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The Ideal Crisis System:
Strategies for Mental Health and Law Enforcement Collaboration to Prevent Justice Involvement

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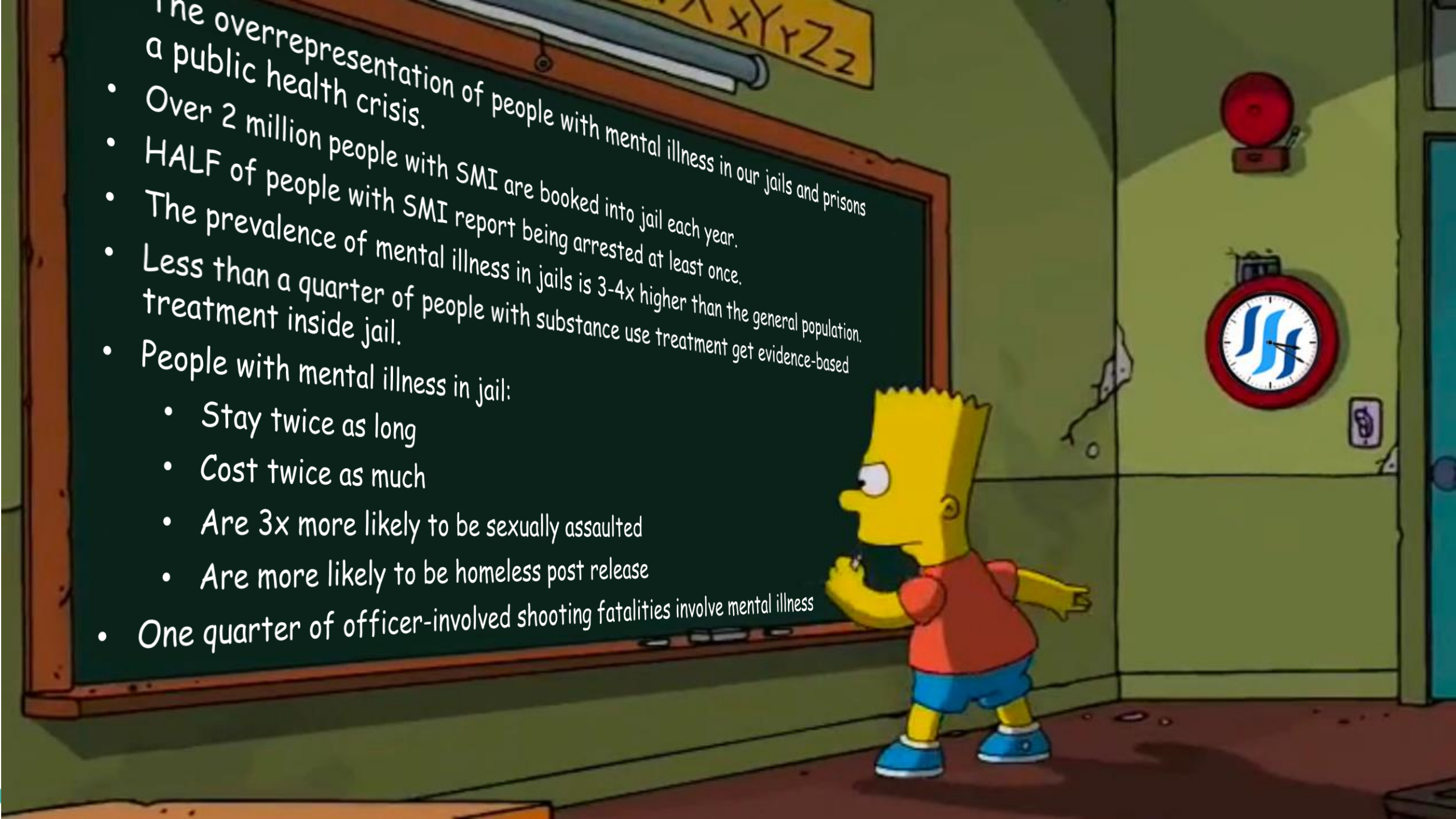
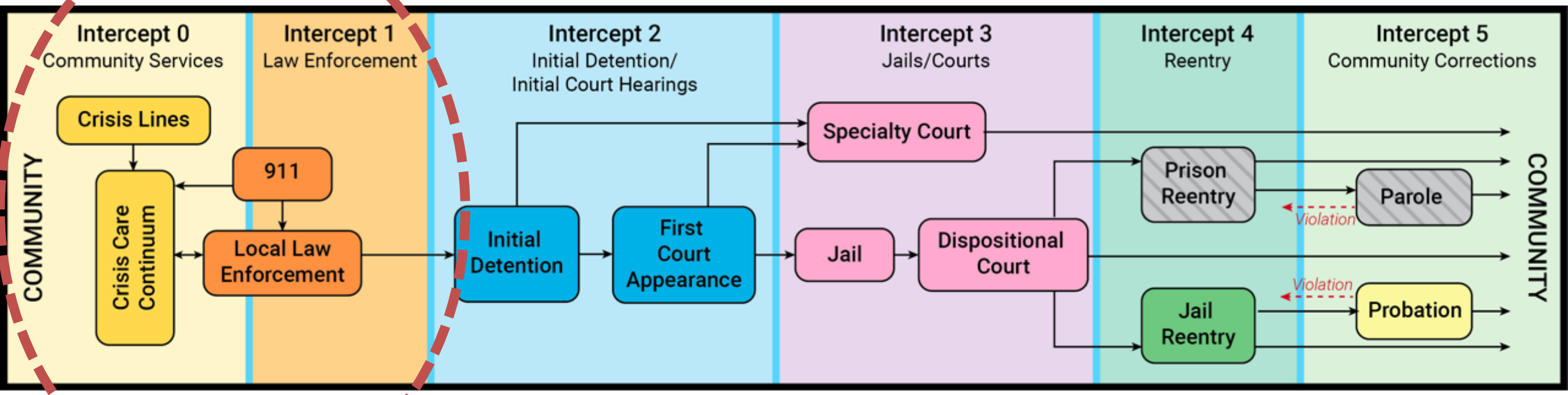

The overrepresentation of people with mental illness in our jails and prisons a public health crisis.
Over 2 million people with SMI are booked into jail each year.
HALF of people with SMI report being arrested at least once.
The prevalence of mental illness in jails is 3-4x higher than the general population.
Less than a quarter of people with substance use treatment get evidence-based treatment inside jail.
People with mental illness in jail:
Stay twice as long
Cost twice as much
Are 3x more likely to be sexually assaulted
Are more likely to be homeless post release
One quarter of officer-involved shooting fatalities involve mental illness

Sequential Intercept Model



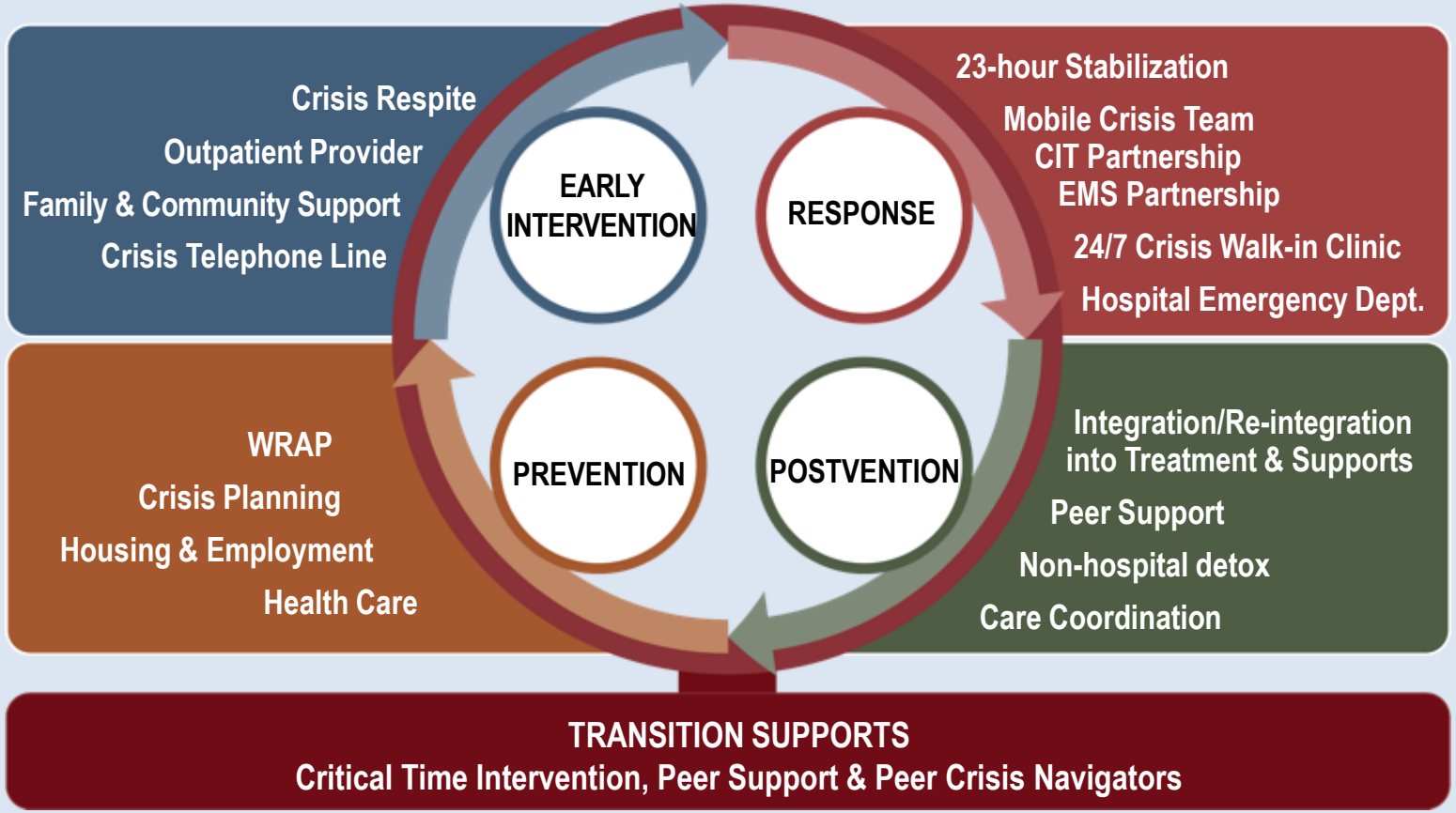
SYSTEM
vs. Services

A crisis system is **more than a collection of services**.

Crisis services must all **work together** as a coordinated system to achieve **common goals**.

And be **more than the sum of its parts**.

A crisis system needs a robust **continuum of services** to meet the needs of people in various stages of crisis.



Adapted from: Richard McKeon (Chief, Suicide Prevention Branch, SAMHSA). Supercharge Crisis Services, National Council for Behavioral Health Annual Conference, 2015.

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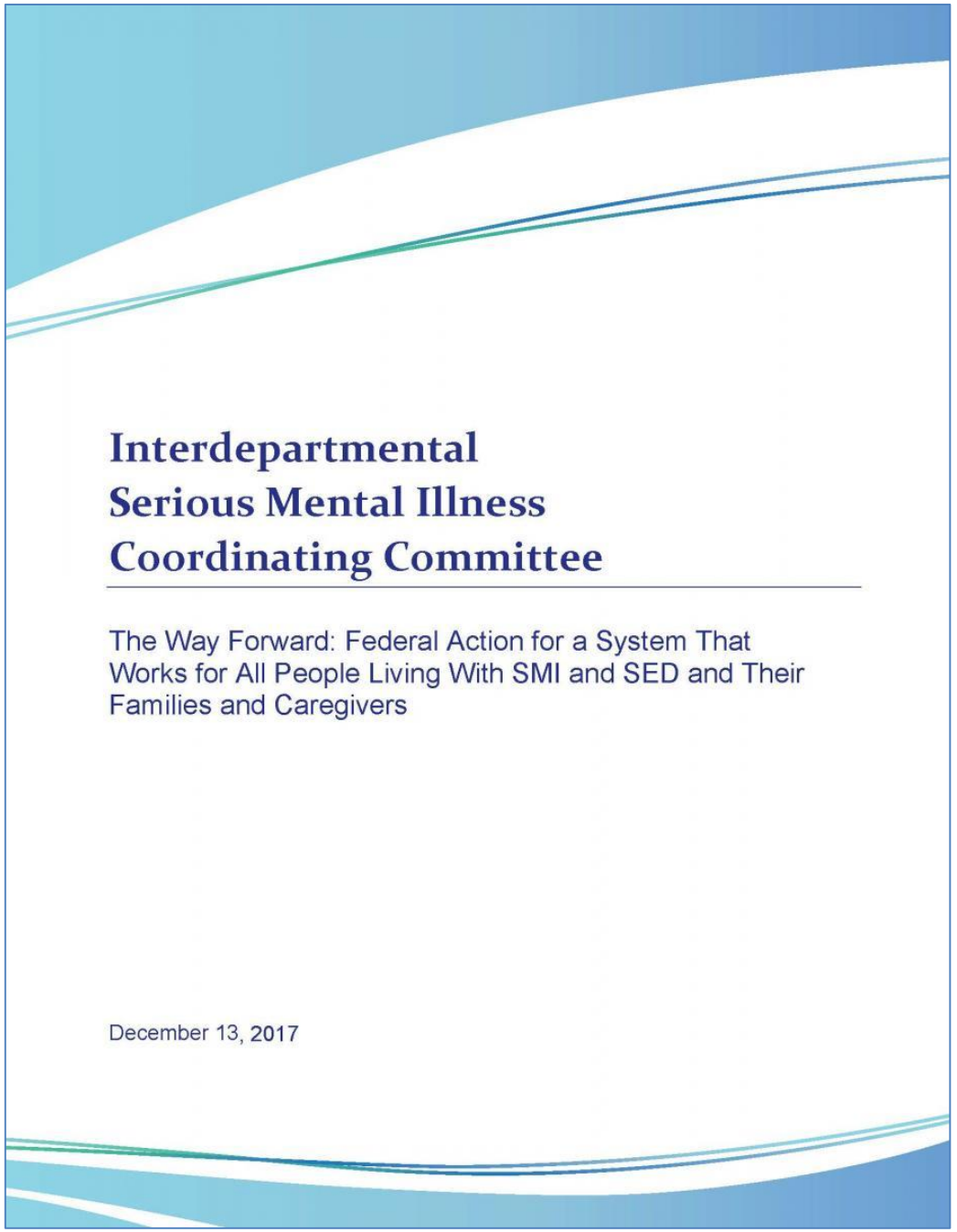
A National Standard for Crisis Services?

