Published in final edited form as:

J Behav Health Serv Res. 2013 April ; 40(2): 191–206. doi:10.1007/s11414-012-9307-x.

Balancing Accessibility and Selectivity in 21st Century Public Mental Health Services: Implications for Hard to Engage Clients

Amy Blank Wilson, PhD, LSW,

Mandel School of Applied Social Sciences, Case Western Reserve University, 10900 Euclid Ave, Cleveland, OH 44106-7164, USA. Phone: +1-216-3682266; Fax: +1-216-3688670; abw38@case.edu

Stacey Barrenger, MSW,

School of Social Policy & Practice, University of Pennsylvania, Philadelphia, PA, USA. Phone: +1-215-5737942; Fax: +1-215-5732791; sbarre@sp2.upenn.edu

Casey Bohrman, LSW, and

School of Social Policy & Practice, University of Pennsylvania, Philadelphia, PA, USA. Phone: +1-215-6817122; Fax: +1-215-5732791; Caseyb@sp2.upenn.edu

Jeffrey Draine, PhD, MSW

School of Social Work, Temple University, Philadelphia, PA, USA. Phone: +1-215-2045443; Fax: +1-215-2049606; jetpak@temple.edu

Abstract

This research highlights the importance of expanding examinations of service accessibility for hard to engage client populations to include assessments of individuals' ability to gain entrance to services and the system's ability to meet the service needs of particular client populations. The results of this research provide a framework to support these examinations. The increasing levels of selectivity and targeting of mental health services to particular client populations found in this study raise fundamental questions about the goals of service accessibility in 21st century public mental health services generally, and for hard-to-engage clients particularly. These findings also point to the need for examinations of the eligibility criteria and gatekeeping mechanism that are used to target services to particular client populations to determine if they are working as intended and to assess what impact these mechanisms have on hard to engage clients' ability to gain entrance to needed services.

Introduction

The accessibility of services in the public mental health system has been a vital topic in research and policy making for over three decades,¹ yet services provided in this system of care are still characterized as "maze like" and cloaked by a veil of invisibility.^{2,3} The lack of transparency surrounding the structure and content of services in the public mental health

system creates major obstacles to peoples' ability to gain entrance to appropriate services, and to researchers' ability to quantify these services.

Access to mental health services is defined as a person's ability to obtain appropriate services.⁴ A key component of this definition centers on a person's ability to identify and gain entrance to necessary and suitable services.⁴ However, the vast majority of research on service accessibility has operationalized access in terms of service utilization rates because, "proof of access is in the use."¹ (p. 272)

Service utilization rates offer descriptions of how individuals use services after gaining entrance to them. But assessments of individuals' actual ability to gain entrance to services and the system's ability to provide needed services are also important to the study of service accessibility. All three types of information (service utilization, individual access, and service availability) are required to help researchers and policy makers more accurately pinpoint barriers in accessing mental health services.

This level of precision in the study of service accessibility is especially valuable when developing services for hard-to-engage client populations, such as people with mental illness with criminal justice involvement. Prior research has characterized this client population as having difficulty with individual access and service utilization.⁵⁻⁹ However, research has yet to determine whether problems with individual access stem from the person's failure to request services, the system's inability to provide services to meet these clients' needs, the presence of access barriers that make it difficult for these clients to gain entrance to services, or problems using services after gaining entrance to them. This gap in knowledge forces policy makers to develop services without a clear empirically driven understanding of the nature of the access problems confronting clients such as these.

This article explores two aspects of service accessibility that require further examination: service availability and individual access. This examination includes analyses of individual access and service availability in a large public mental health system. It also examines the implications of recent service developments for the availability and accessibility of services generally and for hard-to-engage client populations, specifically people with mental illness involved in the criminal justice system. These analyses provide a framework for future empirical examinations of the access problems confronting hard to engage clients, by providing the means needed to study the public mental health systems' ability to provide needed services, and clients' ability to gain entrance to them.

Background

The complexity, of access problems confronting consumers of mental health services, and the problems associated with addressing this complexity, can be seen in experiences of hard-to-engage client populations, such as people with mental illnesses involved in the criminal justice system. The service accessibility problems facing this client population have been framed as a problem of service linkage.¹⁰ This explanation, which focuses on individuals' inability to identify and ask for services, has led to the development of case management services designed to facilitate linkage to services for this client population.¹¹ In order to determine the effectiveness of this service strategy at ameliorating the access problems

confronting this client population, it is necessary to examine the extent to which clients are successful in gaining entrance to the mental health services to which they are linked. However, existing measures of service accessibility cannot address this question because they only measure services clients use after they have gained entrance to them.

