, arrest for drug-related crimes—may result in limitations on an individual's ability to receive important federal benefits such as SSI or to qualify for housing under many public housing programs. Because of the high prevalence of co-occurring substance abuse and mental health disorders, many of those who come into contact with the criminal justice system are people whose past activities have left them unable to access various federal benefit programs. This circumstance places an additional strain on state systems and local agencies seeking reimbursement for integrated services provided to people with co-occurring disorders.

Association of State Alcohol and Drug Abuse Directors (NASADAD).

17. Charles Curie, SAMHSA Administrator, as reported in *Mental Health Weekly* 12: 13, April 1, 2002.

38 Housing

POLICY STATEMENT #38

Develop and enhance housing resources that are linked to appropriate levels of mental health supports and services.

As public mental health policy has moved away from reliance on institutions and toward community integration, policymakers, providers, and advocates have been forced to confront the many obstacles facing persons with mental illness who seek safe and affordable places to live. While some of the difficulties encountered by this population are common to all who live on low or moderate incomes, other challenges are more directly related to the experience of mental illness. In any case, in order to consider steps a community might take to improve housing options, it is first necessary to understand the existing obstacles.

The price of housing stock, particularly in major cities, has risen well beyond the ability of people with low or moderate incomes to pay for it. Since people in the public mental health system are among the poorest in the nation, they are hard hit by this crisis in affordable housing. In 2000, there was no housing market in the country where a person with a disability receiving SSI benefits could afford to rent a one-bedroom or efficiency unit.[18]

Federal housing subsidies for individuals with mental illness do not adequately compensate for the inflated private housing market. In 1992 and 1996, Congress passed laws permitting public and assisted-housing providers to designate housing as "elderly only." This resulted in many "non-elderly" adults disabled by mental illness no longer having access to a major portion of the affordable rental units in this country. Unfortunately, U.S. Department of Housing and Urban Development (HUD) officials have also promoted policies in recent years that have failed to keep pace with the needs of low-income people with disabilities who wish to rent affordable apartments. The Section 811 Supportive Housing for Persons with Disabilities Program has had its funding reduced from $346 million in 1991 to $217 million in the most recent budget.[19]

Federal housing policy makes it especially difficult for ex-offenders with mental illness to secure public housing assistance. At the most basic level, housing subsidies such as Section 8 are available only for the working poor—applicants must have federal income tax forms to be eligible. Because the large majority of individuals with mental illness are unemployed (70 percent to 90 percent) most do not qualify for such programs.[20] In addition, public housing authorities, Section 8 providers, and other federally assisted housing programs are permitted,

18. "Priced Out in 2000: The Crisis Continues," Technical Assistance Collaborative, Inc., Boston, MA and Consortium for Citizens with Disabilities Housing Task Force, Washington, D.C., June 2001.

19. NAMI, Housing Position Paper, available at: *www.nami.org/update/unitedhousing.html*

20. Most reports agree on the statistic that between 70-90% of individuals with

and in some cases required, to deny housing to individuals with certain criminal histories.[21] For example, if an individual is evicted from public housing for drug-related criminal activity, he or she is barred from reapplying to live there for three years. Because many people with mental illnesses have co-occurring substance use disorders, these restrictions affect this population disproportionately. People with mental illness who have histories of any kind of criminal justice involvement also frequently find themselves "jumped over" by others without such histories on waiting lists for assisted housing.

Even without the barriers to receiving federal assistance, the majority of individuals involved in the criminal justice system—regardless of whether they have a mental illness—have limited resources to secure adequate housing. For example, most ex-offenders leave prison without enough money for a security deposit on an apartment.[22] Furthermore, private landlords may require prospective tenants to disclose employment, financial, and criminal histories, as well as mental health information, and may exclude individuals based on these characteristics.

Families and friends are an important housing resource for individuals with mental illness. When these individuals become involved in the criminal justice system their relationships with families and friends are often strained. Families living in public housing may be concerned that allowing an ex-offender to resume residency there will compromise their own housing eligibility (see federal restrictions above). More generally, family and friends may feel incapable of or uninterested in helping an individual who has decompensated sufficiently to become involved in the criminal justice system.

Even if individuals with mental illness who have been involved in the criminal justice system are able to tap family or friends as a housing resource, their reintegratin into the community can be problematic. If an individual with mental illness is simply returning to the environment that fostered his or her involvement with the criminal justice system in the first place, there is a good chance that this reintroduction will result in a rapid return to the behavior that originally caused them to offend.

Individuals with mental illness who are able to locate housing often have difficulty sustaining residency. Sustained residency is usually predicated on the provision of support services (mental health, substance abuse, employment, etc.) in conjunction with housing. Housing and support services can be linked in a variety of ways.

Responses to the housing shortage for people with mental illness differ according to numerous variables: location (group vs. single-occupancy), level of supervision, funding source, intensity of integration with support services, intensity of case management, and others. It is difficult to identify discrete housing "models"; each approach tends to be unique to the community where the housing is provided. The recommendations below are an attempt to identify some of the common characteristics of successful efforts to develop housing options for individuals with mental illness.

RECOMMENDATIONS FOR IMPLEMENTATION

a Form community-based partnerships to develop comprehensive solutions to housing for persons with mental illness.

Lack of affordable housing is a community problem. Just as there is no one cause for the shortage of housing, no one agency can possibly assume responsi-

mental illness are unemployed. See *www.gladnet.org/marrone.htm*

21. Travis et al., *From Prison to Home,* pp. 35-6.

22. Ibid., pp. 35-6.

bility for addressing the problem. Effective solutions require partnership of the most inclusive kind. Local, community-based agencies are almost always the most effective at joining together to access housing funding available from state, federal, and, sometimes, private sources. Local agencies are also best positioned to understand the community's particular need and, most important, to create partnerships that can provide necessary housing and supports for people with mental illnesses.

In every community, collaboration among service providers, housing developers, lenders, and elected or appointed officials is critical to successful development of housing for people with mental illness, especially those with histories of criminal justice involvement. Local mental health service providers should actively seek and form partnerships to meet this most pressing of needs.

