



Promising Solutions to our Nation's Behavioral Health Crisis

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Executive Summary

The country is facing a behavioral health crisis. Even with the increases in health care coverage that have come with the Affordable Care Act, more than 56% of Americans do not receive treatment for their mental illness.¹ The systems in place to deal with behavioral health challenges are often under-resourced and ill-equipped; jails, emergency rooms, and homeless shelters across the country are filled with individuals who have unmet behavioral and mental health needs. Because behavioral health is often intertwined with other challenges, including homelessness, substance use disorders, and incarceration, it is a particularly difficult problem to tackle.

Governments are seeking ways to address the complex challenges associated with behavioral health in order to provide individuals access to treatment, healthcare, and supportive housing. This policy brief provides recommendations to help governments address urgent behavioral health needs, while simultaneously shifting resources from crisis management to prevention. Based on a review of successful government policies, the following stand out as emerging best practices:

1. Identify and target the highest utilizers: Whether it is the highest utilizers of emergency health services, detox, or the criminal justice system, identifying the overlap in systems, high costs of the status quo, and the ineffectiveness of current systems can be used generate the momentum needed to create concrete solutions. Governments may choose to develop solutions for the top utilizers or those with more acute situations; but in either case, identifying and understanding the highest utilizers and the systems affected is a cornerstone step. The Denver Social Impact Bond project and the Los Angeles

Tenth Decile initiative are two examples of identifying and targeting the highest utilizers of the criminal justice system and emergency health services, respectively.

- 2. Implement criminal justice diversion and crisis response programs:** Many governments have worked to improve behavioral health programs within jail systems. While many of these efforts are laudable, they are directed at institutions that, by their very design, are not the ideal facilities for addressing behavioral health conditions. Governments across the country are demonstrating that behavioral health specific alternatives can be developed to divert individuals towards crisis response systems that are better able to address underlying behavioral health needs. Cities including Seattle, San Antonio, Memphis, Denver, and Los Angeles have implemented innovative programs including the co-responder model, crisis intervention training and stabilization units, problem-solving courts that connect case management with the judicial process, crisis centers, and law enforcement assisted diversion.
- 3. Ensure treatment programs are focused on retention:** Institutions often struggle to connect individuals exiting jail with appropriate community treatment. State and local agencies need improved systems for tracking individuals as they move between systems, so that they can use information in real time to improve the handoff to treatment and service delivery. Treatment programs starting in jail and connected to community services can be a vital piece of the solution. Louisville is currently designing a program focused on the critical transition from jail into community treatment.
- 4. Focus on long-term housing solutions:** Safe, secure, long-term housing is perhaps the best treatment for homeless individuals

¹ Mental Health America available at: <http://www.mentalhealthamerica.net/issues/state-mental-health-america>

suffering from behavioral health conditions. For many governments, however, it is often one of the hardest solutions to fund. Many communities are developing models and strategies for leveraging resources for both short- and long-term housing options. Permanent supportive housing, as in the Denver and Massachusetts Social Impact Bond projects, and respite/bridge housing, such as Central City Concern in Portland and Circle the City in Phoenix, are examples of jurisdictions focusing on transitions to long-term housing solutions.

As this brief will show, there are many efforts throughout the country demonstrating sustained progress and promising solutions to the nation's behavioral health crisis. These solutions can be learned from and implemented widely, so that we can collectively tackle one of the country's most challenging social issues.

I. Introduction

Who is the number one provider of mental health services in your state, city, or county? No matter where you are in the U.S., the answer to this question is likely to be the jail system.² The largest providers of mental health services across the country are jails: Cook County in Illinois, Los Angeles County, and Rikers Island in New York.³ Police officers, paramedics, prison guards, and other first responders have become the default practitioners in a country struggling to address the nation's behavioral health crisis. Behavioral health challenges have been consistently identified by governments as a priority issue, in part because the systems in place now to deal with these problems are largely under-resourced and ineffective.

Fortunately there are many efforts throughout the country demonstrating sustained progress and promising solutions to the nation's behavioral health crisis. These solutions are often focused on diversion and prevention, and require a fundamental shift in how governments approach the areas of behavioral health and housing. While behavioral health is not synonymous with homelessness, the growing

lack of affordable housing in cities across the country has exacerbated the epidemic of homeless individuals that suffer from behavioral health conditions, particularly mental health and substance use disorders.⁴

The Harvard Kennedy School Government Performance Lab (GPL) has provided pro-bono government-side technical assistance to over 50 jurisdictions across the country on projects focused on driving better outcomes in areas including behavioral health, homelessness, criminal justice, and substance use disorders. In New Mexico, the GPL has worked with Bernalillo County to develop a system for spending and monitoring the effectiveness of approximately \$20 million/year in sales tax dedicated to behavioral health. In Denver and Massachusetts, the GPL worked to develop comprehensive systems for funding and building permanent supportive housing. In Louisville, Kentucky, the GPL is working with the Department of Corrections to design a system to discharge individuals with substance use disorders from jail into treatment. In Seattle, the GPL helped redesign the system for contracting for homeless services, gearing it more towards housing permanence. Several new projects in additional jurisdictions are just starting.