There are some system-level measures of service accessibility that assess people's ability to gain entrance to a service. But these measures, which include indicators such as *denial of care rates* and *service penetration rates*, focus on service usage patterns of large groups of service users in relation to a particular service.⁴ As such, these aggregate-level measures cannot contribute to understanding individuals' ability to gain entrance to all of the services that they need in the public mental health system.

Examinations of service accessibility that include information related to individuals' ability to obtain needed services, can include within it a test of the systems' ability to meet the treatment needs of particular clients, or client populations. However, examinations such as these require service usage information that is not typically recorded in mental health records used in system-level or population-level analyses. For example, assessments of a service system's ability to provide needed services require information related to the availability of the types of services that a particular client group needs. Research has identified a number of ways to examine the match between identified and met service needs.¹² Yet similar to service utilization rates, these measures do not include the number of services a client tried to gain entrance to, or the number of services available in a given system to meet a particular service need. Rather, these approaches, like service utilization rates, are limited to examinations of the services a person actually receives once access has been gained.

This reliance on utilization measures as a proxy for service accessibility is problematic; without information related to the services available in a given treatment system, the issue of where service accessibility problems begin cannot be determined. This article presents research findings that lay the foundation for studies of service accessibility that include assessments of service systems' ability to provide services and clients' ability to gain entrance to them. Examinations of these aspects of service accessibility require information related to (1) the full range of service options available to people with serious mental illness in the public mental health system; and (2) how each service is structured in terms of program eligibility criteria and application procedures so that any restrictions on accessibility can be identified and included in analyses of service accessibility issues for hard to engage client populations. This analysis adds to research in this area by providing an understanding of the full array of mental health services available to adults with serious mental illness within a particular public mental health system, the range of service options available within each service area, and details related to the processes involved in accessing each service option. Information such as this provides a typology of services that can be used as a foundation for future studies that examine the system's ability to meet the treatment needs of client populations, such as people with serious mental illness and criminal justice involvement, and examinations of clients' ability to gain entrance to needed services in this system of care.

Methods

Site

This study examined what services are available to adults with serious mental illness in the public mental health system in Philadelphia, Pennsylvania, which serves over 40,000 individuals each year.¹³ The Philadelphia public mental health system consists of a combination of community mental health centers, specialty agencies, crisis response centers, and inpatient psychiatric units. The city's Department of Behavioral Health oversees the provision of a full continuum of clinical mental health services, which are provided in conjunction with an array of additional treatments and supports such as residential treatment options, social and recreational services, and peer supports. However, attempts to obtain a comprehensive listing of the services provided in the city's public mental health system were unsuccessful because this public mental health system, like many others, maintains service directories that are indexed by service providers, not services. This practice stands in direct contrast to how services are indexed in general medical settings where consumers are presented with a menu of service options that are grouped by subspecialties when appropriate, from which they can select a particular service provider to approach with a request for a specific service.

Participants and sampling

Key informant interviews—A combination of purposeful and snowball sampling techniques was used to recruit a convenience sample of 15 individuals for key information interviews.¹⁴ The need to protect participants' identities makes it impossible to report on specific job positions or sociodemographic characteristics of the informants. Instead, the sample is characterized in terms of their knowledge of mental health services provided in this mental health system, and sampling techniques used to recruit them. Recruitment for key informant interviews began with purposeful sampling techniques that were used to recruit four professionals in the mental health system who were familiar with the full array of services available in this system. These individuals were recruited because each had high-level administrative job responsibilities within the public mental health system that gave them knowledge of the full array of services available in this system of care, the history of how current services were developed, and plans for service expansion. To identify these first four participants, the research team consulted with administrators in the public mental health system to identify staff with this required knowledge. Each of the individuals approached for these first four interviews agreed to participate. During these interviews, snowball sampling techniques were used to identify staff with expertise in each of the service areas that these first four participants identified as being available.

After the first four interviews were completed, snowball sampling techniques were used to identify participants with detailed knowledge about the range of service options available within each service area identified in the initial interviews, and the eligibility and application procedures associated with each service option. A total of 13 individuals were approached to participate during the snowball sampling phase of key informant interviews, of which 11 agreed. The two individuals who declined cited time availability as their reason for refusal. In each of these cases, snowball sampling techniques were used to identify other

administrative staff with equivalent knowledge of the service area as the two participants who declined.

Key informant interviews during this stage of sampling included eight system-level administrators and supervisors working in specific service areas and three agency-level administrators and supervisors who were identified as experts because they worked closely with the system-level staff of the public mental health system to develop and implement services in a particular service area. Sampling for key informant interviews continued until saturation was reached. This occurred when the structure and content of each type of service was explained and no new service types or options were identified in interviews.

