

PERSPECTIVE

Mental Health Crises And Public Policy: Opportunities For Change?

A crisis can provide the opportunity to make needed changes, but sustaining the changes and gauging their actual impact remain challenging.

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ABSTRACT: Mental health care is a state responsibility. Periodically, tragic incidents involving a person with a mental illness (such as the shootings at Virginia Tech) attract the public's attention. But little is known about the impact of this attention. Does meaningful change occur, and how? In this commentary we explore recent efforts to advance change in the wake of tragedy. [*Health Affairs* 28, no. 3 (2009): 805–808; 10.1377/hlthaff.28.3.805]

MANAGING CHANGE IN state mental health systems is difficult; these systems are complex and subject to both bureaucratic and political dynamics. Yet this challenge has received little attention. Richard Frank and Sherry Glied link changes in mental health care to federal policy advances, as do Gerald Grob and Howard Goldman, and David Mechanic.¹ Clearly, federal policy shapes mental health care in the states. By 2001, Medicaid surpassed the state mental health agencies (SMHAs) to become the largest payer for mental health treatment. Still, the role of these state agencies remains substantial.

Periodically, mental health issues come to the public's attention—often as a result of incidents or crises (for example, the shootings at Columbine or problems in the care of Iraq War veterans). Crises can precipitate change, but they also bring the risk of hasty policy formulation. Mental health programs are dispersed, subject to many masters, and contentious, making change difficult. To further complicate

matters, special-interest groups may seek to use crises to advance positions they favor, such as court-ordered care.

Against this backdrop, we explore efforts to change state mental health systems following well-publicized crises. Can effective leadership in times of crisis result in positive change? What are the determinants and limits of success? In this volume, Richard Bonnie and colleagues describe struggles to change Virginia's mental health system, before and after the Virginia Tech shootings in April 2007.²

New York State

New York State, where we are the mental health commissioner and medical director, has faced similar challenges. The state has an enormous mental health system (\$5.5 billion in annual spending, 650,000 people served annually). The system is famously complex and fragmented, with strong cross-currents (for example, upstate versus New York City, powerful labor unions and a politically potent hospital industry) that militate against planned

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change. As in many states, Medicaid is the dominant payer.

The fragmentation of New York's mental health system has long been evident. Susan Sheehan's account of the journeys of "Sylvia Frumkin" through a chaotic system won a Pulitzer prize.³ The 1999 death of Kendra Webdale, pushed under a subway car by a man with a long history of revolving-door treatment, also revealed a fragmented system, with no one responsible for his care. The 1999 tragedy led to enactment of "Kendra's Law," creating a program of Assisted Outpatient Treatment (AOT) ordered by courts. In addition to the law, New York budgeted \$130 million to expand services, including case management programs and medications.

■ **Response: review panel.** These reforms, however, failed to prevent a murder, several violent assaults, and police shootings of people receiving mental health care in New York City in 2007–08. Following intense media attention, the state's governor and the mayor of New York City established a Mental Health–Criminal Justice Panel to propose ways to reduce incidents of violence and improve police encounters. The panel was led by six state and city officials and comprised multiple city and state agencies with diverse interests. To focus the panel's work, we conducted intensive reviews of patterns of care in several cases and began meetings with presentations by national experts on mental illness and violence and on mental health/criminal justice system coordination.

The reviews yielded rich and disturbing insights into patterns of care that were revealed to be casual and poorly coordinated. Community services, including clinics, case management, and even Assertive Community Treatment, were not consistently coordinating care, engaging and retaining consumers in treatment, communicating with families, or adequately engaging consumers whose conditions were worsening. Hospitalization, poorly connected to community care, was the customary intervention in crises—often after a person's condition had deteriorated for months.

These patterns, against the backdrop of re-

search suggesting that continuous care and integrated attention to substance use are key to mitigating violence, suggested directions for reform. The resulting report recommended improvements for adult and youth mental health care, the adult and juvenile justice systems, and the connections between them.⁴

Panel recommendations included a new "clinical alerts" system that will use Medicaid claims to identify the most vulnerable people who may be at risk for relapse and violence (prompted by breaks in service or prescription refills as well as sudden escalations in acute services, such as emergency room and inpatient care). The alert system will be used by New York City's borough-based monitoring teams run conjointly by the state and city to contact responsible providers and focus attention before conditions worsen. To improve routine care, Mental Health Clinic Standards of Care were issued to clarify expectations for clinical quality (for example, a primary clinician, collaborative treatment planning among multiple caregivers, communication with families, screening and integrated treatment for individuals with co-occurring mental illnesses and addictive disorders, violence risk assessment, and outreach and engagement). Implementation of these standards throughout the state's mental health clinics will be tracked via a state license survey process conducted by the Office of Mental Health (OMH), which will now use a version of the "tracer methodology" developed by the Joint Commission, where the care of high-risk people will be "traced" through the processes of care they receive.

In the area of children's services, the panel focused on youth with mental illnesses in the juvenile justice system. Recommendations included development of a special residential treatment model as an alternative to juvenile prisons and stronger efforts to sustain family involvement with youth.

■ **Response: AOT program.** New York's response to Webdale's death in 1999 was robust, involving sizable investments in services and creation of the comprehensive (and controversial) AOT program. The effectiveness of

AOT is still being reviewed; an evaluation conducted by an external research team will be completed in 2009. (Preliminary results show that the increased and coordinated services provided under AOT orders are beneficial; it is unclear whether the involuntariness/court-ordered nature of the care has any impact.)