Interdepartmental SMI Coordinating Committee (ISMICC)

- Created by 21st Century Cures Act
- Initial report: December, 2017
- 45 recommendations in 5 focus areas
  - Focus 2: Access and Engagement: Make It Easier to Get Good Care
    - 2.1 Define and implement a national standard for crisis care



QUESTION:

WHAT SHOULD BE THE NATIONAL STANDARD FOR CRISIS CARE?

And how should it compare to our expectations for other essential services (Police, Fire, EMS, etc.)?

3 Key Ingredients for a SYSTEM

Accountability

- Who is *responsible* for the system?
- Governance and financing structure
- System values and outcomes
- Holding providers accountable

Collaboration

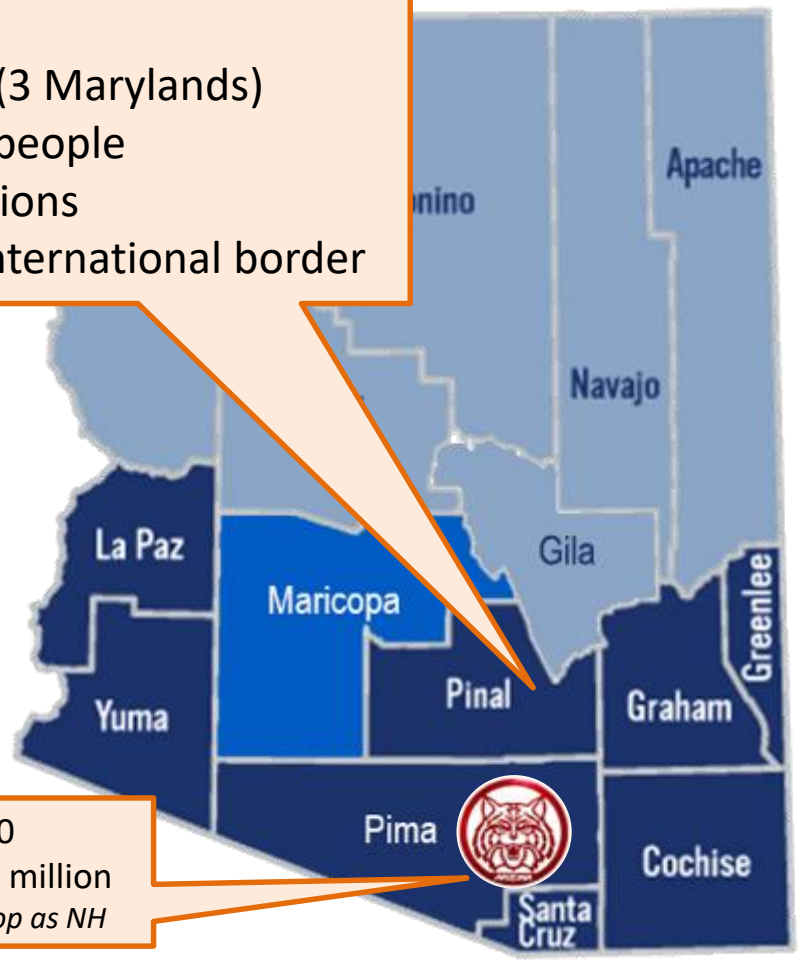
- Broad inclusion of potential customers, partners, & stakeholders
- Alignment of operational processes & training towards common goals
- Culture of communication & problem solving

Data

- Are we achieving desired outcomes?
- Performance targets & financial incentives
- Continuous quality improvement
- Data driven decision making

Arizona Crisis System Structure

Southern Arizona Region:
8 counties
38,542 mi^2 (3 Marylands)
1.8 million people
6 Tribal Nations
378 mi of international border



Tucson: 530,000
Pima County: 1 million
Similar size and pop as NH

AZ Medicaid
AHCCCS
Arizona Health Care Cost Containment System

Other state funds

Regional Behavioral Health Authority (RBHA)
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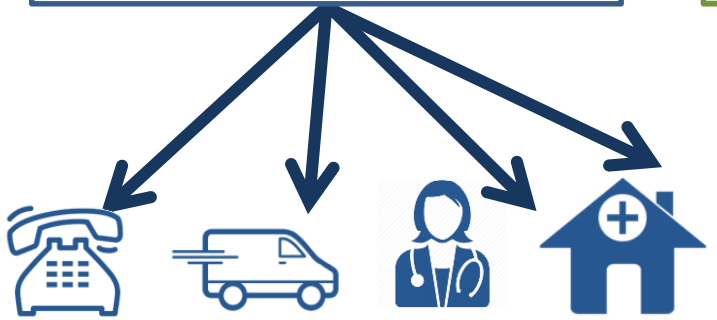
Counties



Contracted Crisis Providers

The **financing & governance** structure supports **organization, accountability, & oversight** of the system.

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What this means for the crisis system

- Centralized **planning**
- Centralized **accountability**
- **Alignment** of clinical & financial goals

Regional Behavioral Health Authority

Performance metrics and payment systems that **promote common goals**

Decrease	**Increase**
• ED & hospital use • Justice involvement	• Community stabilization • Engagement in care

These goals represent <u>both</u>
good clinical care & fiscal responsibility.

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Example of strategic service design

State says: Reduce criminal justice costs for people with SMI.

AHCCCS contracts with regional Medicaid MCOs/RBHAs and includes requirements targeted at reducing criminal justice involvement.

RBHA (which is at risk) uses contract requirements/VBP with its subcontracted providers to create services and processes targeted at reducing justice involvement.

Targeted Services and Processes:

Law Enforcement as a "preferred customer"

CRISIS LINE
- Some 911 calls are warm-transferred to the crisis line
- Dedicated LE number goes directly to a supervisor

MOBILE TEAMS
- **30 minute response time** for LE calls (vs. 60 min routine)
- Some teams assigned as **co-responders** (cop + clinician)

CRISIS CENTERS
- **24/7** crisis facility
- **Quick & easy drop-off** for law enforcement
- **No wrong door** – LE is never turned away

911: WHAT'S YOUR EMERGENCY?

"I'm having chest pain."

"I'm suicidal."

Law Enforcement's Contribution

Training for first responders

- 100% MHFA training
- 80% *voluntary* CIT training
- With support from RBHA and community stakeholders (NAMI, providers, etc.)

A unique, specialized Mental Health Support Team (MHST)

- Select group 12 officers and detectives
- Dedicated to mental health
- Focus on high risk individuals
- Preventing people from falling through the cracks

Collaborative Processes

- 911 calls transferred to crisis line
- Co-responder teams: cop + clinician
- Investment in building relationships

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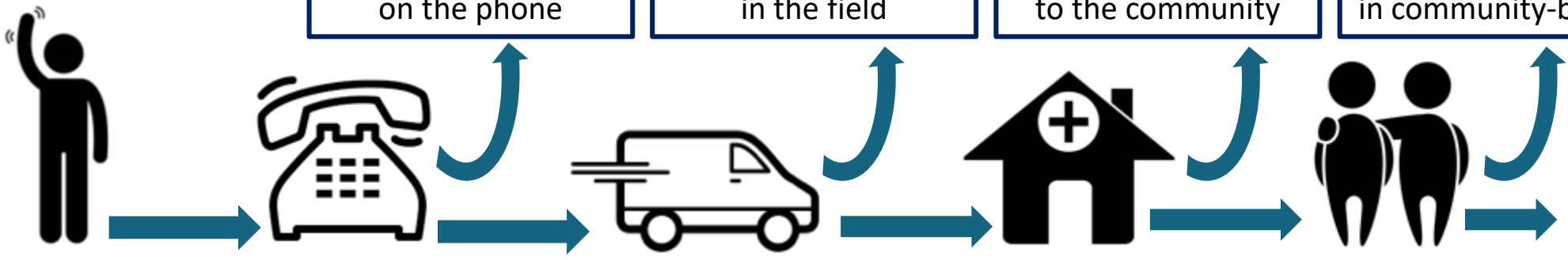
The Crisis Continuum

80% resolved on the phone

70% resolved in the field

65% discharged to the community

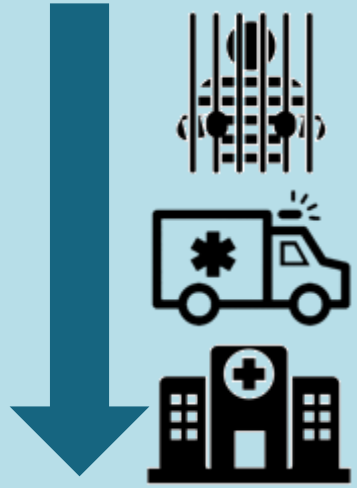
80% remain stable in community-based care



Person in Crisis → **Crisis Line** → **Mobile Crisis Teams** → **Crisis Facility** → **Post-Crisis Wraparound**

Easy Access for Law Enforcement = Pre-Arrest Diversion

Decreased Use
of jail, ED, inpatient



LEAST Restrictive = LEAST Costly

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Many options for law enforcement to **divert people to treatment instead of jail** all with a culture of **NO WRONG DOOR**

Crisis Hotline
- Info, care coordination
- Direct line for LE
- Some co-located at 911

NurseWise

Law Enforcement Training
- Supported by RBHA & multiple community partners
- Tucson PD and Pima Co Sheriff are 100% MHFA & 80% CIT trained

Mental Health First Aid USA

International CIT Crisis Intervention Team

Crisis Response Center
- 24/7 Crisis Center for Adults and Youth
- <10 minute LE drop-off time
- Law enforcement never turned away
- Adjacent to ED, Court, Inpatient psych
- Clinic, 23 hour obs, initiation of Opiate MAT

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Banner University Medical Center

PIMA COUNTY

Mobile Crisis Teams
- Masters level clinicians
- On-site crisis intervention
- 30-min response time for LE

Community Health Associates

CBI Community Bridges, Inc.

Co-Responder Teams
- MHST Detective
- Mobile Team Clinician

MHFA or CIT trained officer/deputy

Access Point
- 24/7 Detox/Crisis for Voluntary Adults
- <10 minute LE drop-off time
- Transitions to substance use tx/MAT

CBI Community Bridges, Inc.

Regional Behavioral Health Authority
- First Responder Liaisons
- Responsible for the network of programs and clinics

arizona complete health

Mental Health Support Teams (MHST)
- In addition to CIT
- Unique specialized team specializing in civil commitment, challenging cases, and follow-up
- Officers/Deputies & Detectives

Crisis Response Canine

"LEO"

BH Services at the Jail
- Instant data exchange with MH history
- Risk screening
- Diversion programs, specialty courts, etc.