Focus groups—Focus groups were conducted with a convenience sample of 14 line staff in the city's behavioral health case management and outreach services who volunteered to participate. Potential participants were recruited using flyers that were distributed to case management departments and outreach services throughout the city, and at mandatory citywide case management training sessions. Case managers and outreach workers were targeted for participation in the focus groups; their experiences working with clients to identify and obtain services in this public mental health system gave them ground-level information about the types of services available, and procedures associated with accessing them, which could be used to test the accuracy and completeness of the list of services that was developed during the key informant interviews.

Data collection

Key informant interviews—The first step in data collection was the 15 open-ended key informant interviews. Key informant interviews began with the systems-level administrators. These interviews were used in part to generate lists of the different types of services available in this public mental health system. Then, service specialists associated with each service area were interviewed to gain more information about the different service options available in their area of specialization, and the eligibility and application procedures associated with their use. All of the key informant interviews began with an open-ended question that asked staff about the services available to adults with serious mental illness in their public mental health system. Probes and follow-up questions were used to obtain information about the range of services available in this system, the types of service options available in particular service area, and the types of eligibility criteria and application procedures associated with accessing each identified service option. Interviewers developed a list of service areas and service options identified in each interview, which they reviewed with participants during the interview in order to check the accuracy and completeness of the list. At the end of each interview, copies of any written materials associated with services were collected, and participants were asked to identify other service professionals who could be useful informants for the study.

Focus groups

Two focus groups were conducted with line staff after the key informant interviews were completed. Focus groups were conducted by an experienced facilitator and co-facilitator; two research assistants observed the focus groups and took handwritten notes during the

groups. Facilitators used a funnel approach with low levels of moderation to ensure that the participants' understanding of the service system was driving the direction and content of discussions.¹⁵ Each focus group ran for approximately 1 hour.

Administrative and organizational documents

Administrative and organizational documents were obtained from participants and from the public mental health system's web site. Documents included informational pamphlets, training materials, and organizational documents that described a particular type of service, such as case management or crisis services, or service options available in a given area. Written application packets were collected for all services that used them. Written materials and regulations related to eligibility criteria for services were also collected.

Data analysis

Data collection and analysis was an iterative process that involved three stages described below. Data were triangulated by method and source during analysis to ensure the rigor and authenticity of the analysis.¹⁴ During the first stage of analysis, analytic triangulation methods were used by a three-member coding team that consisted of one senior researcher and two research team members. This team of coders used open coding techniques to develop a list of initial codes that represented the different types of services identified by key informants.¹⁶ Whenever program materials were available, the coders triangulated information obtained in the interviews with that available in the written materials as a source of corroboration. In every case when written materials were available, the information in them supported the information obtained during the interviews and often provided additional details related to the eligibility criteria and application procedures associated with specific services. All of the services identified in the key informant interviews were corroborated by at least one other source of information. The vast majority of services were triangulated across all three sources of data (interviews, focus groups, and written materials). The notable exception to this level of triangulation were the boutique services described in the "Results" section, where knowledge about the existence of each of these services appeared to be limited to high level administrative staff working in a particular service area. The coding team met regularly to refine and finalize the initial coding list during the first stage of analysis. During these meetings and all subsequent coding activities, discrepancies in codes were discussed by the team and the data associated with each code further analyzed as a group until consensus was reached among coders on how to resolve discrepancies.

The second stage of analysis began after the key informant interviews were completed and the initial list of codes was finalized. During this stage, the services identified in the first stage of analysis were presented to focus group participants in order to check the completeness and accuracy of this list. Data collected from focus groups were coded using the open coding techniques described above. These codes were then triangulated with codes developed from the key informants and written materials using the consensus approach to coding described above. The results of this stage of analysis confirmed that saturation had been reached as no new service areas or options were identified by the focus group participants. However, data collected during this stage did provide more comprehensive

understanding of the eligibility criteria and administrative procedures associated with gaining access to specific service option.

In the last stage of analysis, selective coding and the constant comparative method were used by the full study team to categorize the different types of services within broader service categories.¹⁷ After these core service categories were developed, these coding techniques were used to systematically categorize individual service options within a core service category. This method of data analysis made certain that service categories and options were sufficiently grounded in the data. It also provided a structured process that ensured that the core service categories did not overlap and that service options available within each area represented all of the services available within this public mental health system.

Results

The public mental health system under study was found to contain a complex array of services for adults with serious mental illness developed at different times and for different purposes. Earlier services reflect elements of the community mental health system that were developed to meet the needs of deinstitutionalized populations. Later services became more selective and specialized in their target population and service content in attempts to bridge newly identified service gaps. The word “services” carries multiple meanings in the mental health literature. It is used in some cases to denote a general category of service used in the public mental health system, such as case management, which represents a service platform that contains many specific service options. In other cases, the word “service” is used to indicate a particular service option associated with a service platform such as intensive case management services.

