AMERICAN PSYCHIATRIC ASSOCIATION
Medical leadership for mind, brain and body.

ROADMAP TO THE IDEAL CRISIS SYSTEM: WHAT EVERY PSYCHIATRIST SHOULD KNOW

Ken Minkoff, MD
ZiaPartners
Senior System Consultant
Harvard Medical School
Assistant Professor of Psychiatry
kminkov@aol.com

Margie Balfour, MD, PhD
Connections Health Solutions
Chief of Quality & Clinical Innovation
University of Arizona
Associate Professor of Psychiatry
margie.balfour@connectionshs.com

Joe Parks, M.D.
National Council for Mental Wellbeing
Medical Director
VP for Practice Improvement
JoeP@TheNationalCouncil.org

APA Annual Meeting | New Orleans, LA | May 22, 2022

911: WHAT'S YOUR EMERGENCY?

"I'm having chest pain."

"I'm suicidal."

Police-involved deaths

One quarter

are linked to **mental illness.**·

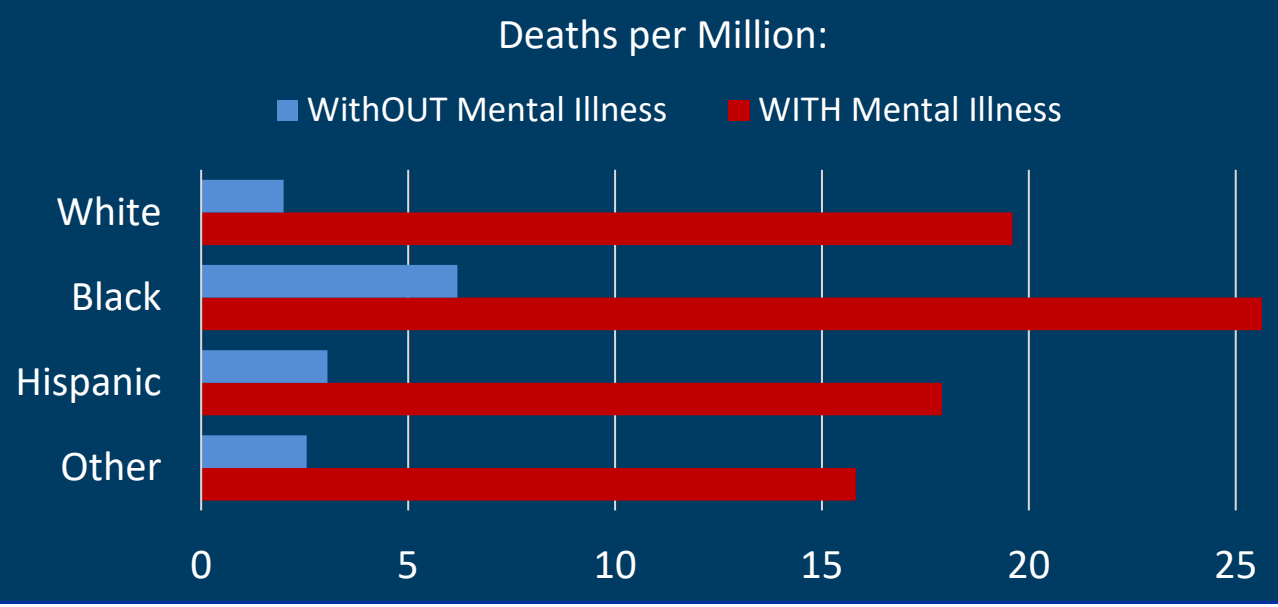
Half

occur in the person's own home.

The effect of mental illness is magnified by race/ethnicity:

Compared to Non-Hispanic Whites, the risk of being killed by police is

- **2.6x** for Black Americans
- **10x** for Black Americans *with mental illness*



AMERICAN PSYCHIATRIC ASSOCIATION

The "Divert to What?" Question

Individuals experiencing crisis often end up in jail when officers don't have a quick and easy way to connect them to treatment.

Jails Are The New Asylums

- Prevalence of mental illness in jails and prisons is 3-4x that of the US population.
- Sentencing bias (e.g. harsher penalties for crack vs. powder cocaine) magnifies this disparity for people of color.

MYTH

"They'll get the treatment they need in jail."

Only one quarter of men and 14% of women receive formal substance abuse treatment while incarcerated.

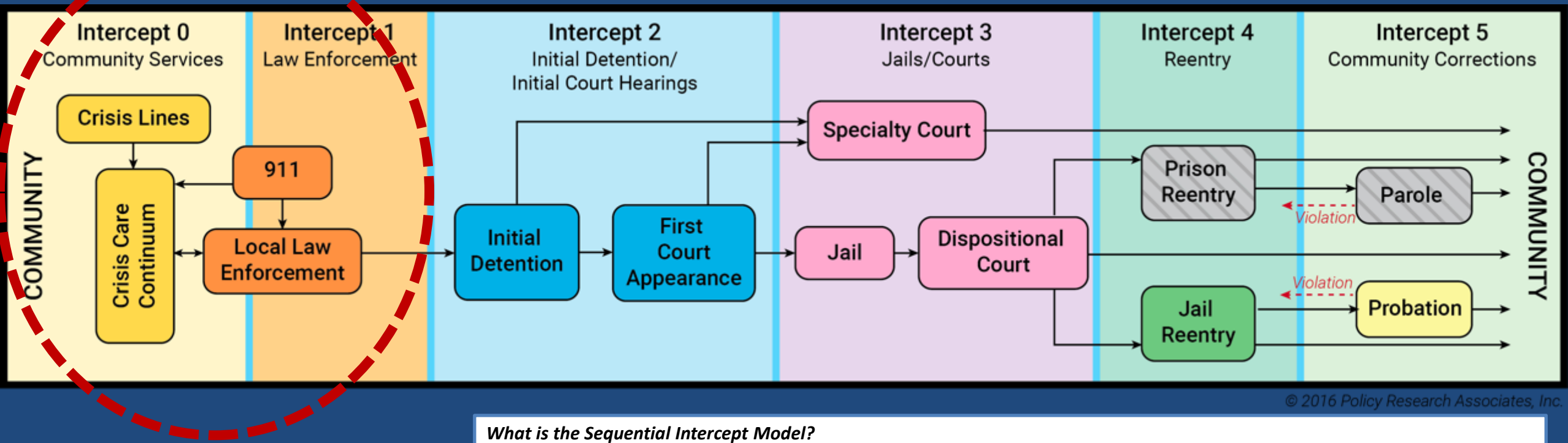
- Inmates with mental illness
  - Often do not get needed treatment
  - Incarcerated 2x as long at 2x the cost
  - 3x more likely to be sexually assaulted in jail
  - More likely to be homeless, unemployed, re-arrested upon release

When the ED is the only treatment option…

- **62% of EDs report there are no psychiatric services** while patients are being boarded prior to admission or transfer
- Without treatment, the default disposition is transfer to an inpatient psych hospital
  - **84% of EDs report boarding** of psychiatric patients on any given day
- The result:
  - **Increased risk:** Assaults, injuries, self-harm
  - **Increased cost:** $2300/day
  - **Poor patient experience:** Nontherapeutic environment with untrained staff

Officers are often required to wait with involuntary patients – sometimes for hours or days – until they can be transferred to a psychiatric hospital.

The Sequential Intercept Model
Intercepts 0 and 1 focus on *preventing arrest*



What is the Sequential Intercept Model?

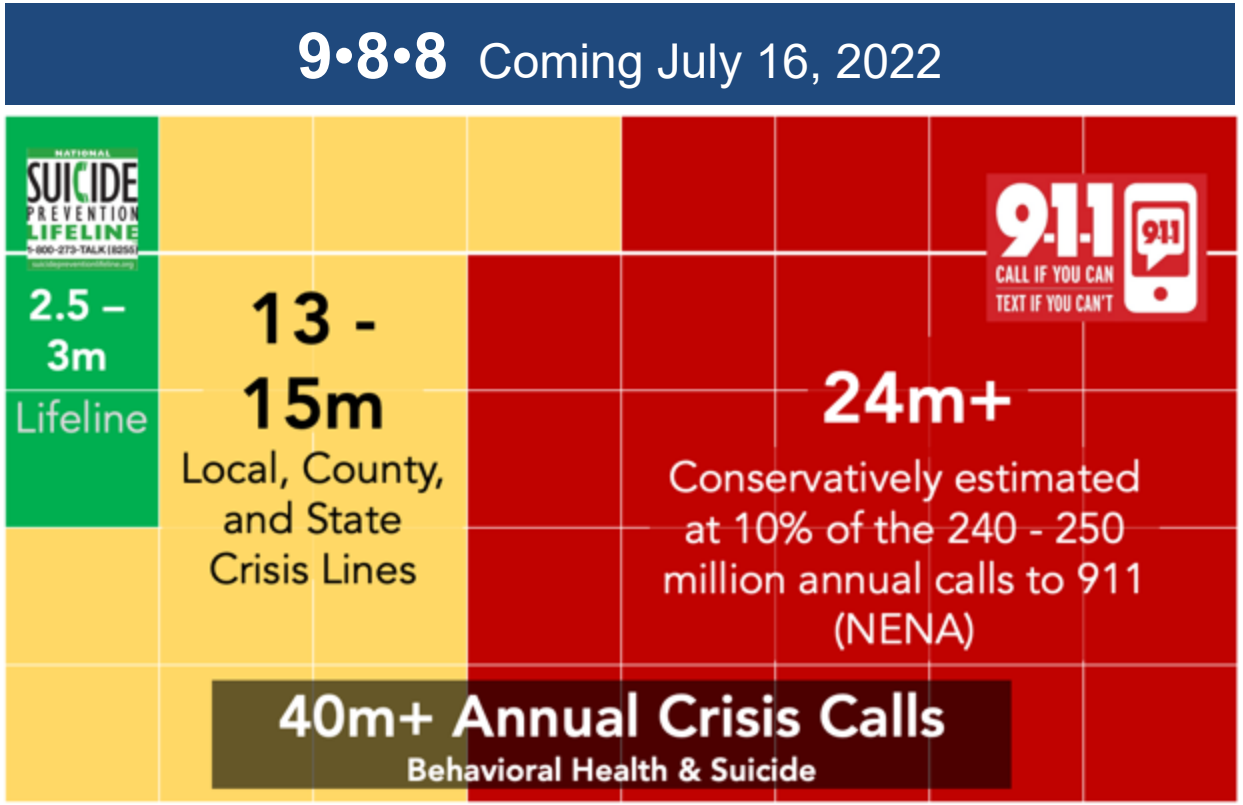
- Every person follows a path through the justice system: Arrest, detention, arraignment, pre-trial, etc.
- At every point along this path, there is an opportunity for the behavioral health system to "intercept" the person and either
  - Stop them from progressing further (diversion)
  - Mitigate the effects of justice involvement
- Crisis services are focused on Intercept 1:
  - Interactions with law enforcement to prevent unnecessary arrest

Munetz MR and Griffin PA. (2006) "Use of the Sequential Intercept Model as an Approach to Decriminalization of People With Serious Mental Illness." Psychiatric Services 57:4.

AMERICAN PSYCHIATRIC ASSOCIATION

988: The new nationwide 3-digit number for behavioral health emergencies

- **Connects to the National Suicide Prevention Lifeline (currently 1-800-273-TALK)**
- Network of nearly 200 call centers with call-takers trained in suicide/crisis intervention
- National standards
  - SAMHSA oversight
  - single national administrator
    Vibrant Emotional Health: www.vibrant.org
- Alternative to 911
- Makes it easier to ask for help
- Lessens stigma by sending the message that mental health is like other health emergencies
- More info: https://www.samhsa.gov/988



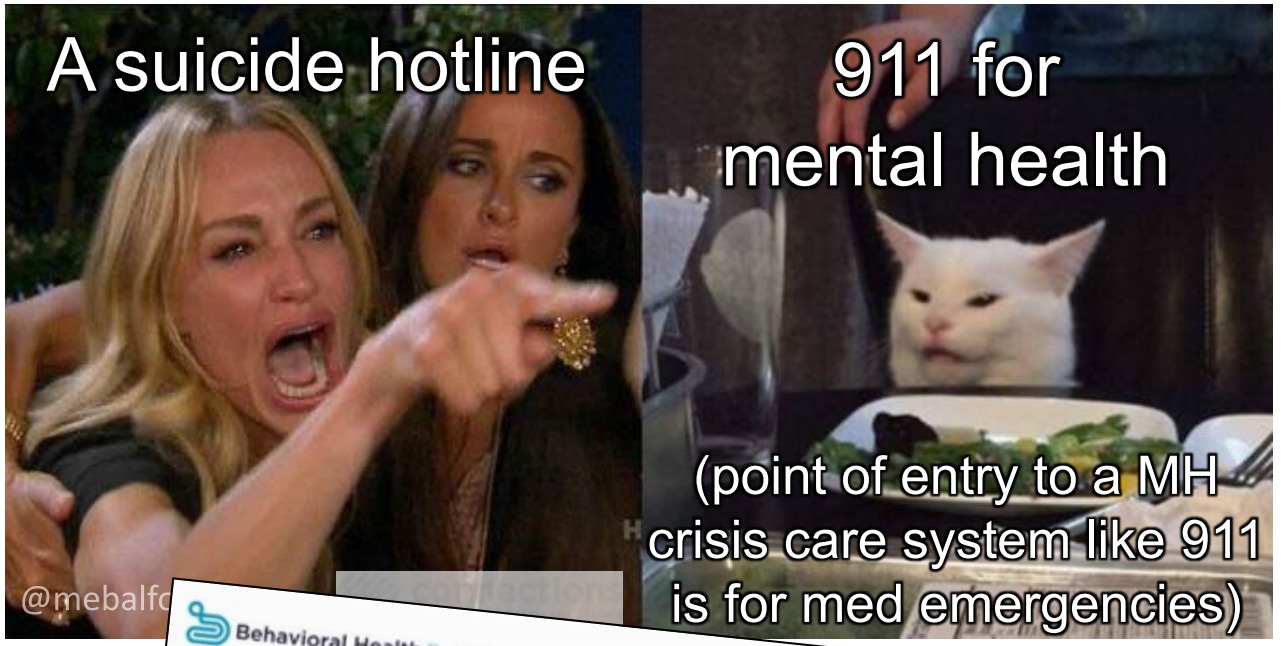
https://talk.crisisnow.com/wp-content/uploads/2021/04/01-Universe-of-potential-988-calls-2020-10-21.pdf

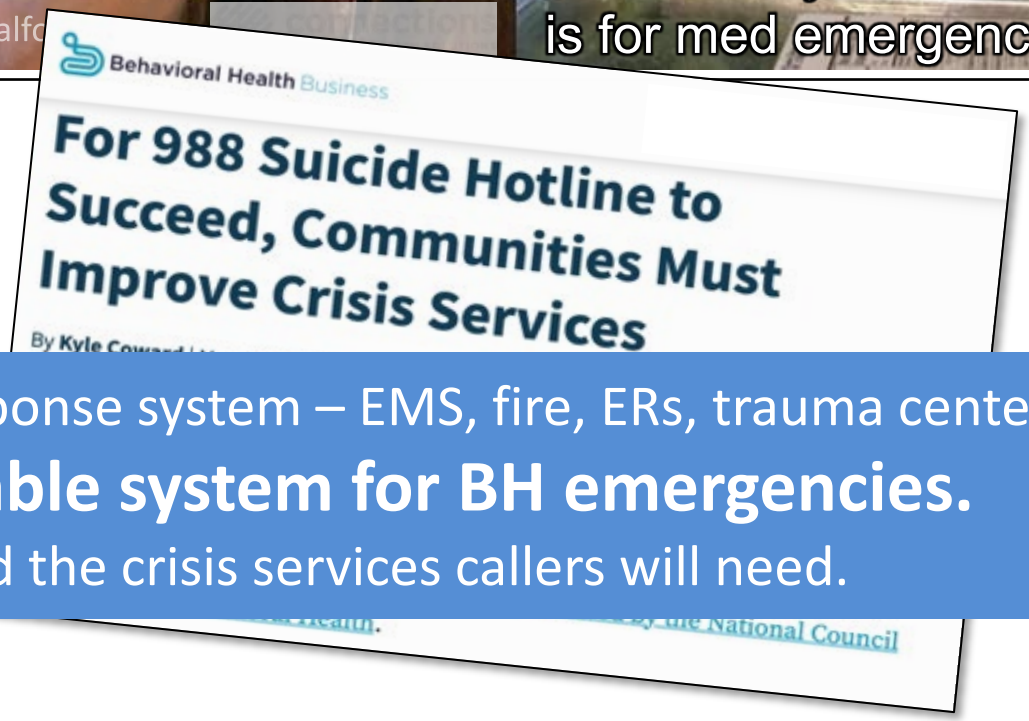
AMERICAN PSYCHIATRIC ASSOCIATION

What happens on 7-16-2022?
It depends….

