25th Annual

BETTER GOVERNMENT COMPETITION **2016**

Improve the Quality & Access to Care for

Individuals Living
with **Mental Illness**

PIONEER INSTITUTE
PUBLIC POLICY RESEARCH

25th Annual

BETTER GOVERNMENT COMPETITION **2016**

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Foreword

Aquarter century of "Better Government" has passed, and we are proud of what a prize, good communication and belief in the ingenuity of individuals and government officials have spawned. Since its inception in 1991, the Competition has saved Massachusetts taxpayers almost a billion dollars. Of equal importance is how it has improved the quality of public service by introducing unique ideas that have become part of the Massachusetts policy conversation.

The Competition turns 25 in 2016.

Our 2016 competition focuses on mental health policy and how to make Massachusetts a leader in the care of individuals with mental illness and co-occurring addictive disorders. We crowdsourced new ideas covering a broad range of areas, including proposals to improve psychiatric emergency legislation and crisis intervention, as well as developing better support channels for those with co-occurring substance abuse disorders and for vulnerable jail and prison populations.

As with all things, history matters when it comes to caring for those with mental illness.

From the activism of Dorothea Dix in the 1840s to the creation of institutional inpatient care over the century that followed, and finally de-institutionalization half a century ago, attitudes about how best to care for the mentally ill have shifted periodically. With the 1963 passage of the federal Community Mental Health Centers Act came the decline of state psychiatric hospitals, which thereafter served only those posing imminent danger to themselves or others. In their stead grew a variety of community-based care models.

Today, however, with rising incidence of mental health issues, efforts to achieve parity with other forms of medical care and expand preventative mental health care strategies, and a recognition that prisons and jails are increasingly approximating the role of the 20th century's large-scale institutions, mental health policy has again taken center stage in state and federal health policy debates.

Understanding the breadth and depth of this issue, Pioneer has approached the 2016 Competition with modesty: The Competition does not seek to "solve the problem," but rather

to add practical value to state policymakers' various strategies. The emphasis here is on the *practical*.

In this work, we sought the advice of and were aided by an outstanding lineup of local, state and national experts who helped the institute craft the Competition guidelines. They include: Dr. Ron Manderscheid of the National Association of County Behavioral Health & Developmental Disability Directors, Linda Rosenberg of the National Council for Behavioral Health, Dr. Paul Barreira of Harvard University Health Services, Michael Jellinek, President of Lahey Health, Laurie Martinelli of NAMI-Massachusetts, Dr. Frederick Stoddard of MGH, Sheriff Michael Ashe, Dr. Ross Ellenhorn and many others who educated us on this complex subject. These experts and leaders in public health, human services and health service delivery were crucial in disseminating the Competition guidelines to their counterparts across the country.

We also want to thank the highly respected panel of external judges who evaluated this year's submissions: Vicker DiGravio of the MA

Association for Behavioral Healthcare, Matt Selig of Health Law Advocates, Kathleen Dennehy, Beth Childs, and Pioneer Board Director, Fred Clifford. This exceptional group was also instrumental in the conceptual development of our guidelines.

As we typically do, Pioneer sought submissions from a wide variety of individuals and institutions across the United States. Some entries came from tech experts with entrepreneurial projects that improve access, others from law enforcement personnel with on-the-ground experience in dealing with the mentally ill in the criminal justice system.

Our 2016 winner addresses some of the most critical mental healthcare delivery barriers, recognizing that most who suffer from behavioral health disorders live alone, without reliable transportation and often in poverty. The North Carolina Mobile Medication Program is an in-home medication support, education and skill-building initiative that serves adults with severe psychiatric illness. The program sends nurses to the homes of the enormous number of individuals who leave psychiatric hospitalization without certainty about continuity of care to reconcile all medications and provide a range of support services to keep participants stable and functioning.

Some of our best ideas were simple and tech-based, such as a texting system targeted at adolescents that replaces outdated suicide hotlines. Other entrants tackled some of the more complicated issues in this space, like the confounding regulatory hurdles for information-sharing between behavioral health providers. One of the local proposals we recognize is a hospital-initiated collaborative that could save the lives of thousands of Massachusetts residents who suffer from opioid addiction.

My sincere thanks to Shawni Littlehale who for two decades has personified the spirit of the Better Government Competition. It is because of her dedication and work that the Competition is a go-to event in Massachusetts and a reference point in national policy conversations. My gratitude and respect also go to Matthew Blackbourn, who has proven invaluable to the Competition's growth over the past three years, bringing social media skills, intern management and policy expertise. They have been ably supported by talented fellows and interns, including Josh Alexakos, Jordan Harris, Brendon Murphy, Yohann Sequeira and Michael Weiner. Staff members Mary Connaughton and Greg Sullivan also played an important role in vetting this year's entries.

I am grateful for the collaboration with dozens of state legislators and executive branch officials, as well as media outlets, whose advice and outreach expanded the number and quality of entries we received. With the winners selected, we now return to them to share the powerful ideas and programs the Competition has recognized.

Finally, and most importantly, thank you. Without your support, neither great ideas like the ones we celebrate here nor the impressive impact they have had would be possible. The Institute and the Commonwealth of Massachusetts are greatly in your debt.

Sincerely,
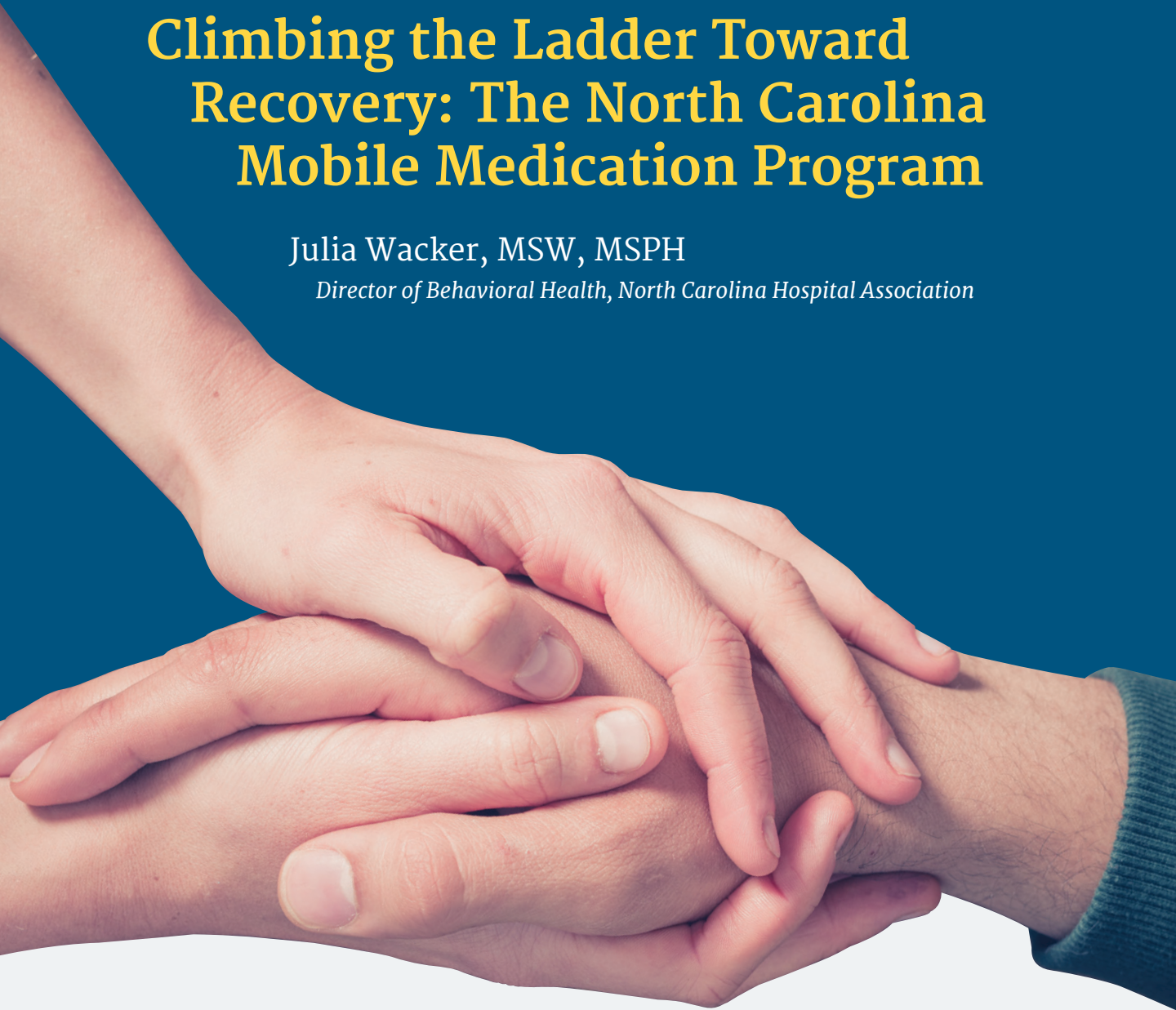
James Stergios
Executive Director