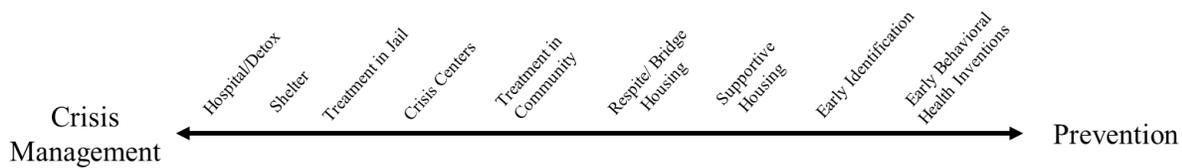
Based on the GPL's direct project work tackling behavioral health related issues across the country and also on site visits GPL staff have made to observe other innovative jurisdictions, this policy brief provides recommendations for governments as they explore initiatives to address behavioral health needs with a particular focus on the most vulnerable individuals. In particular, it is recommended that governments 1) identify and target the highest utilizers to serve, such as homeless individuals with frequent jail stays; 2) implement criminal justice diversion, crisis response programs, and transitions to community treatment, and 3) provide long-term solutions focused on housing and on retention in treatment and services. The ultimate goal is to address current behavioral health needs while accomplishing a larger shift in allocating resources toward prevention efforts that identify and address behavioral health efforts early.

² USA Today available at: <https://www.usatoday.com/story/news/nation/2013/10/20/kennedys-vision-mental-health/3100001/>

³Ibid.

⁴National Coalition for the Homeless available at: http://www.nationalhomeless.org/factsheets/Mental_Illness.pdf

II. A Framework for Change



Mayors and Governors are often faced with a Catch-22: respond to the immediate and growing behavioral health crisis while not spending too much on remedial programs that preclude longer-term preventative solutions. Concerns for immediate public safety will almost always supersede programs that address the early stages of behavioral health challenges, even though the latter programs may have greater long-term effects and returns.⁵

Given the current fiscal environment, attempting to address all problems at once might lead to a diluted strategy that fails to demonstrate any sustained progress. Instead, picking two or three extremely important projects/initiatives could build the long-term momentum needed to sustain a much larger transformation.

To address current homelessness and behavioral health needs and accomplish a larger shift in where resources are allocated (i.e. from crisis management towards prevention), it is recommended that governments focus on four main areas:

1. *Identifying and targeting the highest utilizers*— Whether it is the highest utilizers of emergency health services, detox, or the criminal justice system, identifying the overlap in systems, the high costs of the status quo, and the dismal outcomes of current efforts can be used generate the momentum needed to create concrete solutions. Governments may choose to develop solutions for the top utilizers or those with more acute situations; but in either case, identifying and understanding the highest utilizers and the systems affected is a cornerstone step. Identifying and targeting highest utilizers across systems

can help maximize the government’s impact by providing services to the most at-risk individuals, and showing that it is possible to reduce the high costs of remedial services. It can also be a critical step toward identifying the whole population of those in need, developing an appropriate service array, and connecting the right people to the right services.

2. *Criminal justice diversion and crisis response*— Many governments have worked to improve behavioral health programs within jail systems. While these efforts are laudable, they are directed at institutions that, by their very design, are not the ideal facility to address behavioral health conditions.⁶

Governments across the country are demonstrating that behavioral health specific alternatives can be developed to divert individuals towards crisis response systems that are better than jails at addressing underlying behavioral health needs. These systems often involve strong partnerships with police and sheriff’s offices.

3. *Better support and monitoring in the transition to community treatment* — Even when strong diversion programs are implemented, there will still be individuals exiting corrections and hospital systems in need of substance abuse treatment and behavioral health services. These institutions often struggle to effectively connect individuals with care they need in the community. State and local agencies also need improved systems for tracking individuals as they move between systems, so that they can use information in real time

⁵ SAMHSA available at: <https://www.samhsa.gov/capt/practicing-effective-prevention/prevention-behavioral-health>

⁶ NACo available at: http://www.naco.org/sites/default/files/documents/Addressing%20Mental%20Illness%20-%20Full%20Report_updated.pdf

to improve the handoff to treatment and service delivery. Examples of key benchmarks for systems to track include: (1) successful initiation of community treatment, (2) treatment engagement and progress, and (3) the medium- and long-term outcomes of individuals referred to behavioral health treatment.

