

Communities in Crisis: Local Responses to Behavioral Health Challenges

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Executive Summary

Cities and counties across the country are grappling with the devastating human and economic impact of the opioid epidemic and untreated serious mental illness (SMI). Ten million adults suffer from SMI, while drug overdoses claimed 60,000 lives in 2016, doubling in the last decade and topping annual deaths from car crashes and gun violence combined.^{1,2} The rapid rise in opioid addiction and the related fallout is straining local criminal justice systems, law enforcement, and community and public health resources beyond capacity. City and county leaders are on the front line and are responding by developing programs that engage and divert individuals with SMI and substance use disorders (SUD) to treatment and therapeutic settings. Thousands of these local programs have been established, each differing in scale and scope. Some are training law enforcement and other first responders in de-escalation tactics and establishing programs to connect individuals to treatment rather than incarceration. Others are creating diversion programs from the criminal justice system; establishing pathways for individuals to be directed towards treatment and away from the courts and jails. Despite the plethora of local programs, few have been thoroughly evaluated, making it challenging to identify and spread effective initiatives.

Local communities are confronting the fallout of untreated SMI and SUD, developing programs that can make a difference in the lives of individuals, families, and their communities. This report explores local initiatives through the lens of a taxonomy that was constructed to classify their salient features in an effort to identify critical success factors [see Figure 1]. Based on comprehensive research and a close examination of 13 locally-run programs that included interviews and site visits, this report identifies themes and critical success factors.

Initiative Objectives, Target Populations, and Intercept Points.

Local program objectives are rooted in addressing one or more manifestations of the local impact of untreated SMI and SUD. The majority are aimed at reducing crime, incarceration, and recidivism. As a result, “intercept points” – settings where the target populations are engaged and connected to therapeutic services – tend to be focused on law enforcement and the criminal justice system. Police are being trained to identify and direct individuals to treatment. Prosecutors, public defenders, and judges are creating processes to assess the mental health and addiction status of individuals at pre- and post-booking stages so that they may be diverted to treatment. While cities and counties generally target intercept points based on the problems and settings most impacted by untreated SMI and SUD, the

Figure 1: Taxonomy of Local Initiatives

Element	Description
Initiative Objective and Target Population	Purpose and goals of treatment and recovery initiatives targeting individuals with SMI and/or SUD that consume a disproportionate share of community resources.
Points of Engagement (“Intercept Points”)	Places and interactions in which initiatives engage individuals, including: (1) homeless shelters and places on the street where individuals experiencing homelessness may be living; (2) law enforcement and the criminal justice system; (3) other emergency first responders; and (4) schools.
Intervention Model	Models for engaging individuals and providing a therapeutic setting to deliver mental health and substance use disorder treatment and recovery services.
Sponsoring and Participating Agencies and Organizations	Lead agencies or organizations and partner entities involved in the initiative.
Type of Locality	Small: fewer than 100,000 inhabitants Large: 100,000 or more inhabitants
Funding Sources	City, county, and state general funds, earmarked fees and levies, Medicaid, and philanthropy.
Evidence of Success	Evaluations or other findings of return on investment, improvements in health outcomes and/or reductions in ED utilization, incarceration rates, recidivism, and homelessness.

most successful programs tend to draw upon a broad set of intercept points to cast a wider net and increase the number of opportunities to intervene.

Intervention Models. There are a wide range of intervention models, but a few predominate. Community policing crisis intervention teams have been deployed and customized in 2,600 localities to help safely de-escalate behavioral health crises. Law enforcement and post-booking diversion programs are increasingly common collaborations between police, prosecutors, community, and public and private health agencies allowing for arrested individuals to be directed to public and community-based treatment instead of incarceration. Less common, but promising, are jail-based and housing first models; the latter incorporates sustainable housing as a means to support long-term recovery. Many localities have adopted and are synchronizing multiple models, recognizing that none of the models on their own are sufficient to address the needs and impact of individuals with untreated SMI and SUD. Program success necessitates significant coordination across city and county agencies and community-based organizations to coordinate program elements and treatment and recovery services.