- **For some communities, 988 will mostly function as a suicide hotline** providing evidence-based telephonic crisis counseling and safety planning.
- **In other communities, the 988 call center may have access to mobile crisis teams and crisis facilities** – with the ability to connect the person to crisis care (mobile team dispatch, appointment scheduling, bed placement, etc.)
- **Most communities will find that they need to improve their crisis system of care.**

988 is…




Behavioral Health Business

For 988 Suicide Hotline to Succeed, Communities Must Improve Crisis Services

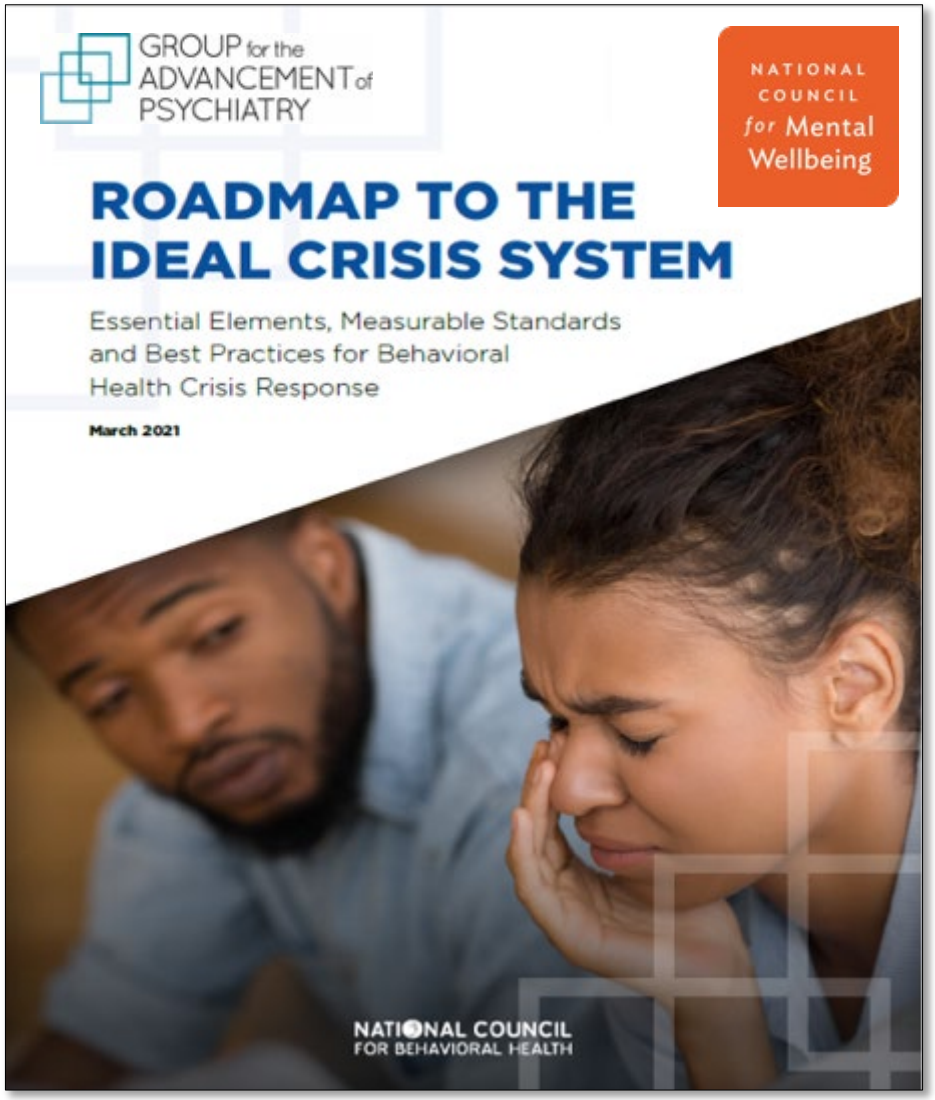
By Kyle Coward

Today, we can't imagine 911 without thinking of the response system – EMS, fire, ERs, trauma centers...

988 is the first step towards a comparable system for BH emergencies.

NOW is the time for leaders to fund and build the crisis services callers will need.

AMERICAN PSYCHIATRIC ASSOCIATION



A report of the

Committee on Psychiatry & the Community

for the

Group for the Advancement of Psychiatry

and published by the

National Council for Mental Wellbeing

Jacqueline Maus Feldman MD, co-chair
Ken Minkoff MD, co-chair

Current Co-chairs:
Ken Minkoff, MD & Margie Balfour, MD, PhD

Available at:
https://www.thenationalcouncil.org/resources/roadmap-to-the-ideal-crisis-system & http://www.CrisisRoadmap.com

AMERICAN PSYCHIATRIC ASSOCIATION

Roadmap Vision

- Every individual/family in every community in the U.S. will have access to a continuum of best practice BH crisis services that are welcoming, person-centered, recovery-oriented, and continuous.
- ***An excellent Behavioral Health Crisis System is an essential community service, just like police, fire and emergency medical services (EMS).***
- Every community should expect a highly effective BH crisis response system to meet the needs of its population.
- A BH crisis system is more than a single crisis program.
- ***It is an organized set of structures, processes, and services that are in place to meet all types of urgent and emergent BH crisis needs in a defined population or community, effectively and efficiently.***

Guiding Principles & Values of an Ideal Crisis System

Ideal BH Crisis Systems are:

- ***Based on a shared set of values***
  Welcoming and engaging, customer-centered, hopeful, safe, compassionate, empowering, recovery-oriented, trauma informed, and culturally appropriate.
- ***Accountable for all people and populations***
- ***Designed for the expectation of complexity:*** MH and SUD, plus I/DD, health, housing, criminal justice, child/adult protection, etc.
- ***Designed to be clinically effective and cost effective***
- ***Able to use involuntary intervention*** when there is no other way to prevent harm
- ***Organized to share and use data for continuous improvement***

READING THE REPORT

The report begins with an organizing framework that describes how to build an ideal crisis system that is "person-centered" and "customer-oriented", inclusive of a foundational set of values and operational principles.

The report describes how implementation of successful systems requires **3 interacting design elements**, along with measurable indicators for the components of each.

These 3 interacting design elements provide the structure for the 3 major sections of this report:

1. ***Accountability & Finance***
2. ***Service Continuum***
3. ***Clinical Practices***

The Roadmap complements the SAMHSA Crisis Best Practice Toolkit

Section I: Accountability And Finance

An ideal behavioral health crisis system must have both a mechanism to finance and implement a comprehensive continuum of crisis services and a mechanism to ensure oversight, accountability, and quality of the performance of that continuum.

This section defines the concept of an **Accountable Entity**, which is a structure and a mechanism for allocating responsibility and accountability that holds the behavioral health crisis system accountable to the community for meeting performance standards and the needs of the population. There are numerous different models of these structures.

Section I: Accountability & Finance

- There is an entity accountable for behavioral health crisis system performance for everyone and for the full continuum of system capacities, components and best practices.
- There is a BH lth crisis system coordinator and a formal community collaboration of funders, providers, first responders, human service systems and service recipients.
- There is a stated goal that each person and family will receive an effective, satisfactory response every time.
- Geographic access is comparable to that of EMS.
- Multiple payers collaborate so that there is universal eligibility and access.
- There are multiple strategies for successfully financing community behavioral health crisis systems.
- Service capacity of all components is commensurate to population need.
- Individual services rates and overall funding are adequate to cover the cost of the services.
- There is a mechanism for tracking customers, customer experience and performance.
- There are shared data for performance improvement.
- Quality standards are identified, formalized, measured and continuously monitored

Section II: Crisis Continuum: Basic Array Of Capacities And Services

An ideal BH crisis system has

- Comprehensive array of service capacities
- Continuum of service components
- Adequate multi-disciplinary staffing
- To meet the needs of all segments of the population.

Section II: Crisis Continuum: Basic Array Of Capacities & Services

- The system has welcoming and safe access for all populations, all levels of acuity and for those who are both voluntary and involuntary.
- Family members and other natural supports, first responders and community service providers are priority customers and partners.
- Crisis response begins as early as possible, well before 911 (or 988) and continues until stability is regained.
- There is capacity for sharing information, managing flow and keeping track of people through the continuum.
- There is a service continuum for all ages and people of all cultural backgrounds.
- All services respond to the expectation of comorbidity and complexity.
- Welcome all individuals with active substance use in all settings in the continuum.
- Medical screening is widely available and is not burdensome.
- There is a full continuum of crisis components, including a crisis call center, mobile crisis, walk-in urgent care, secure crisis center, 23-hour observation, residential crisis services, hospitalization and intensive crisis outpatient services.
- Telehealth is provided for needed services not available in the local community.
- Program components are adequately staffed by multidisciplinary teams, including peer support providers.
- There is clinical/medical supervision, consultation and leadership available commensurate with provisions for emergency medical care.

Section III: Basic Clinical Practice

An ideal behavioral health crisis system has guidelines for utilization of the best clinical practices for crisis intervention with associated processes for practice improvement and developing workforce competency.

CORE COMPETENCIES FOR ENGAGEMENT, ASSESSMENT AND INTERVENTION

POPULATION-SPECIFIC CLINICAL BEST PRACTICES

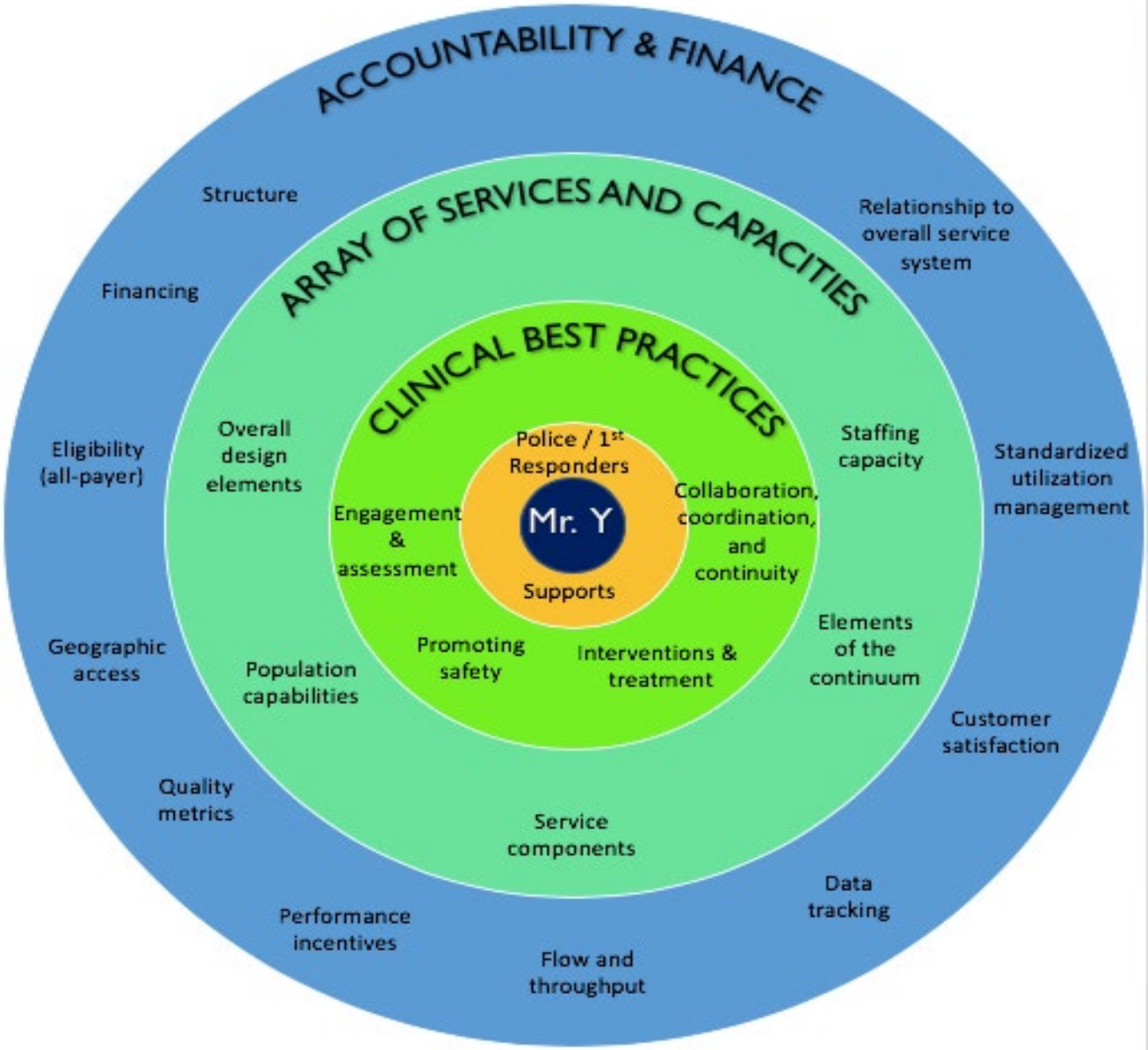
SCREENING AND INTERVENTION TO PROMOTE SAFETY

COLLABORATION, COORDINATION AND CONTINUITY OF CARE

PRACTICE GUIDELINES FOR INTERVENTION AND TREATMENT

Section III: Basic Clinical Practice

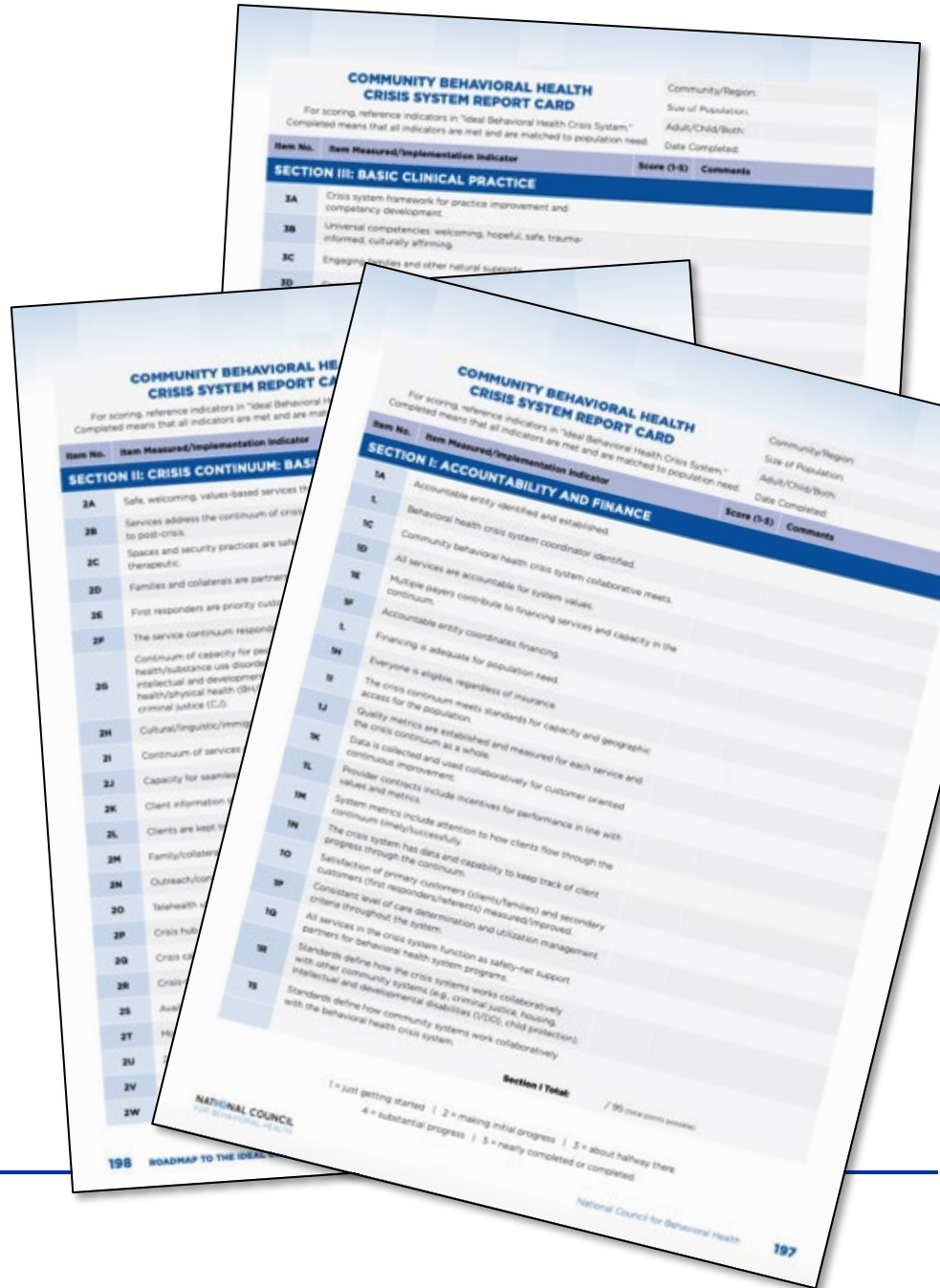
- The system has expectations of universal competencies based on values. Welcoming, hope and safety come first.
- Engagement and information sharing with collaterals is an essential competency.
- Staff must know how to develop and utilize advance directives and crisis plans.
- Essential competencies include formal suicide and violence risk screening and intervention.
- “No force first” is a required standard of practice.
- Risk screening guidelines for medical and substance use disorder (SUD)-related issues must facilitate rather than inhibit access to behavioral health crisis care.
- Utilizing peer support in all crisis settings is a priority.
- Behavioral health crisis settings can initiate medication-assisted treatment (MAT) for SUD.
- Formal practice guidelines for the full array of ages and populations, including integrated treatment for mental health, SUD, cognitive and medical issues.
- Utilize best practices for crisis intervention, like critical time intervention, to promote successful continuity and transition planning.