4. *Long-term solutions focused on housing*— Safe, secure, long-term housing is perhaps the best treatment for homeless individuals suffering from behavioral health conditions.⁷ But, for many governments, it is often one of the hardest solutions to fund. Many communities are developing models and strategies for leveraging resources for both short- and long-term housing options.

III. Identifying and Targeting the Highest Utilizers:

In a perfect world, governments would have an integrated database within homelessness and behavioral health, one that helps prioritize which individuals to connect with specific services, and allows agencies to know which other agencies are interacting with the same individuals. However, if every government waited for this to exist before proceeding on behavioral health initiatives, no progress would be made. Governments need to start somewhere *and then* begin to think about larger systems.

Because the highest utilizers are often known to a lot of systems, targeting the highest utilizers to serve is one method for demonstrating tangible progress to a large array of partners while developing the building blocks of larger infrastructure that includes multiple systems. The Denver Social Impact Bond Program and the Los Angeles Tenth Decile projects offer two examples of how governments might begin with tangible initiatives:

- **Denver Social Impact Bond Program⁸:** In 2011, the Denver Crime Prevention and Control Commission (DCPCC) began the process

of tracking the top 300 utilizers of the county court system. These individuals were interacting frequently with the court system due to citations involving public nuisance, public consumption of alcohol, trespassing, and low-level drug offenses. Often times, the citations were not enough on their own to warrant jail time, but because these individuals would not show up in court after their citations, they would be issued a bench warrant for their “failure to appear.” On average, this group of 300 individuals was responsible for more than 17,000 days in jail per year.

Starting with this list of 300 high utilizers of court and jail services, the DCPCC asked its partners, the Denver Health and Hospital Authority (DHHA), other criminal justice systems, and various homeless service organizations to check the utilization of their services among this high user population. Data sharing agreements allowed partners to share de-identified and aggregate-level data, meaning DCPCC could see the utilization among the population, but not attribute particular utilization to a single individual. This process allowed DCPCC to comply with privacy concerns while still moving relatively quickly.

The utilization data became the basis for several initiatives in Denver. This group of 300 individuals was using detox services, emergency rooms, and other costly emergency health services at very high rates, but they were not accessing shelter and other homeless services in large amounts. In a given year, an individual on this list would spend close to 60 nights in jail, be arrested eight times, visit detox eight times, and make two trips to the emergency room. The emergency health system and the criminal justice system had become the default response system for this group of individuals who largely were dealing with underlying behavioral health conditions. In response to these findings, the DCPCC was able to demonstrate the costs of the status quo as well develop responses ranging from a problem-solving court that provided case management and creative sentencing to a large-scale supportive housing initiative.

⁷ USA Today available at: <https://www.usatoday.com/story/news/nation/2014/08/27/mental-health-homeless-series/14255283/>

⁸ City of Denver available at: https://www.denvergov.org/content/dam/denvergov/Portals/344/documents/Denver_SIB_Summary.pdf

The Importance of Using Data

Whether it's targeting the high utilizers of safety-net services or demonstrating the enormous breadth and costs of the current behavioral health crisis, data analysis is fundamental. By targeting a specific group of individuals and building the case for intervention using data, governments can:

- **Generate partnerships:** By demonstrating that a particular set of individuals uses multiple systems and generates high costs for very minimal outcomes, data can form the basis of a larger partnership. Issues seen primarily as criminal justice problems can be also seen as health or housing problems.
- **Secure additional payment mechanisms:** By demonstrating the costs of particular populations, state and local governments can leverage funding partnerships that bridge levels of government, access opportunities within the Medicaid system, or generate momentum for increased funding. For example, the efforts within Denver led directly to conversations about the increased use of Medicaid as a funding stream for behavioral health supportive services.
- **Target vulnerable and underserved populations:** Most homelessness and behavioral health programs are over-subscribed, meaning that they often have waitlists for enrollment in their programs. While it is often much easier for organizations to enroll individuals who are proactively seeking services, these individuals are not always the highest need or highest priority for the government. By focusing on high utilizers, governments can place specific attention on individuals who might not proactively seek services, but represent the largest behavioral health challenges and would benefit the most from an intervention.
- **Track progress (e.g. understand baselines and impact):** Most ten year plans to end homelessness have not ended homelessness, but have made progress. It is important that governments develop baselines to properly describe the scope of the problem and demonstrate the extent to which programs are making progress with a particular population and how the government's overall strategy is making an impact.
- **Provide the appropriate service array:** As exemplified by Denver and Los Angeles, data was critical to developing the right service array for individuals. Many communities have made great progress in developing coordinated access and assessment tools, but digging deeper into data and targeting specific populations allows governments to purchase services that match the needs of the target population.

