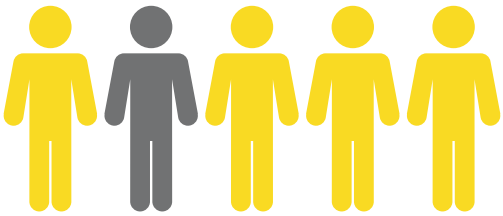
THE KENNEDY FORUM

Improving Crisis Response for
Individuals with Mental Health Challenges:

West Side Community Outreach Pilot Project

Background

Mental health and substance use disorders are common. Recent national data indicate that approximately one in five adults in the United States live with a mental illness and close to one in 10 live with a substance use disorder.[1] Locally, data from The Chicago Department of Public Health's 2016 Healthy Chicago 2.0 survey indicates that 5.4% of the adult population in the City reported experiencing serious psychological distress on a validated screening tool for serious mental illnesses. The numbers are higher when considering Non-Hispanic African Americans (7.2%) and those living at or below the Federal poverty level (11%),[2] suggesting a greater need for service access in disadvantaged and minority communities.



Recent national data indicate that approximately one in five adults in the United States live with a mental illness

Unfortunately, many individuals experiencing mental health difficulties and distress do not access effective mental health services due to lack of mental health literacy and stigma.[3] They may not access treatment until their distress reaches the point that an emergency response is needed or they otherwise come to the attention of police. This is unfortunately also common, as a recent review of studies found that in the United States approximately six percent of police calls for service involved persons with mental illnesses; and among individuals with serious mental illnesses receiving mental health care, 29% had police involved in their pathway to care.[4]

1 Substance Abuse and Mental Health Services Administration. (2017). Key substance use and mental health indicators in the United States: Results from the 2016 National Survey on Drug Use and Health (HHS Publication No. SMA 17-5044,NSDUH Series H-52). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. Retrieved from https://www.samhsa.gov/data/

2 Healthy Chicago 2.0 Health Atlas: Serious psychological distress. Adults who frequently felt nervous, hopeless, restless or fidgety, depressed, worthless or that everything was an effort in the past month. Accessed https://www.chicagohealthatlas.org/indicators/serious-psychological-distress

3 Borges, G., Levinson, D., de Girolamo, G., Andrade, L. H., Kovess-Masfety, V., Jin, R., . . . Kessler, R. C. (2014). Barriers to mental health treatment: Results from the WHO world mental health surveys. Psychological Medicine, 44(6), 1303-1317.

4 Livingston, J. D. (2016). Contact between police and people with mental disorders: A review of rates. Psychiatric Services, 67(8), 850-857.

Recognizing that police are all too often the first line of response to individuals who are experiencing a mental health crisis, law enforcement agencies across the country are examining ways to enhance mental health literacy among officers and establish inroads to local healthcare systems and providers in order to improve outcomes in mental health response. To this end, and to best help people in need, the Chicago Police Department (CPD) utilizes a collaborative approach based on the Crisis Intervention Team (CIT) model. One element of the program is intensive training for select officers who volunteer to take on a specialist role in responding to individuals experiencing mental health crises. Currently, approximately 20% of officers have received this intensive 40-hour training, which gives them the tools to more safely and effectively intervene with a person undergoing a mental health crisis. Additionally, all officers are being provided with 16 hours of Force Mitigation Training, which includes content on signs and symptoms of mental illness and de-escalation skills.

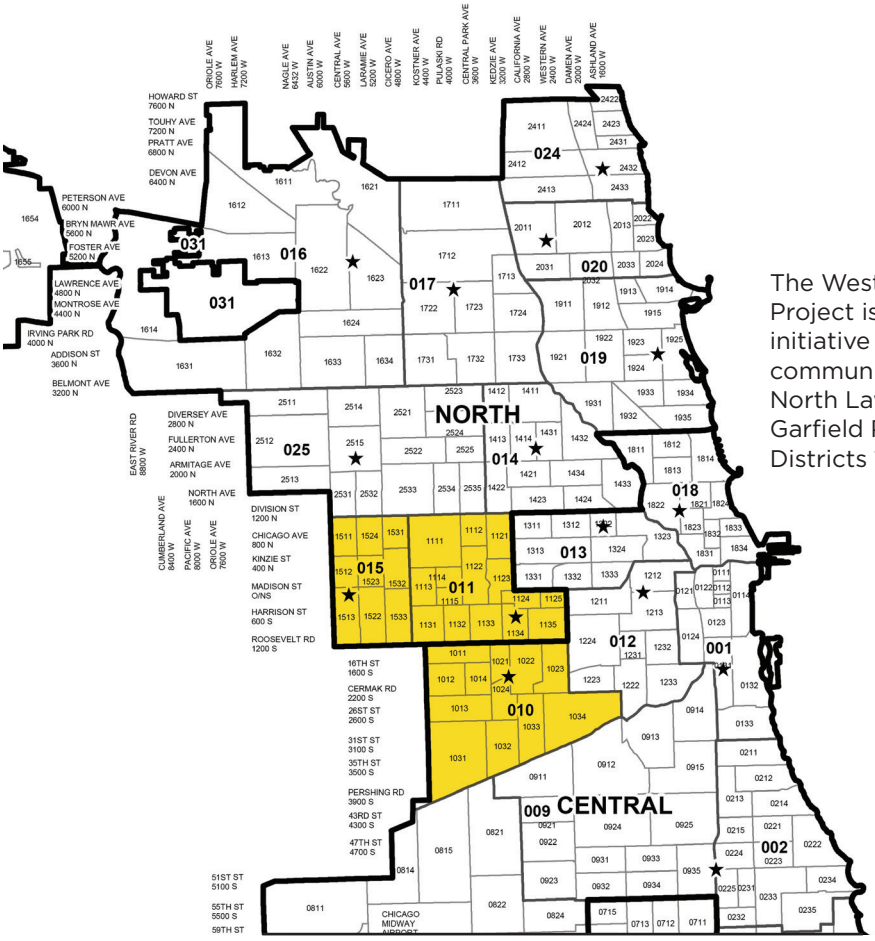
Twenty-percent of Chicago officers have received