ACCOUNTABILITY & FINANCE
ARRAY OF SERVICES AND CAPACITIES
CLINICAL BEST PRACTICES
Police / 1st Responders
Mr. Y
Supports
Engagement & assessment
Collaboration, coordination, and continuity
Promoting safety
Interventions & treatment
Overall design elements
Staffing capacity
Population capabilities
Elements of the continuum
Structure
Financing
Relationship to overall service system
Eligibility (all-payer)
Standardized utilization management
Geographic access
Customer satisfaction
Quality metrics
Service components
Data tracking
Performance incentives
Flow and throughput

Tools to Help Implementation

- **Ten Steps** for Communities
- **Ten Steps** for System Leaders and Advocates
- **Six examples** of successful crisis system local implementation
- **Community BH Crisis System Report Card**

  An instrument to assist communities to assess their current status on each of the elements of an "ideal crisis system," and to help prioritize next steps.



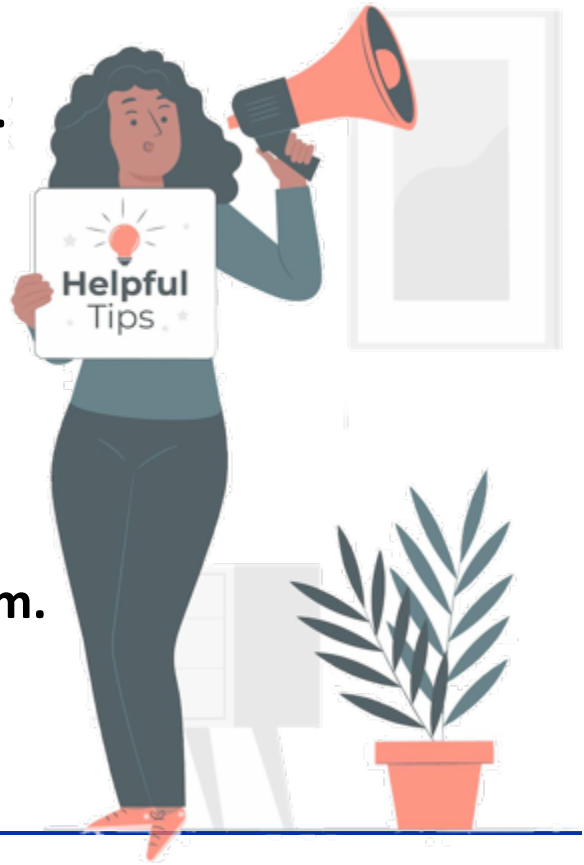
AMERICAN PSYCHIATRIC ASSOCIATION

10 STEPS FOR COMMUNITIES

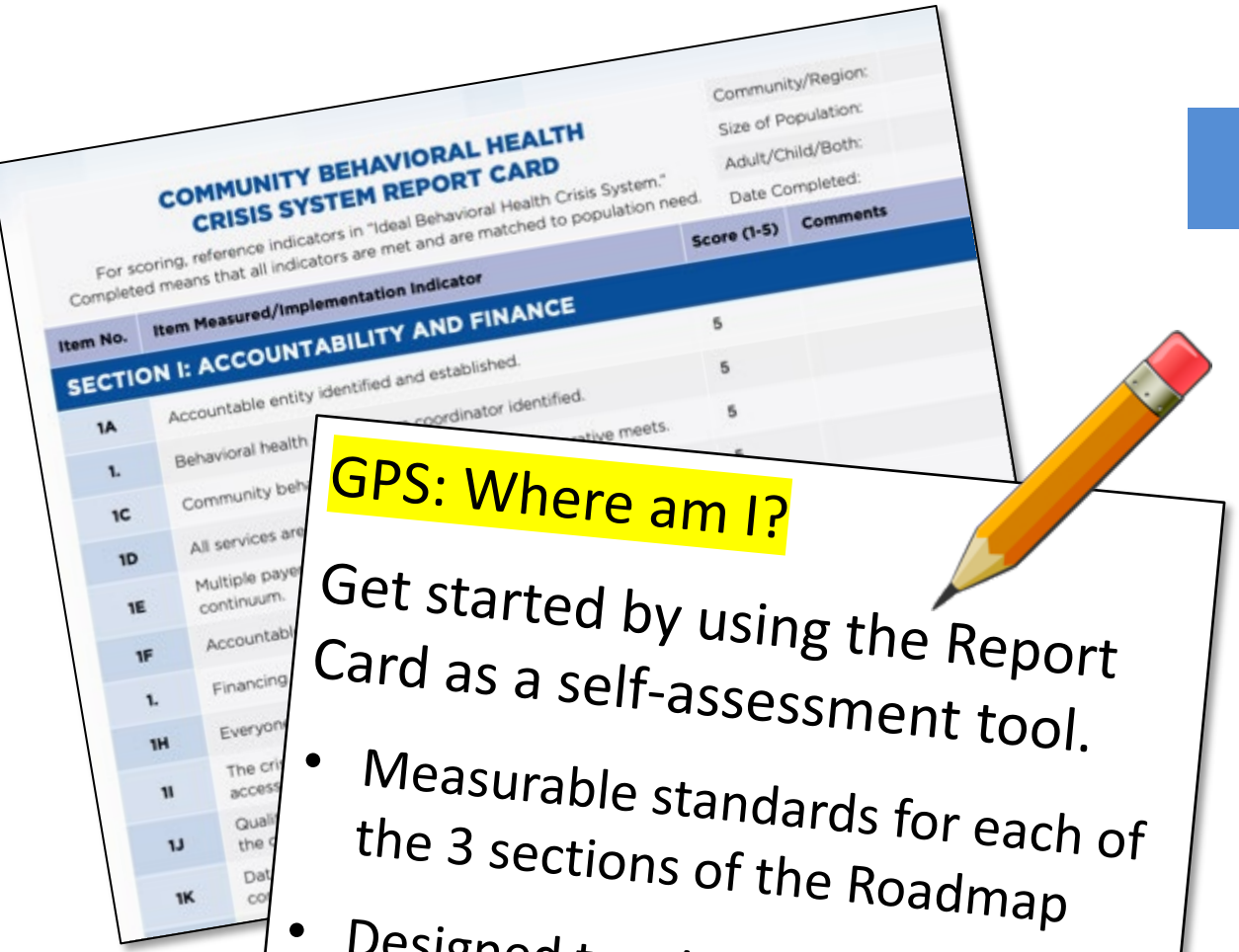
1. **Identify and convene community partners.**
2. **Read and process relevant sections of the report.**
3. **Develop a local vision.**
4. **Disseminate the vision.**
5. **Identify one or more "Accountable Entity(ies)."**
6. **Create a planning and implementation team:**
7. **Use the Report Card to perform a baseline self-assessment and track progress.**
8. **Create some "Early Wins" by focusing on 3-5 achievable improvement opportunities.**
9. **Gather data on clinical performance, cost and funding opportunities.**
10. **Develop a comprehensive collaborative plan.** *Continue meeting and working towards the goals set out in the plan, using the Report Card to measure progress.*

10 STEPS FOR SYSTEM LEADERS & ADVOCATES

1. **Establish & communicate a systemwide vision of ideal behavioral health crisis systems for all.**
2. **Develop a 10-year implementation plan for working collaboratively with stakeholders & funders.**
3. **Disseminate this report as a guiding document.**
4. **Use the Report Card to perform a baseline self-assessment and track progress.**
5. **Identify performance metrics based on input from system stakeholders.**
6. **Award planning and implementation grants: Develop a process to award planning and implementation grants to community crisis collaboratives.**
7. **Create a framework for identifying and empowering accountable entities.**
8. **Require all-funder participation, including all types of insurance plans.**
9. **Require coverage of and adequate rates for all elements of the crisis continuum.**
10. **Incorporate best practice standards into system regulations.**



Expanding the Roadmap


COMMUNITY BEHAVIORAL HEALTH CRISIS SYSTEM REPORT CARD

For scoring, reference indicators in "Ideal Behavioral Health Crisis System." Completed means that all indicators are met and are matched to population need.

Community/Region:
Size of Population:
Adult/Child/Both:
Date Completed:

Item No.	Item Measured/Implementation Indicator	Score (1-5)	Comments
SECTION I: ACCOUNTABILITY AND FINANCE			
1A	Accountable entity identified and established.	5	
1.	Behavioral health	5	
1C	Community beh	5	
1D	All services are		
1E	Multiple payo continuum.		
1F	Accountabl		
1.	Financing		
1H	Everyon		
1I	The cri access		
1J	Quali the c		
1K	Dat co		

GPS: Where am I?

Get started by using the Report Card as a self-assessment tool.

- Measurable standards for each of the 3 sections of the Roadmap
- Designed to stimulate discussion
- Creates baseline starting point for collaboration and goal-setting

Roadmap Learning Community
Ongoing pilot with 5 communities across the US

++ New Roadmap tools in the works ++

New CrisisRoadmap.com website
www.CrisisRoadmap.com

Scenic Routes In-depth explorations of specific topics such as difficult-to-reach populations

Driver's Ed
Curricula and training materials
Expanded learning communities

Roadside Assistance
Consultation and peer-to-peer TA

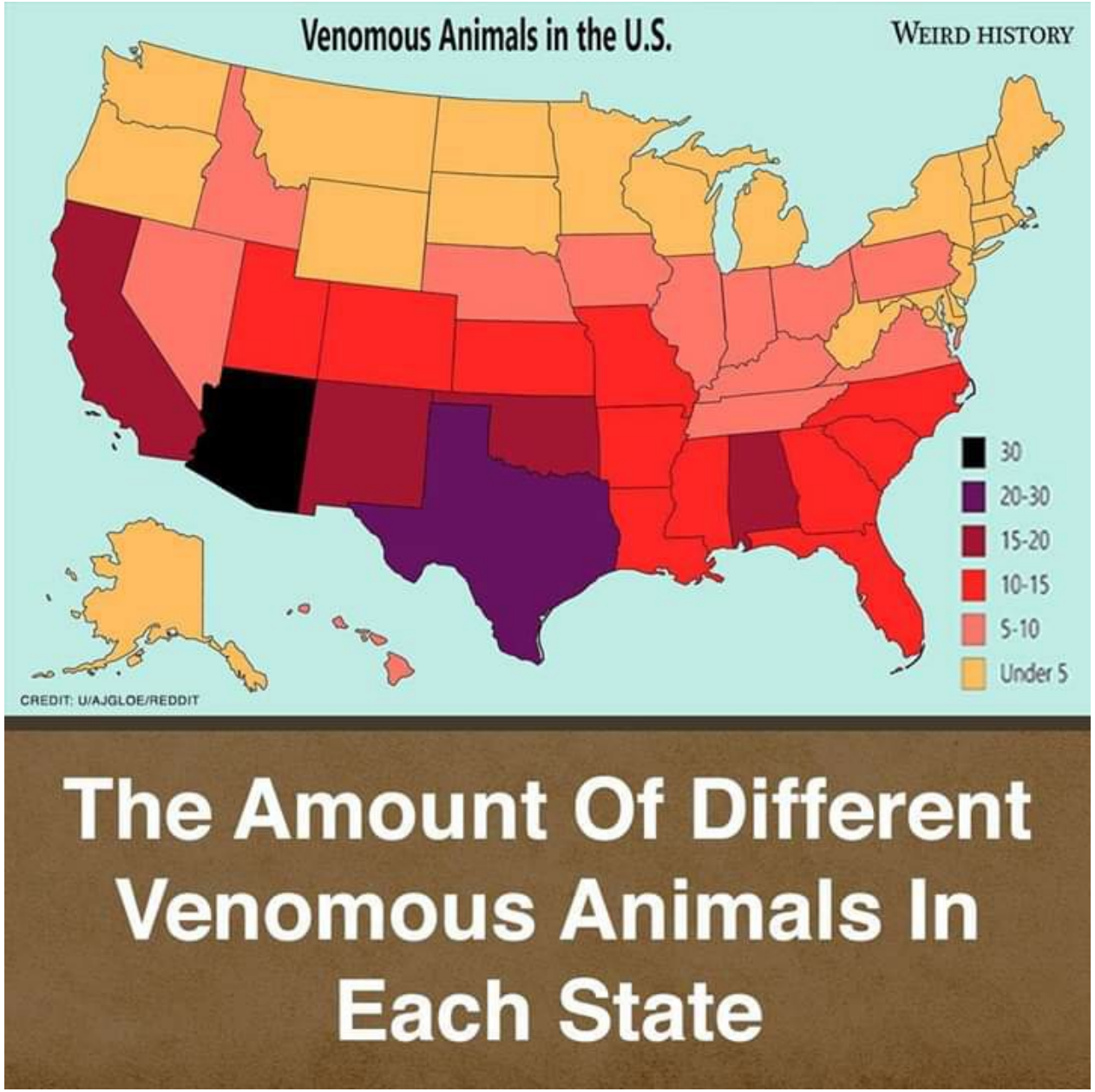
Atlas Curated collection of outside resources

What's so special about Arizona?

Arizona's crisis system design incorporates many of the principles outlined in the Roadmap.

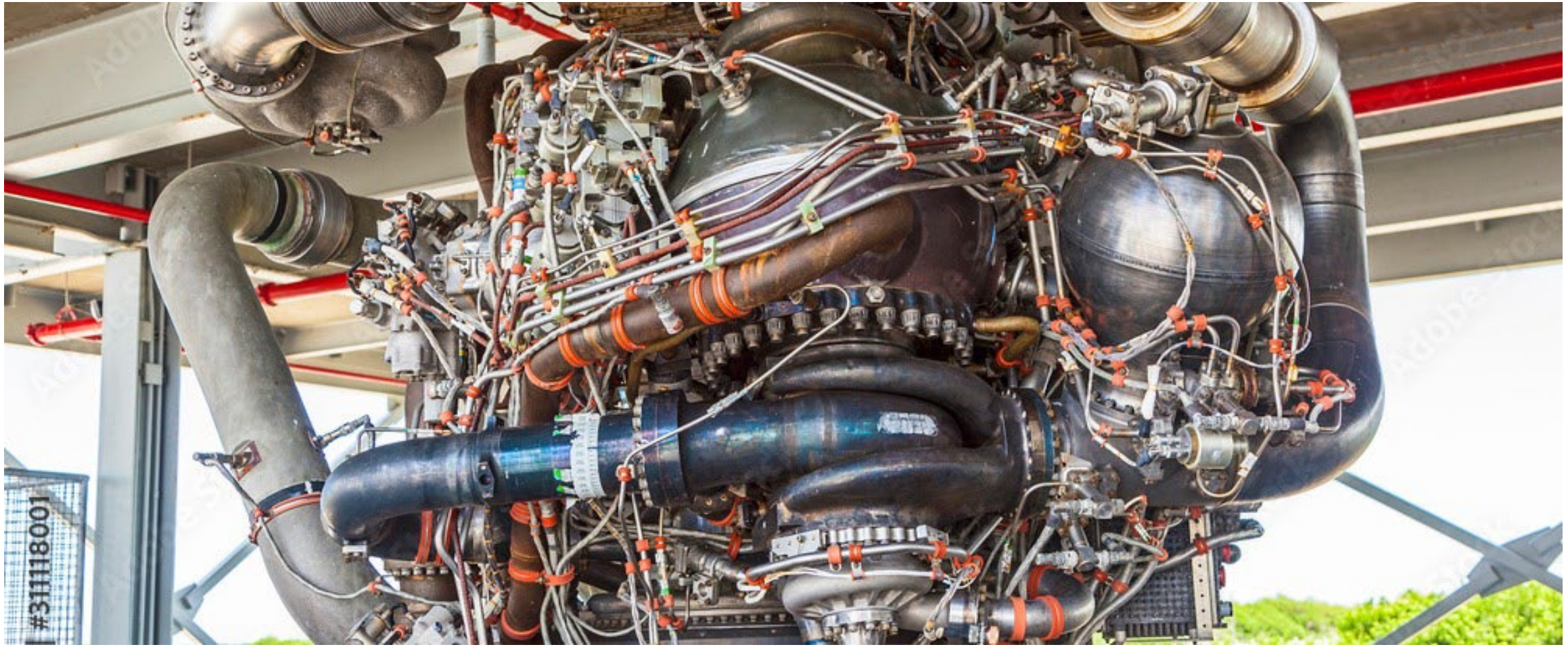
and

Successes in Arizona informed much of the development of the Roadmap.