- **Los Angeles Tenth Decile Project⁹:** The Los Angeles Tenth Decile project focuses on connecting high-utilizers of hospitals and emergency health services to housing and integrated healthcare services. Similar to Denver, the project targets high-utilizers of county services who are experiencing homelessness, but with a specific focus on the health system.

Launched in 2011, the Tenth Decile project aims to house individuals experiencing homelessness who are frequent users of health and emergency services, and typically cost public systems over \$70,000 annually per person. Tenth decile refers to the population of people experiencing

homelessness who are at the top 10% of highest-cost and highest-need in the county. Individuals in the target population often have co-occurring disorders, including chronic health conditions, mental health diagnoses, and/or substance use disorders. They are high utilizers of emergency services and are less likely to access medical help through primary care.

Hospital staff were trained to identify potential participants and use a triage tool to screen for eligibility. The triage tool uses demographics and health status to predict the likelihood that an individual is in the top 10% of cost and need. Once deemed eligible, participants are referred to intensive case management services coordinated by a Tenth Decile case manager. The case manager is responsible for linking homeless service providers, health centers, substance abuse treatment providers, and

⁹ CSH available at: <http://www.csh.org/wp-content/uploads/2015/10/Frequent-User-Initiative-Profile-Booklet-10th-Decile-Project-Final.pdf>

hospitals to provide coordinated health services and supportive housing to the participant.

According to studies of the program, 68% of patients in the 10th decile were engaged as program participants by the navigators and virtually every patient who remained engaged obtained permanent supportive housing (98%).¹⁰ Through this targeting and direct connection to services, the program was able to demonstrate a framework for lasting impact.

IV. Crisis Response and Diversion:

Stories of police officers being asked to respond to mental health crises or jails attempting to develop comprehensive behavioral health response systems have become too common in a country where our criminal justice system is used to solve behavioral health issues.

Communities need to better equip first responders to address behavioral health; but more importantly, they need to develop alternative solutions that divert individuals from jail in the first place. Diversion programs will not solve behavioral health problems on their own and should not be a substitute for long-term housing and treatment efforts, but they are an important component of transforming our response to behavioral health.

The following are promising examples of crisis response and diversion programs that are moving the needle on responding to behavioral health issues.

Crisis Response:

It may be inevitable that the first contact of a homeless individual suffering from behavioral health issues is with a police officer or paramedic, but the next steps and options for that first responder can and should be adjusted away from jail and emergency rooms. Many communities have started preparing first responders for these situations to a greater degree and more advanced communities have developed alternative crisis responses that better address the need of individuals and first responders.

- **Crisis Intervention Training (CIT):**

CIT trains law enforcement officers on effective responses to individuals experiencing behavioral health crises. Police officers, who are often the first-responders, are trained to help people with mental illness and/or substance use disorders access medical treatment instead of placing them in the criminal justice system due to illness-related behavior.¹¹ Participating police officers receive 40 hours of instruction from community-based behavioral health experts and

Key Measures of Alternative Systems of Care

While there are several measures that programs can use to assess program progress, there are five main measures that governments should focus their attention:

- **Diversions**— How many or what percentage of individuals with behavioral health issues are successfully diverted from jail, detox, or emergency rooms?
- **Connections / Hand-offs**— Did the program or location (e.g. jail) connect the individual to longer-term treatment options or additional services such as housing and employment? How many or what percentage of individuals actually received services after their referral?
- **Retention in Treatment Programs**— Of those individuals entering treatment programs, how many or what percentage actually completed treatment?
- **Longer-Term Housing Stability**— How many or what percentage of individuals connected to housing maintain that housing over a set period of time (ideally, more than a year)?
- **Recidivism**— How many or what percentage of people return to the systems or programs?