40-hour

Crisis Intervention Team training

Unfortunately, CIT-trained officers are not always directed to emergencies where their skills are needed. For example, this can happen when 911 calls are not correctly identified as mental health-related. Often emergency communications personnel do not have the information necessary to connect a CIT officer to a mental health crisis. Indeed, as part of its April 2016 report, the Police Accountability Task Force recommended a number of steps to increase accurate identification of calls, including calling for a community education campaign to help key community members identify the signs of mental illness, request CIT-trained officers when speaking with 911 operators, and refer people to appropriate mental health services prior to a crisis.

To improve response for individuals experiencing mental health crises, The Kennedy Forum, NAMI-Chicago and partner organizations launched the West Side Outreach Pilot Project in January 2017. The pilot is a community-based initiative to provide free training to community members in the Austin, North Lawndale, and East/West Garfield Park communities (Police Districts 10, 11, and 15). These west side communities were selected because data provided by the City of Chicago and the Illinois Department of Public Health showed high rates of mental health-related incidents in the last five years. Outreach focused on school staff, faith leaders, and those who work in community-based organizations (CBOs). These target groups were selected due to their position within the community as trusted messengers, their presumed higher likelihood of coming into contact with someone experiencing a mental health distress, and their ability to intervene before the situation becomes a crisis.



The West Side Outreach Pilot Project is a community-based initiative to provide free training to community members in the Austin, North Lawndale, and East/West Garfield Park communities (Police Districts 10, 11, and 15).

The pilot included two different types of training: Mental Health First Aid and Mental Health Awareness.[5] Mental Health First Aid Training is an eight-hour structured course that was developed in Australia by Anthony Jorm almost two decades ago. A growing body of research supports its effectiveness for improving mental health literacy and confidence in assisting persons experiencing mental health difficulties.[6] However, few studies have examined the effectiveness of the training in populations in the United States and none were found to examine the effectiveness of the training in urban, African American adult populations. It is now being disseminated widely in the United States and other countries.

5 Mental Health First Aid is an eight-hour training that addresses signs and symptoms of a mental health issue and how to react to help someone in a time of crisis. Mental Health Awareness is a 2-2 and a half hour training that focuses on identifying the signs and symptoms of a mental health issue and how to communicate with someone experiencing a crisis. Mental Health Awareness also offered specific trainings for some audiences. Bridges of Hope was offered to those in the faith community. Trauma and the Impact on Youth is another that was offered to audiences who work with youth population.

6 Kitchener, B.A., & Jorm, A. (2006). Mental Health First Aid Training: Review of Evaluation Studies. Australian and New Zealand Journal of Psychiatry, 40(1), 6-8. DOI: 10.1080/j.1440-1614.2006.01735.x

Mental Health Awareness trainings were developed by NAMI Chicago and Sinai Health System's Under the Rainbow program. In addition to curricula focused on mental health and substance use, all instructors were trained by NAMI Chicago on how to access a CIT-trained officer. This allowed all trainers to teach their curricula about mental health and substance use as well as CIT awareness. Additionally, all participants were provided with informational material on Chicago's CIT program and mental health resources on the west side.

The goal of this pilot was to train at least 200 members of CBOs, 100 members of the faith community, and 100 staff of schools (for a total of 400 community stakeholders) over an eight month period to:

- Increase mental health literacy (knowledge of signs and symptoms of mental illness).
- Reduce stigmatizing attitudes/beliefs about mental illness.
- Increase requests for CIT trained officers in crisis situations.
- Increase referrals to professional mental health services.

To help evaluate the pilot's effectiveness, the University of Illinois Chicago's (UIC) Jane Addams College of Social Work surveyed training participants to assess their level of knowledge before and after the trainings. The evaluation received Institutional Review Board approval to protect those participating in the research. All training participants reserved the right to decline participation in the evaluation. Data and findings from the pilot are summarized in the results section below.

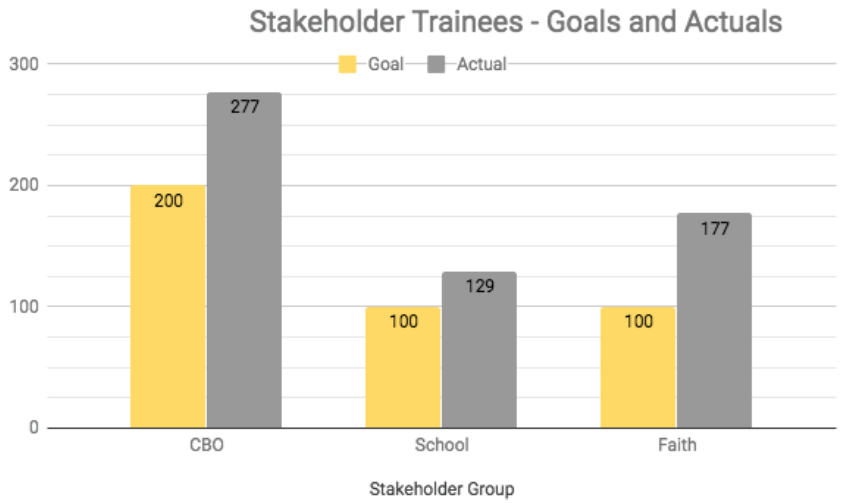
This pilot was coordinated with work of the Citywide Mental Health Crisis Response Steering Committee,[7] which Mayor Rahm Emanuel created in January 2016. The Steering Committee was formed to improve how emergency personnel respond to incidents involving an individual facing a mental health crisis and better connect people in crisis to appropriate care and assist the City in making reforms.