HOPE Incorporated

PIMA COUNTY

The Crisis Response Center

- Built with Pima County bond funds in 2011
  - Alternative to jail, ED, hospitals
  - Serving 12,000 adults + 2,400 youth per year
- **Law enforcement receiving center with NO WRONG DOOR**
  (no exclusions for acuity, agitation, intoxication, payer, etc.)
- Services include
  - 24/7 urgent care clinic (adult length of stay 2 hours, youth 3 hours)
  - 23-hour observation (adult capacity 34, youth 10),
  - Short-term subacute inpatient (adults only, 15 beds, 3-5 days)
- Space for co-located community programs
  - peer-run post-crisis wraparound program, pet therapy, etc.
- Adjacent to
  - Banner University Medical Center (ED with Level 2 Trauma Center)
  - Crisis call center
  - Inpatient psych hospital for civil commitments
  - Mental health court

Crisis Response Center (CRC) in Tucson, AZ
ConnectionsAZ/Banner University Medical Center

Connections Model

"We address any behavioral health need at any time."

- Patients can be voluntary or involuntary
- Mental health, substance use, or both
- Arrive via
  - Law enforcement (45%)
  - Transfers from EDs (10%)
  - Walk-ins
  - Crisis Mobile Teams
  - Foster Care
  - Jail post-release
  - Special programs (specialty courts, etc.)
- Studies show this model:
  - Critical for pre-arrest diversion[2]
  - Reduces ED boarding[3,4]
  - Reduces hospitalization[3,4]

These 2 are the hardest to do well

CIT Recommendations for Mental Health Receiving Facilities[1]

1. Single Source of Entry
2. On Demand Access 24/7
3. **No Clinical Barriers to Care**
4. **Minimal Law Enforcement Turnaround Time**
5. Access to Wide Range of Disposition Options
6. Community Interface: Feedback and Problem Solving Capacity

1. Dupont R et al. (2007). Crisis Intervention Team Core Elements. The University of Memphis School of Urban Affairs and Public Policy
2. Steadman HJ et al (2001). A specialized crisis response site as a core element of police-based diversion programs. Psychiatr Serv 52:219-22
3. Little-Upah P et al. (2013). The Banner psychiatric center: a model for providing psychiatric crisis care to the community while easing behavioral health holds in emergency departments. Perm J 17(1): 45-49.
4. Zeller S et al. (2014). Effects of a dedicated regional psychiatric emergency service on boarding of psychiatric patients in area emergency departments. West J Emerg Med 15(1): 1-6.

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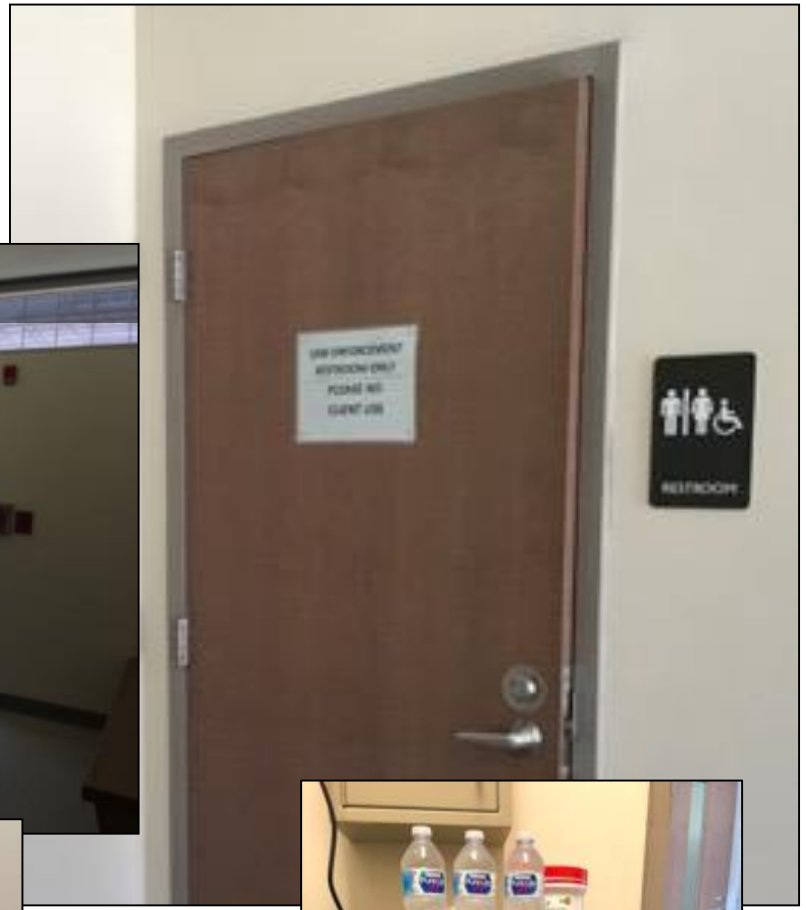
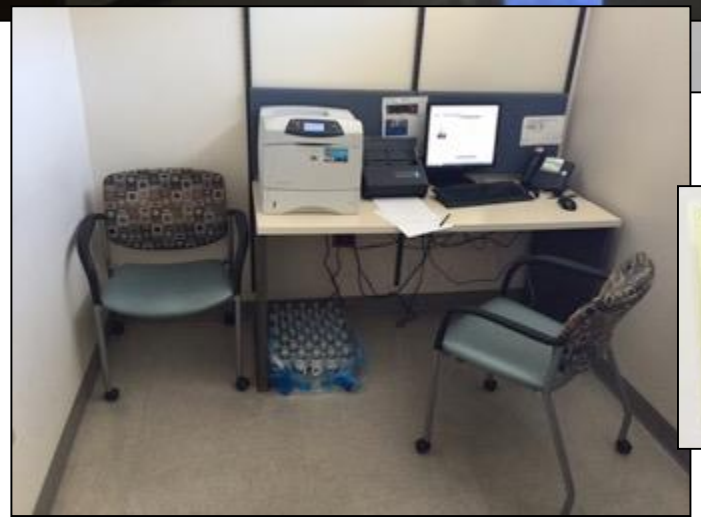
It's easier to get into **heaven** than a **psychiatric facility**

Law Enforcement is a "Preferred Customer"



Law Enforcement Entrance

Gated Sally Port
Crisis Response Center - Tucson AZ



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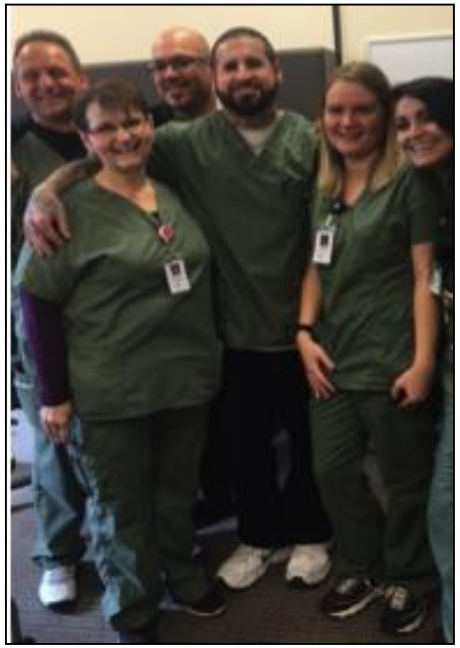
23-Hour Observation Unit

- Staffed 24/7 with MDs, NPs, PAs
- Medical necessity criteria similar to that of inpatient psych (danger to self/other, etc.)
- Diversion from inpatient:
  - **60-70% discharged to the community the following day**
  - Early intervention
    - Median door to doc time is ~90 min
  - Interdisciplinary team
    - Including peers with lived experience, nurses, techs, case managers, therapists, unit coordinators
  - Aggressive discharge planning
  - Collaboration and coordination with community & family partners
  - ***Culture shift: Assumption that the crisis <u>can be</u> resolved***



Peers with lived experience are an important part of the interdisciplinary team.

"I came in 100% sure I was going to kill myself but now after group I'm hopeful that it will change. Thank you RSS members!"

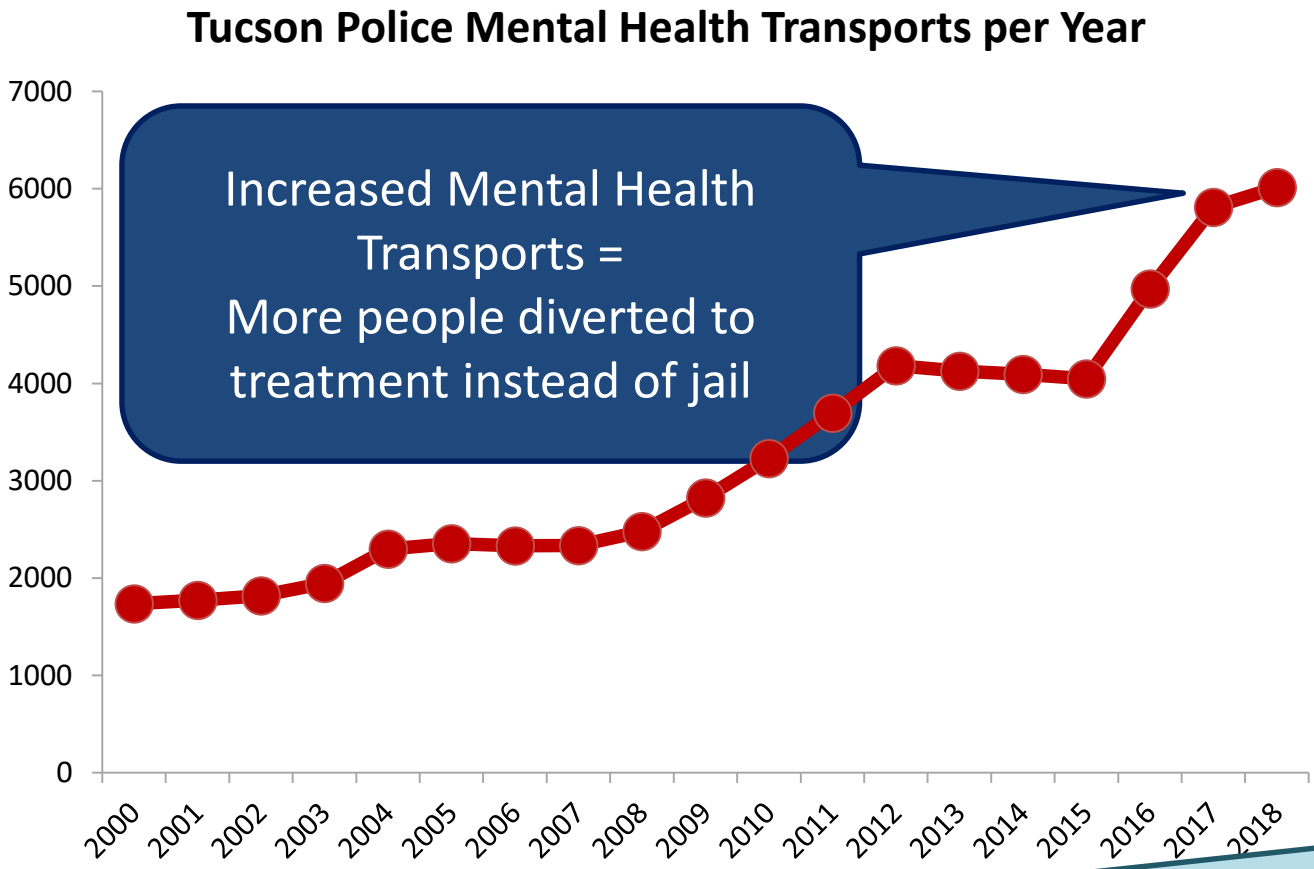
The locked 23h obs unit provides a safe, secure, and therapeutic environment:

- Continuous observation
- Lack of means to hurt oneself or others
- Therapeutic milieu: Open area for therapeutic interactions with others
- As welcoming as possible

