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Mental Health Outreach Program (MHOP) Evaluation Report

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Submitted by
Center for Child and Family Policy
Duke University

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Introduction

This report summarizes preliminary findings associated with the MHOP program that began in Durham County in January of 2011. The program was made possible through a grant to the Durham Police Department by the U.S. Department of Justice's, Bureau of Justice Administration (BJA). Using the conceptual framework of System of Care, the Durham Police Department (DPD) built upon existing programs and expanded partnerships with Durham's mental health authority, the Criminal Justice Resource Center, Duke's Center for Child and Family Health and other stakeholders in an effort to accomplish four key goals:

1. To reduce re-arrest rates for persons with mental illness;
2. To decrease the number of repeat 911 calls for service by such individuals;
3. To increase the number of individuals engaged in mental health services; and
4. To increase the number of law enforcement personnel trained in de-escalation and identification of mental illness.

Program Background

MHOP worked to achieve the above mentioned goals by providing comprehensive training to law enforcement and other community partners, in conjunction with hiring qualified mental health professionals to conduct outreach and follow-up with citizens interfacing with law enforcement and suspected of having underlying mental health conditions. MHOP was designed to improve the services law enforcement provides to citizens and to help address the overrepresentation of persons with mental illness within the jail system.

Staffing. Grant funding supported 1.5 FTE mental health case managers hired through a contract with the Criminal Justice Resource Center but housed within the Durham Police Department. This staffing pattern provided the police department with access to mental health expertise and follow-up 7 days per week.

Eligibility. Any person age 16 or older diagnosed with a mental health and/or co-occurring condition that was not involved in a violent offense and not currently engaged in mental health services, qualified for participation based on established eligibility requirements. The program design had a special focus on underserved populations including juveniles and females with mental health conditions given their increased propensity to come to the attention of law enforcement agencies.

Referral Process. For non-violent 911 calls where citizens were suspected of having underlying mental health issues, police officers referred citizens for mental health follow-up. Working in collaboration with the DPD Crisis Intervention Team (CIT) investigator and staff from the North Carolina Child Response Initiative (NCCRI), MHOP case managers determined eligibility and then contacted citizens within 24 hours to determine interest in the program and

arrange for a home visit. During the home visit, case managers began the development of a Plan of Care, initiated linkages to appropriate programs and mental health services, and provided ongoing case management as needed.

Training. Training was provided by Duke's Center for Child and Family Health with a focus on developing open working relationships between law enforcement and mental health specialists. Training included patrol officers, emergency dispatch personnel, supervisors, investigators, and special divisions staff (e.g. Gang Resistance & Selective Enforcement Team). The training built upon the existing NCCRI curriculum which was designed to improve services to child witnesses and victims of violent crimes following incidents involving police response. This modified training program focused specifically on 1) signs and symptoms of mental illness across the lifespan, 2) the impact of mental illness on daily functioning, 3) the role of officers in managing situations arising from mental illness, 4) evidenced-based services available to those individuals with mental illness, and 5) how to access and utilize services provided by MHOP.

Policy Changes. Three policy changes were implemented over the last 12 months stemming from MHOP. System changes were implemented to allow officers to accurately identify cases involving mental health issues using a new clearance code of 5 or 5R within the police automated dispatch system as meeting criteria for referral to the MHOP team. These cases were then triaged to determine the most appropriate program and associated staff assigned. Additionally, the inebriated person protocol was established allowing 24-hour holds at the Durham County Sheriff's Detention Facility to be diverted to Durham Center Access. This emergency mental health facility provided a voluntary alternative to jail for individuals with co-occurring mental health and substance abuse issues and facilitated treatment services more immediately. Finally, the Prostitution Initiative was created in collaboration with special crimes enforcement teams within DPD. This coordination allowed MHOP case managers to conduct outreach to every female arrested for prostitution.