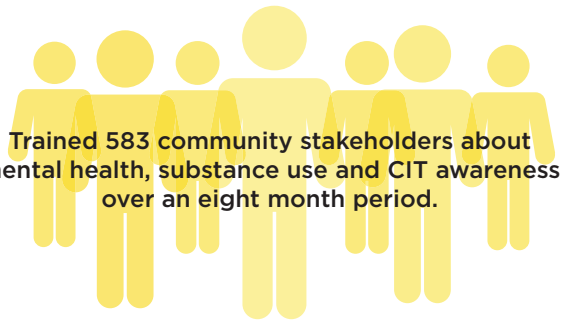
7 Participants include Mayor Rahm Emanuel's Office, Chicago Police Department, Office of Emergency Management and Communications, Chicago Fire Department, Chicago Department of Public Health, The Kennedy Forum, NAMI-Chicago, Thresholds, The University of Illinois at Chicago, Presence Health, Sinai Health System.

Number of Persons Trained

The pilot exceeded its target goal of training 400 community stakeholders. In total, 583 stakeholders received mental health training, CIT awareness training, and information on where to receive help in the community. The goals for each stakeholder group were also surpassed, with over 275 people from CBOs, over 125 from schools and over 175 from faith communities receiving training.

Table 1





Trained 583 community stakeholders about mental health, substance use and CIT awareness over an eight month period.

Structure of UIC Evaluation

UIC's Jane Addams College of Social Work conducted pre- and post-training surveys at the time of the training, as well as follow-up surveys at three and six-month intervals once the training was complete. The following data was captured from participants:

- Age
- Race/ethnicity
- Whether they lived or worked in the west side communities
- Whether they or a family member had experienced a mental health problem

Surveys were administered at four timepoints: pre-training, post-training, three months, and six months. Participants were asked questions that assessed mental illness stigma, knowledge of CIT, comfort in requesting a CIT officer, expectation that a CIT officer will be dispatched, and confidence that a CIT officer response will result in a better outcome.

UIC separately evaluated two types of training: Mental Health/CIT Awareness trainings and Mental Health First Aid with CIT Awareness trainings. Mental Health/CIT Awareness training participants were asked whether they had referred at least one person to mental health services in the three months prior to training or whether they had wanted to refer someone but did not know how or where to refer the person. Participants in Mental Health First Aid trainings were also asked to complete a series of measures developed by the Georgetown University Center for Child and Human Development to measure the effectiveness of Mental Health First Aid trainings. The questions measured participants' mental health knowledge, perceived difficulty in taking mental health actions to assist someone, and self-confidence in taking those actions.

UIC's Jane Addams College of Social Work conducted surveys administered at four timepoints:

Pre-training | Post-training | Three months | Six months

Final Results

This report reflects final results from 24 separate trainings: 14 mental health awareness trainings and 10 mental health first aid trainings.

Characteristics of Participants

In the 14 mental health awareness trainings, a total of 329 people participated in the evaluation of the trainings, though not all participants answered every survey question. Over two-thirds (68%) of respondents identified as African-American, 22% as white, 19% as Hispanic/Latino, 5% as Asian, 2% as multiracial, and about 1% each as Native Hawaiian/Pacific Islander, American Indian/Alaska Native, and some other race. Ages ranged from 19 to 79 years old, with an average of about 46 years old. Nearly 80% identified as female and 20% as male.

> **Thirty-seven percent of participants reported they had personally experienced a mental health problem, while 69% reported a family member had experienced a mental health problem.**

More than two-thirds (71%) worked on the west side and 30% lived on the west side. Of these, 23% lived and worked on the west side. More than one-third (36%) indicated they had personally experienced a mental health problem, while approximately two-thirds (67%) said a family member had experienced a mental health problem.

More than one-third (36%) reported having referred one or more people to mental health services in the past month, while one-quarter (26%) reported that, in the prior three months, they had wanted to refer someone but did not know how or where to refer the person.

Characteristics of participants in the 10 Mental Health First Aid with CIT Awareness trainings were somewhat different. A total of 176 people participated in the evaluation. More than half (56%) of respondents identified as African-American, 32% as white, 22% as Hispanic/Latino, 2% as Asian, approximately 1% each as Native Hawaiian/Pacific Islander, Middle Eastern, and American Indian/Alaska Native, and 3% each identified as some other race and multiracial. Ages ranged from 21 to 78 years old, with an average of about 40 years old. Sixty-one percent identified as female, 37% as male, and 2% genderqueer.