¹⁰ Economic Roundtable available at: <https://economicrt.org/publication/getting-home/>

¹¹ CIT available at: <http://www.citinternational.org/Learn-About-CIT>

previously trained CIT officers, and from individuals who live with behavioral health disorders and their families. After completing the training, officers are meant to: 1) understand the signs and symptoms of mental illness and co-occurring disorders, 2) recognize behavioral health crisis situations, 3) safely de-escalate individuals experiencing behavioral health crises, and 4) utilize the community resources and diversion strategies to provide emergency assistance.¹²

- **Co-Responder Model:**

Some police departments across the country are using a co-responder model in response to the growing behavioral health crisis. In the co-responder model, a mental health professional works with police officers to respond to incidents with individuals experiencing a mental health crisis. In Denver, mental health workers are partnering with police officers on foot and in their patrol cars to help people experiencing behavioral health crises receive treatment instead of jail time.¹³ Six professionals of the Mental Health Center of Denver are working at police headquarters as part of the co-responder program, responding with officers to calls that are flagged for suspected mental health issues. During a test phase of the program, the teams responded to 427 calls, 408 of which resulted in diversion to medical treatment or social services instead of jail bookings.¹⁴

Los Angeles was one of the first communities to utilize this approach and has had a co-responder model in place since 1993. The police partner with the LA County Department of Mental Health to use co-responder teams in order to link individuals with mental illness to appropriate services.¹⁵ In 2005, Los Angeles also launched the Case Assessment and Management Program (CAMP), which focuses on individuals who have a mental illness and

frequently make emergency calls. Police detectives are paired with psychologists, nurses and/or social workers to develop long-term solutions for these clients.¹⁶

San Antonio's co-responder unit is just one part of their larger system of behavioral healthcare, which includes a crisis center for psychiatric and substance abuse emergencies, a 22-acre campus for the homeless, and thousands of emergency responders trained in managing mental health crises. Over an eight year period, local officials report over 100,000 people diverted from jail and emergency rooms to appropriate treatments and a savings of nearly \$100 million.¹⁷

- **Community and Mobile Crisis Teams:**

Mobile crisis teams provide acute mental health crisis stabilization and psychiatric assessment services to individuals within their own homes and in other sites outside of a traditional clinical setting. Studies suggest that mobile crisis services are effective at diverting people in crisis from psychiatric hospitalization, linking suicidal individuals discharged from the emergency department to services, and linking people in crisis to outpatient services.¹⁸

Diversion:

Too often, officers are left with an unfortunate tradeoff; do very little in response to an individual or take that individual to an expensive and ineffective system, whether that be jail or the emergency room. Officers and first responders rightly become frustrated when they start to know individuals on a named basis and watch them cycle in and out of system untreated. Diversion centers or programs are one solution that can ameliorate this problem.

- **Crisis Centers (Crisis Stabilization Units):**

There are different versions of crisis centers, but a growing trend towards crisis centers targeting homeless individuals has emerged in that past decade. These centers typically include a crisis triage and stabilization component as well as a

¹² CIT available at:

<http://www.citinternational.org/resources/Pictures/one%20page%20Overview%20of%20CIT.pdf>

¹³ Denver Post available at:

<http://www.denverpost.com/2016/09/02/mental-health-workers-join-denver-police-officers-to-help-divert-people-to-treatment-instead-of-jail/>

¹⁴ Ibid.

¹⁵ CDCR available at:

<http://www.cder.ca.gov/COMIO/Uploadfile/pdfs/2016/April20/MEU%20Program%20Outline%20updated%20UPDATE%204-13--2016.pdf>

¹⁶ Ibid.

¹⁷ Boston Globe available at:

<https://www.bostonglobe.com/metro/2016/12/10/the-san-antonio-way-how-one-texas-city-took-mental-health-community-and-became-national-model/o8HLKSq1JdXSTZppaEck2K/story.html>

¹⁸ NCBI available at:

<https://www.ncbi.nlm.nih.gov/pubmed/10970919>

step-down housing opportunity. In an ideal scenario, an individual would enter the front door, receive services that start them on their way to treating their condition, and exit the back door to a stable housing option.

