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

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- Friday. 4:30 PM. The phone rings.
- Your spouse's boss needs help with his brother.
- He's been texting family members about how he would be better off dead.
- They're afraid he might hurt himself.
- He might also have a drinking problem and need detox.

BONA FIDE MENTAL HEALTH EXPERT

What do you advise?

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CALL THE PSYCHIATRIST/THERAPIST/CLINIC

CALL 911

GO TO THE
EMERGENCY ROOM

GO TO THE
CRISIS CENTER

GO TO THE
DETOX CENTER

A behavioral health crisis is an emergency.

It requires a **systemic** response with the **same quality and consistency** as the response to heart attack, stroke, fire, and other emergencies.

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- **A SYSTEMIC response to behavioral health crisis**
- that delivers EVIDENCE-BASED care to people who need it
- with MEASURABLE OUTCOMES
- in the LEAST-RESTRICTIVE setting that can safely meet the person's needs
- (and by the way, the least-restrictive settings also tend to be the LEAST-COSTLY)

911: WHAT'S YOUR EMERGENCY?

"I'm having chest pain."

"I'm suicidal."

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Officer-involved shootings

"36% of officer-involved shootings in this sample were found to be **suicide by cop**."

People in the throes of a **MENTAL OR EMOTIONAL CRISIS** made up one-quarter of those killed. Many such deaths may be preventable, police and mental-health experts said.

See The Post's takeaways

Washington Post Nationwide Database of Police Fatalities

https://www.washingtonpost.com/graphics/national/police-shootings-2016/

J Forensic Sci, March 2009, Vol. 54, No. 2
doi: 10.1111/j.1556-4029.2008.00981.x
Available online at: www.blackwell-synergy.com

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Suicide by Cop Among Officer-Involved Shooting Cases

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There are over

2 million jail bookings

of people with serious mental illness (SMI) each year.[1]

Nearly half of people with SMI have been arrested at least once.[2]

Prevalence of Mental Illness		
	US Adults[5]	Jail
SMI[3] -Men -Women	4%	**17.1%** **34.3%**
Any mental disorder[4]	18%	**76%**
+ Co-occurring substance use[4]	3.3%[6]	**49%**

What about kids?

The National Center for Mental Health and Juvenile Justice found that **70.4%** of youth in the juvenile justice system have been **diagnosed with at least one mental health disorder.**

High-risk youth are estimated to cost society **$1.2 to 2 million each** in rehabilitation, incarceration, and costs to victims.

1. Steadman HJ et al. (2009) Prevalence of serious mental illness among jail inmates. Psychiatric Services. 60(6):761-5.
2. 44%. Hall LL et al. (2003) TRIAD Report: Shattered Lives: Results of a National Survey of NAMI Members Living with Mental Illnesses and Their Families.
3. Includes PTSD. Excluding PTSD rates are 14.5% for men and 31.0% for women. Steadman HJ, Osher FC, Robbins PC, Case B, Samuels S. (2009). Psychiatric Services. 60(6):761-5.
4. Glaze LE, James DJ. (2006) Mental Health Problems Of Prison And Jail Inmates. Bureau of Justice Statistics.
5. NIMH Statistics https://www.nimh.nih.gov/health/statistics/index.shtml
6. SAMHSA (2015). Behavioral Health Trends in the United States: Results from the 2014 National Survey on Drug Use and Health.

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Impact of incarceration[1,2]

- Offenders with mental illness are
  - Incarcerated twice as long
  - Three times more likely to be sexually assaulted while incarcerated
  - More likely to be in solitary confinement which exacerbates psychiatric symptoms
- Adverse effects post-release include
  - Interruption in Medicaid and other benefits
  - Difficulty finding employment
  - More likely to become homeless
  - More likely to be rearrested
- At twice the cost to taxpayers.

Jails and prisons lack the policies and trained staff to meet the needs of this population.

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.[3]

1. Treatment Advocacy Center & National Sheriffs Association (2014). The Treatment of Persons with Mental Illness in Prisons and Jails: A State Survey
2. Dumont DM et al. (2012). Annu Rev Public Health. 2012 Apr 21; 33: 325–339.
3. Office of National Drug Control Policy