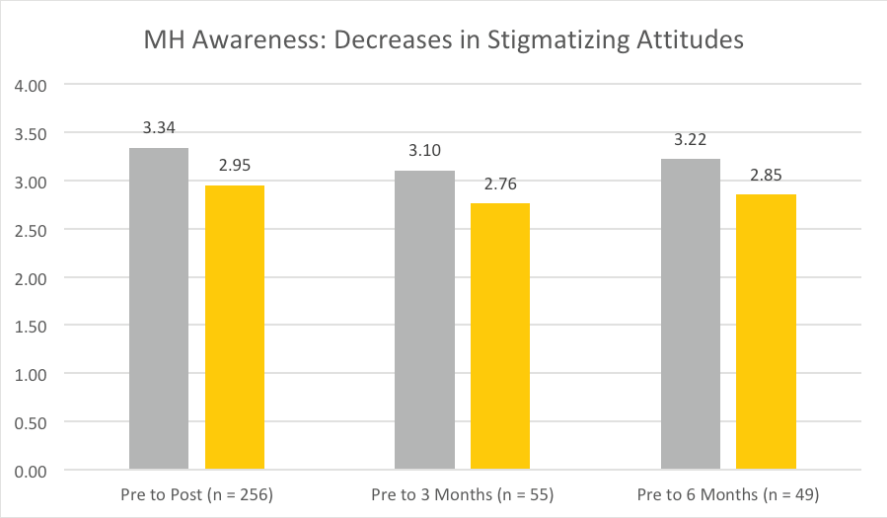
Approximately 67% worked on the west side and 33% lived on the west side. Of these participants who reported working or living on the west side, 25% reported living and working on the west side. Forty-one percent reported they had personally experienced a mental health problem, while 72% reported a family member had experienced a mental health problem.

Changes at Post-Test, Three Months, and Six Months After Training

Participants were tested before, directly after, and three and six months following both the Mental Health/CIT Awareness Trainings (MH/CIT Awareness) and the Mental Health First Aid with CIT Awareness (MHFA) trainings. Note, smaller sample sizes for the follow-up time points, which were conducted via Qualtrics surveys online.

Participants were assessed for stigmatizing attitudes with the AQ-9[8], which is comprised of nine items pertaining to attitudes about mental illnesses. Responses are on a scale ranging from 1 to 9, with higher values indicating more negative or stigmatizing attitudes. The total score is derived from summing the items and dividing by nine so that the score is on the original scale. MH/CIT Awareness participants' stigma scores were significantly lower at all periods after receiving the training (*see Figure 1*). On average, participants' scores decreased by 0.39 of a point from pre-test to post-test (3.34 to 2.95), and these changes maintained in the follow-up period with a difference of 0.34 of a point from pre-test to three months (3.10 to 2.76), and 0.38 of a point from pre-test to the follow-up at six months (3.22 to 2.85).

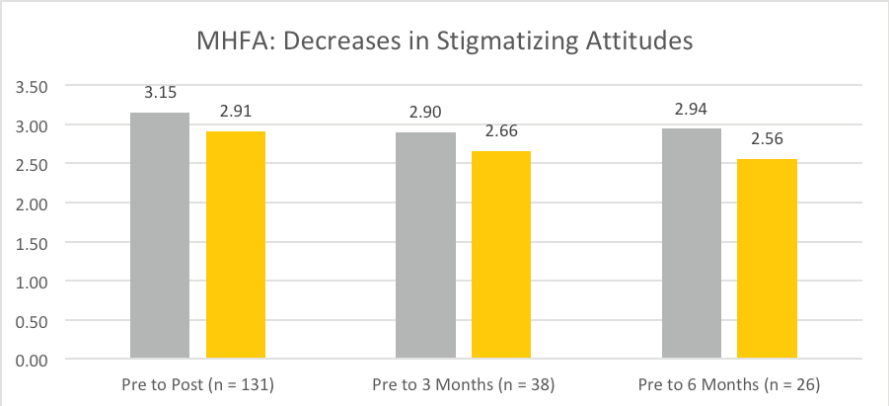
Figure 1



8 Corrigan P, Markowitz F, Watson A, Rowan D, Kubiak M. An attribution model of public discrimination towards persons with mental illness. Journal of Health and Social Behavior. 2003;44:162–179

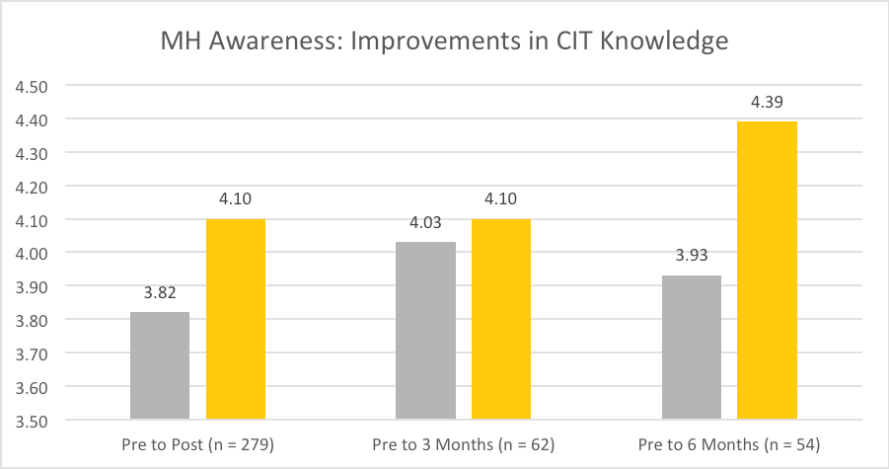
MHFA participants' stigma scores were lower than pre-training at each observation after the training. Differences were statistically significant at post-test and six months, but not at three-month follow-up (*see Figure 2*). MHFA respondents' scores decreased by 0.23 of a point from pre-test to post-test (3.15 to 2.91), 0.24 of a point from pre-test to three months (2.90 to 2.66), and 0.38 of a point from pre-test to six months (2.94 to 2.56).