Evaluation

The Center for Child and Family Policy (CCFP) at Duke University supported the development of a program database, provided technical assistance in data collection activities and produced this report. The Center for Child and Family Policy (CCFP) brings together scholars, policy makers, and practitioners to solve problems facing children in contemporary society by undertaking rigorous social science research and then translating important findings into policy and practice. The CCFP researchers supporting these evaluation efforts included Jeff Quinn, M.P.H., Nicole Lawrence, Ph.D., and Joel Rosch, Ph.D. For more information about the Center or biographical information about specific researchers visit us at: www.childandfamilypolicy.duke.edu

Preliminary Findings

A total of 447 clients were served between January 2011 and January 2012. There was nearly an even split between males and females with men making up 48% and women representing 51% of those served by the program during that timeframe. The majority (53%) identified themselves as

being African American. Twenty-eight percent were White with less than 3% indicating Hispanic/Latino decent. Roughly 14% declined to provide race or ethnicity information.

Table 1: Program Participant Demographics

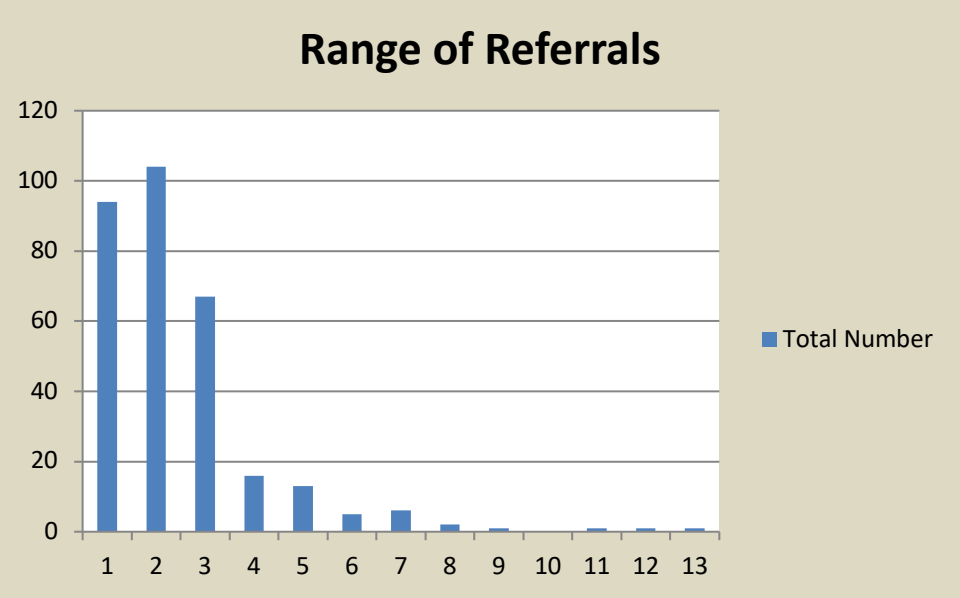
Gender	Total=447	%
Female	229	51.2%
Male	215	48.1%
Not Reported	3	.67%
Race		
American Indian or Alaska Native	1	.22%
Asian	2	.45%
Asian, Native Hawaiian or Pacific Islander	1	.22%
Black or African American	238	53.2%
Hispanic/Latino	12	2.69%
Multi-racial	4	.9%
White or Caucasian	126	28.2%
Other	1	.22%
Not reported	62	13.9%

A total of 620 referrals were completed on behalf of clients participating in the MHOP program. Those referrals involved 122 different agencies/providers offering programs and services within Durham. Many clients were referred to multiple services while others only required a single referral. Table 2 highlights the number of referrals and indicates that 30% of participants had only one referral with slightly more 33%, receiving 2 referrals. Twenty-two percent required three referrals and those requiring four or more referrals made up the remaining 15% of participants. Figure 1 further illustrates these findings.