In 2012, the Crisis Solutions Center opened in Seattle. The Center operates in a voluntary inpatient setting, where mental health and chemical dependency professionals work with an individual to stabilize their current crises as well as to refer them to longer-term assistance and housing. The Center has a Crisis Diversion facility, where clients referred by first responders may stay for up to 72 hours to receive psychiatric services, mental health and chemical dependency assessments, and intensive case management. The Center also has a Crisis Diversion Interim Service, where clients referred from the Diversion facility may stay up to 14 days for access to behavioral health services and case management.¹⁹

In 2008, the Roberto L. Jimenez M.D. Restoration Center opened in San Antonio. It serves as a clinic that offers psychiatric care, substance abuse treatment services, general health care, and transitional housing. The Center's 'Extended Observation Unit' is used primarily for crisis stabilization, where individuals experiencing a mental health crisis can receive treatment and referrals from staffed psychiatrists. This crisis stabilization unit is also a hospital diversion program, and saves taxpayer dollars by serving clients in a less costly and more appropriate setting. The Center has a variety of other programs including a Sobering Unit, Detox Room, Crisis Care Center, Injured Prisoners and Minor Medical Clinic, Opioid Addiction Treatment Services, and Outpatient Transitional Services.²⁰

- **Problem-Solving Courts:**

"Homelessness Courts," "drug courts," or other non-traditional courts work to provide treatment integrated within the criminal justice process. They often provide greater flexibility in determining appropriate sentencing as well as aligning the judicial system with preventive community programs.

¹⁹ DESC available at: <http://www.desc.org/documents/CSC%20Information%20Sheet.October%202013.pdf>

²⁰ Ibid.

Denver's Recovery Court targets frequent offenders who are chronically homeless and in and out of jail for low-level public-nuisance offenses. The City is linking data from the jail, hospital, and social services systems in order to identify the appropriate target population and match them to the right rehabilitation services. The target population for the Recovery Court is chronically homeless individuals who have accumulated the highest number of court cases over the last seven years. Through the program, these individuals are released from jail and placed into court-supervised probation. They are given temporary housing, assistance with chemical dependency, and daily supervision from caseworkers trained in mental health.²¹

- **Law-Enforcement Assisted Diversion (LEAD):**

In 2011, the LEAD program was launched in Seattle to help divert individuals experiencing mental health crises from the criminal justice system. Through the program, police officers and district attorneys use their discretion at the point of contact to divert individuals for law violations driven by behavioral health issues from jail to a community based intervention. Diverted individuals are referred to intensive case-management services which include access to transitional or permanent housing and drug treatment. Instead of (re)entering the criminal justice system, individuals are connected to a service plan and supportive resources in an effort to achieve behavioral change.²² Many other jurisdictions in the US are interested in expanding the LEAD model, and the LEAD National Support Bureau exists to help jurisdictions in developing and implementing the LEAD program in their communities.²³

V. Better Support and Monitoring During the Transition to Community Treatment

Often, the systems determining whether an individual needs behavioral health treatment are not those responsible for delivering and paying for that treatment: A man asking for access to

²¹ Denver Post available at: <http://www.denverpost.com/2015/03/20/mever-denvers-recovery-court-is-working-wonders/>

²² Lead Bureau available at: <https://www.leadbureau.org/about-lead>

²³ Lead Bureau available at: <https://www.leadbureau.org/>

substance abuse treatment as he is released from a local jail; a woman leaving the emergency room after a mental health crisis in need of counseling and support; a parent referred to treatment by their case manager from the child welfare system. Successfully transitioning individuals into care across systems is complex and requires thoughtful planning, assignment of responsibility across systems and a clear plan for monitoring individuals and their progress in real time. As the opioid crisis hits many of our communities, figuring out how to better integrate these systems and hold them accountable to one another becomes even more pressing.

- **Louisville, Kentucky: Discharge Planning**

Louisville has been among the communities in Kentucky hardest hit by the state's rise in opioid use. In 2014, the Louisville Metro Department of Corrections (LMDC) logged 6,100 bookings for individuals in need of detox services and by 2016 the detox log had grown by more than 60% -- surpassing 9,900. Through matching their detox log with jail bookings data, LMDC determined that individuals passing through their detox unit were more likely to recidivate and serve more jail days than those not in need of detox services.

To curb the rise in recidivism among this population and reduce associated costs to the jail, LMDC embarked on the process of planning a project to connect individuals with a warm handoff to local substance abuse treatment providers and free comprehensive treatment. As part of the planning process, LMDC and its project partners are intensively mapping the steps to transition an individual from custody to treatment -- from identifying individuals eligible for the project to arranging timely transportation and orientation on site at the treatment provider. Staff of LMDC and the treatment providers have also jointly determined the responsible party for the individual's walk through each step to increase the odds of a smooth transition into community treatment.

Beyond intentional planning for discharge coordination, the discharging entity also needs to set up systems to assess the success of individuals they refer to behavioral health treatment. Local and state institutions can work with community providers to log key outputs in

a treatment process including:

- *Take Up*: Whether an individual accepts an offer for substance abuse treatment;
- *Enrollment*: An individual's successful attendance for a first appointment and assessment;
- *Engagement*: Ongoing attendance and adherence to their treatment plan;
- *Completion*: The percentage of the individual's treatment plan completed and;
- *Long-Term Outcomes*: Rates of 1-year recidivism, overdose fatalities, NARCAN administration and emergency room use among the population connected with services.