Climbing the Ladder Toward Recovery: The North Carolina Mobile Medication Program

Julia Wacker, MSW, MSPH

Director of Behavioral Health, North Carolina Hospital Association

The Problem

For patients with severe and persistent mental illness, medication is typically the first line of treatment. Proper medications, suited to the needs of the individual and their disease, have the potential to stabilize behaviors, bring clarity of purpose and break down roadblocks toward recovery. Yet patients with severe mental illness regularly take less than 50% of their prescribed medications.[1,2]

While the root cause of medication "non-compliance" proves unique for every individual, systemic barriers to consistent, quality, preventative care play a major role. Many individuals with severe mental illness live alone, without reliable transportation, and in poverty. Typically a mental health disorder is just one of several co-morbidities; roughly 70% of individuals with a behavioral health diagnosis suffer one or more chronic medical conditions and/or a substance use disorder, as well.[3]

Despite their clinical complexity, many individuals with severe mental illness lack consistent medical and psychiatric care. People with psychotic disorders are about half as likely to have a medical home as those without such diagnoses, and are far more likely to seek treatment in urgent care centers or emergency departments. In North Carolina, a behavioral health patient visits an emergency department every three minutes where, if determined eligible for an admission, they wait an average of 3.5 days for a state psychiatric bed.[4]

When discharged, patients often leave with a stack of new medication orders and instructions to follow up with an outpatient provider. The new prescriptions may be in addition to existing medication orders unknown to the hospital providers, as most chronically ill people see three or more clinicians prescribing medications.[5] Follow-up outpatient care is critical, yet difficult to access. Upwards of 70% of recently discharged psychiatric patients fail to see an outpatient provider within the recommended seven days post-discharge.[6, 7] Only 40% of patients with severe mental illness have received any kind of psychiatric treatment in the past year.[8]

This disconnect of care, coupled with persistent social isolation, means that chronic but *treatable* conditions — such as bipolar disorder — are left unaddressed. Emergency departments and jails serve as the social safety net, with both experiencing a "revolving door" effect, where the same individuals continuously cycle in and out of the system. Unfortunately, these safety nets represent not only the most expensive places for care, but more importantly, are not designed nor equipped to provide the customized and supportive treatment these individuals so desperately need.

...patients with severe mental illness regularly take less than 50% of their prescribed medications.[1,2]

The Solution

The Mobile Medication Program (MMP) is a home visiting medication support, education, and skill-building program serving adults with severe psychiatric illness. Modeled after a program of the same name and administered by the Human Services Center in Lawrence County, Pennsylvania, the North Carolina MMP pilot project launched in early 2015 in two sites located in rural N.C. communities: Nash General Hospital, a 280-bed acute care facility, and Daymark Recovery Services, Vance Center, a comprehensive community provider of mental health and substance abuse services.
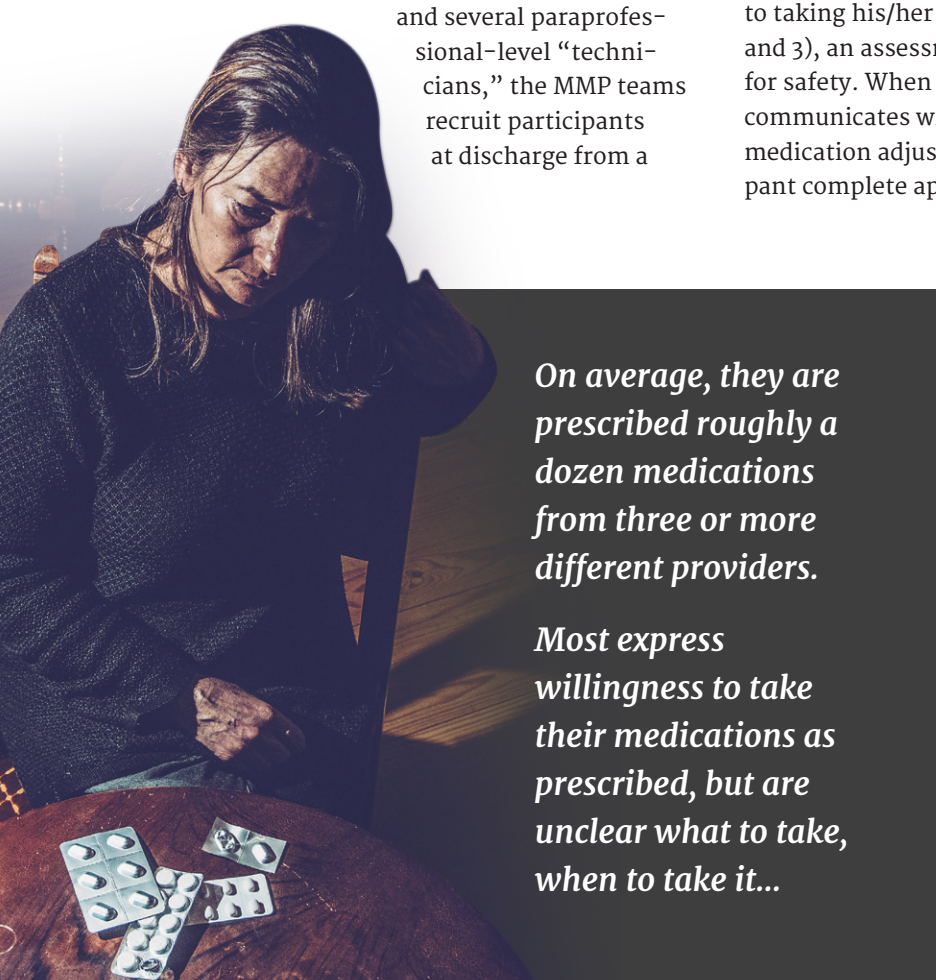
Staffed by a team comprised of a registered nurse-level nurse manager and several paraprofessional-level "technicians," the MMP teams recruit participants at discharge from a psychiatric hospitalization or via referral from primary care, law enforcement, or family. To be eligible, participants must be prescribed one or more oral psychiatric medications, fall below the poverty level, and have a history of psychiatric hospitalizations or repeated emergency department visits for mental health needs.

Within two days following discharge or receipt of referral, the MMP nurse visits the participant at home, which, in some cases, includes homeless shelters. The nurse conducts an intake nursing assessment, which includes: 1) reconciling all the medications (psychiatric and medical) the participant has access to, is prescribed, and is taking; 2) an inventory of barriers (as identified by the participant) to taking his/her medications as prescribed; and 3), an assessment of the environment for safety. When appropriate, the nurse then communicates with the prescribers to make medication adjustments and helps the participant complete applications for pharmaceutical assistance programs, Medicaid or other health insurance.

After the medication regime is clarified, the nurse passes care of the participant to a technician, who initiates the intensive teaching and support phase of the program. Initially, the technician visits the participant daily to review their medications, explore side effects and other barriers, and ensure the participant is aware of upcoming provider appointments. Frequent visits of 10

On average, they are prescribed roughly a dozen medications from three or more different providers.