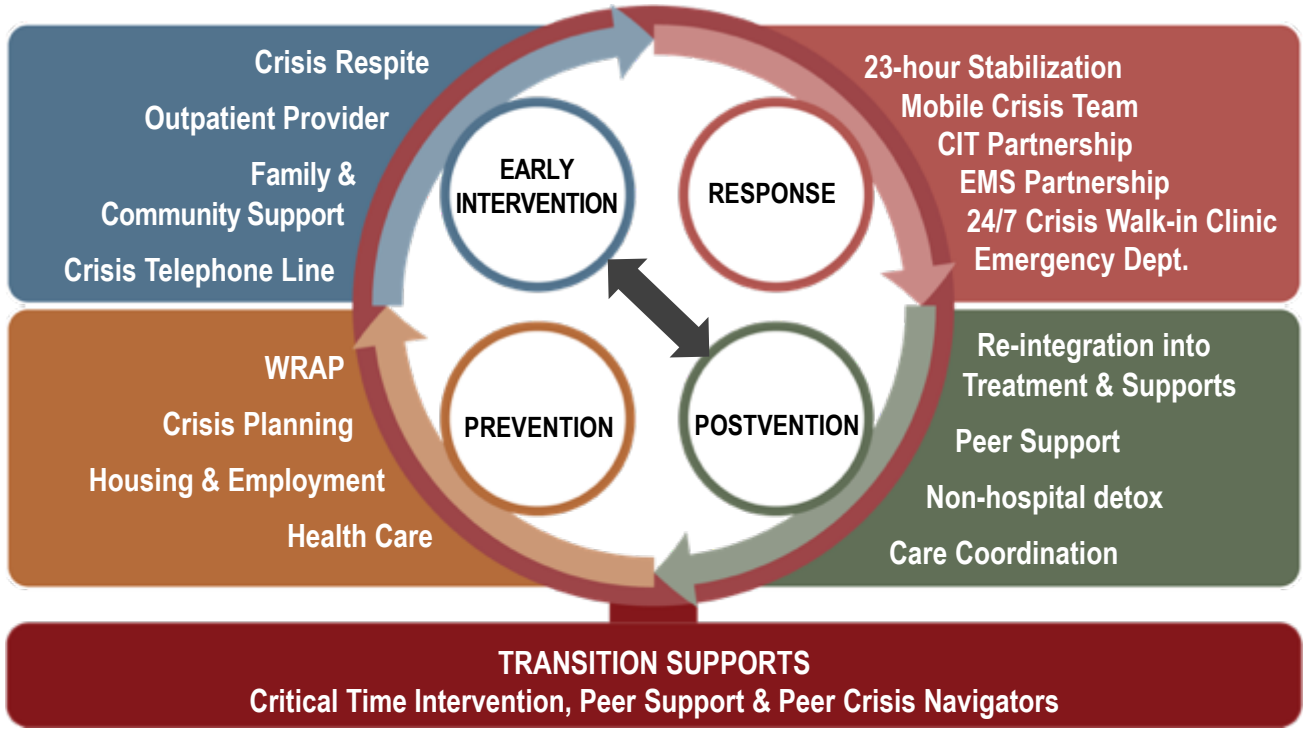
AMERICAN PSYCHIATRIC ASSOCIATION

Key Feature: Systems Thinking



Systems Thinking

A crisis system is
more than a collection of services.

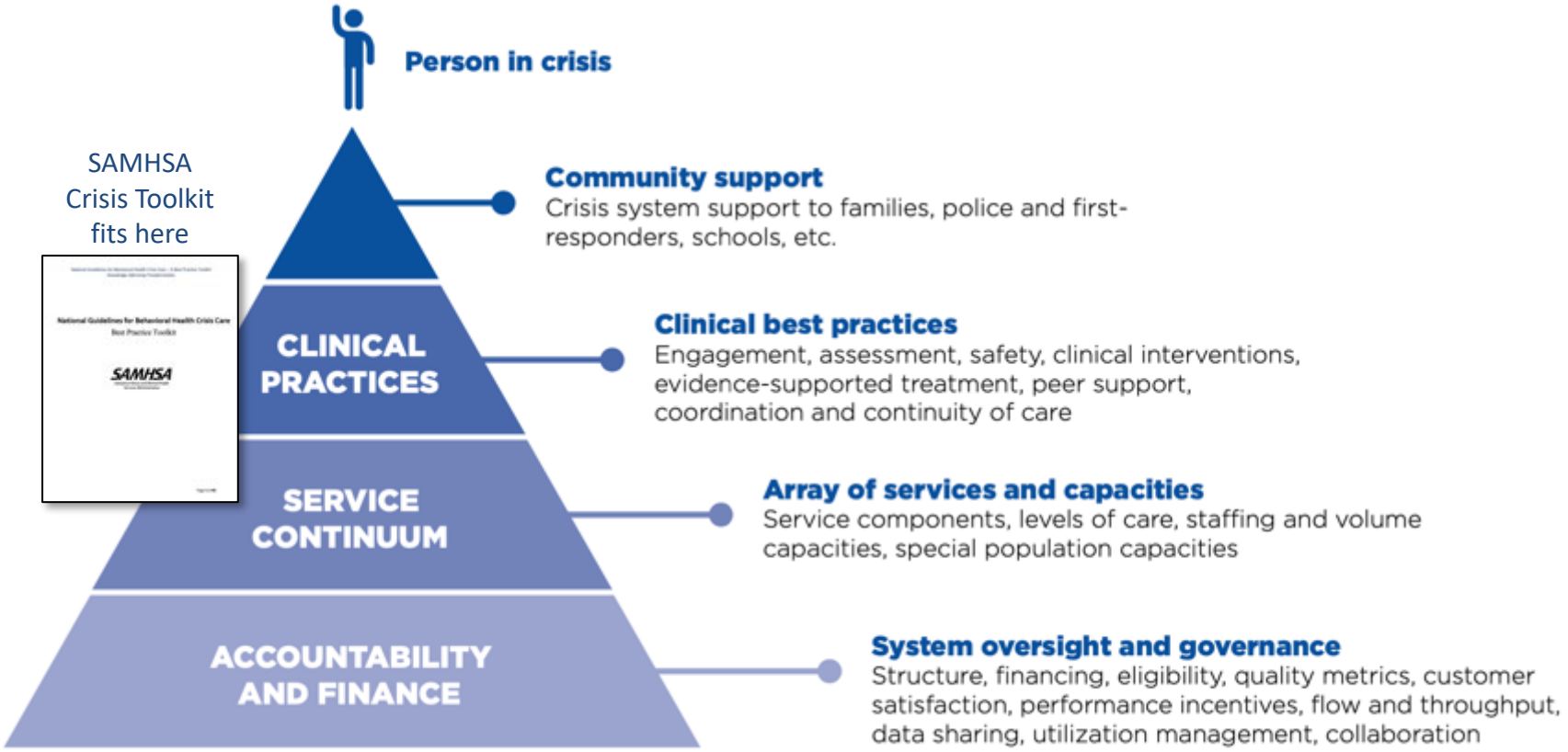


Adapted from: Richard McKeon (Chief, Suicide Prevention Branch, SAMHSA). Supercharge Crisis Services, National Council for Behavioral Health Annual Conference, 2015.

AMERICAN PSYCHIATRIC ASSOCIATION

Start with a Strong Foundation

Crisis systems need a governance and financing structure that ensures accountability, oversight, and sustainability.



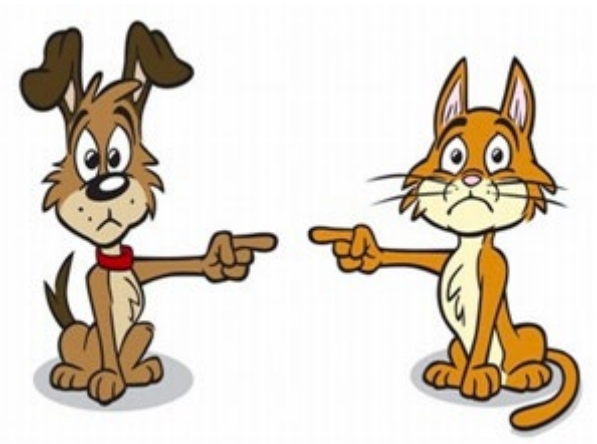
SAMHSA Crisis Toolkit fits here

www.CrisisRoadmap.com

AMERICAN PSYCHIATRIC ASSOCIATION

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

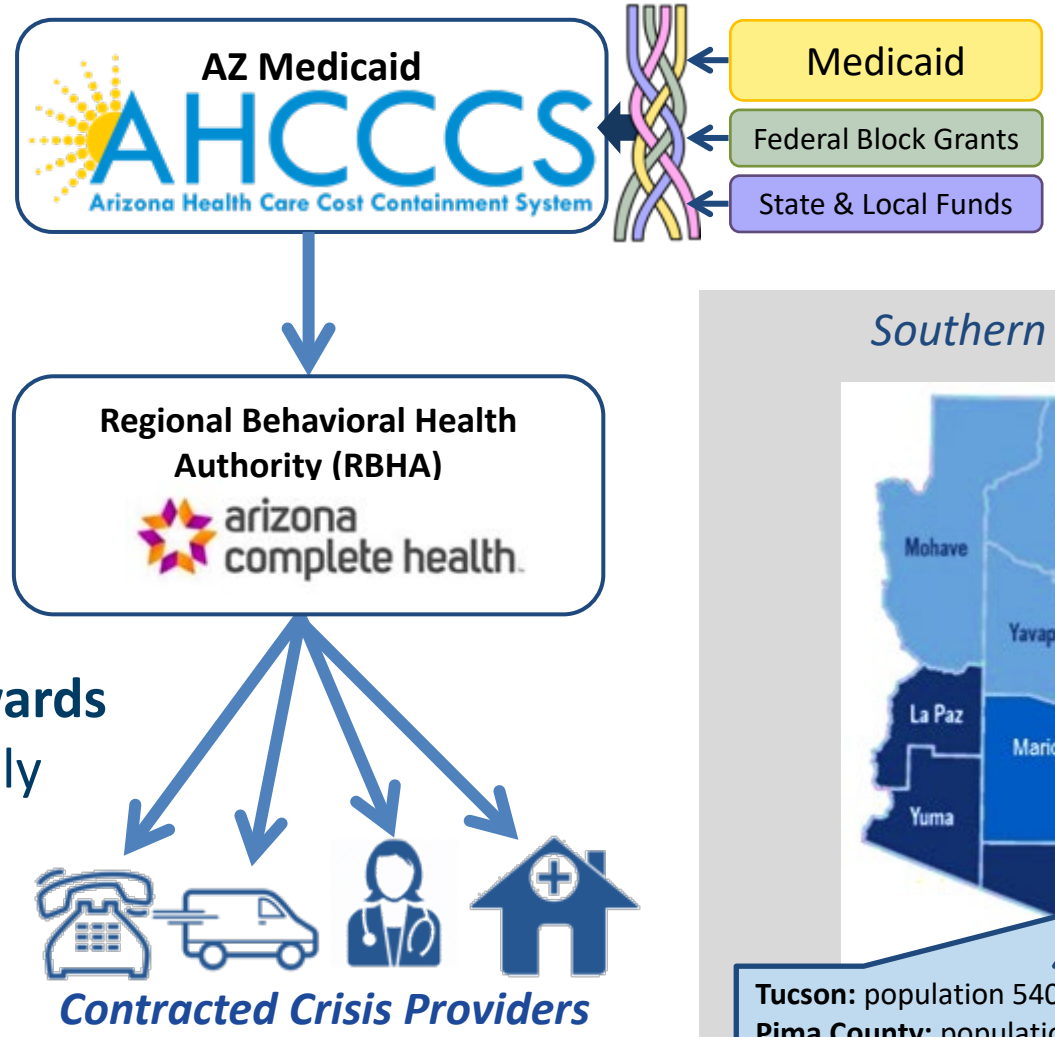
Data

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

Arizona Crisis System Financing & Governance Structure

creates the foundation for an organized, coordinated, & sustainable system

- A **"braided" funding** model maximizes the impact of multiple funding streams, creating a sustainable system that can serve everyone regardless of payer.
- A single **"accountable entity"** creates the structure for strategic planning and oversight.
- Contracted services are **aligned towards common goals** that are both clinically desirable & fiscally responsible:
  - **DECREASE use of ER, Hospital, Jail**
  - **INCREASE community stabilization**

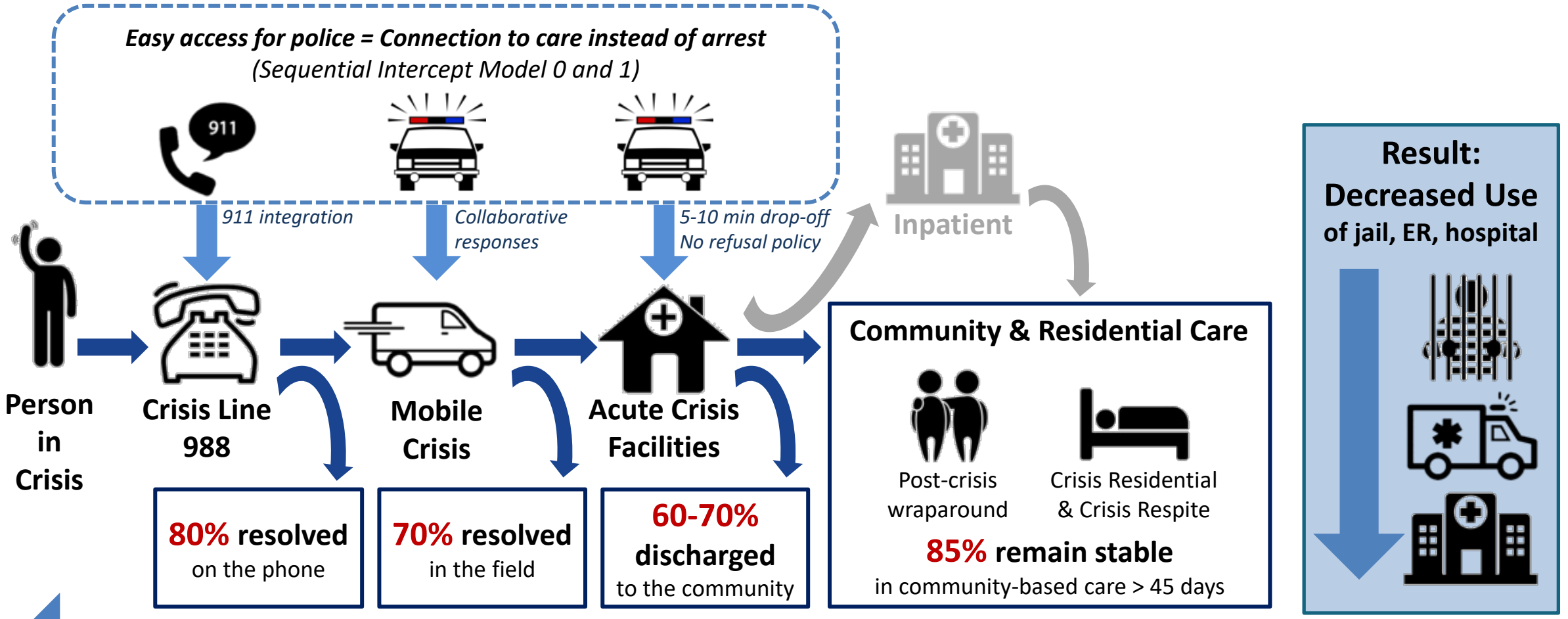


Southern Arizona Region

Tucson: population 540,000
Pima County: population 1 million · 9,187 sq. mi
125 miles of international border · 3 tribal nations
51% White, 38% Latino, 4% Native, 4% Black, 3% Asian

Alignment of crisis services toward common goals

care in the least restrictive (and least costly) setting



Services are easily accessible with a no-wrong door culture across the continuum, e.g., walk-ins at crisis facilities, police or mobile drops-offs to crisis residential, etc.