Table 2: Number of Referrals

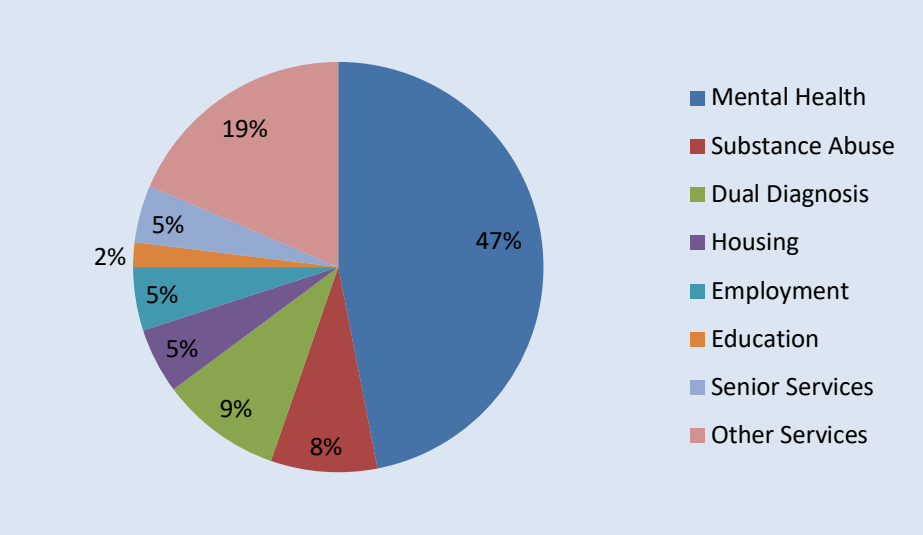
Number of Referrals	Percentage
1	30%
2	33%
3	22%
4	5%
5	4%
6	2%
7	2%
8+	2%

Figure 1: Referrals



As would be expected, the largest number of referrals were made for mental health services representing 47% (n=291) of all referrals. Nineteen percent (n=115) were categorized as "other services". [These other services included food banks, transportation vouchers, clothing, household goods, legal aid, etc.] Numbers for referrals related to employment, housing, education, senior services, substance abuse and dual diagnosis were small individually but collectively made up the remaining 34% of all referrals. Figure 2 below further illustrates these findings.

Figure 2: Service Referrals by Type



The mental health case managers engaged in various forms of contact with clients and collaterals (those engaged in providing services to clients). The total number of contacts made by case mangers and officers was 1675. Phone contacts and personal contacts were nearly evenly split at 514 and 506 respectively. Office contacts were limited to 30. More than 200 collateral contacts were made on behalf of clients primarily to follow-up on referrals and ensure a smooth transition into needed services. Figure 3 below highlights these numbers.

Figure 3: Number &Types of Contacts

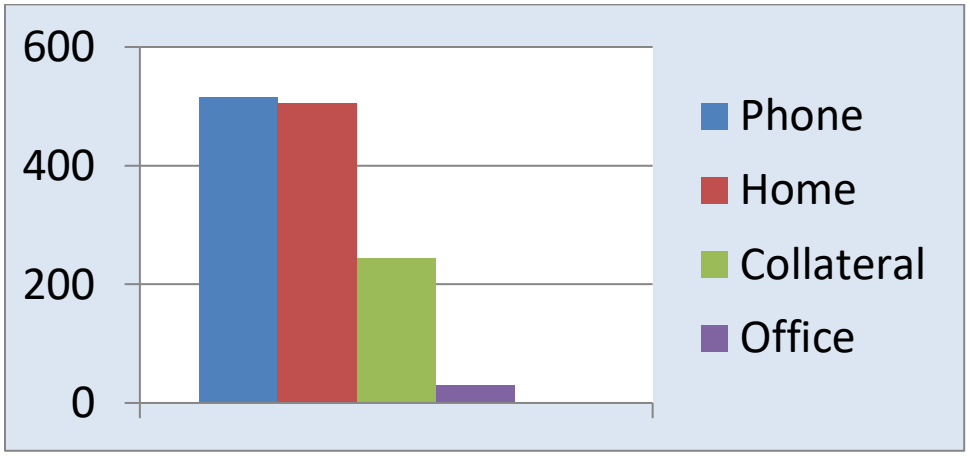


Table 3 breaks down the number of contacts by client revealing that nearly half (48%) had two or three contacts made specific to their case (e.g. direct contact between MHOP staff and participants or collateral contact made on behalf of the participant). Nineteen percent received four or five contacts and 15% had 6 or more contacts.