Most express willingness to take their medications as prescribed, but are unclear what to take, when to take it...

Outcomes of the first year pilot prove promising

↓75%
in # of psychiatric
hospitalizations

↓81%
in length of
stay in days

↓93%
in number
of ER visits

↓72%
number of
police-issued
involuntary
commitments

minutes or less in duration are intended to model the routine and consistency of taking medications. As the participant develops skills, the frequency of the visits gradually decreases from daily to three times a week, twice a week, weekly — and eventually — a weekly phone call. Most participants complete and are discharged from the program within six months.

Impact

At enrollment, the typical MMP client faces a litany of medication-related barriers to recovery. On average, they are prescribed roughly a dozen medications from three or more different providers. Most express willingness to take their medications as prescribed, but are unclear what to take, when to take it, and the purpose and expected side effects of each pill. They lack transportation to obtain their medications, or a means to pay for them. Some have a criminal record, and many are estranged from their families and natural supports.

MMP's long-term impact remains to be seen, but the outcomes of the first year pilot in N.C. prove promising. The program has served roughly 125 participants in the two counties thus far, and among those, there has been a:

- 75% reduction in the number of psychiatric hospitalizations
- 81% reduction in length of stay in days

- 93% reduction in number of emergency department visits
- 72% reduction in number of police-issued involuntary commitments

In total, this reduction represents a cost savings of approximately $1 million for the healthcare system, based on an average psychiatric hospitalization cost of $6,700; ED boarding cost of $4,200; and IVC costs of $2000 per person.[9, 10, 11, 12]

MMP has also helped link participants with outpatient medical homes, and whenever feasible, health insurance. The nurse strives to uncover all who are involved in the participant's medical care, and works with them to identify a lead prescriber. This has resulted in MMP helping to reduce the overall number of medications participants are prescribed – from an average of eight at intake to three at discharge – while increasing the percentage of medications the participants are actually taking as prescribed.

In total, this reduction represents a cost savings of approximately $1 million for the healthcare system

As participants learn more about their medications, they assume ownership, and are more apt to take them consistently. Feeling better,

they are able to repair relationships, which consequently allows for natural supports to be woven back into their care as the MMP team tapers involvement. Participants have also reported significant reduction in use of alcohol and illicit substances since enrolling in MMP, as they no longer turn to them as a form of self-medication.

A unique, cost-saving design

North Carolina chose to test the replication of the Mobile Medication Program because of the unique cost-saving design of the intervention. While many home visiting models have a strong evidence base for improving participant outcomes, most require an interdisciplinary team of licensed professionals to conduct the visits. This proves expensive to implement on a broad scale, especially in rural areas with long travel times between homes.

Participants have also reported significant reduction in use of alcohol and illicit substances since enrolling in MMP, as they no longer turn to them as a form of self-medication.

Relying on mounting evidence that peer-driven interventions generate strong outcomes, certified peer support specialists and other paraprofessional-level staff fill the MMP technician role, and therefore conduct the bulk of the home visits. To ensure they have the resources and tools needed to work with such a clinically complex population, the technicians complete an intensive MMP training program at hire and remain in constant cell phone communication

with the nurse manager throughout their day of home visits. The nurse spends a majority of his/her time at a centralized MMP office, overseeing the administrative aspects of the program and communicating by phone with the prescribers, providers and technicians. The overall program costs, therefore, are moderate and include just three main categories: staffing, vehicles, and computers/phones.

Future Goals

The Mobile Medication Program offers promising insight into a complex problem, yet alone, falls short of a solution. The North Carolina Hospital Association advocates for MMP, along with other evidence-based initiatives, to be part of a larger, thoughtfully-conceived continuum of behavioral healthcare in the state. Cross-agency, cross-discipline collaboration is key to that success.

Early on in the development of MMP, the team convened community partners that touch mental health in some capacity – including hospitals, jails, provider agencies, health departments, schools, law enforcement and first responders, among others, and involved patient and disability advocates. The group brainstormed how the MMP model could fit into existing services and fill gaps. They will continue to build on the energy garnered through these community meetings to collectively advocate for MMP to become a billable service, allowing for self-sustainability.

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"The Mobile Medication Program helps clients reach up and grab hold of the bottom rung of the ladder. The ladder is long, but from there, they are more apt to pull themselves toward recovery."

– Michele Kelly-Thompson, Clinical Director, Human Services Center

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Contact The Author

Julia Wacker, MSW, MSPH
Director of Behavioral Health, North Carolina Hospital Association

2400 Weston Parkway
Cary, NC 27513
919-677-4171
jwacker@ncha.org
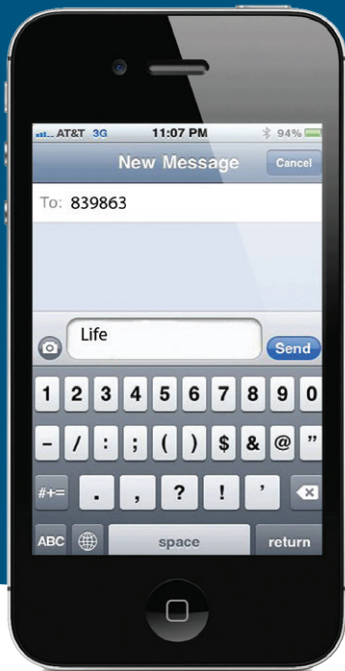
TXT4Life Suicide Prevention Program

Meghann Levitt

*Northeast Minnesota TXT4Life Coordinator,
Carlton County Public Health and Human Services*

Problem

Faced with a rising suicide rate in Minnesota, Carlton County Public Health and Human Services (CCPH&HS) and Canvas Health/Crisis Connection sought out a new and innovative solution. With many traditional mental health resources in place, the partners worked to determine where gaps existed in access to these services for residents experiencing a mental health crisis. Since the very rural northern part of Minnesota is home to the top ten highest counties for suicide rates, the Northeast Region (where Carlton County is located) made sense as the starting point for a crisis text program pilot.

Solution

Passionate about finding ways to reduce the increasing rates of suicide in the region and state, a development team made up of Carlton County Public Health and Human Services staff, school partners, and mental health providers first conceived of the program in 2011. After reviewing the data, the development team uncovered a major gap in the local mental health system. Teenagers and young adults were not getting the help they needed, especially in crisis situations.

After observing behaviors and getting feedback from adolescents, it became clear to the development team that the traditional approach of expecting teens in crisis to find a phone number and call for help was unrealistic in today's culture.

Keeping innovation at the forefront, the group

decided to launch a crisis text service to allow for help during a mental health and/or suicide crisis, as well as an initial connection to potential ongoing mental health help through a referral or connection to other resources. A student group at a local high school tested the software and provided input on the process in late 2011, allowing the service to be accessed by the wider community soon after.

The program began through a $1.4 million grant from the Substance Abuse Mental Health Services Administration (SAMHSA), from 2011-2014, which allowed the launch of the text line and outreach and education to the Northeast Region (seven counties) of Minnesota. Through grant funding, Canvas Health/Crisis Connection opened the National Suicide Prevention Lifeline (NSPL) to text messaging in Minnesota.

The two main pieces of TXT4Life include the text service and the outreach that the regional coordinators provide.

The text service (available 24/7/365) is made up of 12 text counselors who, overseen by a mental health professional, respond to incoming text messages from residents experiencing a mental health crisis, which can include thoughts of suicide. The text counselors work to deescalate the crisis and provide the person with a referral and resources.

Community outreach, in turn, plays a key role in encouraging teens and young adults to use the texting service. The regional coordinators are out in communities spreading the word about the text service as a resource. Regional coordinators provide education presentations to youth in grades 7-12, provide trainings (QPR– Question, Persuade, Refer, & ASIST – Applied Suicide Intervention Skills Training) to community stakeholders, and provide community businesses, organizations, and schools with TXT4Life marketing materials. Complete program implementation details can be found here: https://drive.google.com/file/d/0By3z-jQPMSBHjRWRwd2VraTkyQ0k/view

To date, more than 32,000 youth across Minnesota attended presentations on TXT4Life, while over 2,800 adults have been trained to work as volunteers. More than 86,000 marketing materials have also been given away.