Sponsoring Agencies and Localities. Strong leadership within the city and county agency – judges, sheriffs, mayors, and others – is necessary to galvanize public and community support and secure access to public funding. In rural areas where the rate of opioid-related overdose deaths is 45 percent higher than in metro counties, community paramedicine programs that train and direct emergency medical service personnel to provide outreach, conduct behavioral health assessments, and support diversion show some promise in redirecting individuals towards more appropriate treatment settings.³

Funding Sources. All local initiatives are weaving together a patchwork of funding streams, including state and local general funds and targeted assessments or taxes, which are often coupled with contributions from local health system community benefit programs, local and national philanthropic organizations, and federal programs, such as those administered through the Substance Abuse and Mental Health Services Administration (SAMHSA). While Medicaid is the single largest funder of behavioral health services in the nation, most localities have not fully leveraged Medicaid. This failure to make maximum use of Medicaid suggests a breakdown in communication between state

and local officials, as states have generally been on the forefront of efforts to cover and treat individuals with SMI and SUD, including justice-involved populations and homeless individuals – precisely the target populations of these local initiatives.⁴

Evidence of Success. Successful programs are systematically aligning law enforcement, criminal justice, public health, health care, and social service resources to create client-centric systems of care that coordinate, improve access to, and deliver a broad spectrum of treatment, recovery, health, and social services for people with untreated SMI and SUD. Within these systems of care, we identified five recurrent success factors: partnerships between city and county agencies and community-based health and social service providers; access to health and social service benefits; discharge and care coordination plans with public and community-based health and social service providers; community support for local behavioral health infrastructure and services; and leveraging multiple funding streams to support program sustainability.

Further research however is needed to evaluate the effectiveness of local programs in breaking the cycle of substance use, and improving both physical and behavioral health and long-term recovery. Researchers should also assess the return-on-investment of local programs, including how costs and benefits accrue to participating agencies, community organizations, and other stakeholders.

The President's Commission on Combating Drug Addiction advanced recommendations to combat the opioid epidemic by eliminating the Institutions for Mental Disease exclusion within the Medicaid program, creating federal incentives to enhance access to medication-assisted treatment, enforcing the Mental Health Parity and Addiction Equity Act, and increasing first responder access to Naloxone; prompting the President to announce his intent to declare the opioid crisis a national emergency.⁵ As the opioid and mental health crises continue to gain national attention, local leaders are stepping up to implement programs to address the prevalence and impact of untreated SMI and SUD. While no one program can completely remedy these issues, further research on successful, scalable, and sustainable interventions will empower local leaders to invest in high-value initiatives that tangibly improve the well-being of communities suffering from and impacted by untreated SMI and SUD.

Endnotes

1. Katz, Josh, "Drug Deaths in America Are Rising Faster Than Ever," *The New York Times*, June 5, 2017, available at: <https://www.nytimes.com/interactive/2017/06/05/upshot/opioid-epidemic-drug-overdose-deaths-are-rising-faster-than-ever.html>.
2. The White House, *President's Commission on Combating Drug Addiction and the Opioid Crisis*, 2017, available at: <https://www.whitehouse.gov/ondcp/presidents-commission>.
3. Centers for Disease Control and Prevention, National Center for Health Statistics, *Multiple Causes of Death*, 1999-2013.
4. State Health Reform Assistance Network, *Medicaid: States' Most Powerful Tool to Combat the Opioid Crisis*, July 2016, available at: <http://www.statenetwork.org/wp-content/uploads/2016/07/State-Network-Manatt-Medicaid-States-Most-Powerful-Tool-to-Combat-the-Opioid-Crisis-July-2016.pdf>.
5. President's Commission on Combating Drug Addiction and the Opioid Crisis, *Interim Report*, 2017, available at <https://www.whitehouse.gov/sites/whitehouse.gov/files/ondcp/commission-interim-report.pdf>.

About the Authors

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Jonah Frohlich is a Managing Director at Manatt Health, where he helps health care organizations with strategy, policy, and regulatory advice. He works with health systems and academic medical centers, health plans, state governments, and philanthropic organizations.

To bolster improvements in medical care for individuals and high-risk populations, Jonah leads projects that enable physician-hospital integration, and align IT, clinical, financial, and administrative services.

Jonah also leads and facilitates complex multi-stakeholder engagements, and assists health systems and health plans with the development of accountable care organizations and clinical integration initiatives by creating and advancing strategic and business plans. In addition, Jonah publishes reports describing the impact of state and federal policy on public and private markets.

Before joining Manatt, Jonah was deputy secretary of health information technology at the California Health and Human Services Agency, where he facilitated policy, statutory, and regulatory changes needed to advance health information exchange. As the administration's top executive and advisor on health IT, Jonah was responsible for coordinating the state's \$1.5 billion initiative for the development, application, and use of electronic health records and secure information exchange.

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Deborah Bachrach is a Partner at Manatt Health, where she uses her significant experience with both public- and private-sector health policy and financing to help states, providers, insurers, and foundations analyze and implement the Affordable Care Act. She also counsels clients on Medicaid coverage, payment policies, delivery systems, and other healthcare reforms.

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