Crisis Response Center, Tucson AZ

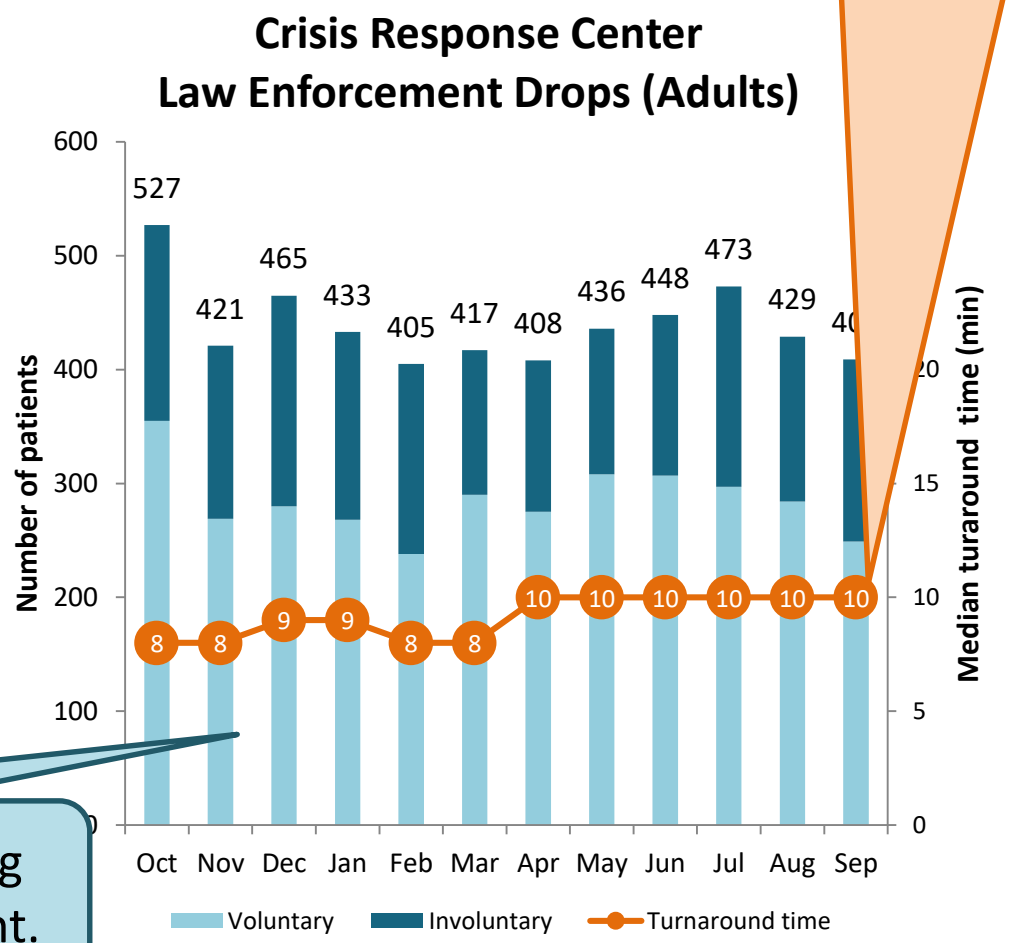
Urgent Psychiatric Center
Phoenix, AZ

MORE People Taken to Treatment…



Increased Mental Health Transports = More people diverted to treatment instead of jail

Cops like quick turnaround time (10 min) so that it's easier to bring people to treatment instead of jail.



Most drops are voluntary (light bars), meaning the officers are engaging people into treatment.

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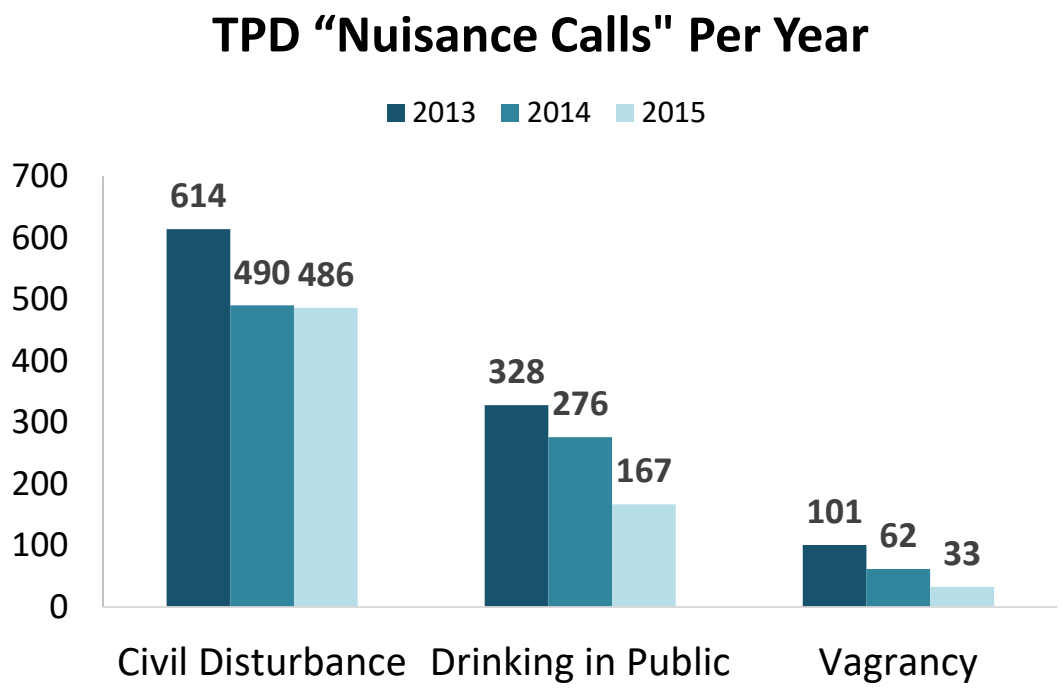
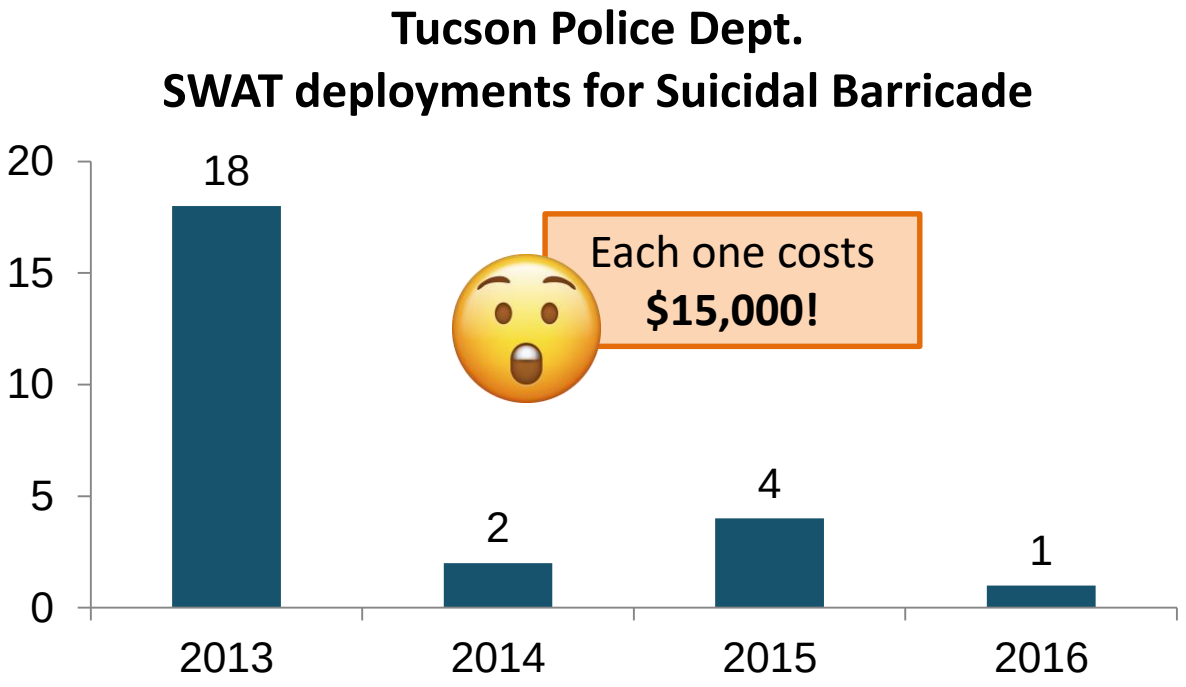
… and LESS Justice Involvement

Fewer calls for low-level crimes that tend to land our people in jail.

Culture change in how law enforcement responds to mental health crisis.





Balfour ME, Winsky JM and Isely JM; The Tucson Mental Health Investigative Support Team (MHIST) Model: A prevention focused approach to crisis and public safety. *Psychiatric Services*. 2017;68(2):211-212; https://dx.doi.org/10.1176/appi.ps.68203

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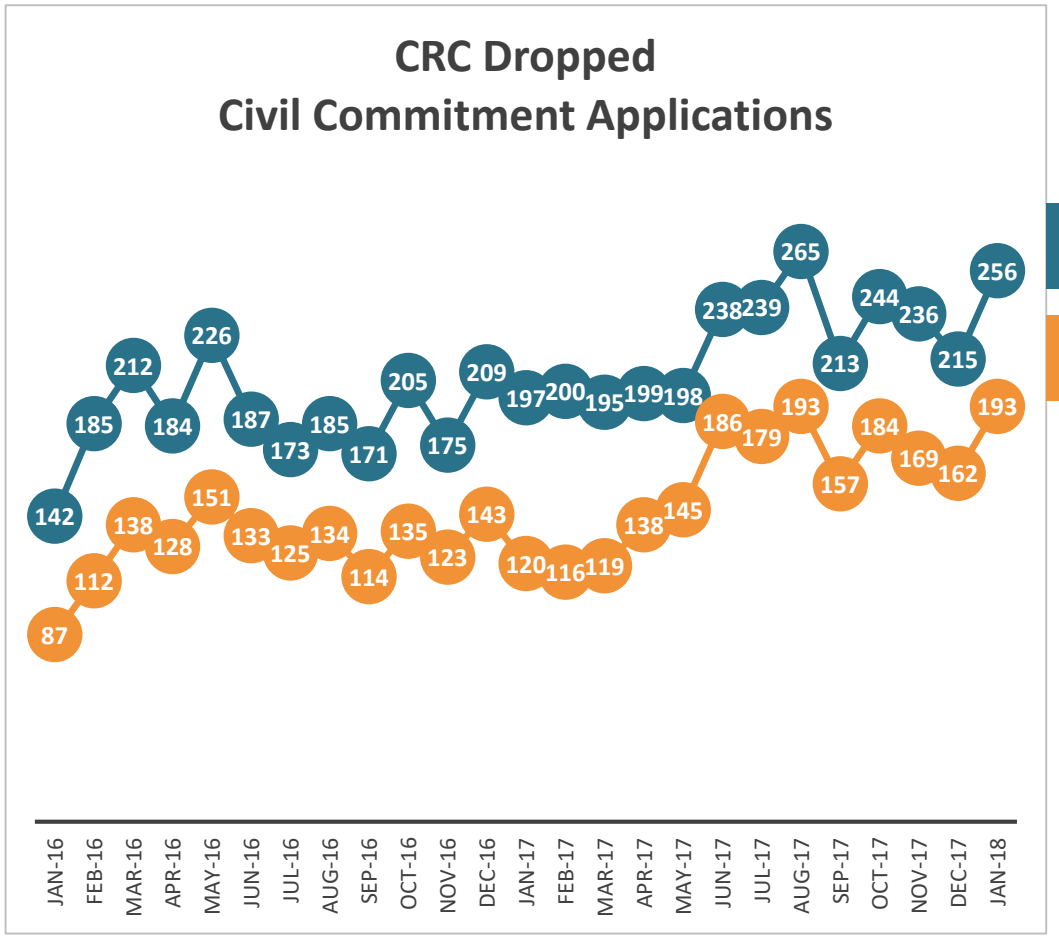
Crisis Stabilization Aims for the **Least-Restrictive** (and least costly) Disposition Possible

65%
Discharged to Community (Diversion from Inpatient)

- People admitted to the 23-hour observation unit who are discharged to community-based care instead of inpatient admission.
- Most can be stabilized for community dispositions with early intervention, proactive discharge planning, and collaboration with families and other community supports



70%
Converted to Voluntary Status

People under involuntary hold who are then discharged to the community or choose voluntary inpatient admission

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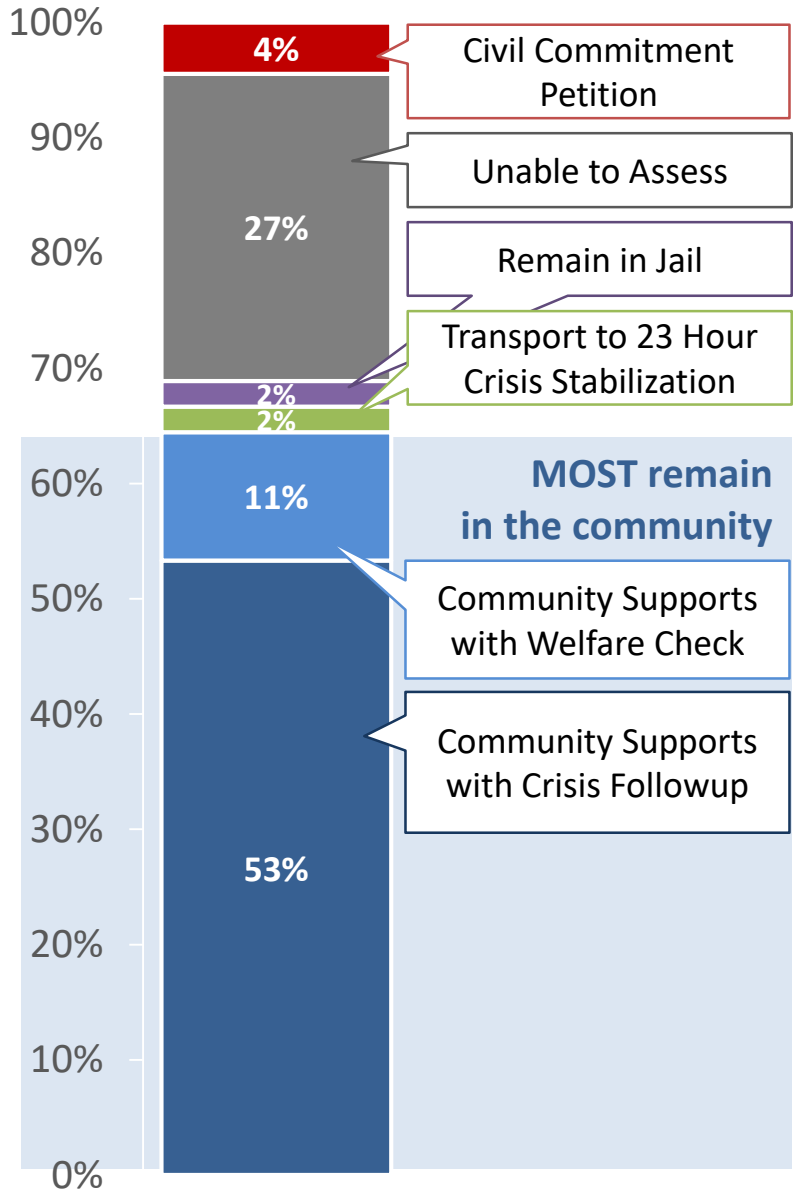
Co-Responder Innovations:
Increasing connection to care while **minimizing** involuntary treatment and/or arrest

- Tucson Police Department Mental Health Support Team (MHST) Detective
- Paired with a Mobile Team Clinician
- Working together on cases flagged by Police
  - Acute, High Needs, High Risk (danger to other, self)
  - People who may need involuntary treatment

The newest co-responder teams use peer navigators and focus on opiate treatment.