The service typology presented here organizes particular service options according to the service platform from which they were developed. The term “service platform” is used to denote the general category of service, and “service option” is used to indicate individual services available within each platform. In the following tables, the rows of the table provide a comprehensive accounting of all of the service options that are available in this public mental health system. The columns organize each service option according to the service platform to which each option belongs.

The tables then organize service options and platforms into a typology. Service platforms are organized into three analytic categories referred to as “stages.” A listing of the service platforms and their stages of development can be found at the top of Tables 1, 2, 3, and 4. Service options are organized into four analytic categories referred to as “generations.” Each generation of service options is listed sequentially in Tables 1, 2, 3, and 4, so Table 1 lists the service options associated with the “first generation,” Table 2 lists the service options associated with the “second generation,” and so on.

Interviews with the staff of the public mental health system showed that the service platforms available in this system of care developed over time in response to the system’s identification of treatment needs that were not being adequately addressed in the existing

service structure. Therefore, the service platforms are categorized into stages based on the type of need that the platform was designed to address.

This analysis of service platforms found that the first two stages of development in this public mental health system were consistent with developments occurring in public mental health systems across the country. For example, the first stage of development in service platforms titled, “The Beginning” (see Table 1), contains the three service platforms—crisis, inpatient, and outpatient—which collectively constituted this mental health system’s initial community-based response to deinstitutionalization. These platforms were categorized as belonging to the first stage of service development in this system because they were each developed as part of the city’s initial efforts to create a community-based public mental health system and fulfilled the early service mandates established by the Community Mental Health Centers Act of 1963.¹⁸

The second stage of development in service platforms in this public mental health system is titled, “Service Expansions” (see Table 2). Service platforms developed during this stage include community-based case management and residential treatment services. Professionals in this service system explained that these service platforms represented a system-level response to service needs of recently deinstitutionalized clients who were left unaddressed by service platforms associated with the initial stage of service development in this system of care. The development of these new service platforms was also consistent with the evolution in service development that was taking place across the country at the time.^{19,20}

The last and most recent stage of development in service platforms in this public mental health system is titled, “Addressing Underserved Populations” (see Table 3). Service development during this stage was more selective, focusing on addressing the needs of specific client populations who had difficulty engaging the services available in the more general platforms developed during the previous two stages. This selectivity stands in contrast to service developments during the earlier stages when the emphasis was on developing a comprehensive system of care for persons with serious mental illness generally.

While the three stages of development in service platforms in this service system provide an overview of the general types of services that have been developed in this public mental health system generally, this level of analysis is where most prior discussions of service development in this system of care ends. However, focusing only on the general type of service does little to elucidate the nature and content of services being provided within each platform. In order to understand the full extent of this service system’s efforts to develop a comprehensive array of community-based mental health interventions for people with serious mental illness, one has to look at the specific service options that the system developed within each platform. Analysis of staff interviews in combination with document analysis revealed a progression of service development, wherein over time the target population and/or focus of intervention of particular service options became more selective. This resulted in the categorization of service options within this typology based on the degree of selectivity associated with how services were targeted. This selectivity was

identified by analyzing the service eligibility criteria and application procedures that governed how people enter and exit the service (gatekeeping).

The term “generations” is used to categorize three of the four rows of services illustrated in Tables 1, 2, 3, and 4 in order to indicate an evolution in the development of service options within each service platform that was similar to how psychoactive drugs developed. More selective forms of service options have developed within service platforms over time to address problems associated with service options available in early generations. Table 1 illustrates the first generation of service options that were associated with the initial stage of program development in this mental health system. Analysis of the eligibility and application procedures associated with these service options found that, as would be expected in the early stages of the community mental health system, these service options had few system-level gatekeeping measures because they were designed to serve a broad population of consumers. These options lacked written eligibility criteria or formalized application procedures associated with their use.

Table 2 illustrates the second generation of service options in this system of care. Formalized service eligibility criteria and application procedures, designed to select who among those in need of service would actually receive them, began to be incorporated into service options developed during this generation. This development is one of the features that delineate the second generation of services from the first, as these service apparatus represent attempts to narrow services to subpopulations of people with serious mental illness by using a number of different mechanisms. For example, eligibility criteria, written applications, and gatekeepers, who were key-level administrators who make decisions about the use of service on a case-by-case basis. For example, residential and case management service options began using formalized eligibility criteria in conjunction with written applications and gatekeepers early in their operations. In addition, new service options that developed in service platforms in the initial stage of program development also began to incorporate different combinations of these service apparatus to restrict their access. For example, mobile crisis services and extended acute inpatient services used system-level gatekeepers to narrow access, while long-term structured residences used explicit eligibility criteria in combination with system-level gatekeepers and formalized application procedures.