Figure 2



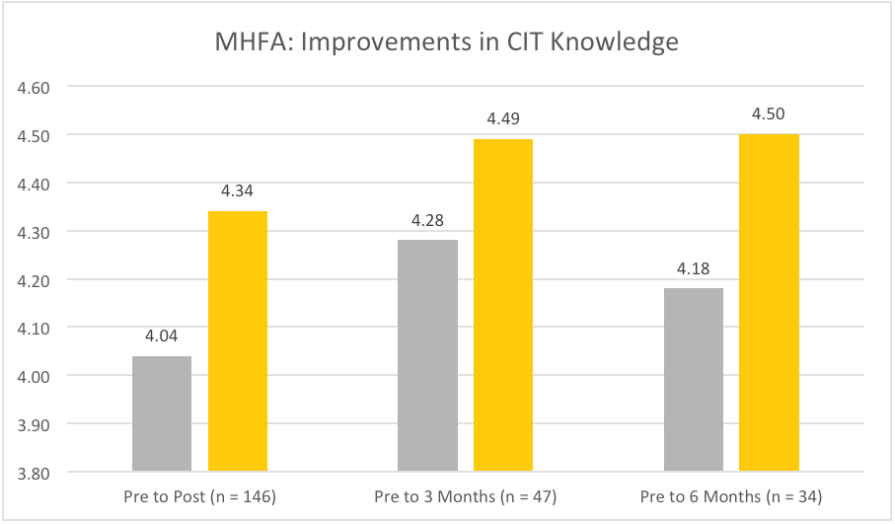
Participants from both groups were also asked five true or false questions about CIT at all four timepoints (*see Figures 3 & 4*). The average number of correct responses increased from pre-training scores at all timepoints for both groups, but not all differences were significant. For example, the MH/CIT Awareness group averaged an increase of 0.29 of a point from pre-test to post-test (3.82 to 4.10), 0.06 of a point from pre-test to three months (4.03 to 4.10), and 0.46 of a point from pre-test to six months (3.93 to 4.39), but improvements were not significant at the three-month period.

Figure 3



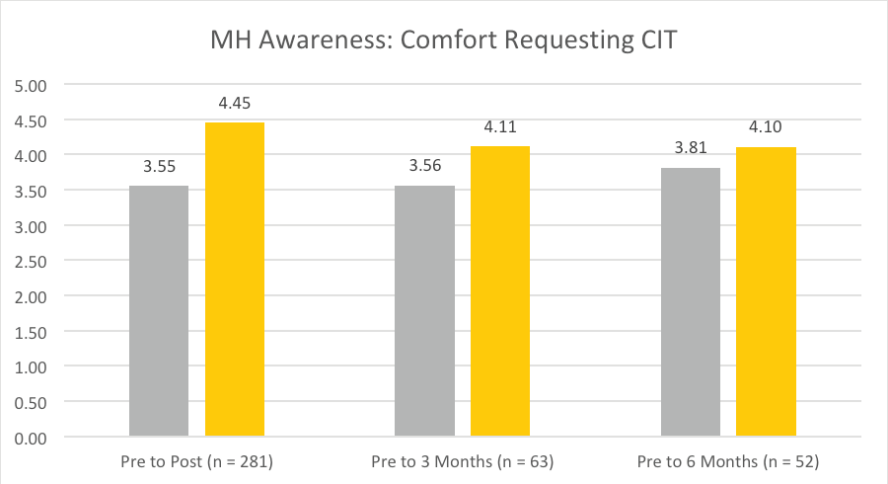
MHFA trainees' improved scores were only significant at post-test and three months. On average, scores increased by 0.29 of a point from pre-test to post-test (4.04 to 4.34), 0.21 of a point at three months (4.28 to 4.49), and 0.32 of a point at six months (4.18 to 4.50).

Figure 4



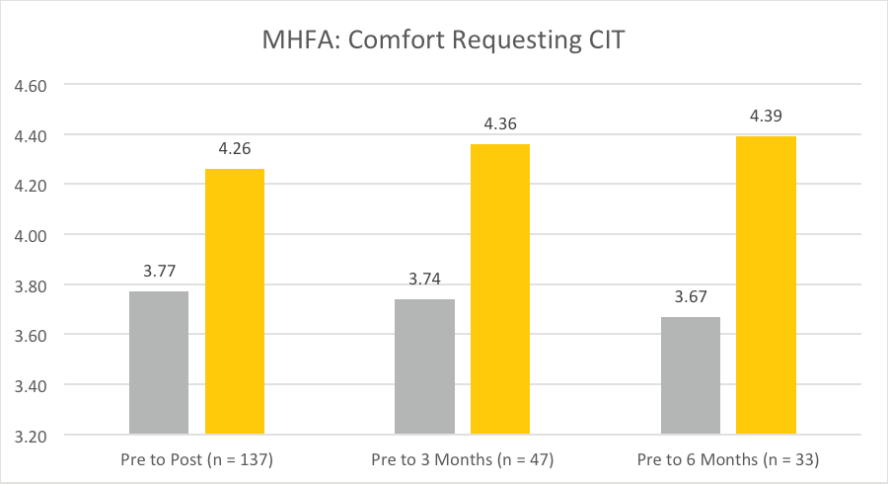
The comfort of participants in requesting a CIT officer also increased for both groups following trainings (*see Figures 5 & 6*). Using a scale from 0 - 5, MH/CIT Awareness training participants' self rated comfort level increased over baseline by 0.90 of a point at post-test (3.55 to 4.45), 0.56 of a point at three months (3.56 to 4.11), and 0.29 of a point at six months (3.81 to 4.10). However, differences were not significant at six months.