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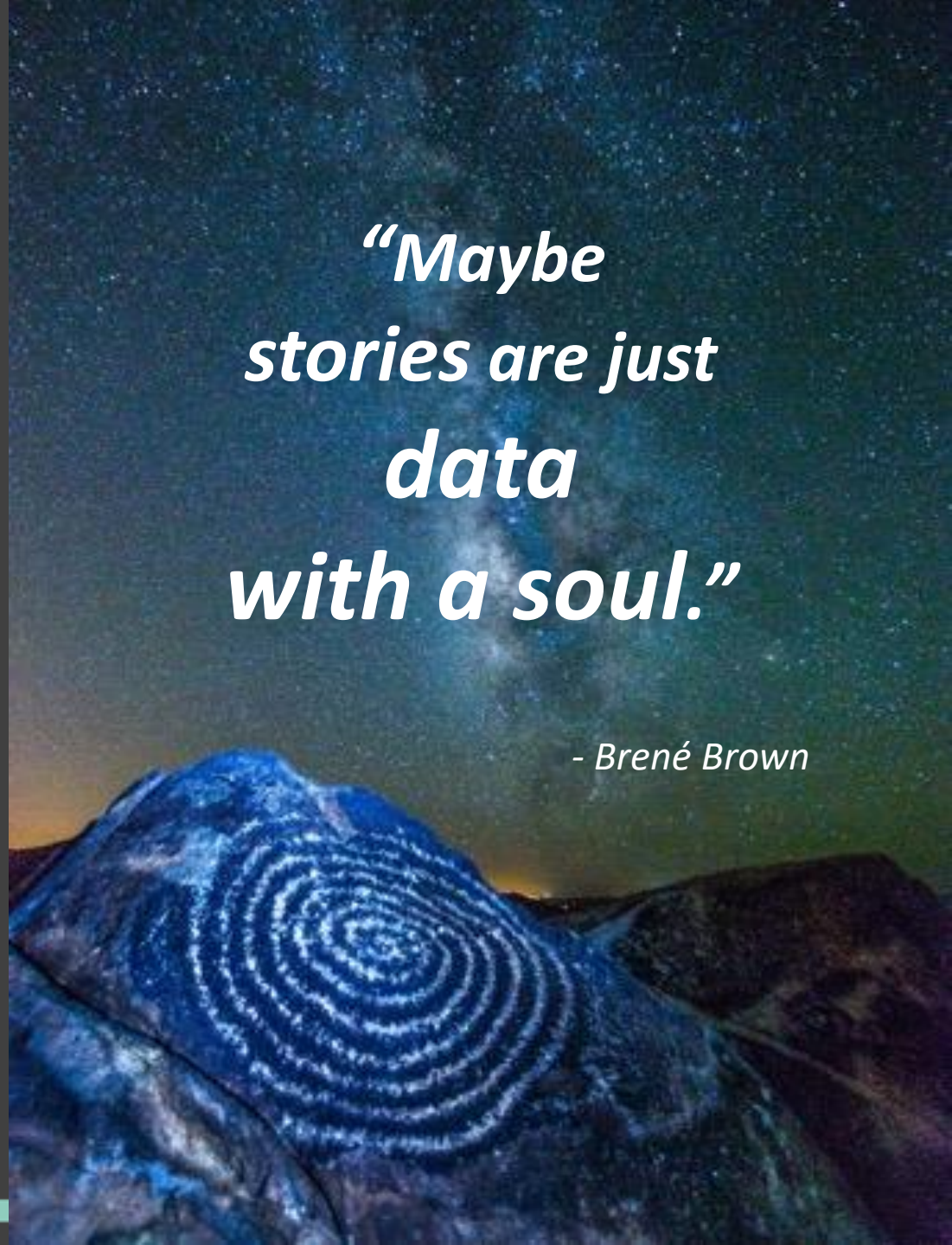
Using data to improve care

How can crisis data help improve the whole behavioral health system?

Every crisis visit is a **story** about how someone **couldn't get their needs met** in the community.

If we **turn the stories into data**, it can **reveal trends** about things that need improving in the overall behavioral health system.



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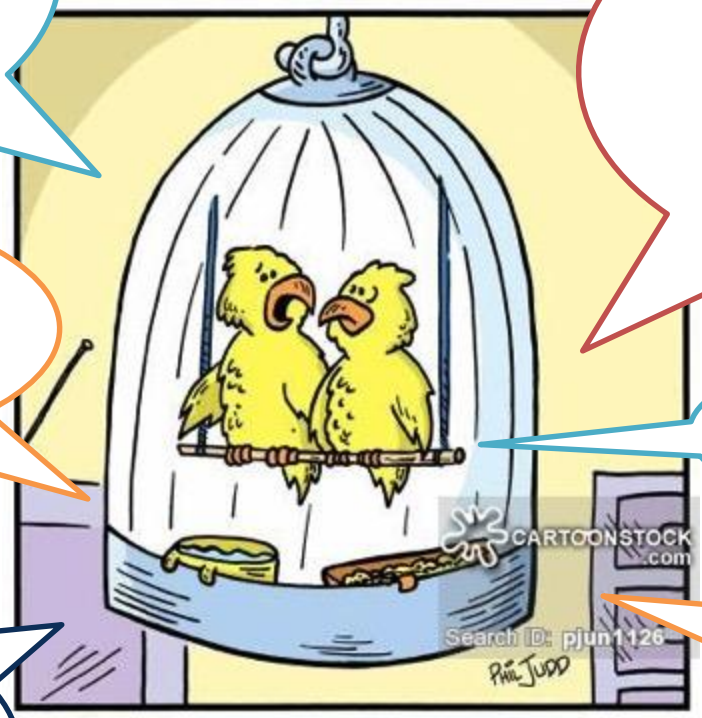
Crisis Center



"These meds aren't working."

"I couldn't get in to see my doctor at my clinic."

"There was a problem at the pharmacy and I couldn't get my meds filled."

"I couldn't get my case manager on the phone."

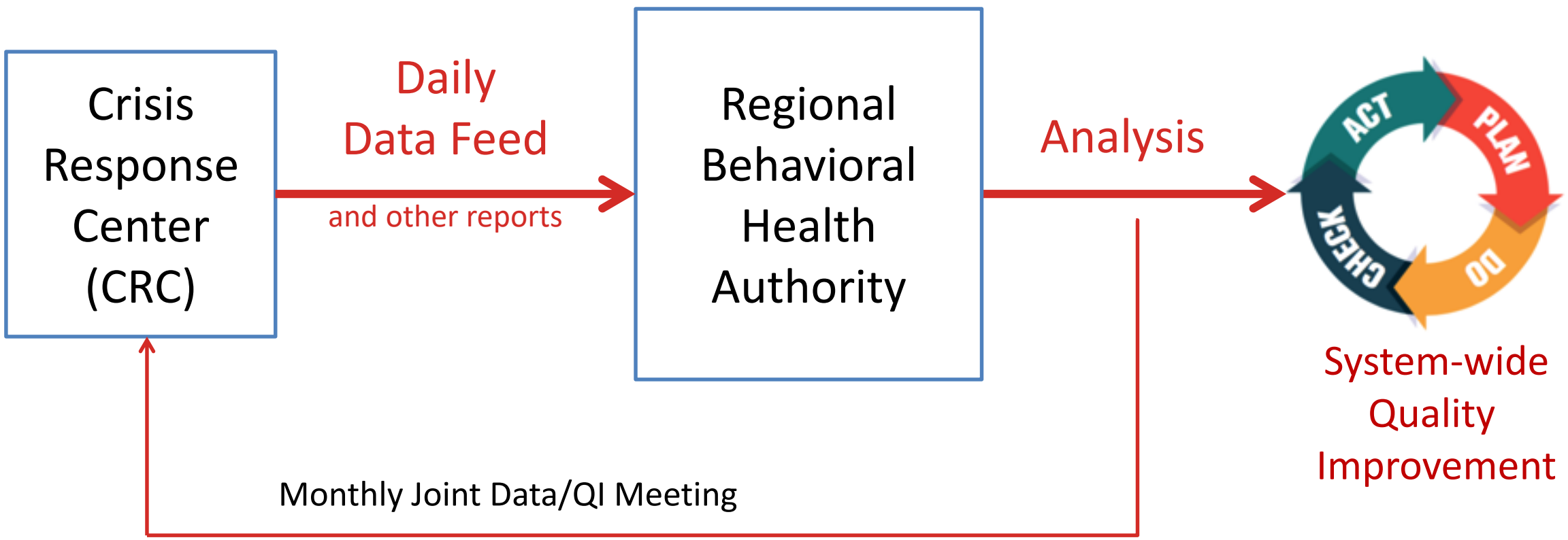
"I don't have a safe place to stay."

"I missed my appointment because I don't have transportation."

"I got kicked out of my group home… AGAIN."

"My mom can't handle me at home by herself."

Provider + Payer Partnership



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Balfour ME, Zinn T, Cason K, Fox J, Morales M, Berdeja C, Gray J; Provider-Payer Partnerships as an Engine for Continuous Quality Improvement; *Psychiatric Services;* 2018;69(6):623-625; https://doi.org/10.1176/appi.ps.201700533

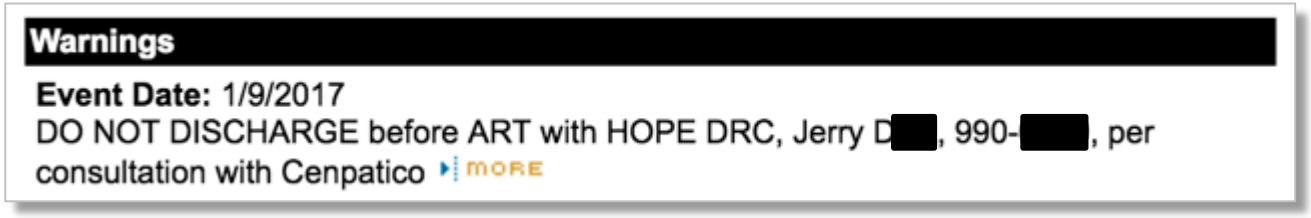
“Familiar Faces” Project

1 **DATA REPORTING:** The CRC sends a monthly rolling frequent utilizer report to the RBHA.

Last name	First name	dob	ICC	T19 status	rbha	payer	Clinic Only	Obs	Total	Visit this month?
			LA FRONTERA	SMI T19	Cenpatico	AHCCCS only	9	10	19	Y
			LA FRONTERA	SMI T19	Cenpatico	AHCCCS only	0	4	4	Y
			COPE	SMI T19	Cenpatico	AHCCCS & Medicare	0	4	4	Y
			LA FRONTERA	SMI T19	Cenpatico	AHCCCS only	0	6	6	Y
			COPE	SMI T19	Cenpatico	AHCCCS only	1	4	5	Y

2 **MULTI-AGENCY TEAM MEETINGS** with CRC, RBHA, clinic staff to discuss the patient’s needs and develop improved crisis and service plans. The goal is at least 3 staffings per patient regardless of whether they are at the CRC that day.