VI. Long-Term Housing Opportunities:

A crisis response system will only truly be successful if it is complemented with long-term solutions that include housing and ongoing treatment. Strong diversion and crisis response efforts can successfully break the cycle of criminal justice involvement, but individuals might become stuck in a cycle of diversion programs that do not lead to long-term stability.

Respite programs provide many individuals with a needed transition into permanent housing options and permanent supportive housing, as indicated by its name, provides long-term housing opportunities.

Permanent Supportive Housing

Supportive housing can be a solution for many different types of individuals suffering from homelessness, including seniors, families, and individuals with behavioral health conditions. Typically, this model combines a Housing First approach with wraparound services, which focuses on providing permanent supportive housing as quickly as possible and then offering supportive services to help individuals sustain housing. Under this approach, supportive housing tenants are not subject to additional conditions of tenancy, including participation in treatment or other services. Studies have found this to be a more effective model in engaging clients and generating long-term outcomes, compared to other models which require sobriety or enrollment in services before receiving housing.

- **Denver Social Impact Bond Program²⁴:**

Denver, like many other communities, had created a ten-year plan to end homelessness that started in 2005. The plan included additional Housing First units to address chronic homelessness. Unfortunately, Denver was not able to connect all of its homeless residents with stable housing by 2015 and was in a situation where few new Housing First units were being generated. It was difficult to find vacant units, and more importantly, the critical service funding for those units that were being generated was hard to come by.

As mentioned previously, the Denver SIB program targets high utilizers of jail and other safety-net services. Housing at least 250 individuals, the program is based on a proven model that combines the approaches of Housing First with a modified Assertive Community Treatment (ACT) model of intensive case management. Services within the program include case management, crisis intervention,

substance use counseling, mental health treatment, peer support, skills building, connection to primary care, and various other services identified as appropriate to the client's goals.

Through this project, the City was able to bring together a partnership that has leveraged multiple levels of funding, including from foundation, State, and Federal sources. Traditional housing financing resources, including Low-Income Housing Tax Credits and housing vouchers, were combined with increased Medicaid payment for services as well as City funding in the form of future outcome payments. Engaging both the State Medicaid office as well as the local Managed Care Organization (MCO) has helped to develop a model for how services could be funded in future years and projects.

Key Lessons from Denver Social Impact Bond Program

The Denver program is still in the early years of implementation, so long-term outcomes and results are not available. Yet, the project has already shed light on many key lessons:

- **Targeting Highly-Vulnerable Individuals:** By using an eligibility criteria and an enrollment mechanism that asked providers to serve particular individuals, the program has been serving individuals who are much more vulnerable than other comparable programs. Many police officers and other systems had often called these individuals “service resistant” and skeptically said they would not enter the program. Through great outreach and engagement, the two providers within the project have currently been proving everyone wrong.
- **Ensuring there are Adequate Housing Options:** Because this program is targeting a more vulnerable population, they have had to ensure that they have housing options beyond their typical supportive housing array. Whether it is for greater medical needs or more intense mental health needs, the providers have had to use versions of assisted-living for some individuals. These individuals still received all of the same case management services, but receive additional care that supports their specific needs.
- **Connections to Comprehensive Services:** The fact that both the Mental Health Centers of Denver (MHCD) and the Colorado Coalition for the Homeless (CCH) run additional programming specifically for homeless individuals with behavioral health needs has been critical to the program. MHCD has an Adult Recovery Center that provides services ranging from group support to pharmaceutical treatment. CCH's Stout Street Clinic provides comprehensive health services ranging from dental to behavioral health.

²⁴ City of Denver available at: https://www.denvergov.org/content/dam/denvergoals/344/documents/Denver_SIB_Summary.pdf

The project is also in the process of constructing 160 new units of housing specifically serving the targeted high-user individuals. These two new buildings with 60 units and 100 units combined with a plan to house 90 individuals in scattered sites will demonstrate how a community can come together in a relatively short period of time to house a very vulnerable population.

The Colorado Coalition for the Homeless and the Mental Health Centers of Denver have used trauma-informed care philosophies and best practices from providers across the country to ensure their buildings and model addresses the specific needs of very vulnerable population and find alternative assisted living situations where appropriate.