Figure 5



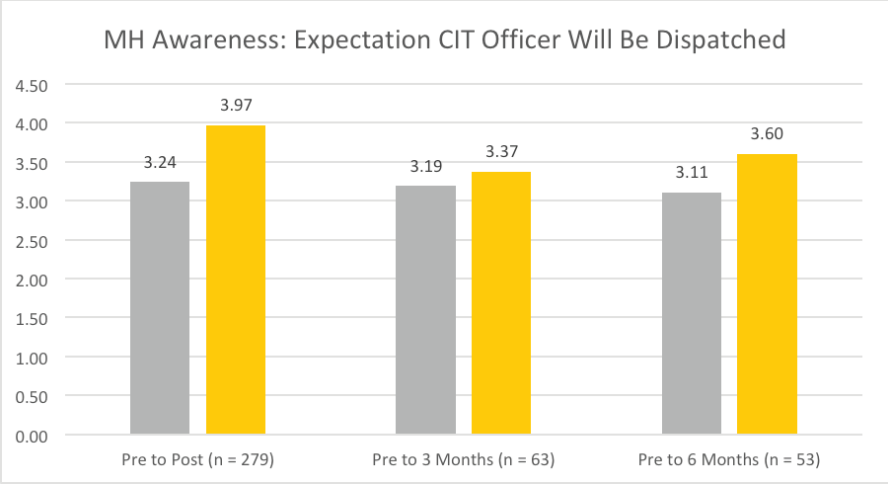
In contrast, MHFA participants comfort-levels significantly increased over pre-training levels at all follow-up time points. Comfort scores increased by 0.49 of a point at post-test (3.77 to 4.26), 0.62 of a point at three months (3.74 to 4.36), and 0.73 of a point at six months (3.67 to 4.39).

Figure 6



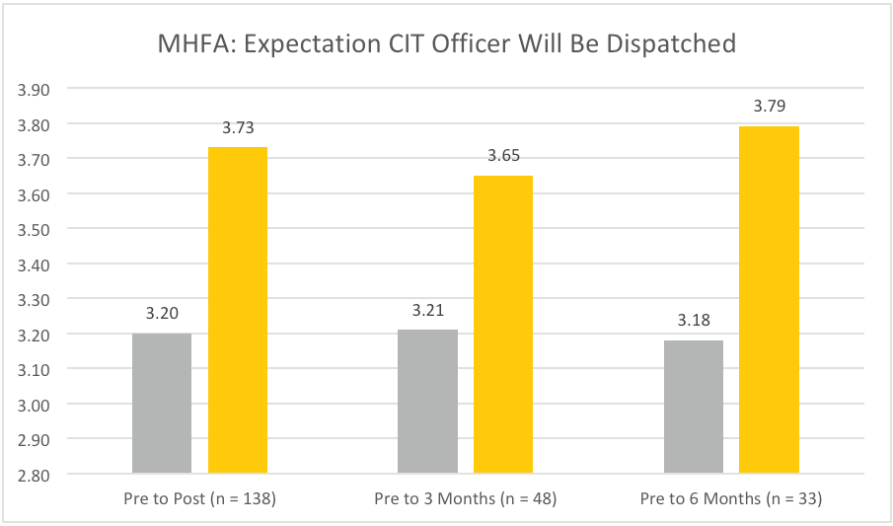
Participants' expectations that a CIT officer will be dispatched also increased in both training groups (*see Figures 7 & 8*). Using a scale from 0 - 5, MH/CIT Awareness participants' average expectation scores increased over pre-training scores by 0.72 of a point at post-test (3.24 to 3.97), 0.17 of a point at three months (3.19 to 3.37), and 0.49 of a point at six months (3.11 to 3.60), increases were significant at post-test and six months.

Figure 7



By way of contrast, MHFA participants expectation scores were significantly higher at all follow-up periods. Their expectation scores increased over baseline by 0.53 of a point at post-test (3.20 to 3.73), 0.44 of a point at three months (3.21 to 3.65), and 0.61 of a point at six months (3.18 to 3.79).

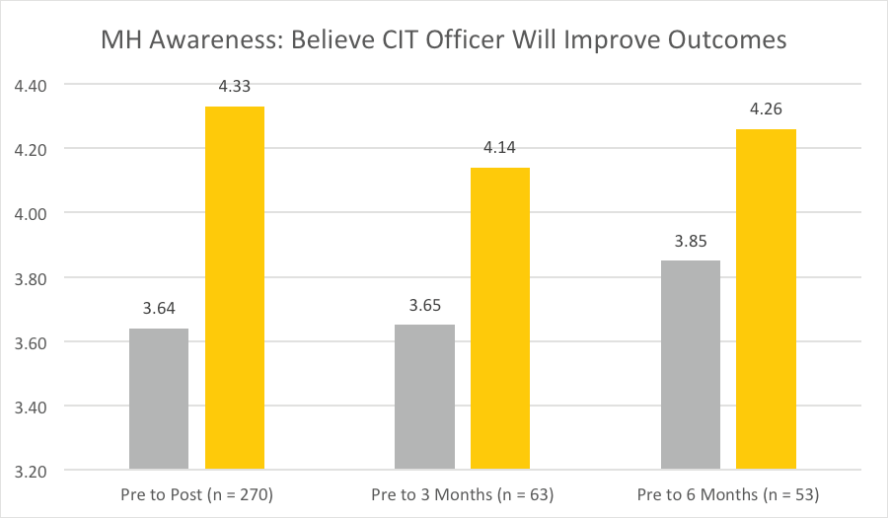
Figure 8



The survey also measured whether participants believed that having a CIT officer respond would improve outcomes of a mental health call. Both groups had increased belief scores over pre-training averages at all time points (*see Figures 9 & 10*). Increases in MH/CIT Awareness participants' scores were statistically significant over pre-test at all follow-ups. On average,