Example: **Community Mental Health Centers, Vermont**
In Vermont, every Community Mental Health Center (CMHC) has hired a housing coordinator. These coordinators work with staff from state housing agencies, public housing authorities, nonprofit developers, and others to develop cross-system, collaborative efforts to provide housing for individuals with mental illness. CMHC housing coordinators also work with private landlords, nonprofit developers, case managers and others to ensure that clients are on Section 8 waiting lists, tenant/landlord disputes are settled amicably, and housing development efforts consider the needs of the mentally ill population.[23]

"People with [mental illness and addiction who are] on the street...see acutely the need for housing, for a place to feel safe and secure, before they're even ready to consider treatment. Recovery starts when you have something you care about, a place where you can go."

DR. SAM TSEMBERIS
Executive Director, Pathways to Housing, NY

Source: Christina McCarroll, "Pathways to Housing the Homeless," *The Christian Science Monitor* May 1, 2002 edition, available at: *www.csmonitor.com/2002/0501/p11s02-lihc.html*

b Establish leadership and coordination at the state level to provide technical assistance and ensure access to resources.

State mental health agencies should examine their role in housing development. Depending on the structure of state mental health systems, state mental health agencies may be able to require provider agencies to participate in local housing collaborations. More likely, it is through force of leadership and, especially, provision of incentives that state mental health agencies can assume a role in meeting this critical need. A relatively small matching grant or provision of technical assistance in completing often complicated applications can be crucial contributions to local housing initiatives.

Although solutions to the housing shortage for people with mental illness ultimately must be locally based, state agencies should encourage local providers to address this issue, and they should facilitate such projects with assistance and funding. Creation of a state-level office that concentrates on housing for persons with mental illness indicates the centrality of housing in the service array.

23. Elizabeth Edgar, and Anne D. Lezak, *Preventing Homelessness Among People with Serious Mental Illness: A Guide for States*, National Resource Center on Homelessness and Mental Illness, April 1996, pp. 31-34.

24. Ibid., pp.26-28.

25. Dennis P. Culhane, Stephen Metraux, and Trevor Hadley, "The Impact of Supportive Housing for Homeless

Development of housing for individuals with serious mental illness is a complex challenge for local communities. By providing centralized expertise, state offices can help local agencies learn to negotiate regulations and requirements related to zoning, property acquisition, licensing, federal funding mechanisms, and the many other issues that arise in housing development.

Similarly, state housing offices can locate disparate funding sources and assist local communities in accessing them.

Example: **Office of Housing and Service Environments, Ohio Department of Mental Health**

The Ohio Department of Mental Health has created an Office of Housing and Service Environments. In 1989, this office, which has since been sub-divided into three offices, began to redirect some funds, formerly used in the development and renovation of hospitals, to housing development. The DMH Office of Housing also provides technical assistance to local community health boards to create independent corporations to develop housing for individuals with serious mental illnesses.[24]

C Institute linkages between housing options and service availability.

Almost all successful housing initiatives for individuals with mental illness are integrated with the provision of other services, including mental health, employment, crisis management, and substance abuse. This model of "supportive housing" recognizes that housing issues must not be viewed as isolated from the other needs of this population; housing should be viewed as part of a broader model of integrated treatment for individuals with mental illnesses (see Policy Statement 36: Integration of Services). Research has shown repeatedly that retention rates for housing with services are considerably higher (often twice as high) than for housing that is not linked to services.[25]

The issue of whether services should be a mandatory condition of receiving housing is contentious. Some housing developers favor agreements that require individuals with mental illness to have their adherence to treatment closely monitored by case managers as a condition of receiving housing. Some service providers and mental health advocates hold strong philosophical positions against requiring acceptance of services as a condition of housing. This issue remains difficult and divisive.

In all cases, availability and use of service models such as Assertive Community Treatment can go a long way toward meeting the needs of both tenant and landlord in most housing situations.

People with Severe Mental Illness on the Utilization of the Public Health, Corrections, and Emergency Shelter Systems," *Housing Policy Debate* 12, 2001.

26. See *www.omh.state.ny.us/omhweb/omhq/q0901/Pathways.html*

Example: Pathways to Housing, New York City (NY)

In 1992 the New York State Office of Mental Health established the Pathways to Housing program, which seeks to relocate individuals from shelters and the streets into permanent housing. Crucial to the Pathways mission is the integration of intensive services, based on the ACT model.[26] Pathways to Housing favors the eradication of all restrictions for housing clients; employment, substance abuse treatment, life skills, and other services are aggressively offered, but not required of program participants.

Example: Corporation for Supportive Housing (CA)

The California branch of the Corporation for Supportive Housing has established the Health, Housing, and Integrated Services Network. This initiative brings together four county public health departments with more than 20 different nonprofit service providers (mental health, substance abuse, HIV/AIDS, employment, and others) to link a broad array of services to housing.[27]

Many programs that provide housing to individuals with mental illness are linked to case management services. These services may be provided by community mental health providers, the housing providers themselves, or other nonprofit agencies. The intensity of case management, i.e., the volume of cases each case manager handles, varies widely. Case management is often crucial in linking a client to the services that are integrated with housing providers. Many individuals with mental illness who have been involved in the criminal justice system have had bad experiences with treatment programs, and without a dedicated case manager they may not successfully reach out to these services, even if these services are provided in conjunction with housing. Case managers are also extremely important in helping consumers deal with crisis situations. (See Policy Statement 13: Intake at County / Municipal Detention Facility for discussion of the Thresholds Jail Program and Policy Statement 14: Adjudication for discussion of the Nathaniel Project; both programs provide case management and help connect to supportive housing individuals with mental illness who have been involved with the criminal justice system.)

d Blend funding for development and operation of stable, affordable housing.