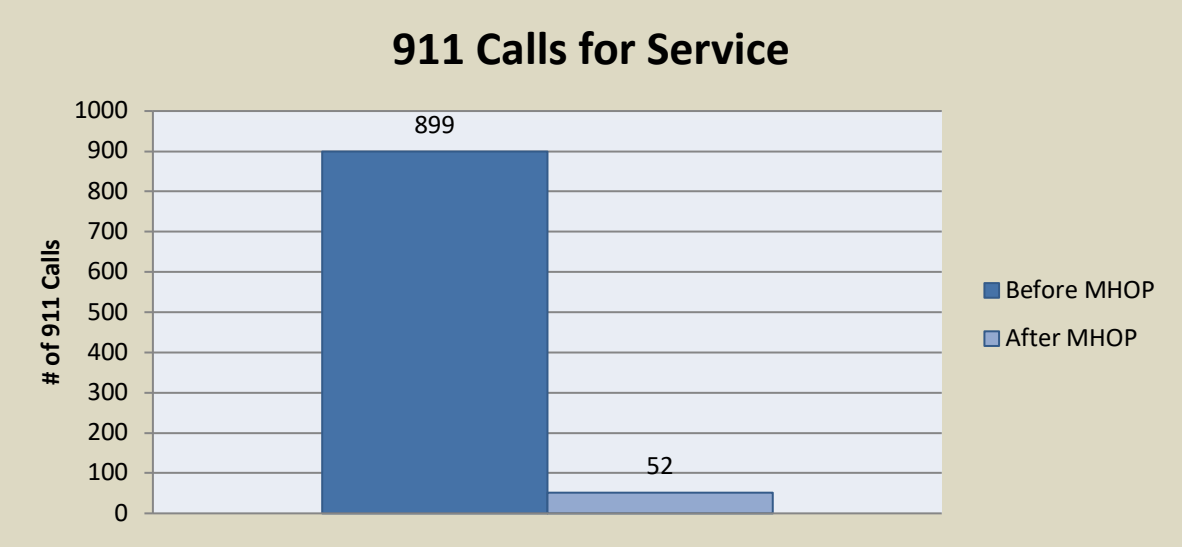
Table 3: Number of Contacts

Number of Contacts	Percentage
1	18%
2	27%
3	21%
4	12%
5	7%
6+	15%

One of the key objectives of MHOP was to reduce the number of 911 calls for service initiated and/or involving citizens with underlying mental health issues. Often these individuals utilize 911 frequently for non-emergency situations or those that would be more appropriately handled by mental health professionals or other agencies serving the community. As such, a relatively small number of citizens can represent a disproportionately large number of 911 calls. In order to

explore this issue, records for MHOP participants who had ten or more 911 calls for service prior to enrollment in the program were examined. Utilizing this criteria, 39 MHOP participants were identified and were found to collectively represent almost 900 calls for service (n= 899) prior to enrolling in MHOP. After receiving services through the program those same 39 individuals were associated with only about 50 calls. Figure 3 illustrates the reduction in 911 calls associated with these 39 high utilizers.

Figure 3: 911 Calls for Service



To further exemplify these findings the records of four MHOP participants who were identified as citizens who frequently call 911 were extracted from the data base and examined more closely. These four individuals had an average of 56 calls for emergency service in the six months prior to their involvement with MHOP. After enrollment in the program these four individuals had a total of 4 calls among them (1 call per person). Many of these former "high utilizers" also received a significant number of contacts from MHOP personnel as well as referrals to services which are likely contributing factors in the subsequent reduction in 911 calls. Table 3 highlights these findings.