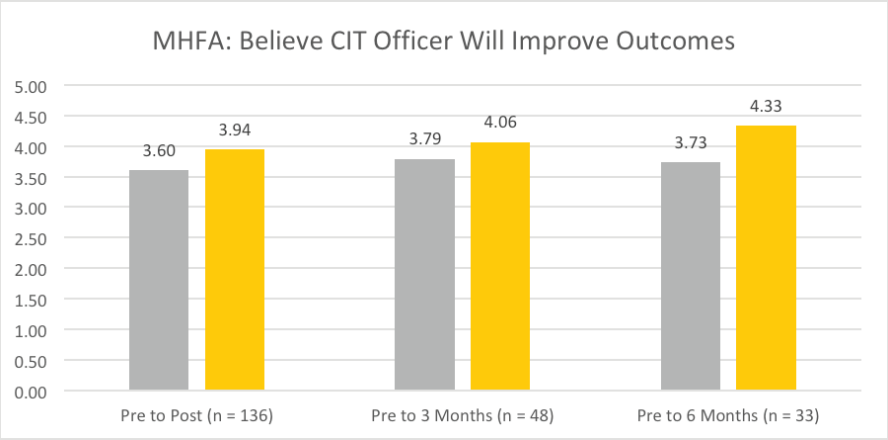
participants' beliefs in CIT officers leading to improved outcomes increased over pre-test by 0.68 of a point at post-test (3.64 to 4.33), 0.49 of a point at three months (3.65 to 4.14), and 0.42 of a point at six months (3.85 to 4.26).

Figure 9



The MHFA group's belief scores also increased at each observation, differences over baseline were significant at post-test and six months. Their belief scores increased over pre-training averages by 0.35 of a point at post-test (3.60 to 3.94), 0.27 of a point at three months (3.79 to 4.06), and 0.61 of a point at six months (3.73 to 4.33).

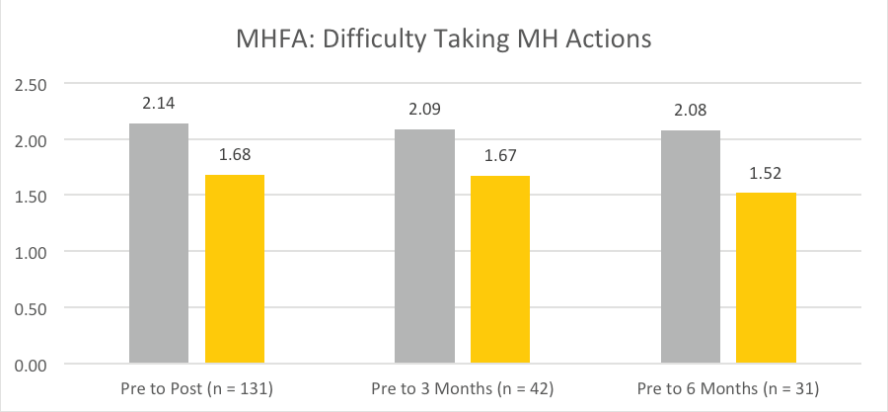
Figure 10



MHFA Specific Measures

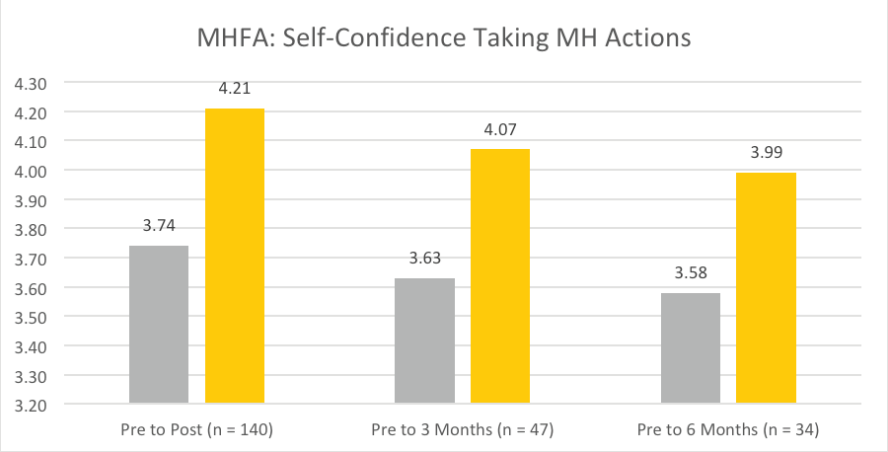
Finally, participants in the MHFA trainings were also asked to complete a series of measures developed at Georgetown Center for Child and Human Development to test the effectiveness of MHFA trainings. The measures, administered at pre/post and follow-up, asked about perceived difficulty in taking mental health actions to assist someone, self confidence in taking those actions, and mental health knowledge. Using a scale from 0 - 5, participants' difficulty scores decreased significantly (meaning less difficulty) from baseline averages at all follow-up periods (*see Figure 11*). Scores decreased from pre-training by 0.46 of a point at post-test (2.14 to 1.68), 0.42 of a point at three months (2.09 to 1.67), and 0.56 of a point at six months (2.08 to 1.52).