The most successful housing partnerships are those that identify several funding sources that will allow them to make housing affordable for people with disabilities such as mental illness. Since funding sources frequently impose restrictions on the use of their available funds, this blending of funding sources may be the only way to gain access to funds for both development and operation of properties. When considering funding for housing this population,

27. See *www.csg.org/whohhis.html*

28. A recent study of more than 3,500 formerly homeless individuals with mental illness involved in a New York City supportive housing program showed that the per annum costs of the housing program were only slightly higher than the service costs typically accrued by the individuals. The supportive housing model cost $13,750 per placement per year and resulted in a cost reduction of $12,145 per placement per year. Dennis Culhane et al., "The Impact of Supportive Housing."

it is important to remember that supportive housing for individuals with mental illness has proven very cost effective when compared with the cost of services (shelter, criminal justice, hospitals, etc.) typically provided to individuals who are homeless and have a mental illness.[28]

Example: Common Ground (NY)

Common Ground, a New York City nonprofit organization that develops and manages large, congregate, supported housing properties, receives funding from more than 30 different sources. Their funders include foundations, private sector corporations, the New York City Departments of Housing, Human Resources, and Homeless Services, and the New York State Office of Mental Health, among others.[29]

There are many federal programs that can be used for people with mental illness. These include: HOME, Community Development Block Grant, Section 8 rental assistance (including Section 8 Mainstream Housing Opportunities for Persons with Disabilities), McKinney/Vento Homeless Assistance, Section 811 Supportive Housing for Persons with Disabilities, and Housing Opportunities for People with AIDS (HOPWA). Each program comes with its own requirements and restrictions, but those interested in developing housing in their communities should become familiar with these options.[30]

Example: Connecticut Local Housing Authorities

During the 1990s, local housing authorities in Connecticut received more than $40 million from HUD, primarily from the McKinney grants program, to support the provision of housing and services for individuals with mental illness. The state aggressively educated local housing authorities on how to apply for the grants, and fostered collaboration between state mental health service providers and local housing authorities.[31] The federal Shelter Plus Care Program offers substantial funds specifically targeted to individuals who are homeless and disabled, including those with serious mental illness. Title VII of the National Affordable Housing Act of 1990 amended the McKinney Act to create this grant program. The program provides rental assistance but requires a local match of an equal or greater amount of services.

Some states have found ways to make funds available for development of housing for people with low incomes, including those with disabilities. Bond issues, trust funds, and one-time appropriations have been used for these purposes in different states. For example, Oregon recently negotiated the sale of its former Dammash State Hospital. A 1999 statue establishes a trust fund with the sale proceeds; 70 percent of the trust fund interest will be used to finance community-based housing options for individuals with mental illness.[32] Agencies such as Housing and Mortgage Finance Corporations may also have state-specific programs that encourage housing developers to tap various funding sources.

29. See *www.commonground.org/docs/Overview/funders.html*.

30. See *www.hud.gov*.

31. Robert J. Burns, *Strengthening the Mental Health Safety Net: Issues and Innovations,* NGA Center for Best Practices, p. 7.

32. Ibid., p. 7.

e Develop an array of housing to meet the varied needs of individuals with mental illness.

Typically, community response is most favorable to development of housing that mixes people with mental illness with others who may require no support and/or who will rent at market rates. Most of the programs mentioned above are predicated on development of such "integrated" (also known as "scattered-site") housing. A building with eight units, for example, may include just one or two units for persons with mental illness. Developers and most community mental health agencies frown on development of properties with many units, all of which are to be occupied by people with mental illness. Such "congregate" housing is a target for community opposition and is seen by many advocates as inimical to the concepts of community integration and recovery. Just the same, it should be pointed out that some communities have seen opportunities arise for development or redevelopment projects that are targeted exclusively to people with mental illness. Still, such projects are growing less common.[33]

> **Example: Project Renewal (NY)**
> Project Renewal, a New York City based nonprofit, has facilitated the construction of both "integrated" and "congregate" housing throughout the city. One of its several congregate housing facilities, Renewal at Clinton Residence, opened in 1990 and houses and provides services for 57 individuals with mental illness who were formerly homeless. Project Renewal also maintains more than 90 units of "scattered-site housing," some of which are occupied by graduates from Project Renewal-run treatment programs. Rent subsidies are provided by HUD and federal section 8 programs, among other funding sources.

It should be remembered that people with mental illness fall at different points on a continuum. For some, independent housing with only occasional supports is appropriate. For others, intensely supervised housing is necessary to ensure their safety and success in the community. It would be a mistake for a community to institute a housing plan that doesn't account for this range of needs. To ensure appropriate housing development, a community should assess the housing options available as well as indications of need, such as waiting lists for section 8 housing or the numbers of people with mental illness found to be inadequately housed in shelters, with relatives, or, indeed, in jails or prisons.

33. Another reason for the decline in popularity of congregate housing is that, compared with some integrated housing models, congregate housing can be more expensive. This is due in large part to the extensive in-house services available, especially having 24-hour trained mental health staff on-hand. Yves Ades, director, the Nathaniel Project, Center for Alternative Sentencing and Employment Services (CASES), interview, December 20001.

39 Consumer and Family Member Involvement

POLICY STATEMENT #39

Involve consumers and families in mental health planning and service delivery.

People whose lives have been affected by mental illness develop a vast reservoir of experience that can be put to constructive use to meet their immediate needs, those of their peers, and, ultimately, those of the mental health system. In still too many places, this reservoir remains untapped, and consumers and families have little meaningful involvement in determining the direction of services and a system that are meant to meet their needs.

In the 1980s, Congress recognized the value of including consumers and families in mental health services planning when it created the precursors to today's statewide mental health planning and advisory councils. A major requirement for the composition of the councils is that no more than 50 percent of their membership be drawn from the ranks of professionals or state administrators. The intention is to make councils hospitable to consumers and family members and, in fact, consumers and family members serve on these federally mandated councils in every state.

RECOMMENDATIONS FOR IMPLEMENTATION

a Build consumer and family participation into all levels of the service delivery system.

Inclusion of consumers and family members at the county and/or local level is more variable than at the state level. County boards, for example, may or may not require participation by consumers and family members. Many local agencies include consumers and families on their governing boards or on agency planning committees, and such inclusion is encouraged by national associations. Still, consumers and family members in many areas report their frustration with what they view as a lukewarm commitment to this principle, espe-

cially in instances where they feel their inclusion reflects tokenism rather than an openness to their experience or perceptions of the system.