3 **CHARTS FLAGGED** at the CRC with information about the new crisis plan and who to contact so that the new plan can be implemented.



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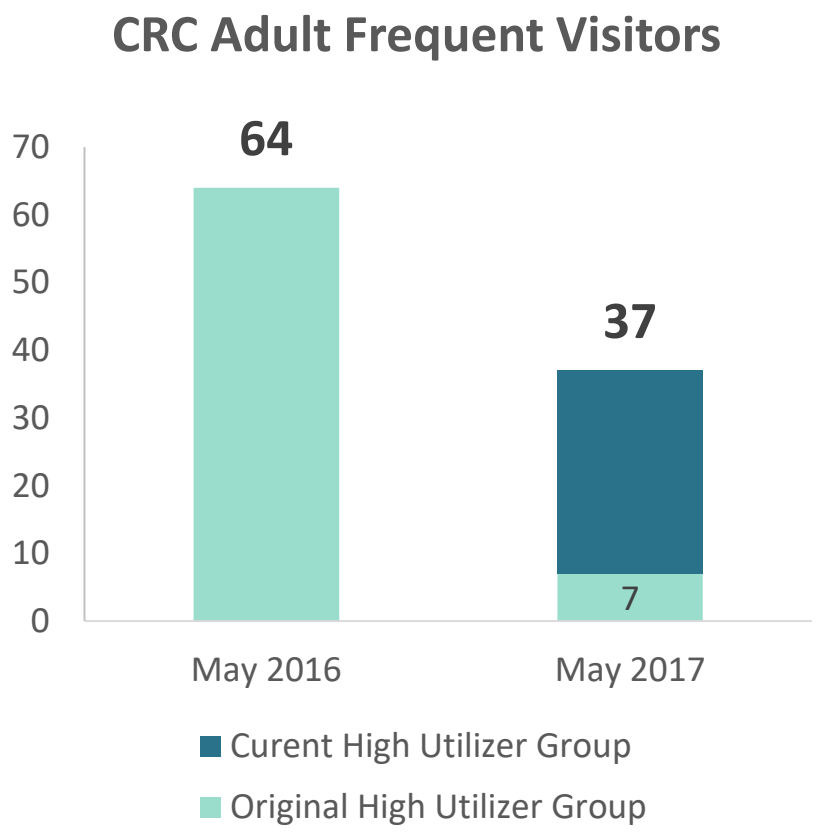
Results: Fewer "Familiar Faces"

There were 64 individuals on the original list of high utilizers. One year later, only 7 of the original 64 remain high utilizers, and only 37 meet the high utilizer definition.



Case Example: Ms. X becomes lonely during the weekend, which is a trigger for feeling overwhelmed and suicidal and coming to the CRC. She has a partner who is also enrolled in services.

Individualized Plan:

- The outpatient provider will proactively do welfare checks on nights and weekends to help plan for triggers that historically result in CRC visits.
- The team will explore working with her partner's team (with consent) in order to assist both in recovery together.
- The CRC will call her clinic Peer Support Specialist immediately upon arrival to reinforce the relationship with her outpatient team and help connect her more quickly with outpatient support.

Results: CRC visits **decreased from 14** in 2016 Q1 **to only 1** during the same time frame in 2017.

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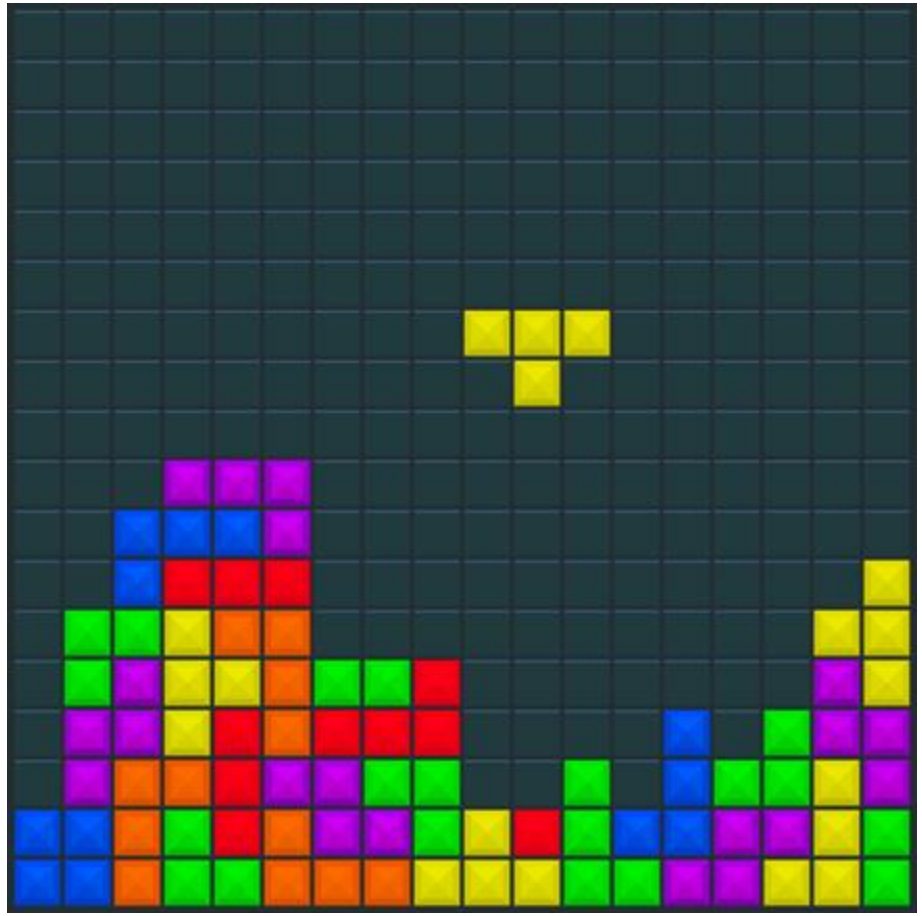
Balfour ME, Zinn T, Cason K, Fox J, Morales M, Berdeja C, Gray J; Provider-Payer Partnerships as an Engine for Continuous Quality Improvement; *Psychiatric Services;* 2018;69(6):623-625; https://doi.org/10.1176/appi.ps.201700533

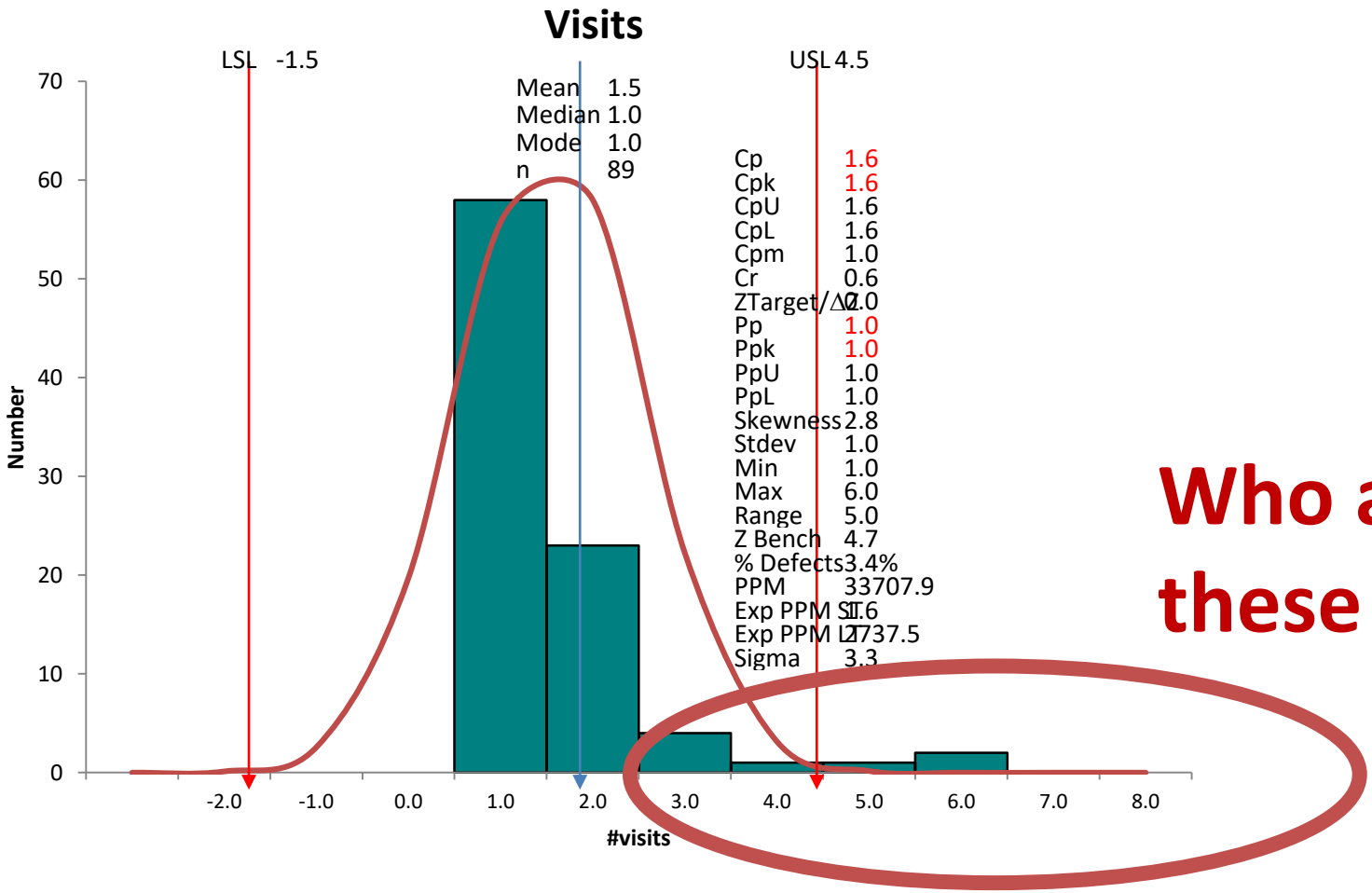
Putting it all together…



Stakeholders from multiple systems coming together around data dashboards to solve a complex problem.

Example: Repeat revocations to the CRC

(for patients on COT/outpatient civil commitment)

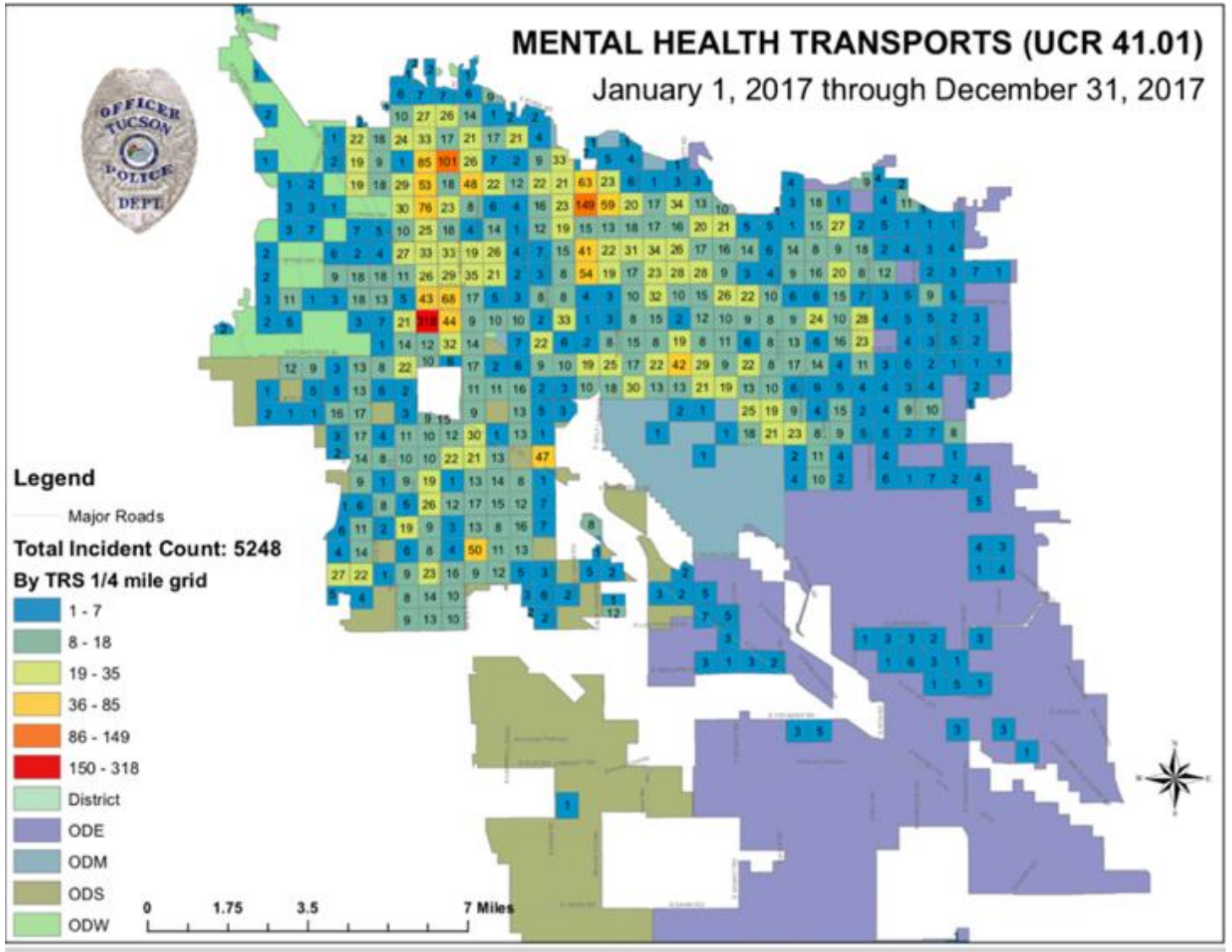


Who are these people?