Figure 11



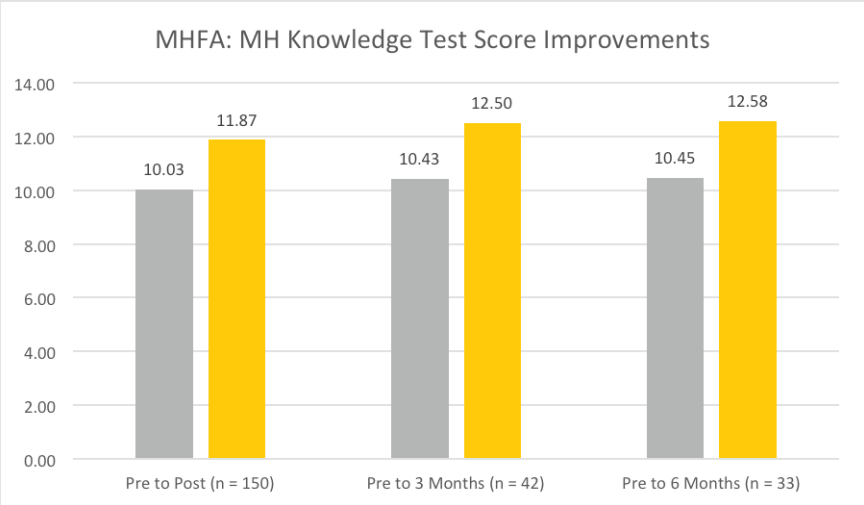
At the same time, MHFA participants' self-confidence in performing these actions increased significantly at all follow-ups (*see Figure 12*). Scores increased over pre-training averages by 0.47 of a point at post-test (3.73 to 4.21), 0.44 of a point at three months (3.63 to 4.07), and 0.41 of a point at six months (3.58 to 3.99).

Figure 12



Lastly, scores on the mental health knowledge test also increased significantly at all observations after training (*see Figure 13*). Out of a possible score of 15 correct responses, the average number of correct responses increased from pre-test by 1.84 correct responses at post-test (10.03 to 11.87), 2.07 correct responses at three months (10.43 to 12.50), and 2.12 correct responses at six months (10.45 to 12.58).

Figure 13


MHFA: MH Knowledge Test Score Improvements
14.00
12.00
10.00
8.00
6.00
4.00
2.00
0.00
10.03
11.87
10.43
12.50
10.45
12.58
Pre to Post (n = 150)
Pre to 3 Months (n = 42)
Pre to 6 Months (n = 33)

Conclusion & Recommendations

The results of this pilot project show that partnering with communities and providing brief mental health trainings can decrease the stigma associated with mental health and addiction, increases knowledge and comfort in contacting a CIT trained police officer, and confidence that requesting a CIT officer will result in better outcomes in case of a mental health or addiction crisis. While the response rate for the follow-up surveys was not ideal, the data suggest that the improvements generally maintain over time.

Both trainings appeared to have positive effects, with some minor differences that may be attributable to differences in the training conditions or in the training participants across conditions (this was not a randomized trial). While we were not able to collect reliable data on actual behaviors related to assisting individuals in need of mental health care, the positive findings related to the MHFA trainings and reduced perceived difficulty and increased self confidence in taking steps to assist someone are encouraging. Additionally, comments written on the study surveys indicate that participants appreciated the trainings and found them very relevant, helpful and informative.

The findings from this evaluation suggest that partnering with community stakeholders to provide mental health training is a positive step toward supporting individuals with mental health and addiction disorders in the community, improving access to care when needed, and increasing the likelihood of requesting a CIT-trained officer response when police are needed to assist during a mental health crisis. Findings support the plan to expand the pilot into communities across Chicago, prioritizing those with the greatest need and where infrastructure and capacity already exists.

Acknowledgments

This pilot project was supported by the Chicago Department of Public Health, Michael Reese Health Trust, Sandy Hook Foundation. Each organization contributed time and energy to help bring the pilot to fruition. Thank you to BBF Family Services and their staff for being a champion and host throughout this process.

Trainings were delivered by many providers located throughout Chicago, including: Ann & Robert H. Lurie Children's Hospital of Chicago: Center for Childhood Resilience, Laynie Foundation, NAMI Chicago, Presence Health, Sinai Health System: Under the Rainbow, Thresholds, and Trilogy Behavioral Healthcare.

UIC's Jane Addams College of Social Work was led by Dr. Amy C. Watson, Dr. Lorrie Rickman-Jones, and their research team, including Emily Janvier, Ioana Qureshi, Emily Keating and Andrew Repp.

Community Partners that helped shape, inform, and raise awareness of this project, including: Advocate Health Care, Alderman Burnett, Alderman Ervin, Alderwoman Mitts, Alderman Scott, Alderman Taliaferro, Anixter Center, Ann & Robert H. Lurie Children's Hospital of Chicago: Center for Childhood Resilience, BBF Family Services, Bethany Fund, Blue Cross Blue Shield Illinois, Bobby E. Wright Comprehensive Behavioral Health Center, Catholic Charities of the Archdiocese of Chicago, Chicago Area Project, Chicago Department of Public Health, Chicago Police Department, Chicago Public Schools, Chicago Urban League, Cook County Health and Hospitals System, Gateway Foundation, Hartgrove Behavioral Health, Health and Disability Advocates, Hope Community Church, I Am Able, Interfaith Mental Health Coalition, The Kennedy Forum Illinois, Laynie Foundation, Loretto Hospital, Mt. Vernon Baptist Church, MADO Healthcare, Michael Reese Health Trust, NAMI Chicago, Next Level Health, Presence Health, Primo Center, Saint Anthony Hospital, Sandy Hook Promise, Sinai Health System, Thresholds, Trilogy Behavioral Healthcare, Westside Community Stakeholders, Westside Health Authority, and University of Illinois-Chicago.

For more information, visit thekennedyforumillinois.org

The Kennedy Forum works to end stigma and discrimination against people with mental health and addiction challenges. Our aim is not just to change the conversation, but to change the system.

THE KENNEDY FORUM