TXT4Life works alongside school-based therapy services, mobile crisis teams, and other community mental health services to make sure teens, young adults and others feel comfortable contacting at least one of those services.

The new program has resulted in a dramatic increase in the number of teen and young adults seeking mental health help. Prior to SAMHSA grant funding, the Minnesota affiliate
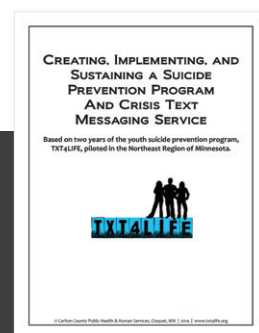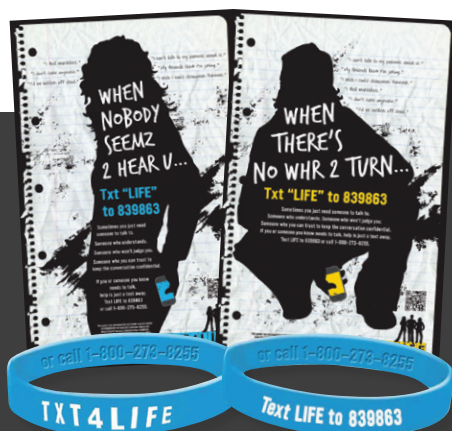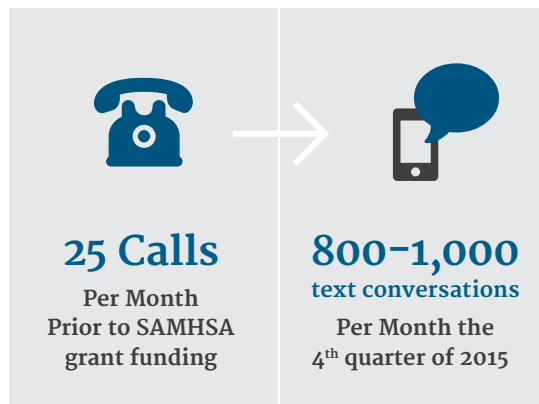

For complete program implementation details, visit:
https://drive.google.com/file/d/0By3z-jQPMSBHjRWRwd2VraTkyQ0k/view

of the NSPL reported answering about 25 calls a month from youth and young adults — a small percentage in comparison to their volume from other age groups. With implementation of the text line and outreach, they are now receiving, on average, 800-1,000 text conversations per

25 Calls
Per Month Prior to SAMHSA grant funding

800-1,000
text conversations
Per Month the 4th quarter of 2015

month, based on data from the fourth quarter of 2015, with a majority of the conversations with youth and young adults.

The Minnesota Legislature has since come through with additional funding, enabling TXT4Life to expand from one regional coordinator to seven, covering 39 of Minnesota's 87 counties.

TXT4Life has been successful because of the program's partners' commitment to playing a role in suicide prevention with young people, with over 70 memoranda of understanding and contracts with schools, government agencies, mental health clinics, tribes, non-profits, trainers, and others.

Based on text comments, TXT4Life has been the first connection some people have had to any mental health services. Others use it in between their therapy sessions as an immediate crisis resource.

"TXT4LIFE is honestly a great organization. The people who respond to you are truly caring, and they try their best to understand what you're going through. I have used this service many times, and each time I feel cared about, and decide not to harm myself. The very first time I used TXT4LIFE, I was going to end my life. But I remembered that I had this number saved in my phone from a poster at school, and I texted it. When the conversation was over, I ended up deciding to tell my mom to bring me to the hospital, instead of committing suicide. Thank you so much. You are all amazing."

– Anonymous, 2014

Contact The Author

txt4life

Meghann Levitt
Northeast Minnesota TXT4Life Coordinator, Carlton County Public Health and Human Services
14 N 11th St., Cloquet, MN 55720
218-878-2846
meghann.levitt@co.carlton.mn.us
www.txt4life.org

The Psychosis Identification and Early Referral (PIER) Model

William R. McFarlane, M.D.

PIER Training Institute, LLC

The Problem

Psychosis is the most severe disorder that strikes the largest number of adolescents and young adults. Psychotic disorders affect about 2.5% of the population and most often first appear when a person is in his or her late teens or 20s. They tend to affect men and women equally. Many of the young people affected are above-average in intelligence, athletic ability or creativity. The burden of the psychotic disorders on individuals, their families and society as a whole is very substantial. If the first episode marks the onset of schizophrenia, there is a 60-75% likelihood of a subsequent episode and a lifetime of full disability, including a heightened risk of suicide, incarceration, and homicide. The National Academies of Sciences, Engineering, and Medicine estimate that the total economic cost of all mental disorders among those under age 25 was $247 billion in 2007. For schizophrenia alone, the annual cost was the same as the Iraq War, $61 billion.

However, it is increasingly clear that for many people there is a substantial amount of time within which it is possible to identify pre-psychotic ("prodromal") symptoms, allowing preventative intervention that can avert the most common and persistent residual effects. In that regard, psychotic disorders are quite similar to cancer and heart attacks. Typical and early warning signs of psychosis range from a worrisome drop in grades and job performance to mistaking noises for voices and being suspicious or displaying uneasiness with others.

...the total economic cost of all mental disorders among those under age 25 was $247 billion in 2007.

For schizophrenia alone, the annual cost was the same as the Iraq War, $61 billion.

The Solution

Early intervention can transform the way society addresses severe mental illness, reducing the severity of psychotic illness, keeping young people in school or at work and putting them on a path to better health. Early intervention can mitigate symptoms, decrease rates of onset, cut hospital stays, reduce interruptions to school and work, and promote faster and longer response to treatment. Early intervention has the potential to empower young persons and their families to manage the illness and their own life course while reducing spending on mental health treatment and care. And one of the most successful models to date has been Psychosis Identification and Early Referral (PIER).

PIER is an early detection, intervention and prevention approach for adolescents and young adults between the ages of 12 and 25. It focuses on the pre-psychotic ("prodromal") and early active phase of a developing psychotic illness. The prodromal and very early phases are a time when psychotic disorders are highly treatable and interventions may set the foundation for an unusually good outcome and long-term prognosis. This model includes early identification of those individuals with prodromal and active symptoms, as well as state-of-the-art treatment for as long as the person remains vulnerable. The PIER model is substantially more intensive and targeted to the individual and family's specific needs, compared to standard current practice.

## This new treatment model has three key parts:

Community outreach: The program establishes a community-wide network of early detection and referral for youth and young adults at risk for prodromal psychosis. PIER offers training to the provider community, particularly school-based professionals, primary care and pediatric physicians and mental health clinicians about the early warning signs and active symptoms of severe mental illness. It also helps teach community members (families, clergy, youth workers, students) how to identify young people who are showing either prodromal or active symptoms of major psychotic disorders.

Assessment: This treatment model relies on the Structured Interview for Prodromal Syndromes (SIPS) to assess whether a young person is in the prodromal phase. The interview consists of specific questions about the onset, frequency, duration, and intensity of symptoms in four areas: psychotic, negative, disorganization, and general symptoms. A person who rates between three and five on any one of the positive symptom scores has "Attenuated Positive Symptom Prodromal Syndrome," and is eligible to participate.