Example: National Council for Community Behavioral Healthcare

The National Council for Community Behavioral Healthcare (NCCBH) includes the following among the principles of governance it suggests to its members: "Governing boards should include members of or access to the views and input of individuals who are consumers and/or family members of consumers of the organization's services."[34]

"Peer provided supports and services are a vast untapped resource for recovery when it comes to community based resources for diversion from the criminal justice system. And those supports and services are equally valuable for persons transitioning back into the community."

TOM LANE
Consumer Activist/ Advocate, Director, Forest Park Drop In Center at South Florida State Hospital, FL

b Include consumers and family members in service delivery.

Consumers and family members can also make important contributions to service delivery. Evidence is mounting to demonstrate the effectiveness of consumer-operated support services, for example. Systems that employ people with mental illness to help others gain insight into their illness and build strategies that can help them cope with it report success as measured by lowered use of crisis services. Services such as "warmlines," which make it possible for a person needing support to prevent an exacerbation of symptoms by talking with someone who has had direct experience with mental illness him-or herself, have been shown to succeed in a variety of settings. "Drop-in centers" are consumer-operated sites where people with serious mental illness can meet others and participate in social, vocational, and educational activities.

Similarly, some programs employ consumers to act as "peer educators" who provide generalized information about coping with mental illness in a manner that is authenticated by their own experiences. Peer educators frequently run groups for consumers at mental health service agencies in which they discuss issues of common concern. By removing the experience of mental illness from a wholly clinical approach, peer educator programs often allow people to make connections with one another and understand how to deal with their illness in a more individualized way. Consumer-operated services such as these are seen as part of the continuum of services that also includes professional services; they are not to be seen as a replacement for the professional system.

Example: Harbor Inn Residential Facility, Boston (MA)

In Boston peer educators every week visit Harbor Inn, a residential facility on Long Island in Boston Harbor. They meet with residents who are in transition from hospitals to community settings. Many residents have histories of involvement with the criminal justice system. Educators, who themselves are in treatment for mental illness, show videotapes or share written materials that provoke group discussions of issues such as housing, basic living skills, and tobacco use that are relevant to the lives of those in the residence.

34. *Principles for Behavioral Healthcare Delivery*, National Council for Community Behavioral Healthcare, Rockville, MD, 2001.

Example: Assertive Community Treatment Programs

Assertive Community Treatment programs in many locations around the country have recently added positions on their professional teams that are intended to be filled by consumers of services. Sometimes known as "peer counselors" or "peer advocates," the consumers who fill these positions provide insight into the experience of mental illness and recovery that professionals without a consumer background are unable to offer.

C Ensure that people with mental illness are accessing the full range of entitlements for which they are eligible (e.g., SSI, SSDI).

For many people, access to appropriate services is determined by their ability to access the health benefits and other entitlements for which they are eligible. People with mental illness who are found to be disabled by their illness or who have little or no income as a result of their disability are eligible for an array of income and reimbursement benefits. Many mental health and addiction services provided by community agencies are reimbursable through Medicaid and Medicare, which are generally available to people who qualify for Supplemental Security Income (SSI) or Social Security Disability Income (SSDI). Qualification for income support also can lead to eligibility for housing supports. In any case, income support through SSI and SSDI provides funds with which an individual can pay rent and meet other basic needs. Other valuable benefits programs for which persons with mental illness may be eligible include Temporary Assistance for Needy Families (TANF), food stamps, and benefits available to veterans through the Veterans Administration.

Rules and procedures for accessing disability entitlement programs are difficult for many with mental illness to understand. There is also a shortage of staff at community mental health agencies who are trained to provide assistance to clients who may qualify for either entitlement program. It is more common than not for first-time applications for entitlements to be denied, at a minimum causing a delay in benefits for qualified applicants. Because these entitlements are frequently the only legitimate source of income for many with mental illness, such delays can lead to homelessness and such "survival crimes" as shoplifting and bill evasion.

The issue of accessing government benefits is also examined in the sections of this report that look at the release of people with mental illness from jails and their reentry to the community from prison (see Policy Statement 13: Intake at County / Municipal Detention Facility and Policy Statement 21: Development of Transition Plan). Because many people with mental illness coming out of jail or prison have no other means of support, linkage with appropriate government benefits in a timely manner can make the difference between success and failure in the community. As discussed elsewhere in the report,

mental health provider agencies must work with partners in jails and prisons to establish protocols that will result in people with mental illness gaining speedy access to appropriate benefits.

Mental health agencies must train staff to provide assistance with applications for SSI and SSDI and the follow-up that is so often needed to secure these benefits. Further, they must ensure that case managers, employment counselors, rehabilitation therapists, and others who may be working with clients to secure employment are familiar with the each client's benefits profile. An increase in income can mean an end to benefits. When clients are working, especially when they are doing so through "transitional employment" or "supported employment" programs, staff should make sure that their transition does not leave them without health insurance or sufficient funds for housing and food. The rules and regulations applied by the Social Security Administration to these programs can create challenges for staff to provide guidance to clients on entitlement and benefit matters. It can also be time-consuming. Training and prioritization of this service are necessary if clients are to access supports intended to help them at a difficult time in their lives.

Example: **International Center for Clubhouse Development**

The International Center for Clubhouse Development (ICCD) publishes standards for programs that receive its certification. Among its most firmly held principles is the importance of employment in the recovery of clubhouse "members." In the ICCD standards are two that are meant to encourage training and consistency in maintaining the benefits of members who are working in transitional or more competitive employment. Clubhouses receiving ICCD certification are expected to provide sufficient training to ensure appropriate access to benefits by clubhouse members.

40 Cultural Competency

POLICY STATEMENT #40

Ensure that racial, cultural, and ethnic minorities receive mental health services that are appropriate for their needs.

Among the many barriers to appropriate treatment that people with mental illness must negotiate, those arising from cultural differences can make a profound difference in the quality of care a person receives. To supplement the groundbreaking 1999 report on mental health, the U.S. Surgeon General in 2001 issued *Mental Health: Culture, Race, and Ethnicity*, in which the disparities in mental health treatment are documented and discussed. The main message of the supplemental report is: "culture counts." It states, "The cultures that patients come from shape their mental health and affect the kinds of mental health services they use. Likewise, the cultures of the clinician and the service system affect diagnosis, treatment, and the organization and financing of services. Cultural and social influences are not the only influences on mental health and service delivery, but they have been historically underestimated—*and they do count*. Cultural differences must be *accounted for* to ensure that minorities, like all Americans, receive mental healthcare tailored to their needs."[35] Failure to provide mental health services in a culturally sensitive context almost certainly results in higher numbers of people with mental illness from racial, cultural, and ethnic minorities in our nation's jails and prisons.