In the third generation, illustrated in Table 3, selectivity in services was characterized by a further narrowing of program eligibility criteria in new service options across all service platforms. Service options in this generation continued to use different service apparatus such as gatekeeping and application procedures to restrict their use. However, service options in this generation further restricted their eligibility criteria in order to narrow their point of entry to subpopulations of potential consumers. For example, the crisis intervention team (CIT) represented a narrowing in the point of intervention of crisis services because it is only available to people with serious mental illness who police personnel identify as being in crisis at the point of a police contact. Residential and case management service options associated with the third generation each restricted their use to subpopulations of consumers in need of their services, such as those with multiple involuntary commitments or individuals with behavioral problems that impeded their adjustment to more traditional

residential program settings. There is also a narrowing of target populations in this generation even in the service platforms that already restricted their point of intervention to particular client populations. So, for example, service options associated with homeless individuals with mental illness contain a further restricting of service eligibility for particular service options to specific subpopulations of homeless individuals, such as people living in shelters or on the street long term and those in need of housing that address mental health and substance abuse issues.

A number of service options for people with criminal justice involvement were developed during the third generation of service development. However, forensic services during the third generation were not developed as a coordinated system-level response to the need of people with mental illness involved in the criminal justice system. As such, these service options were classified under the service platform from which they were developed because during this generation these service options represented increasing selectivity in the focus of intervention in existing service platforms. CIT, however, was classified as a forensic initiative because it was one of the first system-level efforts to create a service option specifically for persons with serious mental illness involved in the criminal justice system that included cross-system collaborations in its development, implementation, and ongoing operations.

Analysis of the structure and content of service options in each generation found that the growing selectivity of services during the third generation was accompanied, in some cases, by service configurations that blurred traditional service platform boundaries. For example, CIT services involved a level of collaboration and coordination between the police and crisis services that included co-training, with staff in the mental health and police department dedicated to work collaboratively on the provision of CIT services. Additionally, the housing-first program integrated services traditionally provided by the city's housing department with ACT teams run by the Department of Behavioral Health into one service program.

This emerging trend is important to note because it converges with the increasing levels of service selectivity and gatekeeping in the final generation of service options titled Boutique Services (Table 4). In this generation of service options the trend toward increasing selectivity and blending of traditional service platforms led to the hybridization of services where elements of service options from different service platforms are combined into new hybrid service options that are so selective and specialized that few people even know of their existence. This stage was labeled "boutique services" because these service options were found to operate as niche services, with a limited capacity to provide intensive, high-end services to a very select client population identified internally by key high-ranking mental health administrators. Each of these service options are defined by extremely specific eligibility criteria by which individuals are identified and selected for a service, often without their knowledge, by key systems administrators using internal administrative data sources. Decisions about program entrance and exit are made by high-level administrators who take referrals only from set lists of administrative data and/or other key system-level administrators. Such an insular type of referral process was found to create services that have no external access points, which means that there is no way for clients or their

advocates to ask for these services, rather they have to wait to be identified through an invisible, internal process. For example, both the continuity of care teams and rapid response teams were categorized as boutique services because these service options offer an intensive combination of case management and crisis resources to a select group of consumers, who are identified and selected by administrative staff of the mental health system. Interestingly, the continuity of care teams are so small and selective that fewer than five of the people interviewed knew of their existence and only one mentioned this service without prompting from the interview team. These programs maintain no external point of referral because it uses system-level gatekeepers who accept referrals only from a select group of predetermined system-level personnel.

The city's forensic ACT team is also classified as a boutique service because it is a resource-rich service that combines outpatient treatment services, criminal justice support, and traditional case management services into one program and has program eligibility criteria that restrict its use to people with mental illness on specific court dockets. Additionally, it also maintains no external access points. Potential participants are identified by a team of gatekeepers that includes representatives with the mental health and judicial systems who work together to make decisions about program eligibility using internally generated lists of potential candidates.

Discussion

This study demonstrates how a large, urban, public mental health system has worked to develop a comprehensive array of community-based services for people with serious mental illness. This system's early efforts to develop services are consistent with what is known about how community-based services evolved in general during those time periods.¹⁹ This analysis extends knowledge of service development to include how services have continued to evolve and develop during the more recent post deinstitutionalization and managed care eras.

The increasing levels of selectivity and targeting of services found in the more recently developed services in this public mental health system could be signs of system-level service rationing that public mental health services have had to engage in to manage access to scarce resources.²¹ They could also be an example of innovation in a service-rich public mental health system that has secured access to the basic mental health services required for the general population of people with mental illness, and is now working to fine-tune its system to better serve those individuals who slip through the cracks of existing services.

Regardless of the explanation for the high levels of selectivity found in many services in this study, this research found that services in this system were increasingly relying on service apparatus designed to select specific service recipients from among a larger group of individuals in need the service. The widespread use service apparatus such as these support the need to expand examinations of service availability to include measures of individual service recipient's ability to gain entrance to needed services.