Treatment: This approach includes family psychoeducation (primarily in multifamily groups), a method for training families to work together with mental health professionals as part of an overall treatment plan; supported

The prodromal and very early phases are a time when psychotic disorders are highly treatable and interventions may set the foundation for an unusually good outcome and long-term prognosis.
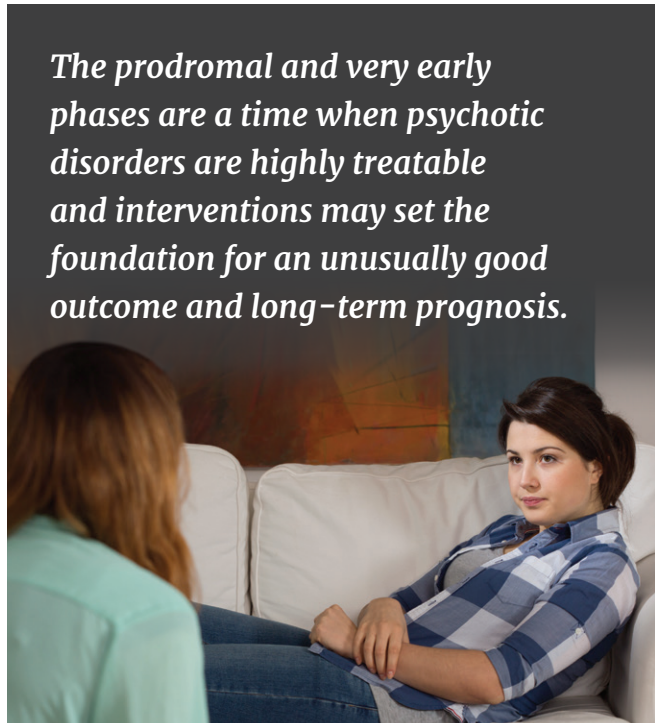
Developed and initially tested in Portland, Maine

1,103
Individuals Referred

139
Individuals Treated

▼26%
incidence of hospitalization for first-episode psychosis

▲8%
increased 8% in the three other urban areas of Maine

education and employment, i.e., active effort with schools and employers to assist youth staying in school and/or finding and keeping employment; occupational therapy, to assess functional strengths and guide supported education and employment; health and wellness interventions, emphasizing optimal nutrition and supplements, exercise, sleep and stress reduction; and low-dose medication, as indicated by the type and severity of symptoms. This approach has been shown to be particularly well suited to early phases of illness.

The PIER model was developed and initially tested in Portland, Maine, with impressive results. From 2001–2007, 1,103 individuals were referred and 139 were treated. Over that same period the incidence of hospitalization for first-episode psychosis dropped by 26%, while it increased 8% in the three other urban areas of Maine, yielding a net decrease of 34% in first hospitalizations for psychosis, attributable to the early intervention program.

The results seen in the Maine pilot have since been replicated across the country. A national effectiveness trial was undertaken in 2007 with support by the Robert Wood Johnson Foundation. PIER model programs were established in Salem, Oregon; Sacramento; Albuquerque; Ann Arbor; and Queens, while continuing in Maine. Outcomes for prodromal and very early psychosis patients were compared to a low-risk subsample receiving standard or no treatment, statistically adjusting for baseline differences in severity.

It is now highly desirable, from the standpoint of public health, maximizing of human poten-

tial and reducing the costs of health care, to begin implementing preventive services across the full range of communities in the United States.

However, PIER will need to continue to expand its base of financial support. On the federal level, an effort is currently underway to support early intervention services through collaboration by NIMH, SAMHSA and CMS. That has not yet supported local programs, but, when realized, could influence some commercial insurers to provide reimbursement for the same services under the Affordable Care Act. Some portions of the model are reimbursable under current commercial insurance plans in most areas.

The effects of implementation to date are so positive that there is a clear need to expand availability to as many youth as possible. In addition, expanding the public's understanding of the causes and influences on the onset of psychosis will enhance the effective treatment models already available.

Contact The Author

William R. McFarlane, M.D.
PIER Training Institute, LLC

380 Danforth Street
Portland, Maine 04102
207-210-2014 & 207-232-7273
mcfarw@maine.rr.com &
pti@maine.rr.com

The Behavioral Health Justice Center (BHJC)

Jennifer K. Johnson, J.D.
San Francisco, CA

Problem

In December, 2015, San Francisco took the rare and controversial step of voting down state funding for a new jail. By rejecting the $240 million new facility, San Francisco raised an important question: Why should we invest in a new jail when what we really need is a full-service facility for those with mental illness as they move through the justice system?

The jail has effectively become the largest mental health facility in the county—but there is still no system of care dedicated specifically to the mental health population.

In recent years, the overall county jail population in San Francisco has dropped to an historic low. Yet the number of inmates with serious mental illness has grown, as has the severity of their symptoms. The jail has effectively become the largest mental health facility in the county—but there is still no system of care dedicated specifically to the mental health population.

Expanding jail capacity or simply adding treatment services to existing jails is not good public policy. Correctional facilities are fundamentally places of punishment and control, not treatment and support. Likewise, expanding mental health programs in the community without correcting the underlying gaps within and between the mental health and criminal justice systems is equally flawed. San Francisco's mental health system is fragmented, inefficient, and historically resistant to working with clients entangled in criminal justice. This problem of mass incarceration cannot be solved until the deeply entangled criminal justice and mental health systems are addressed in tandem and with equal vigor.

In January 2016, San Francisco District Attorney George Gascón commissioned a group of experts to propose an alternative to the county jail replacement project. If implemented, it would be the first of its kind in the country, representing a comprehensive response to the evolving landscape of our intertwined criminal justice and mental health systems.

Solution

San Francisco should invest in a full-service Behavioral Health Justice Center (BHJC), a multi-level, tiered system of care founded on well-researched interventions that would allow for individualized assessment and treatment of people with serious mental illness.

A centralized Behavioral Health Justice Center would become an essential component in a well-designed system of behavioral health care in the community. The BHJC would minimize the disruptive impact of the criminal justice system in the lives of those with mental illness while enhancing access to services for people within the system.

To achieve this goal, San Francisco can apply the underlying principles of its nationally recognized Behavioral Health Court. Launched in 2002, the city's behavioral court helps redirect people with serious mental illness to community-based care. The BHJC would build upon this foundation. A centralized location for service delivery and referral would reach a wider population and intervene to address their treatment needs at an earlier point along the criminal justice continuum.

BHJC Design, Services, and Oversight

Facility Design

Level 1: Emergency Mental Health Reception and Respite Beds

In San Francisco, law enforcement has few options when responding to mental health crisis calls. Level 1 is a 24-hour venue to which law enforcement would transport those in mental health crisis. The first floor reception center would provide an initial assessment of mental health, physical health, substance abuse issues, and emergency care needs. A facility with on-site mental health assessment would save officers time, result in early identification of mental illness, and ensure better outcomes.

Level 2: Short-Term Transitional Housing

Inmates with mental illness who are eligible for release often languish in jail for months waiting for a bed in a program. Level 2 is a short-term transitional residential treatment program and would provide assistance with access to community treatment services. The ability to move people to a less restrictive level of care when they are psychiatrically stable would provide an easy and safe transition to community-based treatment.

Behavioral Health + *Justice Center*

...it should be unacceptable that the homeless person with mental illness is standing on the street corner in the first place — the status quo is shameful.

Level 3: Long-Term Residential Dual Diagnosis Treatment

Level 3 is an intensive residential psychiatric care and substance abuse treatment program.

In San Francisco, priority for residential treatment is granted to people entering treatment from either the public psychiatric hospital or the street—clients in jail are pushed to the bottom of the list. Co-locating a residential treatment program in the BHJC would expand capacity, facilitate a seamless transition to a less restrictive level of care, and reduce days waiting in jail.

Level 4: Secure In-Patient Mental Health Unit

Level 4 is a secure in-patient unit for mentally ill men and women who are approved for community treatment and waiting in jail for placement. Individuals would voluntarily transfer to this locked unit from the county jail with authorization from the court and consent of the public defender and district attorney. Moving clients with serious mental illness out of the county jail when they are psychiatrically stable would decrease jail population, reduce jail time, and create a safer atmosphere for correctional officers.

Moving clients with serious mental illness out of the county jail when they are psychiatrically stable would decrease jail population, reduce jail time, and create a safer atmosphere for correctional officers.

Other services: The center would be an ideal venue for problem-solving courts, classrooms, interview rooms, a family education center, and a peer mentor center.

Facility Services

The public finds it shocking when a homeless person on the street corner, screaming at invisible demons, lashes out or is shot by police. They blame the police, the criminal justice system, the homeless person for not taking medication. But it should be unacceptable that the homeless person with mental illness is standing on the street corner in the first place — the status quo is shameful.