The Surgeon General's supplemental report collects many of the studies that have demonstrated both the particular needs of different cultural and ethnic groups, and the availability, utilization, and effectiveness of mental health services for the different groups. It is clear that African Americans, Native Americans and Alaska Natives, Asian Americans and Pacific Islanders, and Hispanic Americans may all present symptoms of distress or mental illness according to certain idioms of distress that are particular to their cultures. Members of each of these groups may also be more likely to seek and accept alternative therapies than are their white counterparts. In many cases, these alternative therapies are seen as much more acceptable or consistent with cultural norms than the dominant modes of treatment practiced in the mental health system might be. Within each of these broad groups there exist narrower cultural subgroups, making it difficult for outsiders to approach a person showing symptoms

35. Office of the Surgeon General, *Mental Health: Culture, Race, and Ethnicity – A Report of the Surgeon General*, Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental

of mental illness with any certainty about how offers of treatment, for example, will be understood or accepted.

There is a great deal of data that demonstrate the unevenness with which mental illness falls on members of the cultural minority groups. The public system has, to date, been guilty of undertreatment of some mental illnesses in some cultures and what might be called overtreatment of others. The thrust of the Surgeon General's supplemental report and of much that has been published about mental health care for members of different cultures is that policymakers and practitioners must take the time to understand mental illness and treatment in cultural terms so that suffering within various cultural groups that goes either undetected or improperly treated can be abated.

RECOMMENDATIONS FOR IMPLEMENTATION

a Recruit members of minority communities for clinical and administrative positions in which there is regular client contact.

The quest for cultural competency has been under way in the public mental health field for some time, but the results to date are mixed. With so many different cultural groups now living side by side in our society, it would be difficult for mental health practitioners or agencies to develop expertise in each one. It is reasonable, however, for agencies to approach the challenge in a manner similar to the approach suggested by the Surgeon General's office in compiling its supplemental report. That is, it makes sense for each agency to identify practitioners with the cultural understanding and, if applicable, the language skills to communicate effectively with the cultures most highly represented in the community. The underrepresentation of minorities among mental health providers, administrators, policymakers, and consumer and family organizations only helps to perpetuate the system's disparities. Agencies should be encouraged to recruit members of minority communities to fill clinical and contact positions.

Example: **North Carolina Area Health Education Centers**
Since 1985, the North Carolina Area Health Education Center (AHEC) Program has received special state funding to bring its educational services, training programs, and information services to the community mental health facilities in the state. Recognizing that a significant percentage of mental health clients in the public system are from minority groups, yet that the majority of mental health professionals are not minorities, AHECs promote the recruitment of racial and ethnic minority students into mental health professions through special regional programs.

b Provide training in cultural issues to all staff members in contact with clients.

At the same time, each agency should make sure that every staff member who comes in contact with clients has training that will allow him or her to recognize cultural clues in a person's presentation and response to offered services. Cultural competency training itself is evolving, but it is clear that for the mental health system to meet its responsibilities to all in the communities it serves, mental health professionals must develop an understanding of the roles of age, gender, race, ethnicity, and culture in the manifestation of mental illness and its research and treatment. A culturally informed training curriculum is essential if the system is to advance in this area.

Example: **Pacific Clinics (CA)**

Pacific Clinics, a provider of behavioral health care services in Los Angeles, Orange, Riverside, and San Bernardino counties in California, has made a priority of establishing services to meet the needs of different cultural groups. Many of their 50 sites include staff from Spanish-speaking cultures who can provide culturally sensitive services to Latino clients. Pacific Clinics also has developed services that are sensitive to the needs of the multiple Asian populations living in that part of California. Services at the clinics include links to culture-specific family and consumer groups, as well.

c Develop targeted outreach programs to make services available to members of minority communities.

Members of cultural and linguistic minority groups not only have a more difficult time than others accessing services, many simply fail to consider seeking help when they need it. To many in minority communities, the system is remote and frightening, especially when no one working in it appears to share their language or experience. Deep-seated values can also result in even greater stigma within some cultural groups than exist in the general population.

It is therefore very important for local agencies and the public mental health system in general to seek innovative ways to reach out to cultural minorities in their service areas. Outreach can and should take into account the cultural and linguistic barriers that may be standing between people in need and the services that could help them. One effective way to do this is to tailor outreach approaches to specific groups by using their language and by forming partnerships with cultural institutions that traditionally serve specific communities. In many parts of the country, for instance, mental health agencies have sought to improve outreach to African-American populations by forming collaborative relationships with churches in their communities.

Example: Mental Health Association of New York City (NY)

In 1998, the Mental Health Association of New York City extended its LifeNet help line service to the city's Hispanic community by creating *Ayudese*, a Spanish-language 24–hour referral and education toll-free telephone service. In 2000, the help line service became available to members of New York's largest Asian communities when a new number was created to provide information and referrals in Mandarin and Cantonese. The service is advertised on posters in different languages that are carried in the city's subway cars. In a recent pilot project, police in eight of the city's police precincts carried LifeNet referral cards in different languages to give to people they perceived to be in need of services.

Example: Haitian Mental Health Clinic, Cambridge (MA)

Operated through Cambridge Hospital, the Haitian Mental Health Clinic provides culturally and linguistically appropriate ambulatory mental health care for first-and second-generation immigrants of the Haitian community of metropolitan Boston, including individual and family treatment for adults and children, long-term and short-term therapy, crisis intervention, psychological testing, and psychopharmacology within a managed care framework, encouraging preventive and primary care.

41 Workforce

POLICY STATEMENT #41

Determine the adequacy of the current mental health workforce to meet the needs of the system's clients.