It is also clear that the fragmented nature of care was a factor in the 1999 incident and that the reforms that then followed did not address this problem, except for those people under AOT order. This underlying problem, along with quality problems, plays into known risk factors (namely, disintegrated and discontinuous care for mental and addictive disorders) associated with poor outcomes and dangerousness for people with serious mental illnesses. These were prominent problems uncovered in our reviews of the 2007–08 incidents involving mentally ill New Yorkers.

New York's 2008 review panel followed a closely scripted path, driven by a charge from the governor and mayor. Relying on expert testimony to define the field of concerns and then conducting detailed case reviews led to findings and recommendations that are more focused, but also less comprehensive and robust, than the changes following the more highly charged 1999 incident. The "midrange" recommendations developed by the review panel do not seek broad-scale change (for example, reorganizing care systems, dramatic expansions of services) but attend to more narrowly defined problems, such as improving quality of care in existing programs and better tracking and continuity of care for high-need cases.

Potential Lessons

Contrasting case studies of states' responses to tragic incidents illustrate the technical and political challenges of state level mental health reform. Good mental health care for those with serious disorders requires both adequate investment in the right services and

care management strategies (such as enabling counties or local entities to manage access to hospital care and its alternatives). These can be a difficult political "sell," as hospital and state employee unions may resist threats to their domains, while local governments may resist taking on additional risks and responsibilities. Increases in spending or agency staffing are notably difficult to achieve, especially in times of economic hardship.

The Virginia Tech story illustrates how crisis can focus attention on an ongoing policy concern and also affect its trajectory. Progress on rebalancing from hospital to community services, and creating accountable substate entities to orchestrate care, had been slowed by lack of urgency and the complexity and cost of reform. Changes in the law (for example, making community service boards the "single point of entry") were accom-

plished more easily than allocation of the resources needed to carry out the policy. The Virginia Tech shootings galvanized energies to accelerate reform, but perhaps the responses fell short where resource investments or structural change was required.

New York's experience illustrates other challenges of reform. Public and political leaders' concern about Webdale's death in 1999 mobilized major investments of resources but did not address the fragmentation of care—a complex problem whose solutions might require sacrifice by powerful interests such as hospitals, municipal and county governments, nonprofit providers, and state employee unions. Although improvements were made, the reforms did not ameliorate underlying flaws in the system and were unable to prevent subsequent disasters. (We must note that there are limits to preventing rare acts of violence, so it is not clear that any set of reforms would have so succeeded.) The recent New York review panel experience illustrates that the judicious use of expertise and the careful review of inci-

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dents (a core element of continuous process improvement) can help produce a more focused and informed response to crisis. However, the low-cost, midrange approaches that were recommended (such as better monitoring of care received by high-need individuals) might not be adequate to achieve desired changes.

STATE MENTAL HEALTH programs, in a way, are “legacy systems,” like dated computer protocols. They predate and function outside the mainstream health system. The nation’s failure to integrate coverage and care for those with mental disorders means that these systems have remained in place. The periodic incidents that stir crises of confidence present opportunities and threats. The experiences in Virginia and New York make it clear that it is possible to use crises to advance change. Whether the changes are adequate and can be seen through to effectiveness remains unclear.

Excellence in state mental health systems, aside from minimally necessary resource investments, depends on the ability to develop and sustain empowered and accountable local “systems of care” that manage care, including access to and use of hospitalization, and that provide capable community care to help avert deterioration and provide alternatives to costly hospitalization. These systems may be directed by county government (as in Wisconsin), designated local authorities (as in Ohio and Michigan), or nonprofit lead agencies (as in Vermont, Rhode Island, and New Hampshire). In turn, the consolidation of resources and authority needed to manage money and care requires political will, and these arrangements are easier to achieve in smaller states and those without large urban settings.

How can good mental health care within the states be achieved? Although national-level reforms, such as including mental health care in larger health reforms, are necessary, they are insufficient. Adept management of crises offers promise as a motivator of change, but it is not enough. Greater attention to the policy and management challenges of state-level im-

provements might not be as glamorous as federal policy change, but it is what is needed.

NOTES

1. R.G. Frank and S.A. Glied, *Better but Not Well: Mental Health Policy in the United States since 1950* (Baltimore: Johns Hopkins University Press, 2006); G.N. Grob and H.H. Goldman, *The Dilemma of Federal Mental Health Policy: Radical Reform or Incremental Change?* (New Brunswick, N.J.: Rutgers University Press, 2006); and D. Mechanic, *Mental Health and Social Policy*, 5th ed. (Boston: Pearson/Allyn and Bacon, 2008).
2. R.J. Bonnie et al., “Mental Health System Transformation after the Virginia Tech Tragedy,” *Health Affairs* 28, no. 3 (2009): 793–804.
3. S. Sheehan, *Is There No Place on Earth for Me?* (Boston: Houghton/Mifflin, 1982).
4. New York State Office of Mental Health, *New York State/New York City Mental Health–Criminal Justice Panel Report and Recommendations*, 2008, http://www.omh.state.ny.us/omhweb/justice_panel_report (accessed 10 March 2009).