Nationwide, the public mental health crisis has become a public safety crisis. Until a seamless system of mental health care is created that is accessible to all citizens, full criminal justice reform will fail. The U.S. has an unprecedented opportunity to craft public policy where the mental health and criminal justice systems intersect. The Behavioral Health Justice Center is a powerful starting point.

Contact The Author

Jennifer K. Johnson, J.D.
*San Francisco
Public Defender's Office*

*555 7th Street
San Francisco, CA 94103
415-553-1671*

The Integrated Healthcare and Substance Use Collaborative

Peter Holden

President & CEO, Beth Israel Deaconess Hospital–Plymouth

The Problem

Throughout the United States, hospitals and healthcare workers are on the front lines of the opioid epidemic that is ravaging communities, families, and individuals. According to the Centers for Disease Control and Prevention, more than 28,647 people died in 2014 as a result of opioid overdoses.

In Massachusetts, there were more than 1,000 opioid deaths in 2014 based on estimates from the Massachusetts Department of Public Health, and many of those deaths occurred in Plymouth, Massachusetts. According to the DPH Bureau of Substance Abuse, 45% of adults admitted for substance abuse treatment in Plymouth identify heroin as their primary drug of choice, compared to 40% for alcohol. Many of these individuals also have behavioral health needs that are too often ignored or misdiagnosed, leading those using drugs to spiral deeper into despair and, for many, death.

In 2009, there were 33 overdose deaths in Plymouth County.

In 2014, this number jumped to 72 overdose deaths, according Plymouth District Attorney Tim Cruz's Office.
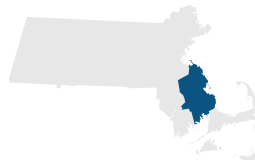
For healthcare workers, these numbers are not a surprise. In 2009, there were 33 overdose deaths in Plymouth County. In 2014, this number jumped to 72 overdose deaths, according Plymouth District Attorney Tim Cruz's Office.

Throughout Massachusetts, children, teenagers, and adults are dying in alarming numbers as a result of the runaway use of heroin and other opioids. Plymouth County, and Plymouth in particular, is at the center of this epidemic, fueled by cheap heroin, a lack of support programs, and cumbersome insurance rules and regulations.

Solution

Two years ago, Beth Israel Deaconess Hospital–Plymouth made a strategic decision to develop a comprehensive community approach to tackling the opioid epidemic in Plymouth, by removing barriers between the Emergency Department, primary care offices, and various community mental health and substance use disorder programs. The hospital also sought to increase involvement among the Plymouth school system, Police Department, and local courts.

What started as an initial pilot program at BID-Plymouth has now grown into the Integrated Healthcare and Substance Use Collaborative. The Collaborative is funded by a $3.7

Health and Drug Court in Plymouth.

The Integrated Healthcare and Substance Use Collaborative now employs psychiatrists, social workers and mental health clinicians in the Emergency Department, primary care offices, and a co-located Clean Slate office. Additionally, various outpatient treatment and support programs are provided by Learn to Cope, Highpoint Treatment Centers, CleanSlate, and the Plymouth County Drug/Mental Health Court.

The collaborative's goal is to help those struggling with mental health and addiction problems, and their family members, find the care they need, and follow them through their recovery. Many people who are addicted to opi-

> *The Integrated Healthcare and Substance Use Collaborative now employs psychiatrists, social workers and mental health clinicians in the Emergency Department, primary care offices, and a co-located Clean Slate office.*

million grant from the Massachusetts Health Policy Commission's Community Hospital Acceleration, Revitalization, and Transformation (CHART) investment program initiative, a $1 million private, anonymous donation, and ongoing fundraising by the hospital's Jordan Hospital Club volunteer fundraising group.

The Integrated Healthcare and Substance Use Collaborative consists of behavioral health providers embedded in BID-Plymouth's primary care practices and emergency department to ensure collaboration with existing community inpatient and outpatient behavioral and substance use disorder facilities. The Collaborative also includes the Plymouth Police Department, School System, and the Massachusetts Mental

oids such as prescription painkillers and heroin often have a dual diagnosis of depression, anxiety, trauma; others suffer from serious isolation and disenfranchisement which complicate access to services. Addressing their behavioral health needs and working with primary care to co-manage their physical health can better support their addiction recovery efforts.

Existing models generally treat the immediate presenting problem, but do not address the complex co-occurring issues in need of attention. BID-Plymouth's model goes deeper, working with those seeking help throughout the entire process — from presenting concern to aftercare.

Tackling the opioid epidemic by removing barriers between

Emergency Rooms ➤◄ Primary Care Offices ➤◄ Community Mental Health & Substance Use Disorder Programs

Initial Results

The pilot program kicked off in July 2014 and the full Integrated Healthcare and Substance Use Collaborative launched in October 2015. Although in the early stages, the Collaborative is making a significant impact. Some initial results in the first four months include:

- Approximately 1,100 "unique" mental health/substance use patients were seen in the Emergency Department in the first four months.
- Of the ED patients seen, approximately 40% received referrals to community-based services.
- Staff have been trained through Project COPE to identify which pharmacies have "standing orders" for Naloxone (NARCAN) rescue kits, where to obtain rescue kits for veterans, and how to access rescue kits for people without insurance and high utilization rates.
- On December 1, 2015, the Plymouth Police Department launched project OUTREACH (Opioid User Taskforce to Reduce Epidemic and Care Humanely). The program is a community-wide collaboration engaging professionals (clinicians, recovery coaches, and case managers) from BID-Plymouth, CleanSlate, High Point Treatment Center, Gosnold, South Bay, and the Court Clinic to provide follow up in the home 24-48 hours following an overdose. Project OUTREACH has been so successful that police chiefs in Middleboro and Carver implemented the program on March 1, 2016, with a county-wide rollout anticipated in the near future.
- BID-Plymouth installed a "MedSafe" drop box for unused medications to make it easier for the public to dispose of medications. In the first month, more than 40 gallons of unused medications were collected.

Conclusion

BID-Plymouth's Integrated Healthcare and Substance Use Collaborative is an important start for reversing the tidal wave of the heroin epidemic. The hospital is hopeful that the model created in Plymouth can serve as a template for hospitals across the United States.

More collaboration between hospitals, community groups, schools, and government agencies is needed. If not, the number of those overdosing on heroin will only increase, resulting in more innocent deaths. As stewards of the public's health, hospitals simply cannot let that happen to the communities they serve.

Contact The Author

Peter Holden
President & CEO
Beth Israel Deaconess
Hospital-Plymouth

275 Sandwich Street
Plymouth, MA 02360
508-746-2000

Adapting Critical Time Intervention as a Scalable Solution to Crisis Homelessness

Thomas Byrne, PhD

Assistant Professor Boston University School of Social Work

The Problem: Crisis Homelessness

In the United States, nearly 1.5 million people, or 1 in every 30 Americans below the poverty threshold, will experience an episode of homelessness at some point over the course of a year.

Homelessness is undoubtedly a serious social problem, but it is not intractable. The rapid expansion of permanent supportive housing (PSH) — an evidenced-based intervention defined broadly as subsidized housing matched with ongoing supportive services — has been linked with 22% and 35% declines nationwide in chronic and veteran homelessness, respectively, between 2009 and 2015

However, PSH is intended primarily for high-need individuals experiencing extended episodes of homelessness, who comprise only about 15% of the overall homeless population. Annual costs can exceed $15,000 annually as extensive services are needed. Alternative solutions that are less resource intensive but equally as effective as PSH are sorely needed for the bulk of the homeless population.

High-need individuals might best be described as experiencing "crisis" homelessness in that their time on the streets is fairly brief and is often preceded by a triggering event such as an eviction, dissolution of a relationship, or transition out of foster care, prison, inpatient hospitalization, substance abuse treatment program, or other institutional setting.

Estimates suggest that about 1.3 million persons, or roughly 85% of the overall homeless population experience crisis homelessness each year. About 915,000, or two-thirds, are single adults.