AMERICAN PSYCHIATRIC ASSOCIATION

Adapted from: Balfour ME, Hahn Stephenson A, Delaney-Brumsey A, Winsky J, & Goldman ML (2020). Cops, Clinicians, or Both? Collaborative Approaches to Responding to Behavioral Health Emergencies. *Psychiatric Services*. Epub ahead of print Oct 20, 2021. https://doi.org/10.1176/appi.ps.202000721

(Community stabilization rates are based on FY2019 data from the Southern Arizona region and were provided courtesy of Johnnie Gasper at Arizona Complete Health/Centene)

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
- Co-located at 911

envolve

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

CIT International

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

connections HEALTH SOLUTIONS

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.

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.

Substance Use Response Team (SURT)
- Co-responder team with peer and TPD
- Connect to treatment instead of arrest

codac Behavioral Healthcare

CODAC @380
24/7 MAT Clinic

codac Behavioral Healthcare

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

arizona complete health

Mental Health Support Teams (MHST)
- Dedicated team specializing in civil commitment, challenging cases, and follow-up
- Officers/Deputies & Detectives

Homeless Outreach Team
- Co-responder team with peer and TPD

Old Pueblo Community Services

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

HOPE Incorporated

CBI Community Bridges, Inc.

PIMA COUNTY

Crisis Response Canines

31

The Regional BH Authority is **more than just a payer.**

Arizona Complete Health (the Southern AZ RBHA) provides oversight, coordination, and support to the system via:

Dedicated Staff:

- First Responder Liaisons work with police, sheriff, EMS, 911
- Crisis Specialists oversee crisis programs and review systemic trends
- Title 36 Coordinators support civil commitment processes.
- Tribal Liaisons ensure culturally appropriate care to the 6 tribal nations in its catchment area.

Coordination functions:

- 1hr Urgent Engagements dispatched to obs units
- My Health Direct real-time scheduling tool
- Crisis Bed Connect bed board
- GPS tracking for crisis mobile teams
- Centralized data collection and review

The Crisis Response Center

- Built with Pima County bond funds in 2011
  - County owns the building, services funded by the RBHA
  - Alternative to jail, ED, hospitals
  - Serving 12,000 adults + 2,400 youth per year
  - Operated by Connections Health Solutions since 2014
- Services include
  - 24/7 walk-in **urgent care**
  - **23-hour observation**
  - Short-term adult subacute **inpatient**
- Police drop-offs with **NO WRONG DOOR that TAKES EVERYONE**
- Space for co-located community programs
- Unique Campus: CRC is adjacent to
  - Crisis Line Call Center
  - Banner University of Arizona Medical Center
    - Emergency Department
    - 66-bed inpatient psychiatric unit that performs most of Pima County's civil commitment evals
  - Mental health court

>60% discharged back to the community
Interdisciplinary teamwork with 24/7 psychiatric providers, nurses, techs, social services, peers

Therapeutic milieu with open design to facilitate continuous observation & social interaction

AMERICAN PSYCHIATRIC ASSOCIATION
33

A Solution to the "Divert to What?" Question
Connections culture of treating law enforcement as a "preferred customer"

CIT Definition of Ideal MH Receiving Facility[1]

1. Single Source of Entry
2. On Demand Access 24/7
3. **No Clinical Barriers to Care**
4. **Minimal Turnaround Time for Law Enforcement**
5. Access to Wide Range of Disposition Options
6. Community Collaboration

What this means in practice: "Be easier to use than jail."

- Drop off time less than 10 min
- Never turn police away. Take everyone.
  - High acuity: No such thing as "too agitated" or violent
  - Can be highly intoxicated, involuntary or voluntary
  - Without using security guards

Studies show this model is critical for pre-arrest diversion,[2] reduces ED boarding,[3,4] and reduces hospitalization.[3,4]

In Tucson…

"For both officer-initiated events and 911 calls, the odds of arrest were lower for mental health/medical incidents than for violent crimes. This finding may be partly due to the role of Tucson's Crisis Response Center, which provides an alternative to arrest and jail booking… the odds of arrest for mental health/medical versus violent crimes were far lower concerning officer-initiated events than 911 calls."

Vera Institute of Justice

Figure 6.2.6: Tucson, AZ. Predictors of arrest: Officer-initiated events

	OFFICER-INITIATED EVENTS			
	Adjusted odds ratio	*p*-value	N	Percentage
PREDICTORS OF INTEREST				
Incident type				
Violent crime	Reference	Reference	729	0.3
Domestic violence	0.75	.059	625	0.3
Property crime	0.85	.146	4,298	1.9
Other crimes	2.21	<.001	5,102	2.3
Proactive	0.34	<.001	44,564	19.9
Police operations	11.87	<.001	2,593	1.2
Traffic-related	0.31	<.001	124,063	55.4
Service assignments	0.93	.492	3,657	1.6
Mental health/medical emergency	0.13	<.001	5,673	2.5

…n, AZ. Predictors of arrest: 911 calls

	911 CALLS			
	Adjusted odds ratio	*p*-value	N	Percentage
	Reference	Reference	8,268	1.4
	2.02	<.001	39,259	6.7
	0.62	<.001	48,030	8.2
	0.92	.034	75,972	12.9
	0.21	<.001	1,233	0.2
	2.34	<.001	1,409	0.2
	0.54	<.001	31,572	5.4
	1.39	<.001	15,537	2.6
	0.61	<.001	67,030	11.4

Neusteter SR et al. (2020) *Understanding Police Enforcement: A Multicity 911 Analysis*. Vera Institute of Justice. https://www.vera.org/downloads/publications/understanding-police-enforcement-911-analysis.pdf

AMERICAN PSYCHIATRIC ASSOCIATION

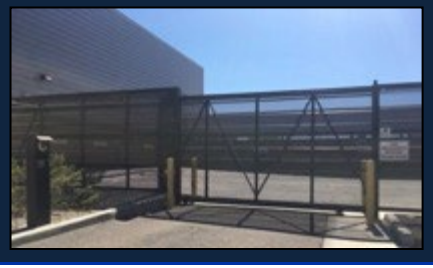
1. Dupont R et al. (2007). Crisis Intervention Team Core Elements. The University of Memphis School of Urban Affairs and Public Policy
2. Steadman HJ et al (2001). A specialized crisis response site as a core element of police-based diversion programs. Psychiatr Serv 52:219-22
3. Little-Upah P et al. (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.

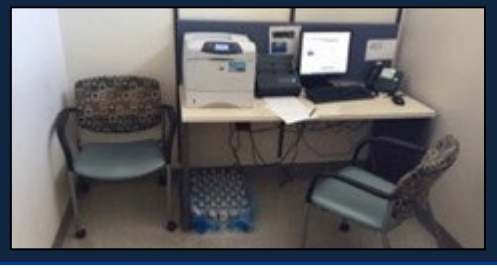
Quick and Easy Access for Police
= the preferred alternative to jail

Officers don't like:
- Waiting
- Being turned away
- Taking their guns off
- Parading people through the front lobby

Dedicated police entrance with secure gated sally port & workspace

Crisis Response Center - Tucson AZ





Interdisciplinary care starting with the *assumption that the crisis CAN BE resolved*

Interdisciplinary Teamwork
- 24/7 psychiatric provider coverage (MD, NP, PAs)
- Peers, nurses, techs, case managers, therapists

Early Intervention
- Door to doc time
- Meds, detox/MAT, peer support, groups

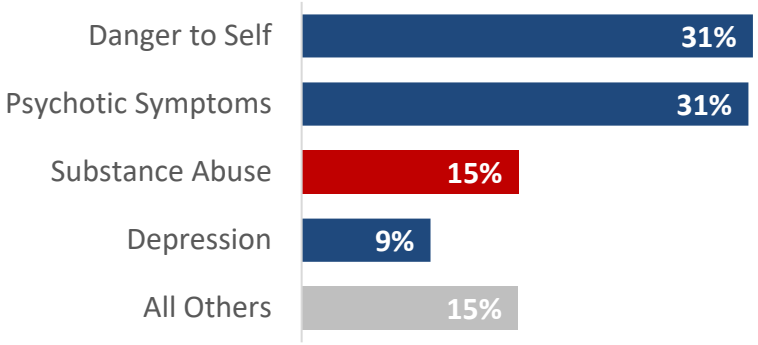
Proactive discharge planning
- Coordination with clinics, community & family supports

~60% discharged to community-based care
~70% converted to voluntary status

AMERICAN PSYCHIATRIC ASSOCIATION

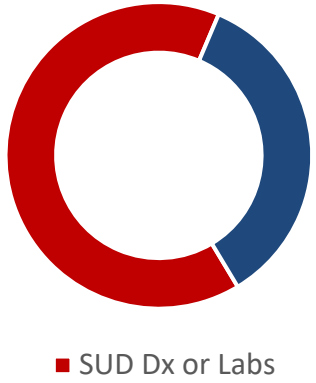
MH and SUD services are fully integrated at the payer level, which gives crisis providers the flexibility to treat co-occurring SUD based on the individual's needs.

15% of CRC adults present with **SUD as the primary concern,**

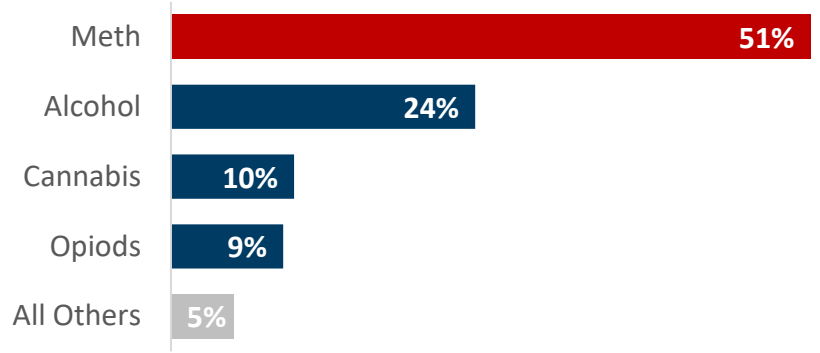


but…

65% have a **SUD diagnosis or positive toxicology results.**



Meth & alcohol account for **three quarters of SUD diagnoses.**



Crisis observation units provide

- Medically supervised detox
- Initiation of MAT
- SUD counseling & peer support
- Naloxone kits distributed at discharge

Youth and SUDs

- **28%** of CRC youth obs patients have a SUD diagnosis or positive toxicology result.
- The most common diagnoses are **Cannabis** (66%) followed by **Alcohol** (12%) and **Opiates** (11%).

Tucson Police Dept. Organizational Approach

Research shows that CIT is *most effective* when the training is VOLUNTARY. TPD mandates basic training for everyone, while more advanced training is voluntary. High rates of training are achieved through culture and by creating incentives to make the training desirable.

LEADERSHIP enacts organization-wide policies, procedures, training, culture

- Community Policing
- Guardian vs. Warrior
- Use of Force Continuum
- De-escalation Required
- Implicit Bias Training
- Officer Wellness

ALL officers receive Basic Training (Mental Health First Aid – 8 hours)

- Mental health basics and community resources
- De-escalation and crisis intervention tools

SOME officers receive Intermediate Training (CIT – 40 hours)

- ***Voluntary*** participation
- ***Aptitude*** for the population

SPECIALIZED Units receive CIT + Advanced Training

- ***Collaboration*** with behavioral health systems, social services, and other community partners
- Dedicated Specialty Teams:
  Mental Health Support Team
  Substance Use Deflection Team
  Homeless Outreach Team
  SWAT & Hostage Negotiators

100% of the dept is **MHFA trained**

60% of first responders & 911 call-takers are **CIT trained**

Specialty units are **100% CIT trained** & receive ongoing **Advanced CIT & other training**

AMERICAN PSYCHIATRIC ASSOCIATION

Balfour ME, Hahn Stephenson A, Winsky J, & Goldman ML (2020). Cops, Clinicians, or Both? Collaborative Approaches to Responding to Behavioral Health Emergencies. Alexandria, VA: National Association of State Mental Health Program Directors. https://www.nasmhpd.org/sites/default/files/2020paper11.pdf

Tucson Police MHST Model: A Preventative Approach

Dedicated Mental Health Support Teams (distinct from CIT trained patrol officers)

Officers focus on **service & transport**.

- Locate and transport individuals with civil commitment pickup orders
- Thousands of people have been transported to treatment without uses of force
- Develop relationships and recognize patterns
- Helps with CIT calls when needed

MHST officers wear plainclothes because it decreases the anxiety of the person receiving services and also has an effect on the officer's attitude.

Detectives focus on **prevention & safety.**

- Investigate calls that otherwise wouldn't be looked at (e.g. "I'm concerned about my neighbor")
- Connect people treatment before the situation escalates to a crisis
- Focus on public safety but avoid criminal justice involvement

The "weird stuff" detectives

Tucson's Police-MH Collaborative Response Model

Breaking the Crisis Cycle

Outreach & follow-up can "break the cycle" by ensuring that the person is connected to the care they need to stay well in the community. Community-based peers and/or clinicians work with LE to help with engagement and navigating the mental health system.

Prevention

- Lower urgency
- Multiple touches
- Outreach
- Follow-up

Response

- Higher urgency
- Discrete event
- De-escalation & other interventions

Health-First Response

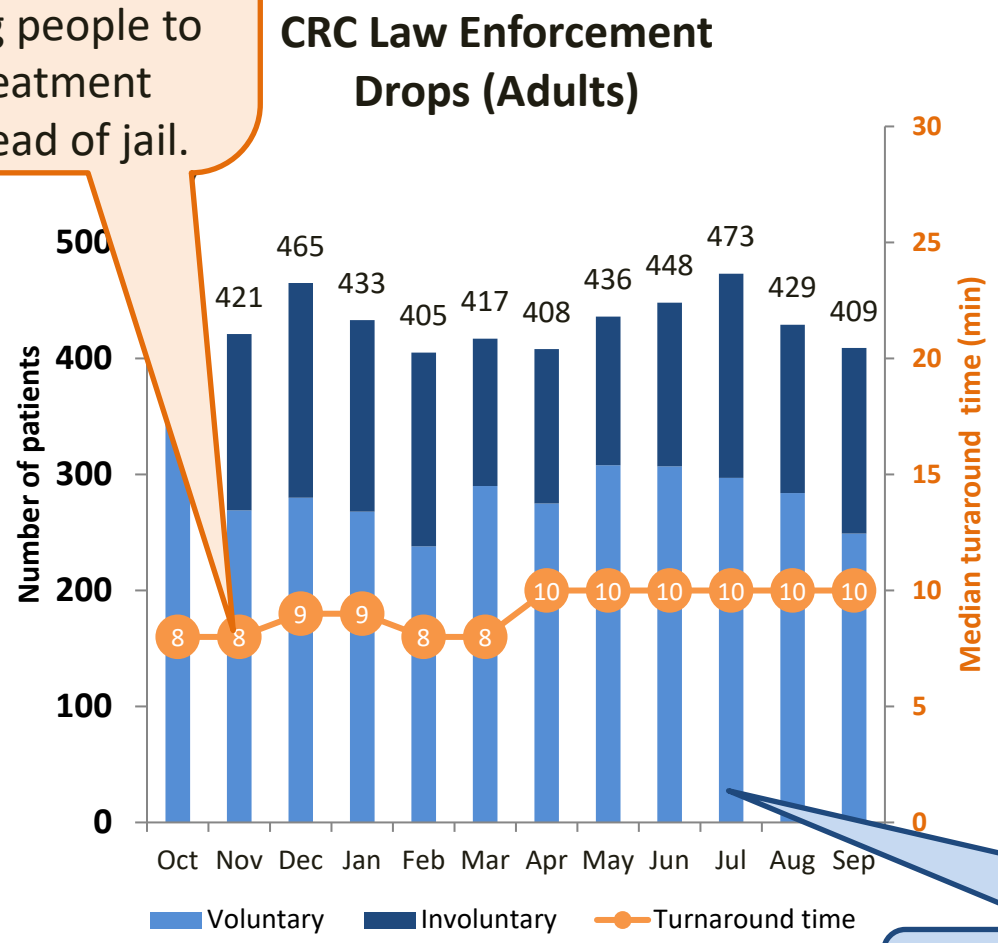
With 911/crisis line integration, low safety risk calls are **triaged to a clinician-only response as early as possible**, with LE reserved for calls with higher safety risk and/or criminal nexus. Responding officers are CIT-trained and can request additional assistance to fit the situation. The more robust the crisis system, the more options.