Bridge Housing/Respite Care

While permanent supportive housing is the solution for most individuals with behavioral health issues, there are interim housing solutions that help individuals transition into more permanent opportunities. Sometime referred to as “bridge housing” or “respite care,” these housing interventions largely differ on the level of services provided, but all are primarily time-limited interventions. Medical or behavioral health respite can be used for homeless individuals who are too ill or frail to recover from a physical illness or injury on the streets but are not ill enough to be in a hospital.

In Portland and Phoenix, two organizations have developed strong partnerships with the hospital systems to address a common problem—homeless individuals who are released to the streets from hospitals with ongoing medical or behavioral needs. Whether is an individual with a stitched wound or someone recovering from a disorder, being released without follow-up treatment too often leads to re-admission and high costs. These situations are preventable.

- **Central City Concern²⁵:**

In September 2016, six healthcare organizations in Portland announced a \$21.5 million investment in 382 new housing units. These units have opened in response to the city’s challenges with affordable housing,

homelessness, and healthcare. Of the new housing units, 176 are located in an integrated health center with a first-floor clinic and 24-hour medical staffing on one floor. This health center will serve individuals in recovery from substance use disorders and mental illness. The remaining units provide affordable housing for workforce (155 units) and families in need (51 units). This investment is part of a larger *Housing is Health* initiative in the city.

- **Circle the City²⁶:**

In Phoenix, a non-profit health organization called Circle the City provides a model of integrated homeless health care. The organization offers a 50 bed medical respite center for homeless individuals needing access to health care. The medical respite center serves homeless individuals discharged from hospitals who need further assistance with care, or those who have been living on the street with acute conditions. Circle the City also provides outpatient primary health care services to the homeless, including a mobile medical clinic.

VII. Moving Towards Early Prevention

Too often the crises of today prevent us from focusing on the preventative solutions of tomorrow. Behavioral health is representative of this paradox. In 1963, President Kennedy signaled that the nation would no longer tolerate the view of mental health as “a problem unpleasant to mention, easy to postpone, and despairing of solution.”²⁷ Using tools such as the Community Mental Health Act and later Medicaid, a movement towards deinstitutionalization and community-based solutions began. In the words of President Kennedy, a “reliance on the cold mercy of custodial isolation will be supplanted by the open warmth of community concern and capability. Emphasis on prevention, treatment and rehabilitation will be substituted for a desultory interest in confining patients in an institution to wither away.”²⁸ Unfortunately, the necessary funding at the federal and state level never emerged to fulfill the dream of providing solutions rooted in communities and based upon

²⁵ Central City available at: <http://www.centralcityconcern.org/announcement>

²⁶ Circle the City available at: <http://www.circlethecity.org/>

²⁷ American Presidency Project available at: <http://www.presidency.ucsb.edu/ws/?pid=9546>

²⁸ Ibid.

prevention.²⁹

Today, state and local governments are tasked with finding innovative, cost-effective solutions to address behavioral health related challenges, such as treating mental health and substance abuse issues, providing affordable and supportive housing, providing child welfare services and foster care placements, and diverting individuals from the criminal justice system. Governments are spending millions of dollars on the issue, but are primarily focused on remedial interventions. The programs and strategies outlined in this brief offer some methods for addressing the current crisis, but much more needs to be done to address problems upstream, before they reach crisis proportions.

With an increased focus on data and prevention, governments can identify young adults and children who have the symptoms of long-term behavioral health issues. Rather than providing supportive housing for individuals whose conditions have become a disability, governments could provide early treatment that directs these individual down a path of self-sufficiency. Right now, Bernalillo County, New Mexico is dedicated a portion of its behavioral health funds to these preventative programs and to rigorous evaluation of them. If successful, they will become strong examples for all of us to learn from.³⁰ But we need more governments willing to investing in these solutions and the research that will adequately build the evidence for them.

Behavioral health is a solvable issue and one worth solving. It has been engrained in the American community for as long as our country has existed, and our response to it will continue to be a barometer of our collective success.

The Government Performance Lab at the Harvard Kennedy School conducts research on how governments can improve the results they achieve for their citizens. An important part of this research model involves providing pro bono technical assistance to state and local governments. Through this hands-on involvement, the Government Performance Lab gains insights into the barriers that governments face and the solutions that can overcome these barriers. For more information about the Government Performance Lab, please visit our website: www.govlab.hks.harvard.edu.

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²⁹ Kaiser Family Foundation available at: <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/7684.pdf>

³⁰ Read more at: <https://govlab.hks.harvard.edu/files/siblab/files/bernalillo-county-project-feature.pdf>