The potential effect that the service selectivity found in this study can have on service accessibility generally, and for hard-to-engage populations particularly, is best illustrated by boutique services. These services lack external access points and use key system-level administrators to identify and select service recipients without outside accountability. This level of selectivity raises questions about whose needs these services are designed to address, the consumer or the system. They also raise questions as to whether the case management programs designed to link hard-to-reach client populations, such as people with serious mental illness involved in the criminal justice system, can even do their job effectively. These questions become important to consider in light of the development of services that have been designed specifically for their client populations, but which case managers are left unaware of and unable to request. Situations such as these lead to questions about the fundamental fairness of investing public resources in service options that remain invisible to all but a few professionals.

The trend toward selectivity and specialization in services found in this study raises questions that require further consideration by researchers and policy makers. For example, how can the public mental health system reconcile the increasing amount of selectivity and administrative controls being placed around the use of services with the president's New Freedom Commission's²² call for the development of recovery-oriented services designed to give consumers a more active and direct role in the selection and provision of services?²³ In order to take responsibility and advocate for access to desired services, consumers must have knowledge of those services and a means to access them.

The increasing levels of targeting of services to particular client groups found in this public mental health system also raise questions about the system's ability to engage the integrated care initiatives currently being developed.^{24,25} These initiatives are based on the recognition that people with serious mental illnesses often have additional, co-occurring needs such as substance abuse, homelessness, chronic medical conditions, or criminal justice involvement that require integrated, coordinated responses. However, segmentation and specialization of services require the public mental health system to categorize individuals in ways that inhibit the system's ability to address the fluid, intertwined nature of these problems. Specialized services make sense from a policy and management perspective in that workers and resources can be used in the most efficient way. However, the specialization and the selectivity in service target populations that accompany it produce more silos of care, rather than addressing individuals in a holistic, integrated way.

The growing number and complexity of administrative controls that accompany the increasing selectivity of services in this public mental health system raise important issues for future studies of service accessibility. Even if one accepts the need for increasing levels of administrative control around the allocation of services, the service system still needs to have mechanisms in place to assess whether these controls are working as intended. This once again, points to the need to develop a more comprehensive range of measures of service accessibility, so that the effect of these administrative controls on individual access and service availability for particular client populations can be assessed. This research is necessary to fully understand how people are using mental health services and how the structure and design of services are affecting these usage patterns, especially when

examining services intended for hard-to-engage client populations. Without this more nuanced understanding of service accessibility, explanations of low usage patterns often presume the problem is a lack of interest or ability on the part of prospective service users. This assumption could lead to highly specialized, yet inaccessible interventions if the real explanation for low service usage is the impermeability of the system to people who need the services most.

Limitations

While this research engages techniques such as data triangulation to improve the rigor and authenticity of its findings,¹⁴ it has limitations. First, the data presented here are drawn from one public mental health system. While this is a large, urban system whose service system was found to have many elements in common with what is known about services in public mental health systems generally; it is likely that some of the developments in services found in this system are particular to the size, location, and service history of this particular system. Second, because of the high level of service specialization present among professionals in this public mental health system and the compartmentalization of knowledge about services that accompany this type of specialization, member-checking techniques were not used. Rather, interviewers took steps to ensure the accuracy and completeness of services identified in each interview, and data triangulation methods were used to ensure a comprehensive, in-depth understanding of services available in this system of care. However, despite these limitations, this research represents an important step in expanding understanding of service accessibility and provides a number of findings that are likely to be present to varying degrees in other public mental health systems. Thus, it is important that future investigations of the accessibility of public mental health services engage the findings of this study and the conceptualization of service accessibility presented here, so that a clearer understanding can be developed related to where problems in service accessibility lie for client populations, such as people with mental illness involved in the criminal justice system.

Implications for Behavioral Health

Public mental health systems in the USA remain one of the last bastions of centrally managed service systems. This reliance on centralized planning is in large part a response to the scarcity of resources in the system. Yet, one unintended side effect of centralization of planning in a context of scarce resources may be that service innovations can be unduly influenced by the financial constraints of a service system, which can lead to the development of niche services that are not able to effectively impact important social problems, such as the criminalization of mental illness at a population level. This analysis has shown that the evolution of mental health services can produce boutique services that are invisible and specialized, and purposefully maintain no mechanisms that support direct service requests. As public mental health systems develop specialization to increase efficiencies, they may be limiting access to important services for certain segments of the population, and limiting the capacity of a system to respond boldly and comprehensively to systemic issues. Therefore, access cannot be measured by utilization only, but must also include some measure of individuals' ability to gain entrance to services in the first place.