Courtesy Margie Balfour, Crisis Response Center, ConnectionsAZ

Where are these patients coming from?

Can we target interventions to prevent the need for involuntary law enforcement transports?



Courtesy Sgt. Jason Winsky, Tucson Police Dept.

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Multiagency QI Process to reduce T36 revocations

“The Group Home Guy”

Group Home

Crisis Line

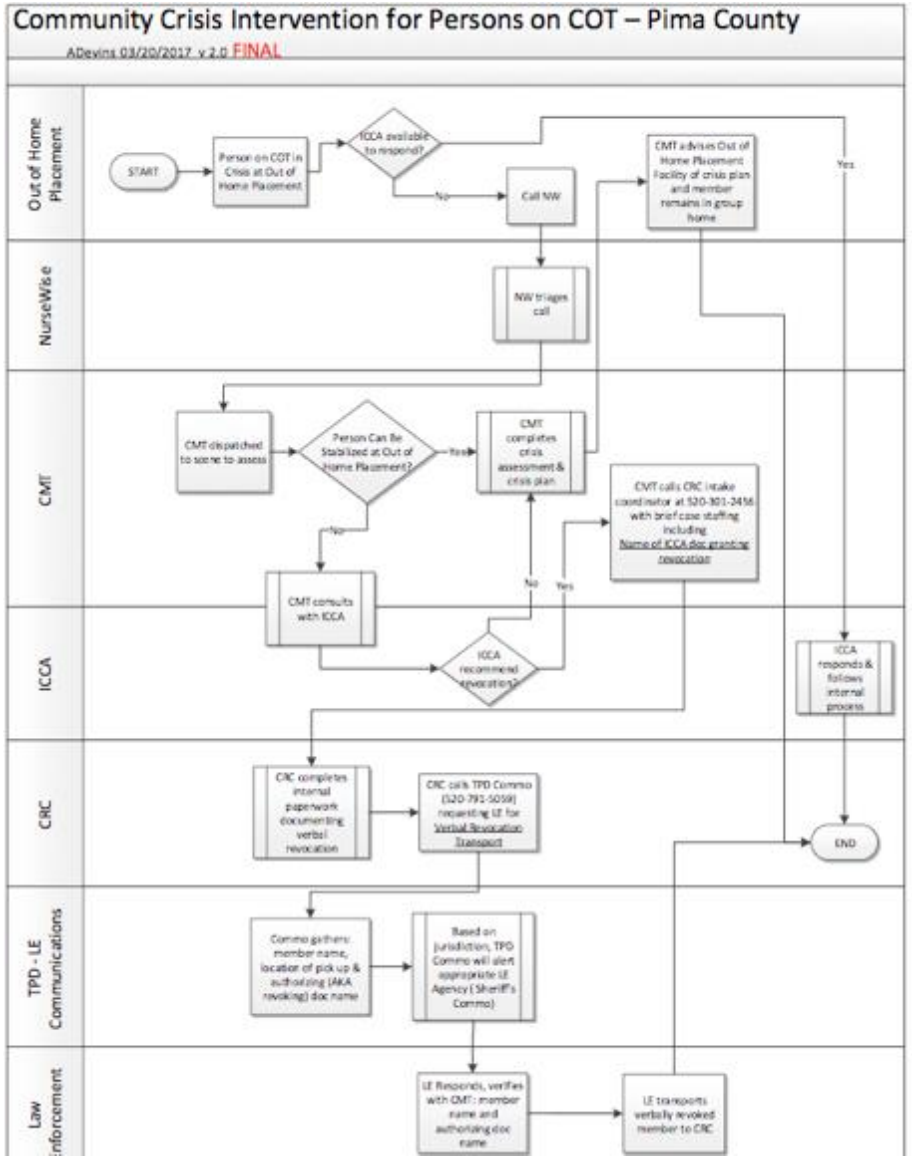
Mobile Crisis Team

Outpatient Clinic

Crisis Response Center

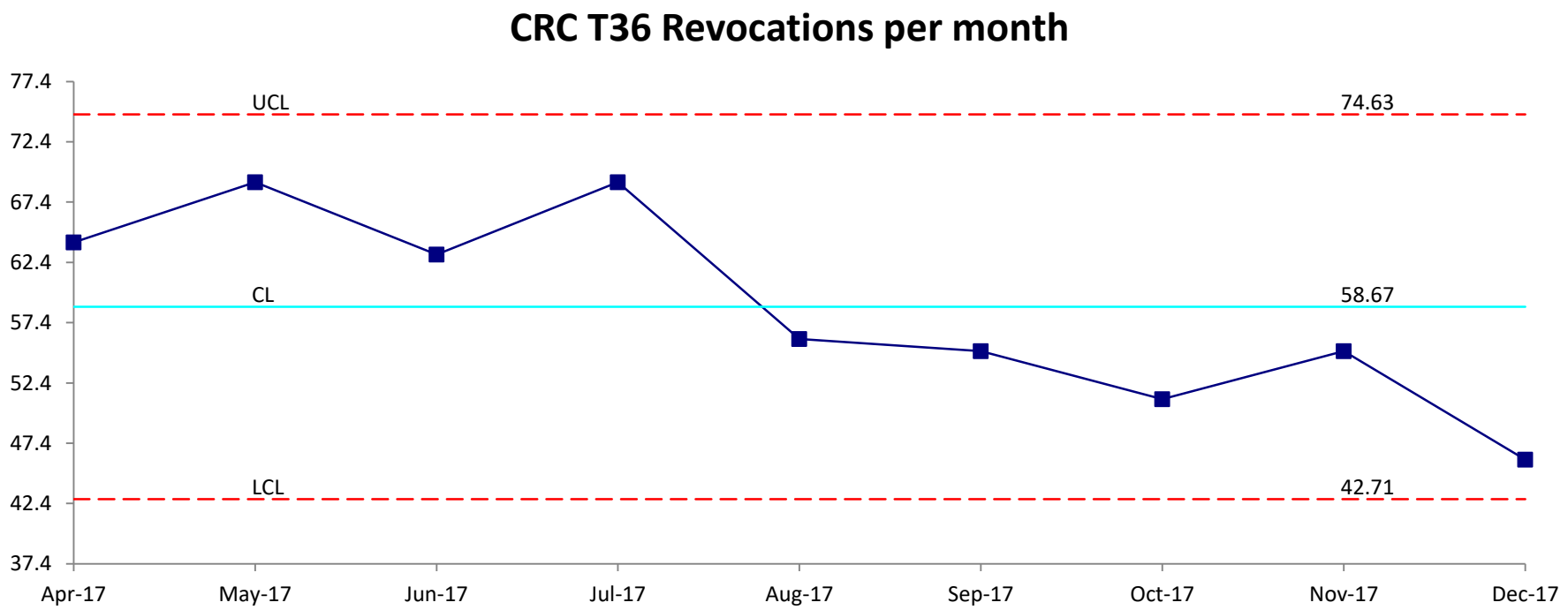
911 Dispatch

Law Enforcement



Courtesy Amy Devins, Cenpatico

Results: Reduced civil commitment revocations



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It took a LONG time and LOTS of collaboration to get where we are today.

2000

< City (Tucson) MH Court

2001

CIT Training > program started

2002

Felony > MH Court

< Mobile Crisis Teams

2004

County bond passes > to build crisis facility

2006

Jail Based > Restoration to Competency

2007

Jan 8 2011 shooting > at *Congress On Your Corner*

2010

< Pima County **Office of BH Administrator**

< DTAP Program
Drug Treatment Alternative to Prison

2011

< Peers in the Jail

< Crisis Response Center opens Aug 2011

2012

< Rural MH Courts

Law Enforcement MH Support Teams

< PCSO TPD >

2013

2014

Jail + MH **Data Exchange** < JHIDE Analytics >

2015

MacArthur Grant > awarded to Pima County

2016

< Co-responders (cop + clinician)

< Repeat T36 Utilization (civil commitment/AOT)
Data Sharing Task Force

< 24/7 access to Opiate MAT at CRC

< 100% MHFA training achieved at TPD and PCSO

2017

< MH First Aid
Training for law enforcement begins

< Learning Site
designation by DOJ/BJA

< MHFA Impact Award
National Council for BH

< Repeat Jail Detainees
Task Force

2018

connections HEALTH SOLUTIONS

Lessons Learned

- The solution is **not** always more inpatient beds!
- Stabilize crisis in the **least-restrictive** setting possible (which also tends to be the **least-costly**)
- **Governance and payment structures** to incentivize these programs and services
- **Data-driven and values-based** decision-making and continuous quality improvement
- Stakeholder **collaboration** across silos
- **Culture of:**
  - **NO WRONG DOOR**
  - **"Figure out how to say YES instead of looking for reasons to say no."**

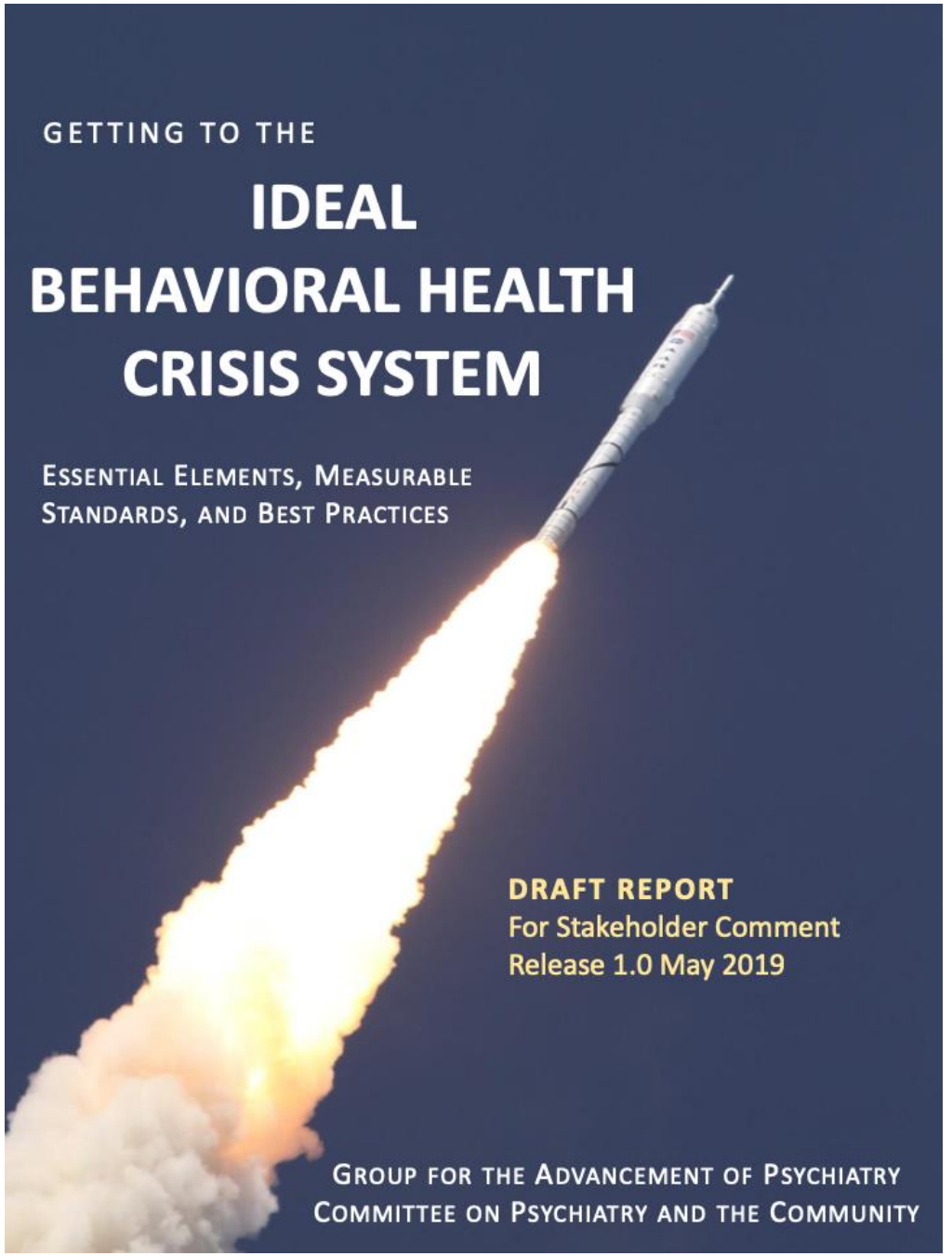
Coming Soon…

- GAP Report on the Ideal Crisis System
- More than a list of crisis services
- Includes elements and approaches needed to make the services function as a **coordinated, effective, and values-driven system**
- **Needs your input!**

Measurable Performance Standards

in the following areas

- Governance & Finance
- Crisis Continuum: Essential Services & Program Capabilities
- Clinical Best Practices & Competencies



connections HEALTH SOLUTIONS

Questions?