Like other segments of the human services field, the public mental health system is experiencing significant difficulty in attracting and retaining qualified personnel to provide appropriate services and to effectively manage the myriad agencies on which it relies at the community level. Constrained state budgets and tightly capped reimbursement rates result in salaries for line staff and other professionals that are barely competitive with fields requiring far less professional commitment and responsibility. Mental health officials in many states report difficulty in filling positions at the service provision level. Some positions remain vacant for long periods of time. Officials also report high rates of turnover in sensitive line positions in both hospitals and community agencies. In many agencies, ironically, the pathways for career advancement lead only to management positions where clinical skills and experience may take a back seat to other attributes. As a result, mental health agencies can find themselves with few experienced clinicians meeting clients and poorly prepared managers dealing with increasingly complex reimbursement, staffing, and planning issues.

Case managers are, arguably, the most important link in an individualized, community-based system. Theoretically, they should be the most constant face of the system to consumers and their immediate families. However, most consumers who have received services in community mental health centers for any length of time report that they have seen their case managers turn over steadily. Moreover, many complain that their case managers are almost universally young, inexperienced, minimally trained, and paid on a par with people working at McDonald's. Many consumers report that they—the consumers—know far more about the mental health system and how it works than do the case managers they are meant to rely on.

At the same time, mental health workers with the ability to provide services with particular sensitivity to cultural, language, or age-related needs are in especially short supply in many areas. At a time when awareness of the need for culturally sensitive services has grown, it is a sad truth that providers in many communities simply cannot attract the workers needed to implement those services.

It is evident that there are any number of reasons for high vacancy and turnover rates. The jobs entail stressful workloads and conditions, while commanding little public respect or compensation. Reality may not jibe with expectations or training, and paperwork and other bureaucratic imperatives place an additional set of burdens on workers who may have a genuine desire to serve people in need. Moreover, staff currently entering the field may find themselves in agencies oriented only toward survival and not toward achieving the high expectations that should be the hallmark of the community mental health system. Services researchers must thoroughly examine the factors involved in workforce recruitment and retention, and steps must be taken to address the gaps evident in the field. Without significant improvement in this area, many

of the important recommendations in this report will not be implemented, simply because competent staff will not be available to do the necessary work.

Example: California State Task Force
A California statute created a task force led by the Department of Mental Health to identify options for meeting the staffing needs of state and county health, human services, and criminal justice agencies. Also in California, the Center for Health Professions at the University of California, San Francisco, has created the California Workforce Initiative to look broadly at needs in the health care workforce, including the behavioral health care field.[36]

RECOMMENDATIONS FOR IMPLEMENTATION

a Plan to increase the supply of skilled and experienced mental health providers.

Using data from research, policymakers and state legislators should consider steps that will ensure availability of sufficient resources to attract qualified workers to the mental health field and to make work in the mental health field an attractive career choice for those with an aptitude for provision of supportive services. At the same time, state mental health officials should undertake efforts designed to raise the professional standing of mental health field workers and others involved in providing mental health services. Working in concert with universities and other entities outside the public mental health system, officials should develop degree or certificate programs that recognize and reward life experience that can be converted to credentials acceptable to regulatory, licensing, and reimbursement bodies. Efforts should also be made to provide financial or other incentives that will attract workers to the mental health field. For example, tuition loan forgiveness or support programs should be implemented. Innovative opportunities for professional development and advancement should be increased.

Example: Ohio Residency/Traineeship Program, Ohio Department of Mental Health
Since 1947, the Ohio Department of Mental Health (ODMH) has funded the training of psychiatric residents, psychology students, graduate-level nurses, and social workers to provide services to persons in Ohio's public mental health system. This program is seen as critical in the development of high-quality and high- performance mental health clinicians. Recruitment and retention is closely linked to experience gained and expertise fostered in this program. ODMH works in partnership with local mental health systems and institutions of higher education to implement this initiative.

Example: Mental Health Worker Certificate Program, Walnut (CA)
A new project at Mt. San Antonio College/Regional Health Occupations Center in Walnut, California, will create a competency-based certificate program for entry- level mental health workers. The program expects to contribute to a more prepared mental health workforce. The curriculum includes 64 hours classroom study and 6 months' clinical practice experience. It expects to train between 20 and 50 workers over a six-month period.

Health, 2001.

36. Little Hoover Commission, *Young Hearts and Minds: Making a Commitment to Children's Mental Health*, Sacra-

b Promote the employment of current and former clients in the provision of mental health services.

The mental health system's own clients may represent a ready reservoir of talent that can supply workers for many positions in the field. An expanding body of research shows that consumers of mental health services bring skills and compassion to such frontline positions. Training programs should be developed to maintain high standards of care and full integration of consumers into the workforce. Programs that ensure appropriate support for consumers working in mental health services should be developed at local agencies. Agencies should also come to consensus on the ethical issues raised by the inclusion of consumers in the mental health workforce; seeing a possible compromise to patient confidentiality, some agencies prohibit their clients from taking on provider positions, while others have founds ways to minimize the issue. Finally, state systems and provider agencies must find ways to substitute experience for education in qualifications for case management and other frontline positions. This may require negotiations with a state Medicaid authority so that providers can bill for experienced peer counselor activities, thus eliminating a major obstacle to consumer employment.

Example: New Jersey Division of Mental Health Services, Department of Human Services

The New Jersey Division of Mental Health Services, Department of Human Services, wanted to open the way for employment of consumers as peer counselors in Assertive Community Treatment programs operated in many of the state's counties. While the benefits of this initiative seemed obvious to the division, Medicaid reimbursement regulations were a barrier. The state Medicaid agency's willingness to defer to state mental health agency guidelines made it possible for this plan to move forward.

c Provide training that specifically addresses the consumer and family experience of mental illness.

While ongoing training of all mental health workers is necessary to ensure familiarity with developments in the field and to address deficits in training received prior to employment, specific training by consumers and family members can help mental health workers better understand the needs of those they serve. Exposure to the experiences of primary consumers of mental health services and their families can provide insights that do not come from much of the training received in classroom or credentialing situations.

Example: NAMI Training Courses

State NAMI affiliates in fourteen states have presented a comprehensive course for providers that is taught by mixed teams of consumers and family members. Classes are presented throughout the year and with significant state mental health agency support in Vermont, Connecticut, Missouri, and Utah. The purpose of the course is to acquaint providers with the firsthand experience of mental illness. Evaluations of early classes indicate that staff have changed clinical practice as a result of what they have learned in the course.