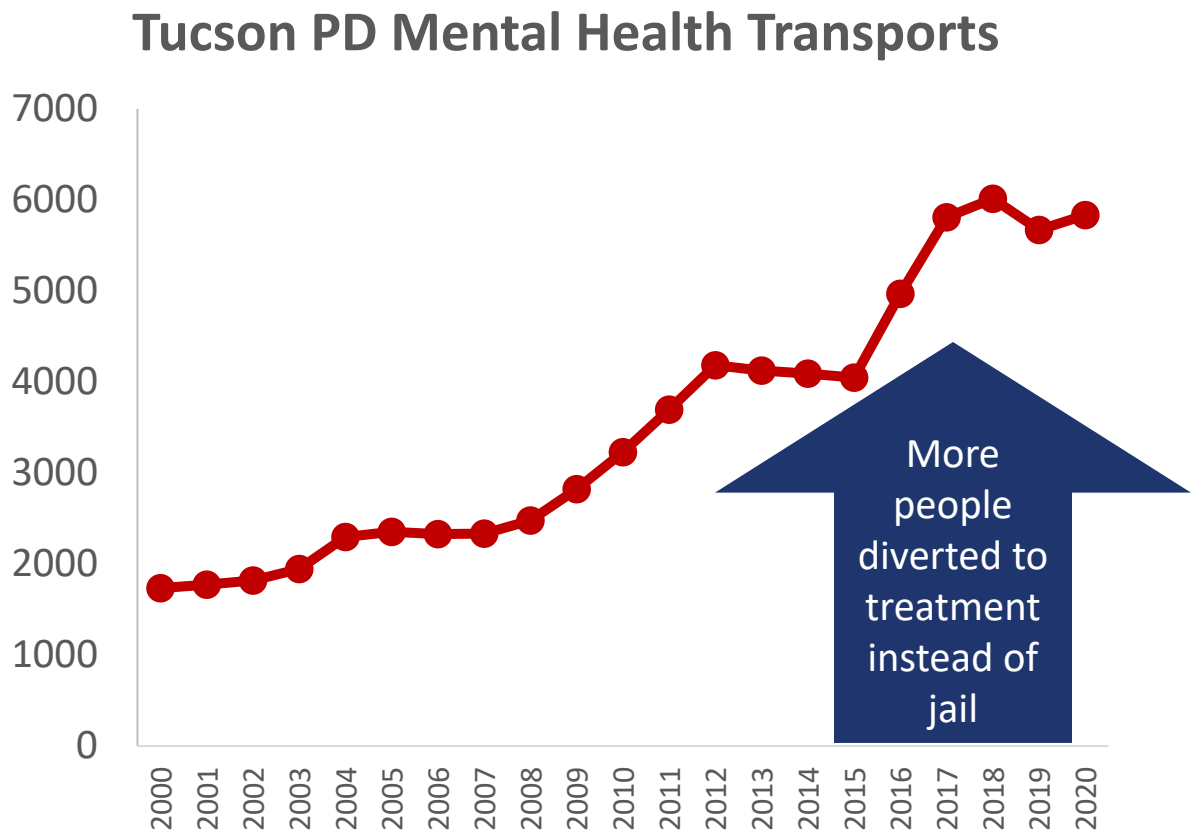
Safety Risk / Urgency	Outreach & Follow-up	Acute Response
	Collaborative ***Dedicated LE specialty teams working with community-based peers*** - **Mental Health Support Team (MHST)** *Civil Commitment orders & public safety risks* - **Substance Use Response Team (SURT)** *follow-ups after OD or SUD deflection* - **Homeless Outreach Team (HOT)**	**Collaborative** ***CIT Trained Officer + assistance from the crisis system to fit the situation*** - CIT officer transport to CRC - Mobile crisis assist at suicidal barricades - Assist from TPD MH dedicated teams
	Clinician-Only ***BH System is responsible*** - "Second responders" - Case management - Timely access to care	**Clinician-Only** ***BH System is responsible*** - Crisis Line/988 - Mobile Crisis Teams - Transport to CRC/crisis facilities

connections HEALTH SOLUTIONS

MORE People Taken to Treatment…

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



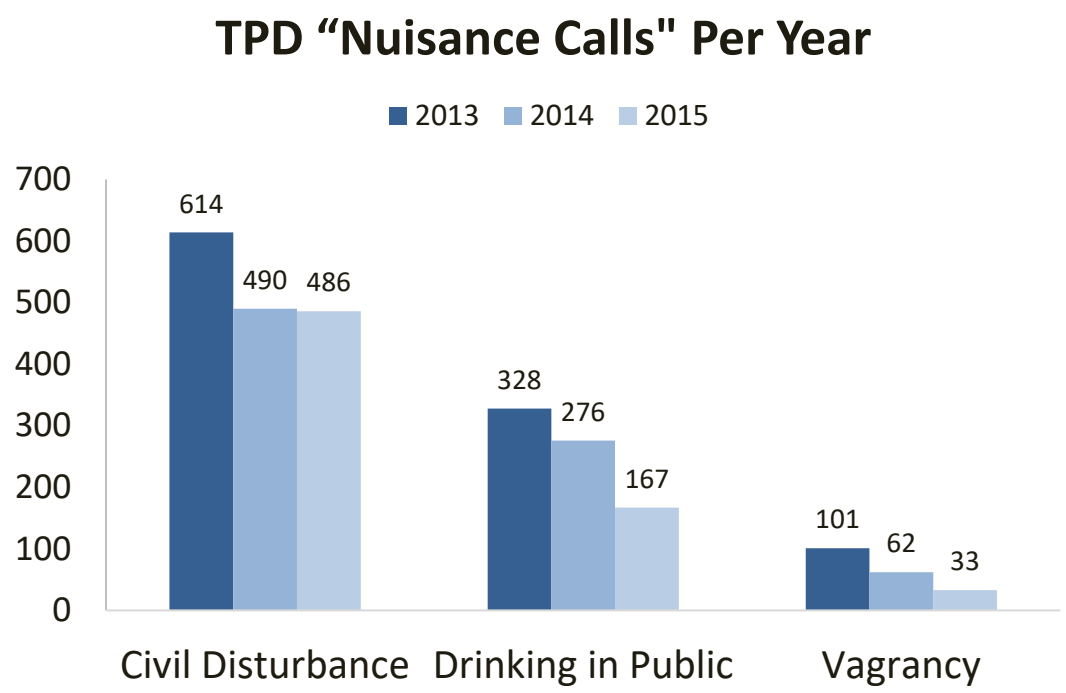


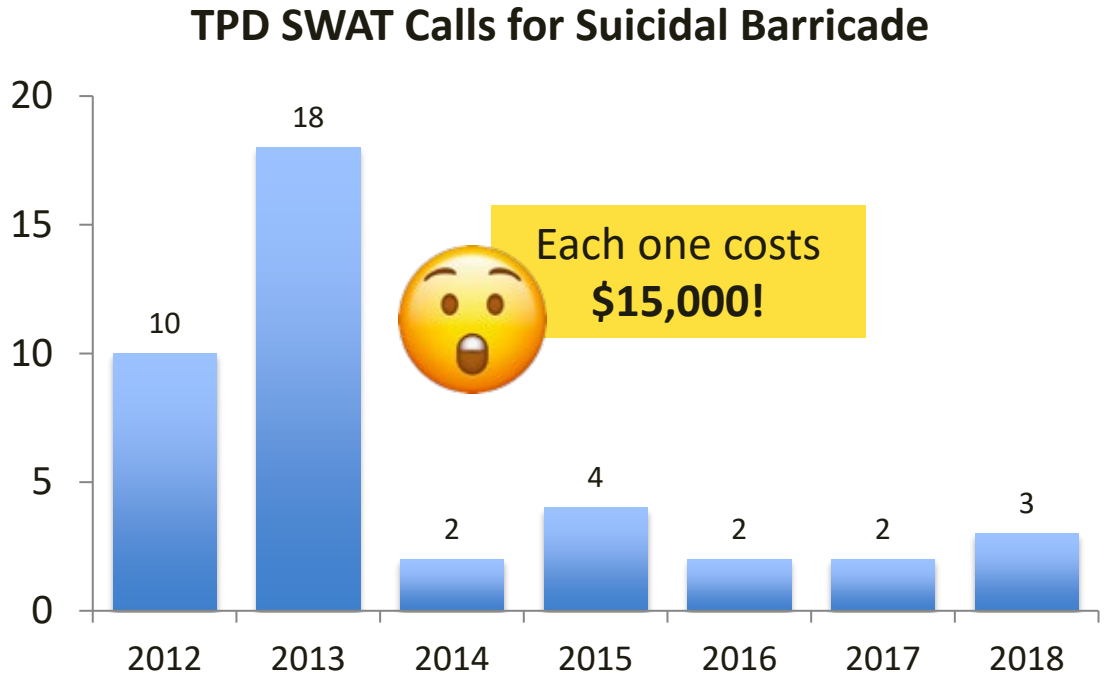
Most drop-offs are voluntary (light bars), meaning the officers are engaging people into treatment.

… 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.





AMERICAN PSYCHIATRIC ASSOCIATION

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

Dedicated Specialty Teams:

Prevention, outreach, & follow-up = more community stabilization

Mental Health Support Team (MHST)

- Mobile crisis clinician assigned to MHST detectives
- Investigations & follow-up for high-risk individuals

Percent of calls resulting in

involuntary hospitalization decreased from

60% to 20%

Substance Use Response Team (SURT) Deflection Program

- Peer co-responders focused on SUD and overdoses
- Option not to arrest for possession of small amounts

In the first 2 years,

2,000 people

connected to treatment instead of arrest

Homeless Outreach Team (HOT)

- Peer co-responders focused on homeless recovery
- Identify and engage with individuals instead of arrest

500 people

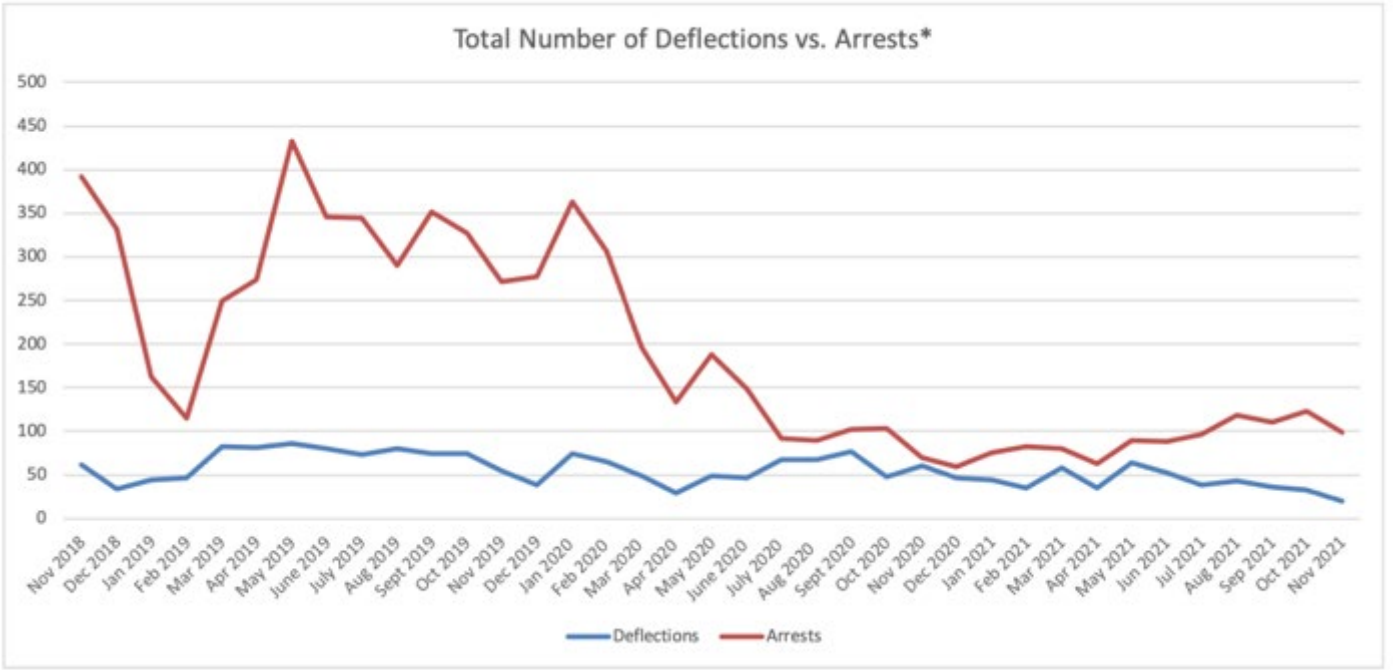
housed

in the first 2 years of the program

Tucson PD Substance Use Deflection Program

Deflection Program Core Elements

1. Officers have discretion to deflect to treatment instead of arrest.
2. Angel Program provides connection to treatment for individuals who self-present asking for help.
3. Co-Responders: SURT Officer + peer for outreach and follow-up
4. Community partnerships:
   - **CODAC Health & Wellness** provides the peers co-responders and operates a 24/7 MAT clinic
   - The crisis system is always available for those who need it



- **69%** of individuals offered deflection **accepted it**.
- **50%** of deflection events resulted in **immediate transport** to a treatment provider.
- **Deflections took less time** (49 min) than arrest/citation (77 min)

Data courtesy Sgt. Ericka Stropka at TPD. Program Evaluation performed by:
Korchmaros J & Bentele K (2020). Tucson Police Department Deflection Program: Impact at 18 Months. Tucson, AZ: University of Arizona, Southwest Institute for Research on Women.

Return on Investment: Phoenix data

The Crisis Now Difference

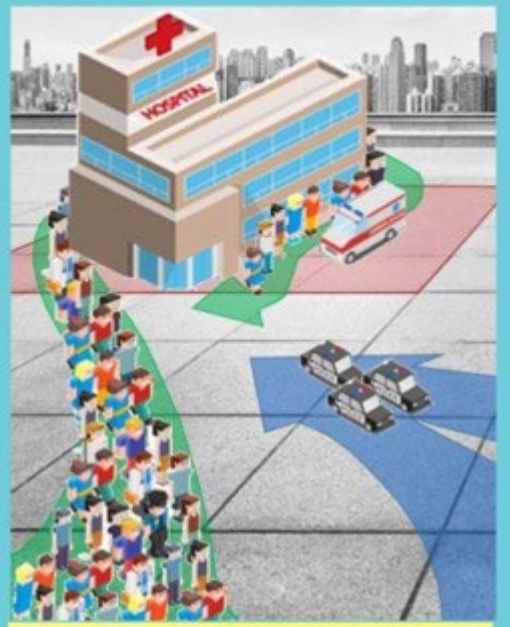
In 2016, metro area Phoenix law enforcement engaged 22,000 and transferred them *directly* to crisis facilities and mobile crisis without visiting a hospital ED.

Aetna/Mercy Maricopa 2017 report

What difference did it make?

Improved Crisis Clinical Fit to Need (CCFN) by 6x

Reduced potential state inpatient spend by $260m



Saved hospital EDs $37m in avoided costs/losses

Reduced total psychiatric boarding by 45 years

Calculated from "Impact of psychiatric patient boarding in EDs" (2012) (Nicks and Manthey)

Calculated from Arizona data, 2017

Saved the equivalent of 37 FTE Police Officers

Fire savings just starting.