This analysis also suggests that future innovations in mental health services for people with mental illness with criminal justice involvement need to increase the visibility of resources available in this system of care, and the ease with which clients can gain entrance to them.

The goal of any large public mental health system is to ensure that the appropriate balance is being kept between the needs of the system (i.e., reducing the overutilization of expensive services) and the service needs of individual clients (i.e., providing appropriate and adequate services). However, the logic that service providers use to target services toward particular clients within a given treatment population needs to be clearly explicated and externally evaluated to ensure that services are being used by all of those in need. In other words, public mental health systems need to possess accessible, visible, negotiable ways for clients to gain entrance to needed services, and decisions about access need to be made in ways that fairly balance a system's financial constraints against a client's service needs. For example, in this study many of the newer, resource-rich services were found to have eligibility criteria that required clients to have a substantial history of failure in traditional services in this service system before being able to access the newer services. Yet, criteria such as these have the potential to systematically exclude clients who the system has failed to engage in more traditional services, or those who receive their mental health services in alternative systems of care, such as jail or prison.

The results of this study found that the push toward selectivity and targeting of services in this public mental health system that accompanied recent service innovations adds additional layers of complexity into an already fragmented system of care. The cost and benefits of this additional complexity need to be considered in future service innovations like the ones undertaken here. While these service innovations help to address the unique needs of specialized populations, they are also making the system so complex that even mental health administrators have difficulty identifying the full range of services provided within each program area. This suggests that there needs to be more transparency in the structure and content of public mental health services, and more analyses of the appropriate balance between specialization and access.

Acknowledgments

This research was funded in part by a grant from the Leonard Davis Institute of Health Economics, University of Pennsylvania.

References

1. Pandini JA, Banks SM, Bramley J, et al. Measuring access to mental health care: a multi-indicator approach to program evaluation. *Evaluation and Program Planning*. 2002; 25:271–285.
2. Glied S, Frank R. Better but not best: Recent trends in the wellbeing of the mentally ill. *Health Affairs*. 2009; 28(3):637–648. [PubMed: 19414869]
3. Osher, FC.; Levine, IS. *Navigating the Mental Health Maze: A Guide for Court Practitioners*. Council of State Governments; 2005.
4. Stiles PG, Boothroyd RA, Snyder K, et al. Service penetration by persons with serious mental illness: how should it be measured? *The Journal of Behavioral Health Services & Research*. 2002; 29(2):198–207. [PubMed: 12032977]
5. Abram KM, Teplin L. Co-occurring disorders among mentally ill jail detainees: implications for public policy. *American Psychologist*. 1991; 46:1036–1045. [PubMed: 1746771]

6. Lovell D, Gagliardi G, Peterson P. Recidivism and use of services among persons with mental illness after release from prison. *Psychiatric Services*. 2002; 53:1290–1296. [PubMed: 12364677]
7. Padgett D, Struening EL, Andrews H. Factors affecting the use of medical, mental health, alcohol, and drug treatment services by homeless adults. *Medical Care*. 1990; 28:805–821. [PubMed: 2402175]
8. Ridgely M, Goldman H, Willenbring M. Barriers to the care of persons with dual diagnoses: organizational and financing issues. *Schizophrenia Bulletin*. 1990; 16(1):123–132. [PubMed: 2185535]
9. Whitmer GE. From hospitals to jails: the fate of California's deinstitutionalized mentally ill. *American Journal of Orthopsychiatry*. 1980; 50:65–75. [PubMed: 7356002]
10. Draine J, Wilson AB, Pogorzelski W. Limitations and potential in current research on services for people with mental illness in the criminal justice system. *Journal of Offender Rehabilitation*. 2007; 45:159–177.
11. Wilson AB, Draine J. Collaborations between criminal justice and mental health system's in prisoner reentry. *Psychiatric Services*. 2006; 57:875–878. [PubMed: 16754768]
12. Smith BD, Marsh JC. Client-service matching in substance abuse treatment for women with children. *Journal of Substance Abuse Treatment*. 2002; 22(3):161–168. [PubMed: 12039620]
13. Department of Behavioral Health and Intellectual disability Services. Offices of Mental Health. Available online at <http://www.dbhids.org/office-of-mental-health-omh>.
14. Padgett, D. *Qualitative Methods in Social Work Research: Challenges and Rewards*. Thousand Oaks, CA: Sage; 2008.
15. Morgan, DL. *Focus Groups as Qualitative Research*. 2nd ed.. Thousand Oaks, CA: Sage; 1997.
16. Emerson, RM.; Fretz, RI.; Shaw, LL. *Writing Ethnographic Field Notes*. Chicago, IL: University of Chicago Press; 1995.
17. Strauss, AL.; Corbin, J. *Basics of Qualitative Research: Techniques and Procedures for Developing Grounded Theory*. Thousand Oaks, CA: Sage; 1998.
18. Grob, G. *From Asylum to Community: Mental Health Policy in Modern America*. Princeton, NJ: Princeton University Press; 1991.
19. Cutler DH, Bevilacqua J, McFarland BH. Four decades of community mental health: a symphony in four movements. *Community Mental Health Journal*. 2003; 39:381–398. [PubMed: 14635983]
20. Mowbray CT, Grazeir KL, Holter M. Managed behavioral health care in the public sector: will it become the third shame of the states? *Psychiatric Services*. 2002; 53(2):157–171. [PubMed: 11821546]
21. Mechanic, D. *From Advocacy to Allocation: The Evolving American Health Care System*. New York, NY: The Free Press; 1986.
22. Hogan MF. The president's new freedom commission: recommendations to transform mental health care in America. *Psychiatric Services*. 2003; 54:1467–1474. [PubMed: 14600303]
23. Power AK. A public health model of mental health for the 21st century. *Psychiatric Services*. 2009; 60:580–584. [PubMed: 19411342]
24. Goldman HH, Glied SA, Alegria M. Conclusion: mental health in the mainstream of public policy. *American Journal of Psychiatry*. 2009; 166:1215–1216. [PubMed: 19884235]
25. Morrissey JP, Fagan JA, Coczza JJ. New models of collaboration between criminal justice and mental health systems. *American Journal of Psychiatry*. 2009; 166:211–214.