The need for training and cross-training of professionals is addressed elsewhere in this report but must be mentioned here again for emphasis (see Chapgter VI: Training Practitioners and Policymakers and Educating the Community). With workforce issues, including job frustration and burnout, looming as large problems in the mental health field, staff training is a tremendously important function. A workforce in which individuals have a firm grasp of their role and of the options open to them in the performance of their duties will provide a more professional response to the challenges faced in the field.

d Plan to increase the supply of skilled and experienced mental health providers in rural areas.

A separate but very much related issue is the acute shortage of mental health workers in many rural areas. Particularly in the rural West, where population density is low, recruitment of psychiatrists and other skilled professionals presents an enormous challenge. Many counties report vacancies in key positions lasting several years. Community mental health therefore takes on a different look in rural areas, especially in the West. Care may be delivered by whatever professionals are available. Primary care physicians often take on the role of psychiatrist in rural communities, and telemedicine and other techniques that allow few professionals to cover vast areas are widely employed. Wide distances distort the meaning of "community" mental health, and institutional care at state hospitals many hours' drive from home can be more common. Practices that have proven effective in more densely populated districts are often simply impractical in rural areas.

The unique needs of people with mental illness in rural states have been explored in detail by the Mental Health Program of the Western Interstate Commission for Higher Education (WICHE), in Boulder, Colorado. By collecting and analyzing data on mental health services in frontier counties (fewer than seven persons per square mile), WICHE has identified the greater challenges in service provision. At the same time, policymakers and providers in states with large rural areas have worked to identify services that are effective in such settings.[37]

Another organization that focuses on the issues in rural mental health is the National Association for Rural Mental Health (NARMH). Founded in 1977 in order to develop and enhance rural mental health and substance abuse services and to support mental health providers in rural areas, NARMH has added the goal of developing and supporting initiatives that will strengthen the voices of rural consumers and their families.

Both WICHE and NARMH address recruitment and retention issues in the rural mental health workforce.[38] NARMH maintains a job bank on its Web site and provides information on recruitment through its annual conference.

mento, CA, October 2001, pp. 63-66.

37. Examples can be found at the WICHE Web site: *www.wiche.edu/mentalhealth/Frontier/index.htm*

42 Accountability

POLICY STATEMENT #42

Establish and utilize performance measures to promote accountability among systems administrators, funders, and providers.

The purpose of performance measures is to evaluate and monitor how well a system responsible for providing mental health care is performing: to report the information in quantitative terms and to direct the system's efforts and resources toward desirable goals. The fundamental problem with defining such a set of indicators is the lack of consensus on these goals and, therefore, the lack of definition of what constitutes "good" performance.

The various stakeholders of the mental health system—consumers, family members, advocates, providers, purchasers, and policymakers—often have different expectations of the system. A purchaser may emphasize efficiency and cost, while a consumer may consider outcomes more important. One stakeholder may define a good system as one that contains costs and increases consumer satisfaction; another stakeholder may consider a system successful when it helps a consumer to participate productively in the life of the community. These different values and expectations of stakeholders in a system help to shape the character of the performance measurement system. They also shape the goals and objectives of the system, which, in turn, determine selection and ranking of performance indicators and the criteria by which performance is judged to be adequate. (See Chapter VIII: Measuring and Evaluating Outcomes.)

RECOMMENDATIONS FOR IMPLEMENTATION

a Utilize performance measures in budgeting, contracting, and managing mental health services.

Different stakeholders also have different uses for performance measures. Payers, for instance, need performance indicators to make purchasing decisions and to ensure that contract provisions are met. Consumers may use information on performance to make enrollment decisions, choose providers, and track quality and responsiveness of the different systems of care available to

them. Providers need performance measures for quality management and improvement purposes. Accreditation agencies are incorporating performance measures to monitor adherence to regulations and standards and to guide accreditation and program-review decisions. Finally, governmental entities need performance measures for policymaking, purchasing decisions, budget formulation, and monitoring accountability.

Performance measures are one set of tools in the arsenal of efforts intended to improve quality, management, and accountability. Often, they are used as a key component of ongoing management functions such as planning, quality improvement/management, contract management, and accountability. The focus of management is to monitor and improve (or maintain) levels of performance: performance measures are quantitative, measurable ways to do so. Performance measures can be used effectively in planning/budget systems, quality improvement/management systems, and in contracts management.

Example: **New York State Office of Mental Health Center for Performance Evaluation and Outcomes Management**

The New York State Office of Mental Health has created the Center for Performance Evaluation and Outcomes Management to develop performance measures and associated performance targets for each priority initiative and major sector of the public mental health system and to evaluate the outcomes associated with each initiative.

b Involve consumers and families in mental health service evaluation.

Evaluation of mental health services by those who use them is an extremely valuable gauge of the system's effectiveness. One way to tap the energy, commitment, and hard-earned knowledge of mental health consumers and family members is to engage them in the independent evaluation of services. Consumers and family members can help design surveys and "report cards" on services. With consumer and family participation, it is more likely that report cards will reflect real-life experiences of consumers: Did they get help applying for benefits? Did they receive help in finding housing and/or employment? Were they treated with respect?

Consumers and families generally respond to such surveys if they feel the results will be made known to them and will lead to any corrective measures indicated. In some places, consumers and family members have gone beyond these efforts to form consumer satisfaction teams, which work with the system to formally evaluate services through site visits, surveys, and interviews with clients. When efforts of this nature are paired with a commitment by providers to make improvements in services based on the team's findings, significant progress can be made.

Example: Consumer Surveys, Mental Health Statistics Improvement Program

Under the auspices of the Center for Mental Health Services and its Mental Health Statistics Improvement Program, consumers and professionals have worked together to develop consumer surveys that are now in use in a number of states. These surveys, which in some states have been translated into Spanish, Cambodian, traditional Chinese, Portuguese, Russian, and Vietnamese, among other languages, provide an opportunity for consumers to indicate how well services do or do not work for them.