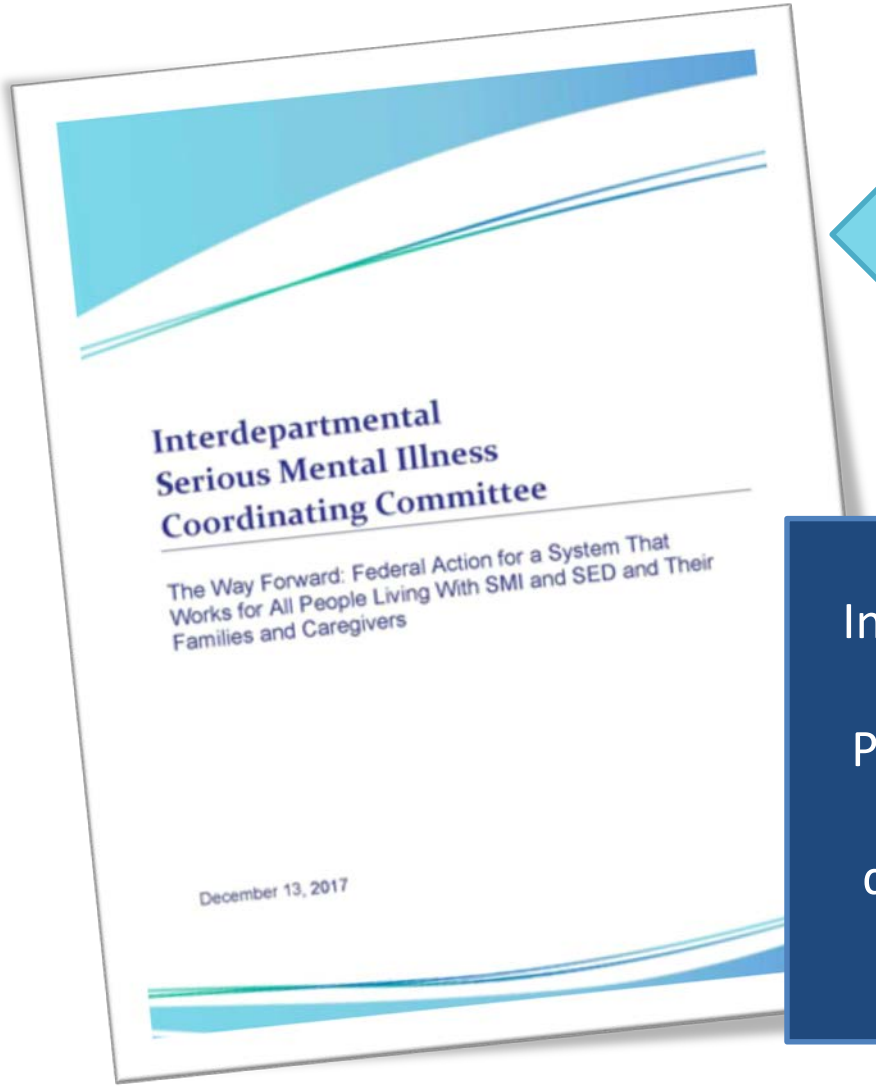
If they do make it to an ED…

- 84% of EDs report boarding of psychiatric patients
- Increased risk
  - Assaults, injuries, self-harm
- Increased cost
  - Sitters, lost revenue
  - Unnecessary inpatient admits
- Poor patient experience
  - Non therapeutic environment with untrained staff

Psychiatric boarding = long waits for inpatient psychiatric beds with little/no treatment, for hours or sometimes even days.

American College of Emergency Physicians (2014) http://newsroom.acep.org/download/ACEP+Polling+Survey+Report.pdf
Zeller et al (2014) https://dx.doi.org/10.5811%2Fwestjem.2013.6.17848

A National Standard for Crisis Services?



- **Interdepartmental SMI Coordinating Committee (ISMICC)**
- Created by 21st Century Cures Act
- 45 recommendations in 5 focus areas
- *2.1 Define and implement a national standard for crisis care*

In response, the Group for the Advancement of Psychiatry is developing a comprehensive report defining elements of the ideal crisis system