Table 1

Typology of first-generation service options

Stages	The beginning: deinstitutionalization			Service expansions: addressing unmet needs	Addressing underserved populations: new service frontiers
Service platforms	Crisis	Inpatient	Outpatient	Community-based case management	Homeless services Forensic services
First-generation service options	Walk in crisis services Suicide prevention Emergency assistance with psychiatric hospitalizations	Acute State hospitals	Individual therapy Group therapy Medication monitoring Family therapy Partial hospitalization		
			Office-based, linkage/referrals service ^a		

^a Short-term, low-contact case management

Table 2

Typology of second-generation service options

Stages	The beginning: deinstitutionalization				Service expansions: addressing unmet needs		Addressing underserved populations: new service frontiers	
	Service platform	Crisis	Inpatient	Outpatient	Community-based case management	Residential	Homeless services	Forensic services
Second-generation service options	Mobile crisis teams		Long-term structured residences ^a	Psychiatric rehabilitation programs	Resource coordination ^b	Community residential rehabilitation (CRR)		
	Short-term in-home therapeutic services		Extended community-based acute inpatient hospitalization	Social rehabilitation programs	Intensive case management (ICM)			
	In home one-on-one crisis service			Drop-in centers vocational training	Community treatment teams ^c			
	Crisis residential programs 23 hour beds			Club house				

^aLocked community-based structured residences

^bIntermediate-contact case management

^cTeam-based ICM with dedicated psychiatric support

Table 3

Typology of third-generation service options

Stages	The beginning: deinstitutionalization			Service expansions: addressing unmet needs		Addressing underserved populations: new service frontiers	
Service platform	Crisis	Inpatient	Outpatient	Community-based case management	Residential	Homeless services	Forensic services
Third-generation service options		Sub-acute inpatient hospitalization	Supported employment programs	Blended case management ^a	Low demand community rehabilitation residences (CRR) ^c	Homeless outreach teams	Crisis intervention teams
		Peer specialists	Assertive community treatment (ACT)	Supported housing	Shelter case management teams		
			Specialized ACT teams ^b	Behavior-shaping units ^d	Housing first teams ^e		
			Forensic ICM teams	Forensic CRRs	Chronic homeless rehabilitation programs ^f		
	Forensic CTT teams		Safe havens ^g		Homeless cafes		

^a Team-based model that incorporates intermediate and intensive CM

^b For people with multiple involuntary commitments

^c Fewer behavioral expectations for residents

^d Specialized CRR for individuals with problematic behaviors

^e ACT teams with rental subsidies

^f Specialized residential programs for dually diagnosed

^g Short-term community residences for chronic street homeless with few restrictions on drug use

Table 4

Typology of boutique service options

Stages	The beginning: deinstitutionalization			Service expansions: addressing unmet needs		Addressing underserved populations: new service frontiers	
Services platform	Crisis	Inpatient	Outpatient	Community-based case management	Residential	Homeless services	Forensic services
Boutique service options				Continuity of care teams ^a		Forensic ACT team ^c	
				Rapid response teams ^b			

^a“ACT-like” team serving needs of managed care clients who do not qualify for any other case management service

^bShort-term outreach and engagement service for people with repeated involuntary commitments

^cSpecialized court-based ACT team for individuals with CJ involvement