BJA presentation at ISMICC (2017), Madison, Wisconsin data

Slide courtesy www.crisisnow.com

⑥ LEVERAGING MEDICAID FOR BH CRISIS RESPONSE SYSTEMS

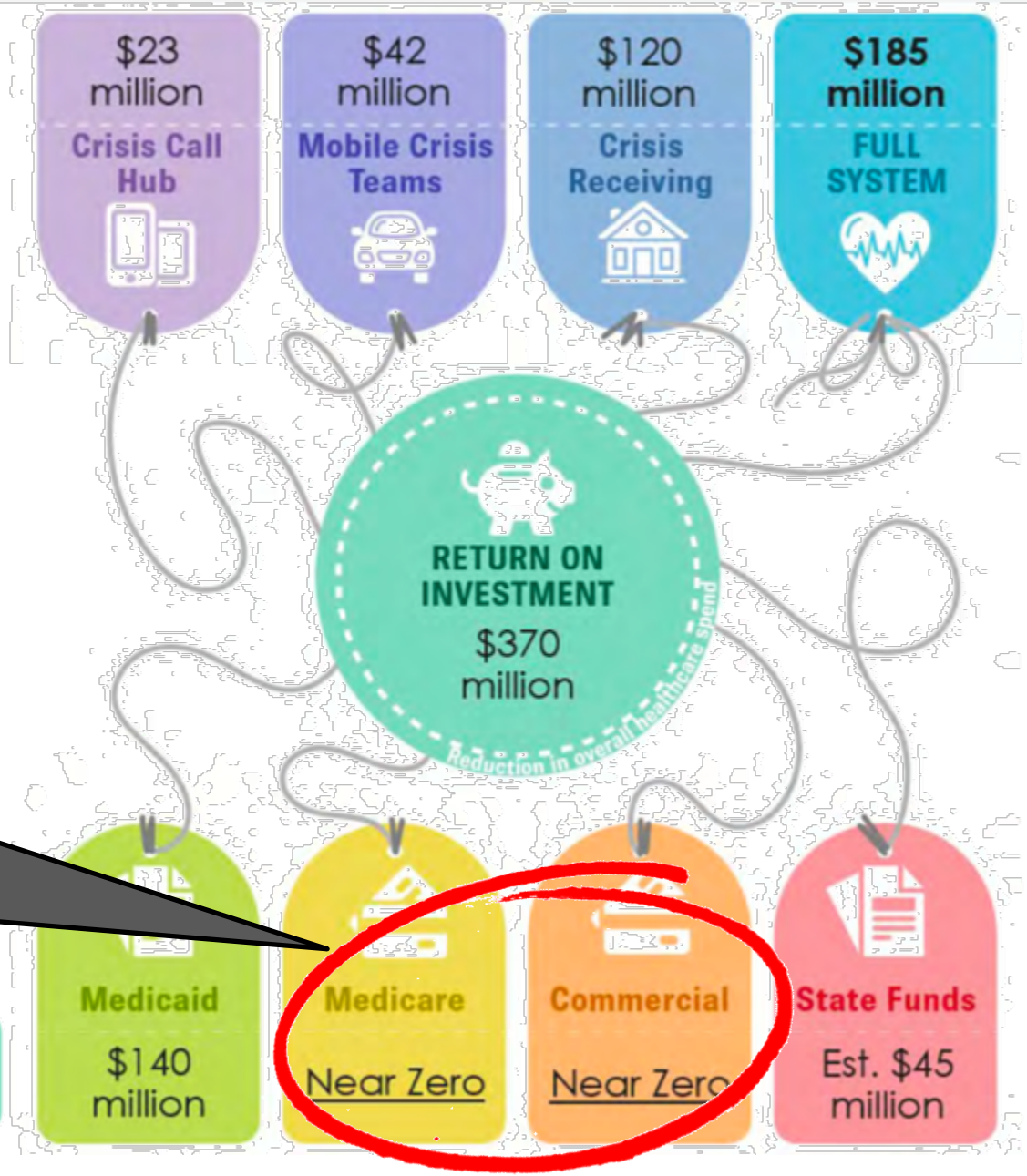
In building comprehensive crisis systems, states must leverage and shape Medicaid to become the key payer for crisis services. Medicaid's financing structure guarantees federal financial support to states with no pre-set limit and allows federal spending to increase as state spending increases. Within Medicaid expansion states, this is particularly critical because crisis service coverage is provided for previously ineligible populations. States also have the option to apply Medicaid's Administrative Match to partially support crisis call center hub services.

ADVOCACY ALERT!

BH Crisis Expansion Act
SB 1902/HB 5611

Bipartisan federal legislation that requires most insurance plans to cover crisis care.

HOW TO **ARIZONA** CRISIS NOW



Infographic created by Tom Betlach
http://www.crisisnow.com

Pima County's Roadmap:
It took a LONG time and LOTS of collaboration to get where we are today.

2000

< City (Tucson) MH Court

2001

CIT Program started >

2002

2004

Felony > MH Court

< Mobile Crisis Teams

2006

Bond passes > to build crisis facility

2007

Jail Based > Restoration to Competency

2010

< Pima County **Office of BH Administrator**

< DTAP Program
Drug Treatment Alternative to Prison

2011

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

2012

< Peers in the Jail

< Crisis Response Center opens Aug 2011

< Rural MH Courts

Law Enforcement MH Support Teams

< PCSO TPD >

2013

2014

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

2015

2016

MacArthur Grant > awarded to Pima County

2017

< Co-responders (cop + clinician)

< Repeat T36 Utilization (civil commitment/AOT)

Data Sharing Task Force

< 24/7 access to MAT

< 100% MHFA training achieved TPD + PCSO

2018

< MH First Aid Training for law enforcement begins

< Learning Site designation by Dept of Justice

< MHFA Impact Award National Council for BH

< Repeat Jail Detainees Task Force

2019

< 911/crisis line co-location

< CoMPaSS Court Consolidated misd. problem-solving court

< Drug Deflection UMATTER program

< Homeless Outreach Team

(2020)

2021

< STEPS Court pre-adjudication diversion

AMERICAN PSYCHIATRIC ASSOCIATION

46

Getting There…

AMERICAN PSYCHIATRIC ASSOCIATION

Certified Community Behavioral Health Center (CCBHC)

A Great Potential Financing and Delivery Platform for the Ideal Crisis System

CCBHCs are **required** to provide

- crisis call line
- 24/7 mobile crisis teams
- crisis stabilization
- emergency crisis intervention

Many also provide:

- ER diversion
- Crisis Stabilization/Drop-in Centers
- Co-response with police/EMS
- Diversion of calls and mobile response instead of police

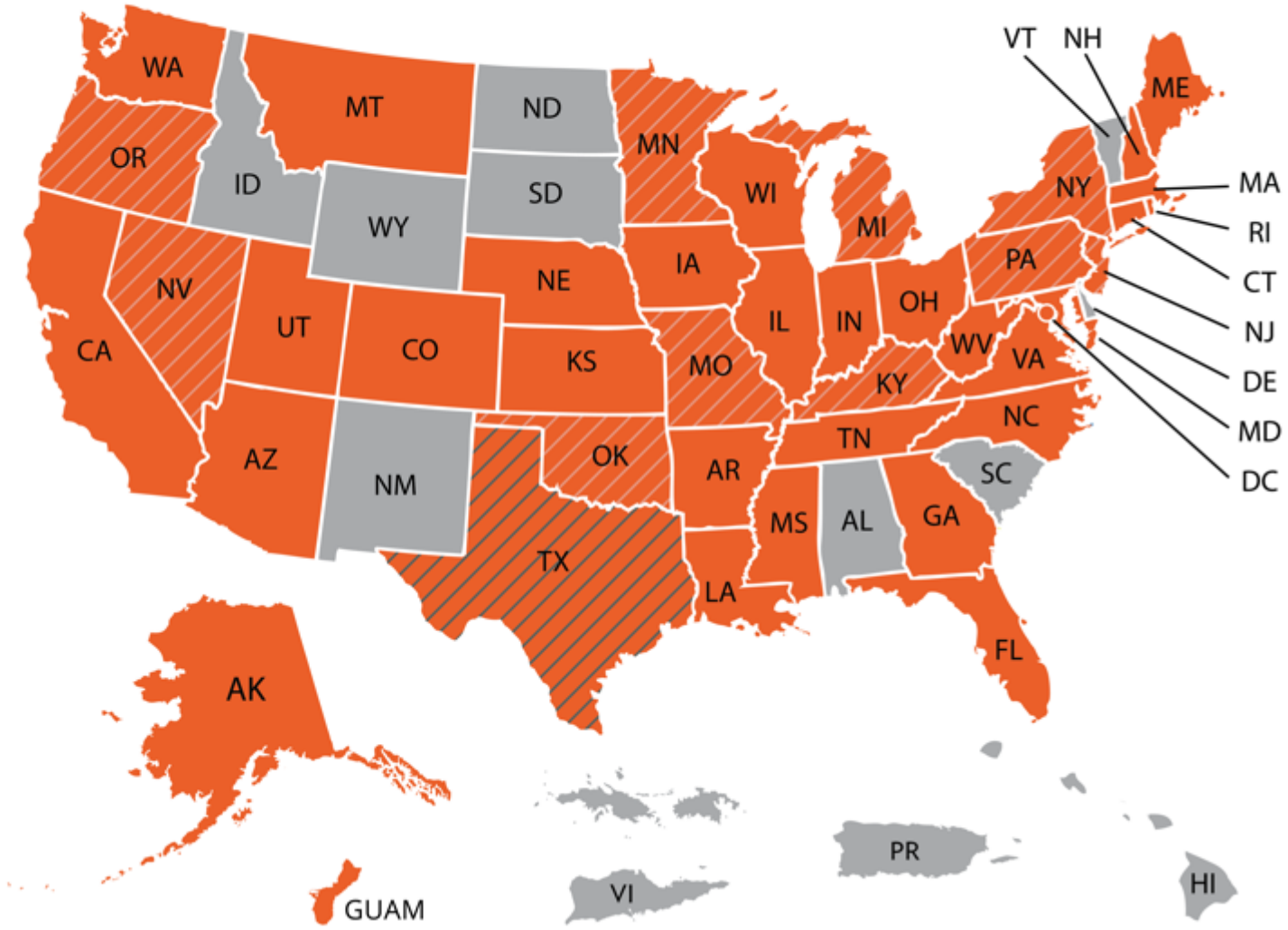
CCBHCs:
Supporting the Clinical Model with Effective Financing

Standard definition	→	**Raises the bar for service delivery**
Evidence-based care	→	**Guarantees the most effective clinical care for consumers and families**
Quality reporting	→	**Ensures accountability**
Medicaid prospective payment system	→	**Covers anticipated CCBHC costs**

Status of Participation in the CCBHC Model

- States where clinics have received expansion grants
- States selected for the CCBHC demonstration
- Independent statewide implementation
- No CCBHC statewide

There are **340 CCBHCs** in the U.S., across 40 states, Guam and Washington, D.C.



What Goes into Being a CCBHC?

CCBHC Criteria

- Organizational Authority
- Staffing
- Access to Care
- Scope of Services
- Care Coordination
- Quality Reporting

CCBHC Payment

- Cost-related Medicaid reimbursement rate (demonstration participants)

OR

- Grant funds: $2 million/year for 2 years (expansion grantees)

Note: This presentation contains a summary of selected CCBHC certification criteria. To view the full criteria: https://www.samhsa.gov/sites/default/files/programs_campaigns/ccbhc-criteria.pdf

CCBHCs' Role in the Crisis Continuum

Prevention	Crisis Response	Post-crisis care
• Early engagement in care • Crisis prevention planning • Outreach & support outside the clinic	• 24/7 mobile teams • Crisis stabilization • Suicide prevention • Detoxification • Coordination with law enforcement & hospitals	• Discharge/release planning, support & coordination • Comprehensive outpatient MH & SUD care

CCBHCs Expand Access to Crisis Support

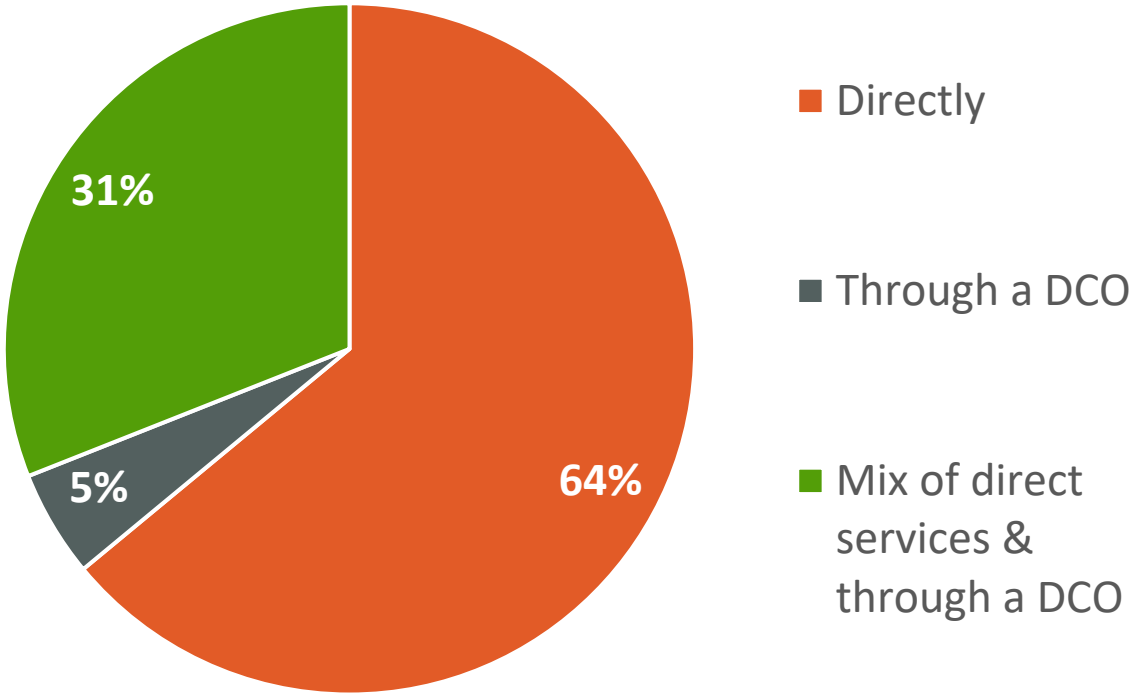
100%

of CCBHCs provided the required types of crisis support (24/7 mobile crisis teams, crisis stabilization, emergency crisis intervention).

51%

added one or more crisis services ***for the first time*** as a result of certification.

How CCBHCs deliver crisis services



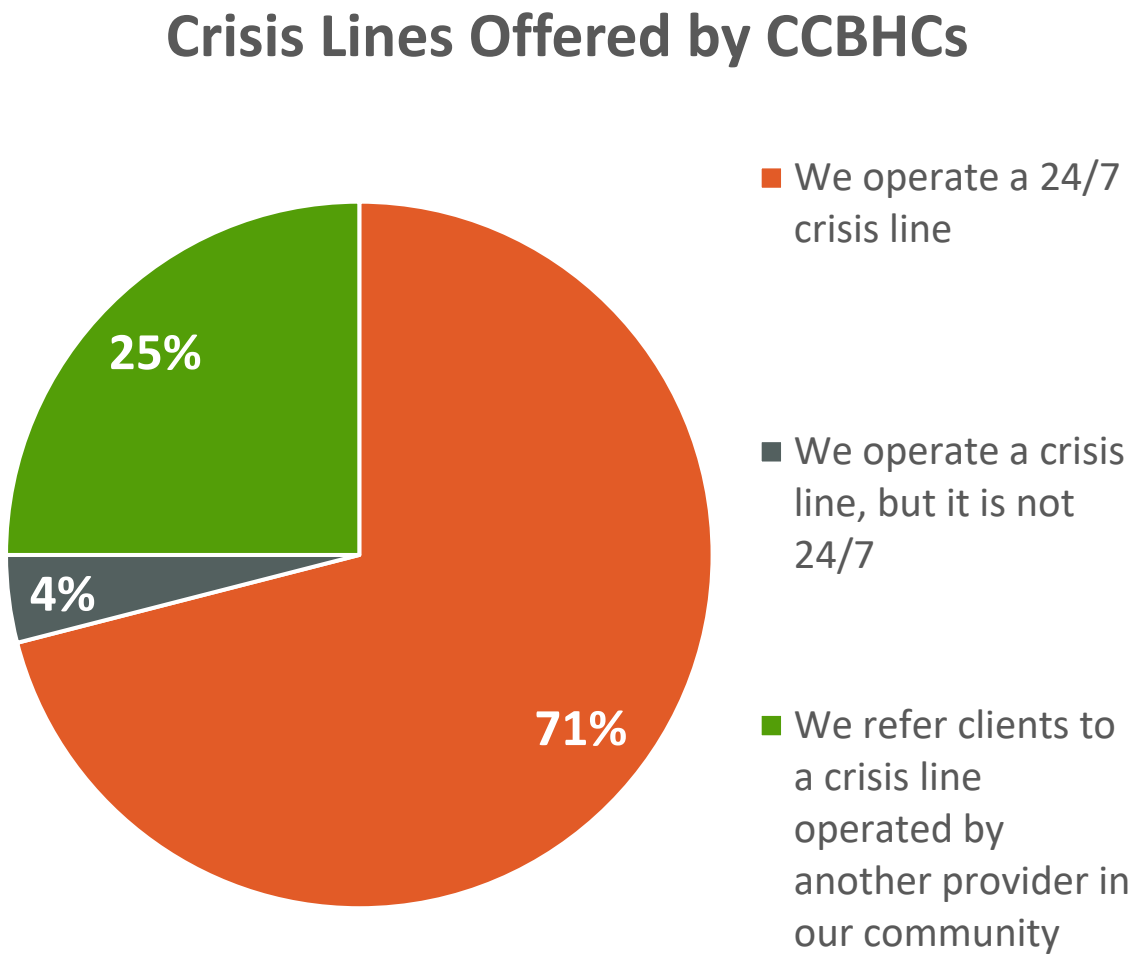
CCBHCs Offering Crisis Call Lines

75%

of CCBHCs directly operate a crisis call line

21%

report they participate in the National Suicide Prevention Lifeline network

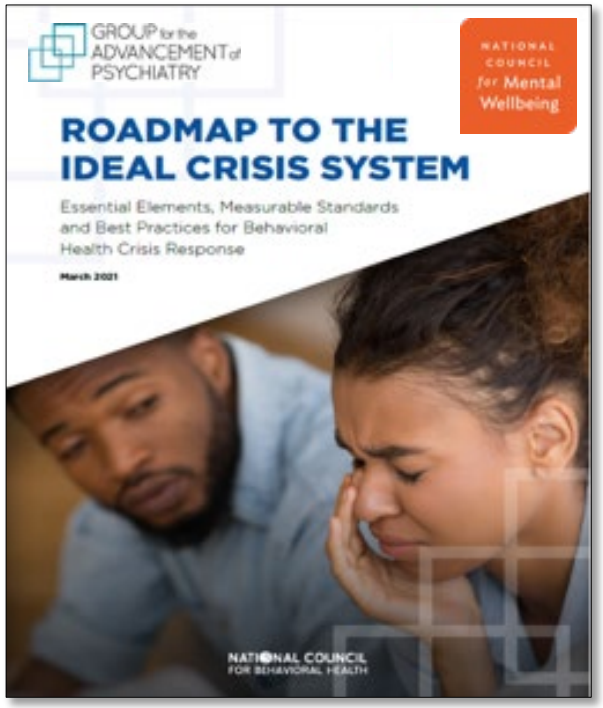


Additional Crisis Response Activities

91% are engaging in one or more identified **high-impact activities** in crisis response