1 in every 30 Americans below the poverty threshold, will experience an episode of homelessness at some point over the course of a year.
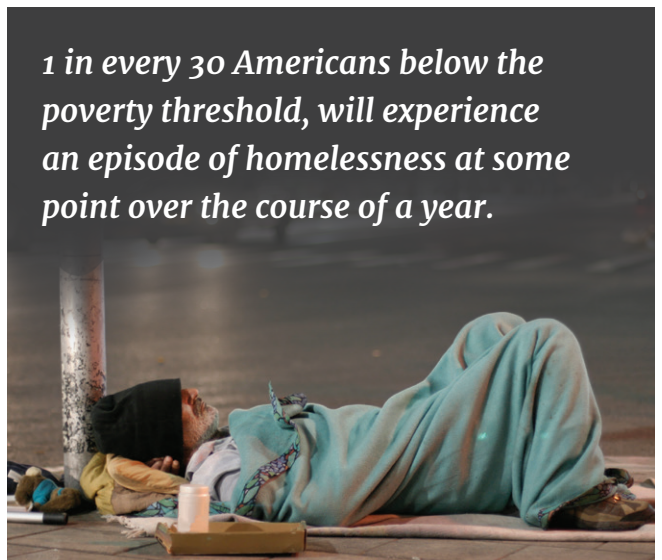
The Solution: Adapting Critical Time Intervention to Expand Rapid Re-housing

We propose to use Medicaid resources to leverage an existing evidence-based intervention known as Critical Time Intervention (CTI) as a means to greatly expand the availability of rapid re-housing for households experiencing crisis homelessness. CTI aligns closely with rapid re-housing, which likewise helps households experiencing homelessness to quickly regain stability by providing them with time-limited, but highly flexible forms of assistance.

Pioneered in New York City in the 1980s, CTI is based on the idea that providing limited support during a "critical" period of transition—typically nine months — is crucial for helping individuals develop and sustain a network of community-based supports over the long-term.

The "transition" phase, which commences prior to a participant's discharge from a shelter or other institutional setting, connects participants to the people and service agencies that will provide them with the necessary supports for community living. During a second, "try-out" phase, CTI caseworkers monitor how well the community supports are working and make adjustments. A third phase completes the transfer of care from the caseworker to the community-based forms of support. During this phase, the caseworker steps back even further in terms of providing direct services to ensure the network of supports operate independently of the caseworker. Rapid re-housing uses a similar, phased approach towards transitioning homeless individuals into stable housing.

 A reasonable estimate might benchmark the cost of rapid re-housing built around CTI at $2,500 at the low end to $6,900 at the high end. Even at the high-end, that is less than half the cost of recent programs to rehouse homeless veterans. There is evidence that the cost of CTI could be partly or totally offset by its benefits. Not only would demands on emergency shelters drop, but new research also points to reductions in both inpatient and outpatient mental health services as well. Recent guidance issued by Center for Medicare & Medicaid Services (CMS) suggests that most of the services that would serve the core of a CTI-based rapid re-housing program could be reimbursed by state Medicaid programs, providing the necessary resources to scale up such an approach with federal entitlement resources.

Using CTI as a means to expand rapid re-housing for persons experiencing homelessness would lead to improved social, economic, health, and quality of life outcomes for those receiving assistance while triggering substantial reductions in homelessness. Finally, the proposal would likely lead to lower costs for society as a whole, through a reduction in demands on emergency shelters, the criminal justice system, and other public services.

> *...the proposal would likely lead to lower costs for society as a whole, through a reduction in demands on emergency shelters, the criminal justice system, and other public services.*

Contact The Author
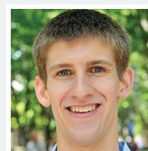
Thomas Byrne, PhD
Assistant Professor
Boston University
School of Social Work

64 Bay State Rd. Boston, MA 02215
617-358-0783
tbyrne@bu.edu

Getting the Mental Health System OnTrak™

Terren S. Peizer

CEO, Catasys

The Problem

Nearly 1 in 5 Americans suffer from mental illness. The majority of those with mental illness did not receive care in the last year. Even among those who did, the care often was either too brief or not of the appropriate kind. The problem is worse in communities of color, which use mental health services at less half the rate of the rest of the U.S. population.

Individuals with mental illness have five principal barriers to engaging in care:

1. They cannot be reliably identified in the primary care physician office;[11]

2. A portion will actively avoid seeking care;

3. Once identified, they may not be able to navigate and engage in care for the reasons noted above;

4. The care they receive may not be evidence-based;[12]

5. Once receiving care, they may not adhere to care or complete care.[10]

Nearly 1 in 5 Americans suffer from mental illness. The majority of those with mental illness did not receive care in the last year.

The Solution

Catasys is rolling out a scalable, integrated, outpatient mental health treatment solution. The Catasys' OnTrak™ Treatment Solution utilizes state-of-the-art, evidenced-based practices that are replicable and consistent in patient care and outcomes.[10]

OnTrak™ reliably identifies members with mental illness, engages them in a relationship with their assigned coach, and treats them with evidence-based approaches, while reducing avoidable utilization of medical services.

OnTrak™ uses claims-based analytics to identify individuals with behavioral health conditions who are expected to become acutely ill (especially medically ill) and incur morbidity and cost.

Through a proactive, multichannel-targeted outreach effort, OnTrak™ leverages motivational interviewing, decision theory and consumer engagement technologies to encourage individuals to participate.

Behavioral health network fidelity to evidence-based care is poor. OnTrak™ creates a specialized sub network of providers for the targeted population and uses levers unavailable to managed behavioral healthcare organizations to ensure adherence to evidence-based care. Pharmacotherapy and cognitive behavior-

al therapy are the mainstays of this approach, because the evidence base for their effectiveness is overwhelmingly positive.

OnTrak™ nurses coach members in an integrated fashion. They are aware of the treatment program, and assist members over the phone to support their progress through the program.

Behavioral and chemical relapses are managed in a supportive rather than punitive fashion to ensure a cycle of continuous improvement and the development of resilience.

Paraprofessional community care coordinators provide face-to-face support in the community for care navigation.

Members enroll at a 20% rate, are retained at an 80% rate, and total claims paid are reduced by over 50% in one year. Durable (50%) reductions in costs can be expected in the second year, and most likely in year three.

OnTrak™ developed an outpatient integrated program with the University of Washington (Seattle) and have expanded rapidly from there, with adopters including major health plans across the country. One of the first, Humana, Inc., has credited OnTrak ™ with improved patient health and reduced "hospital days," ambulance usage, and emergency room visits, reducing costs by 46%.

Given the level of cost savings OnTrak™ has produced, if the program was adopted across the U.S. healthcare system, it could cut mental health costs in half, from $100 billion to $50 billion.

Endnotes

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Humana, Inc., credited OnTrak™ with

↓ **46%**

reduced costs

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Contact The Author

Terren S. Peizer
CEO, Catasys
11601 Wilshire Blvd, Suite 1100
Los Angeles, CA 90025
Office 310-444-4321
Fax 310-444-4394
Terren@AcuitasGH.com

Coordinating Care For Individuals Transitioning Through The Corrections System

Richard A. Sheola

Vice President of Development, Beacon Health Options

The Problem

A majority of justice-system-involved individuals (nearly 65 percent) have mental health and/or substance use disorder needs and are at a higher risk of victimization, recidivism, and suicide.[1]

Correctional systems are fragmented between local and state agencies, probation and parole offices, and Medicaid agencies. Even when individual health information is available, there is no guarantee it will be fully shared between various agencies. Limited resources inhibit correctional facilities from knowing how community behavioral health agencies and/or psychiatric inpatient facilities served these individuals.

...when individual health information is available, there is no guarantee it will be fully shared...

Individuals incarcerated with mental health and substance abuse issues face three problems:

1. an unplanned disconnect with servicing providers and community agencies;
2. inadequate behavioral health services;
3. and failure to reconnect with community agencies upon release.