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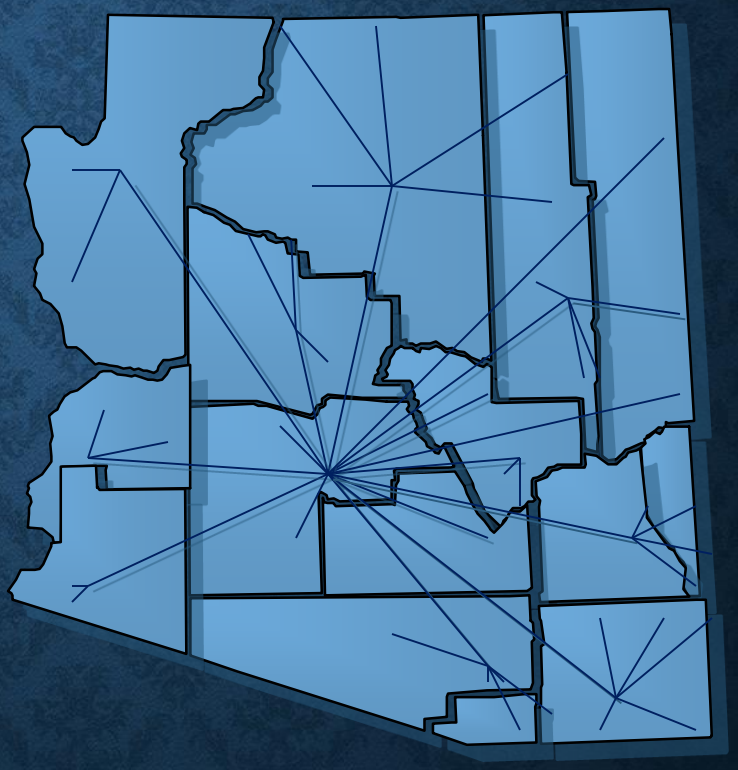
AUTOMATION BRIEFING

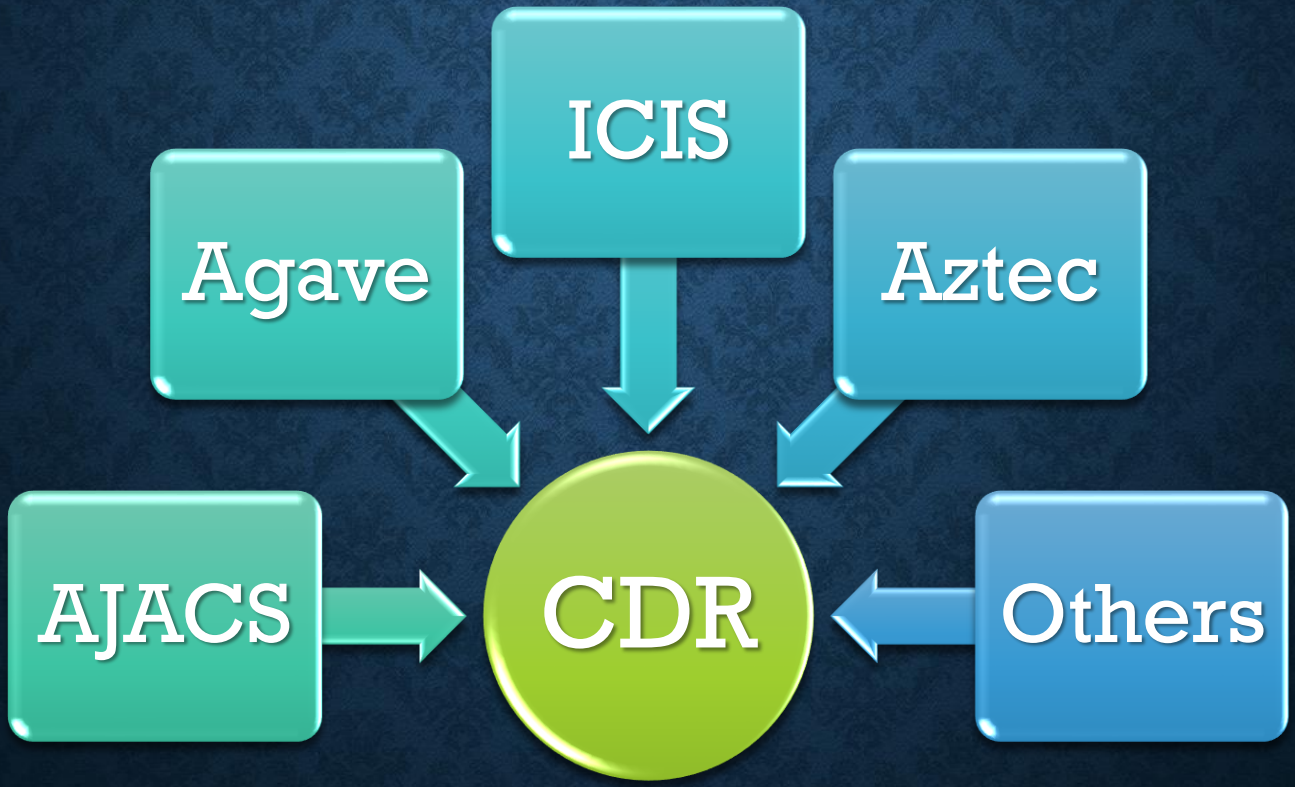
Comm. on Mental Health

AJIN- NETWORK

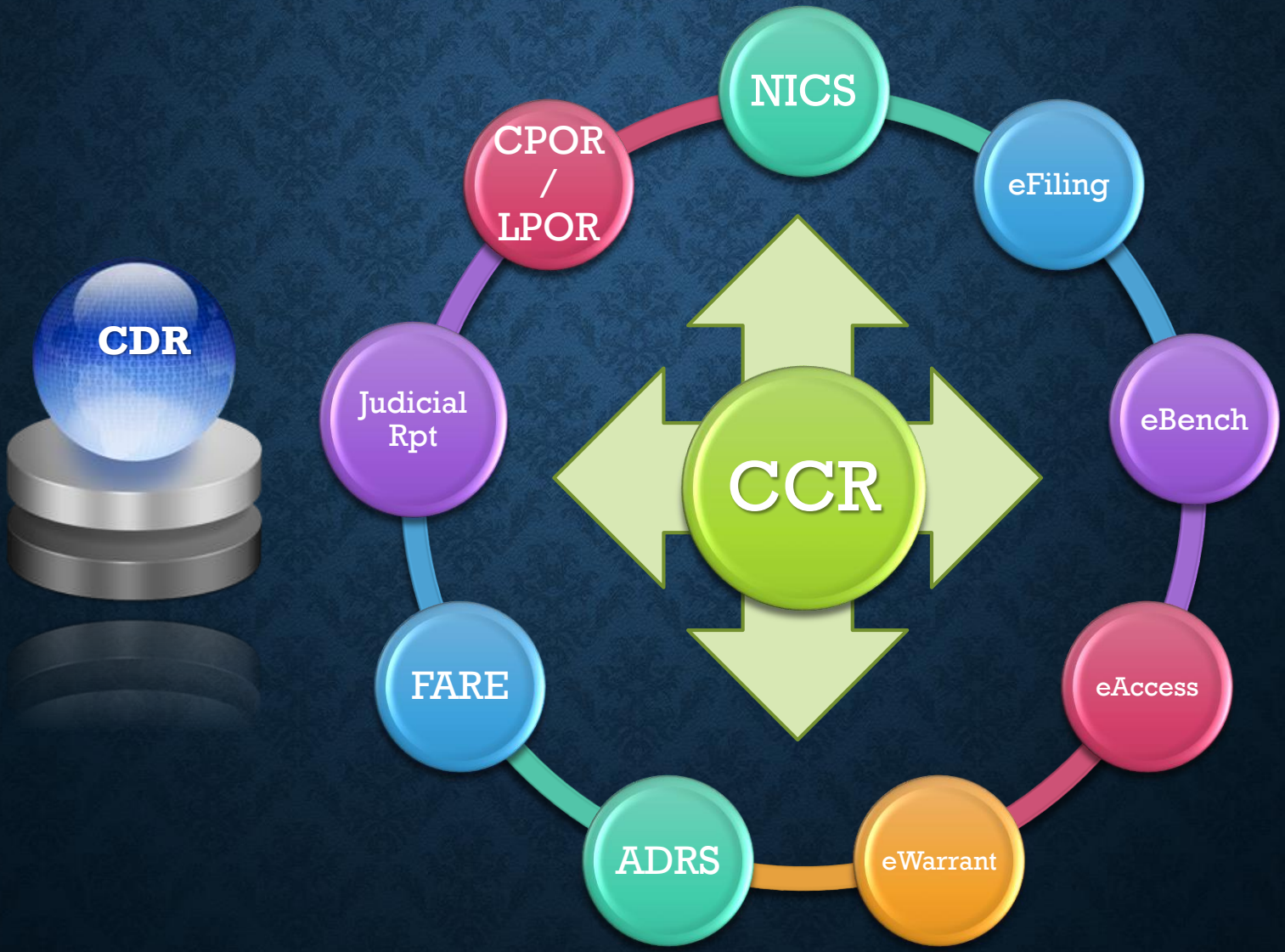
- Foundational Infrastructure
- Interconnected Networks
  - County/City
  - DES, DPS, DOR, MVD
- Email / Cloud Services
- Intranet Collaboration
- Internet
  - Portal Services
  - Info Access
- Security
- Local Access



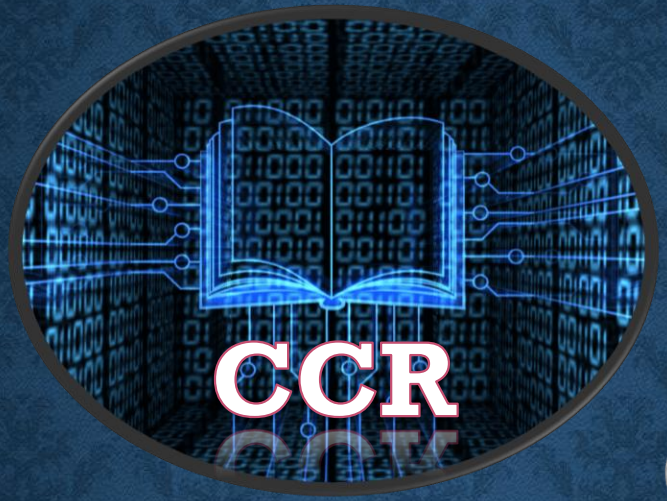
CDR: THE HUB FOR CASE INFORMATION



PROVIDES CENTRAL SERVICES



DATA ANALYTICS



Daily Monitor

Time Stds

MH REPORTING SYSTEM

COMMITTEE RECOMMENDATIONS

11. Work with the Administrative Office of the Courts to create a mechanism for **judges and attorneys** involved in a Rule 11, Title 36 or Title 14 proceeding to **access remotely the basic information on a defendant's involvement in other mental health proceedings**, including current **location**, **findings**, or **pending proceedings** in another court.

    a. At present, there is no way for an attorney or judge to know which court contains records for an individual involved in a Rule 11, Title 36 or Title 14 proceeding. The mechanism to be developed will include the basic information needed for the attorney, having received an order from a court, to properly secure the release of the records from the correct court. Having a mechanism to **locate and request the release** of these records is critical to informing the doctors, the attorneys, and the judge in determining the most appropriate response to the case and is most important for defendants with serious mental health issues. The ability to do this is fundamental to the delivery of fairness in these cases.

MH REPOSITORY DECISIONS

Data

Classification/sensitivity

Standards for transmission

Access /Identity mgmt.

Analytics