- **Coordinating with hospitals/emergency departments** to support diversion from EDs and inpatient (79%)
- **Operating a crisis drop-in center** or similar non-hospital facility for crisis stabilization (e.g. 23-hour observation) (33%)
- **Behavioral health provider co-responder** with police/EMS (e.g. clinician or peer embedded with first responders) (38%)
- **Mobile behavioral health team** responds to relevant 911 calls instead of police/EMS (e.g. CAHOOTS or similar model) (19%)
- **Partnering with 911** to have relevant calls routed to CCBHC (17%)
- **Providing telehealth support to law enforcement officers** responding to mental health/SUD calls (20%)

Resources



Roadmap to the Ideal Crisis System

Executive Summary, Full Report & More:
https://www.thenationalcouncil.org/resources/roadmap-to-the-ideal-crisis-system/
and http://www.CrisisRoadmap.com

CCBHC SUCCESS CENTER

NATIONAL COUNCIL for Mental Wellbeing

Implementation Success Starts Here
https://www.thenationalcouncil.org/ccbhc-success-center/

Email us at ccbhc@thenationalcouncil.org

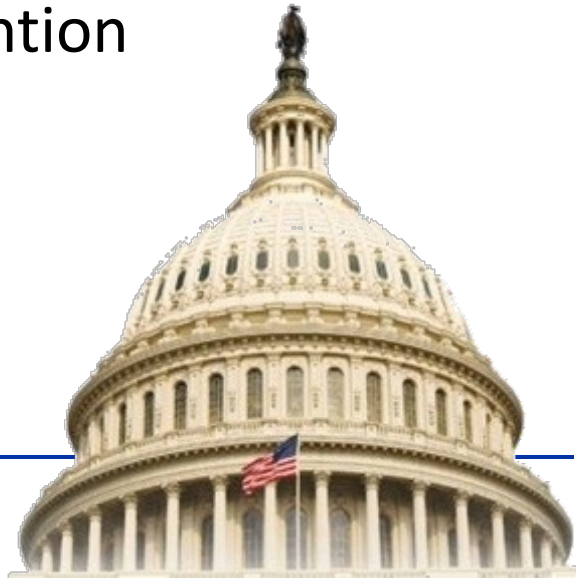
988 + covid + police reform are catalyzing federal, state, and local leaders to address the need for crisis services.

- Federal legislation and funding in Covid relief bills, specific BH bills, federal budget
- States implementing telecom fees and other legislation
- Local leaders creating alternatives to police response, crisis facilities

The future, hopefully!

Federal Funding Passed

- SAMHSA Grant Award for 988 Launch and Operations ($152M over 2 years)
  - Award recipient - Vibrant Emotional Health
- SAMHSA Cooperative Agreements for States and Territories to Build Local 988 Capacity ($105M over 2 years)
  - Awarded to $250K - $14.5M to all states and territories
- American Rescue Plan (ARP) funded CMS Mobile Crisis Intervention State Planning Grants ($15M to 20 states)
- Medicaid FMAP funding for Community-Based Mobile Crisis Intervention Services



SAMHSA Grant Award for 988 Launch & Operations

- $152M over 2 years - Award recipient - Vibrant Emotional Health
- Expand workforce and infrastructure for the National Suicide Prevention Lifeline's national backup centers, text/chat centers, Spanish language centers, and specialized services for high-risk populations
- Establish local collaborations with 911 (PSAPs) and mobile crisis response stakeholders, building and maintaining national databases of local resources, create and implement protocols for national centers' coordination of community dispatch for local crisis outreach and emergency services.

Cooperative Agreements for States and Territories to Build Local 988 Capacity

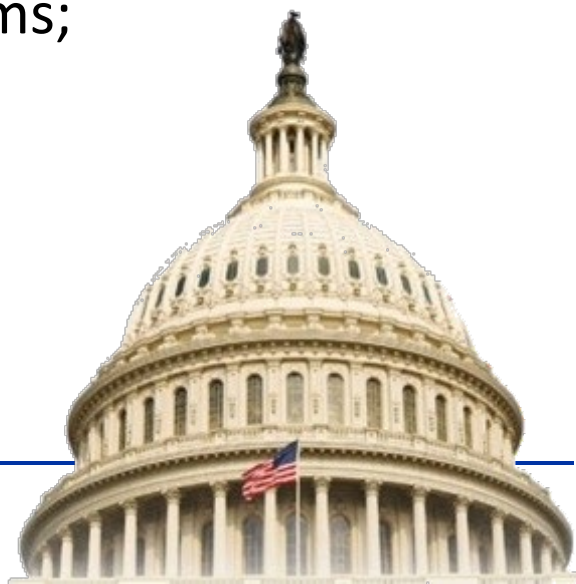
- $105M total over 2 years
- Awarded to $250K - $14.5M each to all states and territories
- Improve 988 Response By: (1) recruiting, hiring and training local 988/Lifeline centers workforce (2) unify 988 response by Lifeline crisis centers across states/territories; and (3) expanding the crisis center staffing and response structure needed for the successful implementation of 988.
- Expectations for Grantees: (1) ensure all calls originating in a state/territory first route to a local, regional and/or statewide Lifeline crisis call center; (2) improve state/territory response rates to meet minimum key performance indicators; and (3) increase state/territory support capacity to meet 988 crisis contact demand.

CMS Mobile Crisis Intervention State Planning Grants

- $15 million in planning grants to 20 states to support expanding community-based mobile crisis intervention services for Medicaid beneficiaries
- For developing a state plan amendment (SPA), section 1115 demonstration application, or section 1915(b) or 1915(c) waiver request (or an amendment to such a waiver) to provide qualifying community-based mobile crisis intervention services.
- State Medicaid Agencies will:
  - assess community needs and develop programs for community crisis intervention services
  - integrate community-based mobile crisis intervention services into their Medicaid programs

FMAP for Community-Based Mobile Crisis Intervention Services

- 5-year, 85 percent Federal Medical Assistance Percentage (FMAP) for state Medicaid programs to offer community-based mobile crisis intervention services
- Components:
  - Regional or statewide crisis call centers coordinating in real time;
  - Centrally deployed, multi-disciplinary 24/7 mobile crisis teams;
  - 23-hour crisis receiving and stabilization programs
- Enhances: training, transportation options, telehealth
- Highlights role of CCBHCs in Crisis systems



Introduced Funding

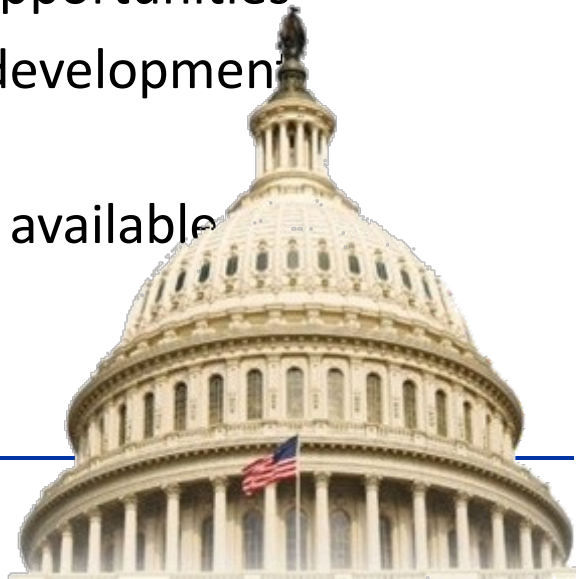
- 988 Implementation Act of 2022 (H.R.7116)
  - $100 million to create or enhance existing mobile crisis response teams
  - 10% set-aside for crisis services from $2.235 billion in Mental Health Block Grant allocations
  - funding to expand CCBHC Medicaid financing demonstration to all 50 states due to CCBHC requirement to provide 24/7 crisis management services
- 988 and Parity Assistance Act of 2022 (H.R.7232)

988 Implementation Act of 2022 (H.R.7116)

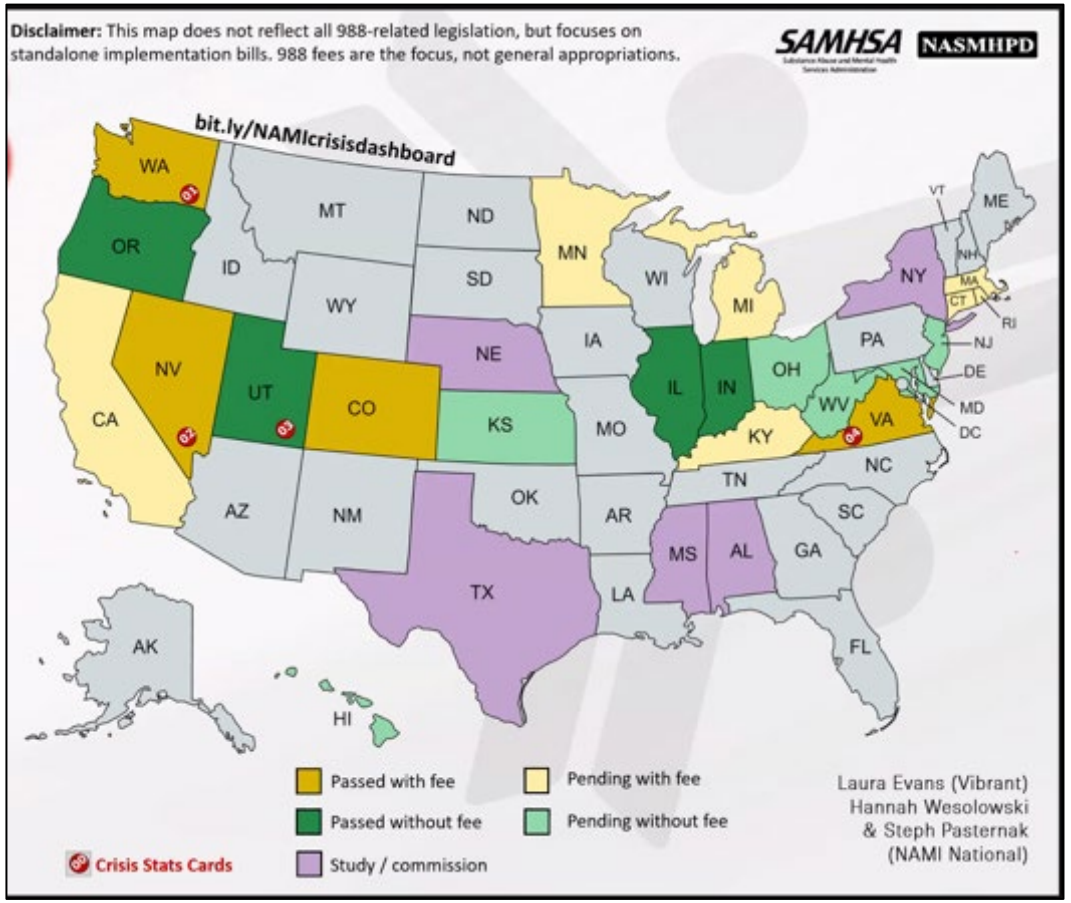
- Provides much needed federal guidance and resources to enable states to establish their 9-8-8 systems and critically needed crisis services when the system launches in July.
- Expands the existing ten state **Certified Community Behavioral Health Centers (CCBHC)** demonstration to permit **any state** to participate through Medicaid
- Dedicates resources to support local and regional call centers, mobile crisis response teams and crisis centers
- Invests in crisis workforce development through training and scholarship opportunities
- Provides for technical assistance to states to implement 9-8-8 and capital development grants for crisis programs and call centers
- Creates a campaign to ensure Americans know that 9-8-8 is available
- Requires all health insurance plans to cover crisis services
- Establishes standards for the crisis care continuum

988 and Parity Assistance Act of 2022 (H.R.7232)

- Provides much needed federal guidance and resources to enable states to establish their 9-8-8 systems and align critically needed crisis services when the system launches in July, in addition to parity implementation funds to states.
- Authorizes grant funding dedicated to states for implementation of mental health and substance use parity enforcement
- Dedicates resources for regional and local call centers, mobile crisis response teams and crisis centers
- Invests in crisis workforce development through training and scholarship opportunities
- Provides for technical assistance to states to implement 9-8-8 and capital development grants for crisis programs and call centers
- Creates in an awareness campaign to ensure Americans know that 9-8-8 is available
- Establishes standards for the crisis care continuum



Legislation & Advocacy: State Level



- Many states have implemented legislation to fund 988 via telecom fees
- Some have passed legislation to fund mobile teams and crisis facilities
- State-level advocacy is needed to encourage states to
  - Take advantage of planning grants, MHBG crisis set aside, and other federal funds
  - Leverage Medicaid: take advantage of increased FMAP, open crisis codes
  - Clear the regulatory path: licensure etc.

State 988 Legislation Tracker: http://bit.ly/NAMIcrisisdashboard

Needs

- **Creating local/regional entities accountable** for behavioral health crisis system performance for everyone and for the full continuum of system capacities, components and best practices.
- Selecting a behavioral health crisis **system coordinator and a formal community collaboration** of funders, behavioral health providers, first responders, human service systems and service recipients
- Individual services rates and overall **funding are adequate to cover the cost** of the services.
- **Multiple payers** collaborating and participating so that there is **universal eligibility and access.**
- **Data systems** for tracking customers, customer experience and performance with shared data for performance improvement.
- **Quality/performance standards** are identified, formalized, measured and continuously monitored

Opportunities

- **Use the *Roadmap to the Ideal Crisis System* report to assess and plan your local system.**
  - Community Behavioral Health Crisis System Report Card – page 196
  - 10 Steps For Communities – page 177
  - https://www.thenationalcouncil.org/wp-content/uploads/2022/02/042721_GAP_CrisisReport.pdf
- **Support passage of H.R. 7116 and H.R. 7232** for more resources and infrastructure to implement and build your local crisis system.
- **Use the CCBHC model** to support crisis system infrastructure, provide crisis services and improve prompt access to routine services to prevent crisis

Questions?

- **Ken Minkoff, MD** | Zia Partners, Inc.
  kminkov@aol.com
- **Margie Balfour, MD, PhD** | Connections Health Solutions
  margie.balfour@connectionshs.com
- **Joe Parks, MD** | National Council for Mental Wellbeing
  JoeP@thenationalcouncil.org

Further Reading:

- ***Roadmap to the Ideal Crisis System: Essential Elements, Measurable Standards, and Best Practices for Behavioral Health Crisis Response***. http://www.CrisisRoadmap.com
- ***Cops, Clinicians, or Both? Collaborative Approaches to Responding to Behavioral Health Emergencies.***
  Paper: https://bit.ly/CopsCliniciansBothPaper
  Podcast: https://bit.ly/CopsCliniciansBothPodcast
- ***CCBHC Success Center:*** email: ccbhc@thenationalcouncil.org
  Web: https://www.thenationalcouncil.org/ccbhc-success-center/

Tucson is one of the DOJ's
Law Enforcement - Mental Health Collaboration Learning Sites
Funding for a visit may be available.
https://csgjusticecenter.org/law-enforcement/projects/mental-health-learning-sites/