Solution

Beacon Health Options' web-based Jail DataLink (DataLink) program addresses these problems. DataLink compares daily public safety and corrections records on individuals in custody with state census and Medicaid eligibility data to "match" detainees. This data is used to identify and address detainees' medical, mental health and substance abuse issues and is shared with local Core Service Agencies, or CSAs, which coordinate care upon release. DataLink also works closely with the Maryland Department of Health and Mental Hygiene, the Behavioral Health Administration, the Department of Public Safety and Correctional Services (DPSCS), and the Mental Health Criminal Justice Partnership as well as county correctional officials.

Coordination Of Support Services

CSA staff receive incoming detainee and newly incarcerated individual DPSCS data via DataLink's automated daily update. With appropriate releases and permissions, correctional institutions and CSAs receive individual psychiatric history to improve treatment outcomes. This collaboration enables priority servicing and ensures necessary supports for high-risk detainees. DataLink updates diag-

nostic and medication changes during incarceration daily, which allows proactive discharge planning and follow-up care, while promoting community reintegration, improving adherence and linkage to follow-up care, and reducing recidivism.

Program Impact Analysis

Over the past year alone, DataLink has processed 144,236 records and matched them to 54,579 individuals receiving Maryland's Public Behavioral Health System services — a match rate of 37.8 percent. As a result, CSA staff and Beacon are able to treat detainees with mental health and substance abuse issues and ensure a readily available support system upon release.

As an active participant in the Mental Health Criminal Justice Partnership and in collaboration with the Maryland Mental Health Association and DHMH, Beacon spearheaded development of a clinical outcomes subcommittee. In collaboration with DHMH and Behavioral Health System Baltimore, Beacon developed an Institutional Review Board proposal to retain DPSCS arrest data to understand factors driving recidivism and develop meaningful program outcomes. Knowing re-entry and re-incarceration risks, Beacon continually improves interventions and designs programs to improve outcomes and assist community integration for ex-detainees. Maryland's preliminary data analysis indicates recidivism has decreased by 30% for individuals struggling with mental health and substance abuse issues.

Going Forward

Connecting individuals to needed care and support during and after incarceration is vital; however, Beacon also focuses on intercepting individuals with mental health and substance abuse disorders before incarceration. Through data sharing within correction and public health systems, Beacon can collaborate with drug and mental health courts and provide

services before trial. Enhanced by the DataLink program, Beacon's diversionary approach proactively identifies individuals diagnosed with mental health and substance abuse problems and diverts them from correctional facilities to community-based care, if appropriate. The presiding judge can be made aware of an individual's medical history and available support and services offered by the local CSA and Beacon staff as viable alternatives to costly incarceration. Therefore, Beacon's intervention can end the cycle of a minor infraction leading to housing and job loss, jail, decompensation, reduced functionality, and recidivism.

> **Preliminary data shows individuals struggling with mental health & substance abuse issues**
>
> ↓ **30%**
>
> **Recidivism**

Endote

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Contact The Author

Richard A. Sheola
Vice President of Development
Beacon Health Options

1000 Washington Street, 3rd floor
Boston, MA 02118
617-350-1977
beaconhealthoptions.com
www.beaconhealthoptions.com

Helping Veterans Prevail in the Battle Against Mental Illness

Richard Gengler
Prevail Health

The Problem

America is experiencing a mental health crisis of epic proportions and our country's veterans are once again on the front lines. To get a sense of the personal dimensions of this crisis, one need look no further than the tragic story of Clay Hunt, a gifted veteran who returned home from war and, afflicted by mental health issues, took his own life. Clay's death ultimately led to the passage of the Clay Hunt Suicide Prevention for American Veterans (SAV) Act. The National Institute of Mental Health (NIMH) estimates that roughly one in five Americans suffer from these mental illness in a given year.

The Substance Abuse and Mental Health Services Administration estimates that mental health care costs in 2009 amounted to $147 billion, which was more than 6.3% of all health spending and greater than 1% of the American GDP. Mental health is the leading cause of disability in the United States, according to the World Health Organization. These costs are estimated at $4,381 per person in lost productivity (Kessler 2008). More than half of people on disability have mental health issues (Melek 2008).

Social stigma means more than half of those afflicted by issues related to mental health suffer in silence instead of coming forth to receive treatment (Goetzel et al., 2004).

America is experiencing a mental health crisis of epic proportions and our country's veterans are once again on the front lines.

The Solution

Recently there has been a shift towards evaluating and using technology-based solutions for a variety of mental health services (Noble 2014). Using technology enables treatment providers to reach more people (Kazdin & Blase, 2011). Interventions such as online Cognitive Behavioral Therapy (CBT) provide an extremely scalable and efficacious model that also allows for anonymity, reducing the challenges associated with stigma.

Prevail Health is a clinically proven mental health prevention and management platform that is easily accessible for anyone with a smart phone or access to the Internet. Prevail, which has been working closely with the Veterans Health Administration, provides individualized one-on-one support, training, and resources for those living with depression, anxiety, and other life challenges, in the most convenient and private setting possible. By joining the community, those with disorders are able to interact with a group of people sharing similar experiences.

Prevail utilizes a model of acquire-engage-assess-triage, whereby reluctant care seekers are proactively acquired through digital marketing and social media efforts. Individuals engage with trained peer specialists, an interactive community, and a points rewards system. Both demographic as well as clinical assessments are given to build a profile of the user in order to create an individualized experience. Users are triaged into the appropriate level of care, which could be Prevail's clinically proven interactive programs, additional online resources, or for

Interventions such as online Cognitive Behavioral Therapy (CBT) provide an extremely scalable and efficacious model that also allows for anonymity, reducing the challenges associated with stigma.

high acuity cases, connection to traditional care. An independent review of Prevail's technology by the Agency for Healthcare Research & Quality (AHRQ) awarded it the highest evidence rating of 'strong,' and 94% of actual users said they would recommend it to their friends (AHRQ 2014).

The Veterans Health Administration has implemented this solution nationally for the last two years. In the last 12 months, over 110,000 veterans were impacted with more than 22,000 interactions; over 17,000 signed up, and over 2,000 higher acuity cases were sent for referral to the VA. At a high level, Prevail's technology is an acquisition and triage model for behavioral health. Prevail should be implemented nationally and provided to all citizens, in order to capitalize on a unique and timely opportunity to reduce mental health symptoms and overall health spending, while increasing the productivity of our country.

Contact The Author

Richard Gengler
Prevail Health

*1105 W. Chicago Ave, Ste. 203
Chicago, IL 60642*

Phone *929-272-9085*
Email *irving@prevailhealth.co*
www.prevailhealth.co

BETTER
GOVERNMENT COMPETITION

Pioneer Institute's Better Government Competition, founded in 1991, is an annual citizens' idea contest that seeks out and rewards the most innovative public policy proposals. The Competition grand prize winner receives $10,000; four runners-up receive $1,000 each, and other proposals receive special recognition. Recent winners have included proposals on pension reform, virtual schooling, job training, housing, and many other pressing topics.

History

2016 25th Anniversary
Improve the Quality & Access
to Care for Individuals Living
with Mental Illness

2015 Fixing Our Troubled Justice System

2014 Leveraging Technology to Improve Government

2013 Revving Up the Great American Job Engine

2012 Restoring Federalism

2011 20th Anniversary – Budget Busters

2010 Governing in a Time of Crisis

2009 Health Care Reform

2008 Sustaining School Reform

2007 Improving Government at the State and Municipal Levels

2006 Better Government Competition
15th Anniversary

2005 Streamlining Government

2004 State and Local Focus

2003 Innovative Ideas on Key Public Issues

2001 Law Enforcement, Education, Housing, Family Preservation

2000 Ideas Into Action

1999 A Wise and Frugal Government

1998 Streamlining Government

1997 Bringing Competition to State and Local Government

1996 Public Safety and Fight Against Crime

1995 Local Solutions to Public Problems

1994 Welfare in Massachusetts

1993 Improving Policies and Programs Affecting Children

1992 Improving Environmental Policies and Programs

1991 Restructuring/Privatizing State Operations

PIONEER INSTITUTE
PUBLIC POLICY RESEARCH