Table 3: MHOP Participants

ID	Total of 911 calls prior to MHOP	Total of 911 calls after MHOP	Total # of referrals during MHOP	Total # of contacts during MHOP
2249	50	1	0	2
2251	50	1	4	42
2119	53	1	1	5
2130	69	1	7	16
Total	222	4	12	65

In addition to reducing 911 calls for service, MHOP also aimed to reduce the number of arrests for individuals with mental health issues. Of the 447 people served by MHOP, only 47 had a subsequent arrest after participating in the program. As a point of reference, prior to involvement with MHOP these 447 individuals collectively had 1827 prior misdemeanors, felonies, violent misdemeanors, or other convictions.

Another core component of MHOP was training that was inclusive of law enforcement as well as other community stakeholders. CCFH provided comprehensive training sessions adapted to meet the needs of various audiences and included 395 participants across training opportunities. Table 4 highlights the types of training offered and participants by role.

Table 4: Training

Training Type	Participants by Role	Number of Participants
CIT Training (40 Hours)	Law Enforcement Officers, Detention Facility Officers, and Investigative Officers	57
CIT Training (40 Hours)	Mental Health Providers and other agency partners	4
Mental Health Signs and Symptoms and Referral Processes (2 Hours)	Patrol Officers	135
Mental Health Signs and Symptoms and Referral Processes (8 Hours)	911 Tele-communicator staff	64
Mental Health Signs and Symptoms and Referral Processes (2 Hours)	Investigative Officers	50
MHOP Program, goals, and referral processes (1 Hour)	Division of Social Services- Social Workers	24
Mental Health Signs and Symptoms and Referral Processes (8 Hours)	EMS First Responders	61
Total		**395**

In order to determine the effectiveness of the training sessions offered, CCFH facilitated pre/post tests for the trainings offered to investigative officers, 911 communicators and patrol officers. The average pre-test score for investigators was 74% increasing to 91% after completion of the training. 911 communicators had a more drastic increase with pre-test scores averaging 45% and post-test scores rising to an average of 78%. Patrol officers also showed modest gains with an average pre-test score of 74% and an average post-test score of 87%.

The policy changes associated with MHOP yielded some noteworthy successes. For example, the inebriated person protocol that allowed for diversion from jail directly to Durham County Access (DCA) for individuals with co-occurring mental health and substance abuse issues appeared to be well utilized upon authorization in the last half of the calendar year. Table 5 shows the total number of individuals with a 24-hour hold and subsequently sent to the Durham County Sheriff's

Office (DCSO) Detention Facility and those successfully diverted as a result of the policy change. Personnel from DCA, DCSO and DPD have reported that they believe the policy change has been beneficial to citizens and has enhanced communication and collaboration between agencies.

Table 5: Inebriated Person Protocol Jail Diversion

Quarters in 2011	DCSO	DCA
January- March	95	0
April- June	89	0
July- September	36	19
October- December	50	19
Total	270	38

Conclusions

The preliminary findings highlighted in this report suggest that MHOP has successfully achieved key program goals including:

- Reduction in re-arrest rates for persons with mental illness;
- 83% decrease in the number of 911 calls for service for these individuals;
- Increased the number of individuals referred to and engaged in needed mental health treatment (n=291);
- Increased the number of law enforcement personnel trained in de-escalation and identification of mental illness to include 306 staff.

It is recommended that MHOP staff continue to collect data within the established database system and explore implementing enhanced evaluation efforts including but not limited to cost/benefit analysis as well as conducting follow-up assessments and longitudinal tracking of participant outcomes. A more comprehensive methodological approach would provide a framework for better understanding which elements of the program most contribute to improved outcomes and provide a framework for continuous quality improvement. Such information would help to improve the existing program over time and inform expansion efforts for other areas of the state. One of the key barriers to program implementation was data entry into the newly developed MHOP database. Much of the information entered into the system had to be manually retrieved from two other DPD database systems. The inability to integrate systems created significant burden on program staff. The creation of system that could track key program outcomes as well as access DPD administrative data would create greater efficiencies.