Example: Consumer Satisfaction Team, Philadelphia (PA)

In 1990, a Consumer Satisfaction Team (CST) was developed in Philadelphia. At the time, a state hospital was closing and patients from the hospital were being transferred to community services. Family members and consumers, skeptical of the system's commitment to provide adequate services, coalesced to form the CST. The consumers and family members won support of local authorities for incorporation of the CST's findings in the overall evaluation of the system's ability to provide services in the community. Relying primarily on multiple interviews with consumers at different agencies, the CST was able to document consumer views on provided services. The Philadelphia CST has served as a model for a number of state and local systems wishing to formalize methods for obtaining consumer feedback.

C Attach funding to outcomes.

States and other government entities responsible for funding the public mental health system should employ budgeting and contracting mechanisms that emphasize improved outcomes. Performance based budgeting and other mechanisms that allow for costs in one system to be balanced against offsets in another – spending in the mental health system versus fewer costs in corrections, for example – should be considered by legislatures of states wishing to better understand the full implications of the policies they establish.

Similarly, state mental health agencies that contract with provider agencies for services in communities should attach funding to the outcomes to be achieved. For example, contracts can include incentives for lower rates of arrest among the population served by an agency, along with safeguards that ensure the agency is not "creaming" or finding ways to provide services only to clients at lower risk for involvement in the criminal justice system.

By their nature, performance-based budgeting and contracting mechanisms promote provision of a full spectrum of services that meet all needs experienced by people with mental illness. Strategic placement of both incentives and accountability can lead to development of a system that stresses collaboration and outcomes and allows those making service decisions to make specific spending decisions, as well.

Example: Performance-based budgeting, Various states

Performance-based budgeting and contracting initiatives are under way in many states across the country. While it is too early in this wave of activity to identify states that are leading the field, it is possible for states and counties to begin to learn lessons from the experiences of their counterparts in other jurisdictions. Florida, Texas, Virginia, Missouri, and South Carolina are among the states that have examined or implemented performance-based budgeting in state government. In addition, the federal government is developing methods to convert existing block grants, such as the Mental Health Block Grant, to "performance partnership" grants. Regulations for this effort will be issued some time in 2002.

43 Advocacy

POLICY STATEMENT #43

Build awareness of the need for high quality, comprehensive services and of the impact of stigma and discriminatory policies on access to them.

The stigma of mental illness is a persistent and pernicious force against which people with mental illness, their families, and those who provide services to them must continually struggle. As noted in the Surgeon General's report on mental health, stigma manifests itself in distrust, bias, fear, stereotyping, embarrassment, anger, and/or avoidance. Stigma derives in part from poor or incomplete understanding of causes and treatment for mental disorders.

Stigma translates into problems that must be addressed by the public mental health system if it is to provide needed services to people with mental illness. Among the most major problems is the reluctance of nearly two-thirds of all people with diagnosable mental illness to seek treatment. Stigma is not the only issue that discourages people in need from seeking treatment, but among many populations, including rural populations and members of many distinct cultural groups, it clearly keeps many away from needed services and supports.[39]

Stigma also manifests itself in negative public attitudes towards payment for mental health services. Even with passage of mental health insurance "parity" laws in nearly two-thirds of the states, private insurance coverage for mental illness often remains inequitable in terms of co-payments and dollar or durational limits on coverage. At the same time, support for public funding of mental health programs remains soft relative to public willingness to pay for highways, prisons, or even other health services.

In recent years, a common approach by the mental heath community to the problem of stigma has been to point out that mental illnesses are illnesses like any other. Much faith has been placed in the promise of research to clarify the etiology of mental illness and to further improve treatments that already can demonstrate effectiveness comparable to treatments for "accepted" diagnoses such as heart disease, cancer, and diabetes. While this approach to stigma and discrimination can be shown to have had some effect, it is clear that public support for greater expenditure on mental health services has simply not materialized.

Recent years have also seen a rise in greater awareness of other problems associated with mental illness, particularly within the law enforcement, judicial, and corrections fields. Low public investment in mental health services has resulted in a system that often cannot adequately meet the complex needs of the people it is meant to serve. A stark

38. See: *www.narmh.org/*

39. Office of the Surgeon General, *Mental Health: A Report of the Surgeon General*, p. 454.

symptom of this undervalued and underfunded system is the increase in criminal justice contact for people with mental illness. Without adequate services, many commit the petty crimes that bring them to the attention of law enforcement and the courts and that may result in stays in jail or prison.

RECOMMENDATIONS FOR IMPLEMENTATION

a Create public support for the investment necessary to make high-quality, comprehensive mental health services available to those who need them.

A significant effect of stigma is that it allows many in society to distance themselves from people with mental illness and the real, if complicated, social issues associated with their condition. People with mental illness, especially those in trouble with the law, are easy to dismiss as unworthy of public notice. At a minimum, they may be seen as inconsequential in the broad political calculus by which limited resources are allocated. Even harsher attitudes prevail when offenders with mental illness are seen exclusively as authors of their own problems or when they become involved in high-profile, often tragic, encounters with the law.

The challenge to public mental health policymakers, providers, consumers, and family members is to find ways to make the public aware of the experience and costs of untreated mental illness. Having found that their own voices alone are ineffective in changing public attitudes, these advocates must search for new allies who can help to carry the message, making support for effective services a public priority.

b Present a common front to advocate for greater investment in improved mental health services.

In the face of stigmatizing attitudes, increased efforts by law enforcement officials, judges, prosecutors, and corrections administrators to understand and address the causes for their increased contact with individuals with mental illness hold the potential to increase awareness of the costs borne by society when appropriate mental health services are not delivered. By highlighting the burdens placed on their systems by people overlooked or underserved by the public mental health system, members of the criminal justice system have an unprecedented opportunity to help shape public opinion and public policy. Increased public awareness of the inefficiency stemming from the current allocation of resources will help to create the political will necessary to direct resources toward development and maintenance of comprehensive, high-quality public mental health programs. Improvement in public mental health programs will result not only in fewer criminal justice contacts by people with mental illness but, more basically, in more opportunities for people with mental illness to participate fully in society. (See Policy Statement 32: Educating the Community and Building Community Awareness.)