Measurable Performance Standards

in the following areas

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

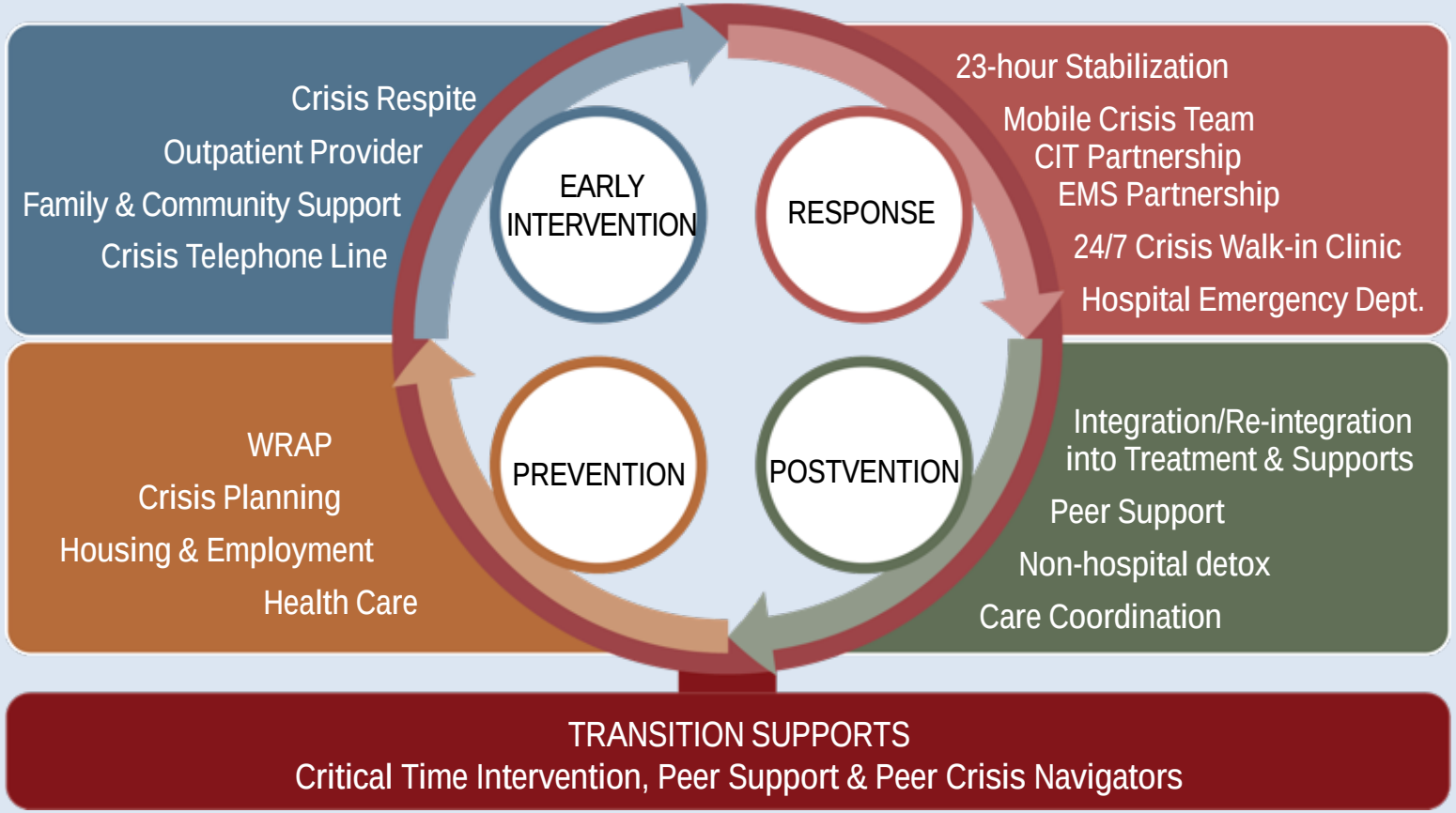
SYSTEM
vs. Services

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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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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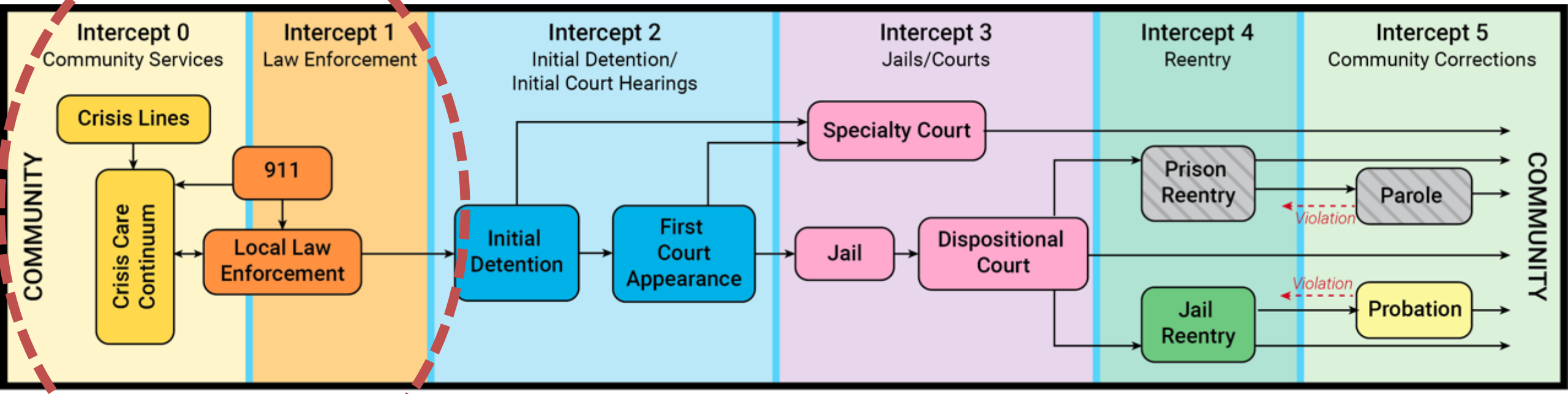
Sequential Intercept Model



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 <u>prevent unnecessary arrest</u>

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.

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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

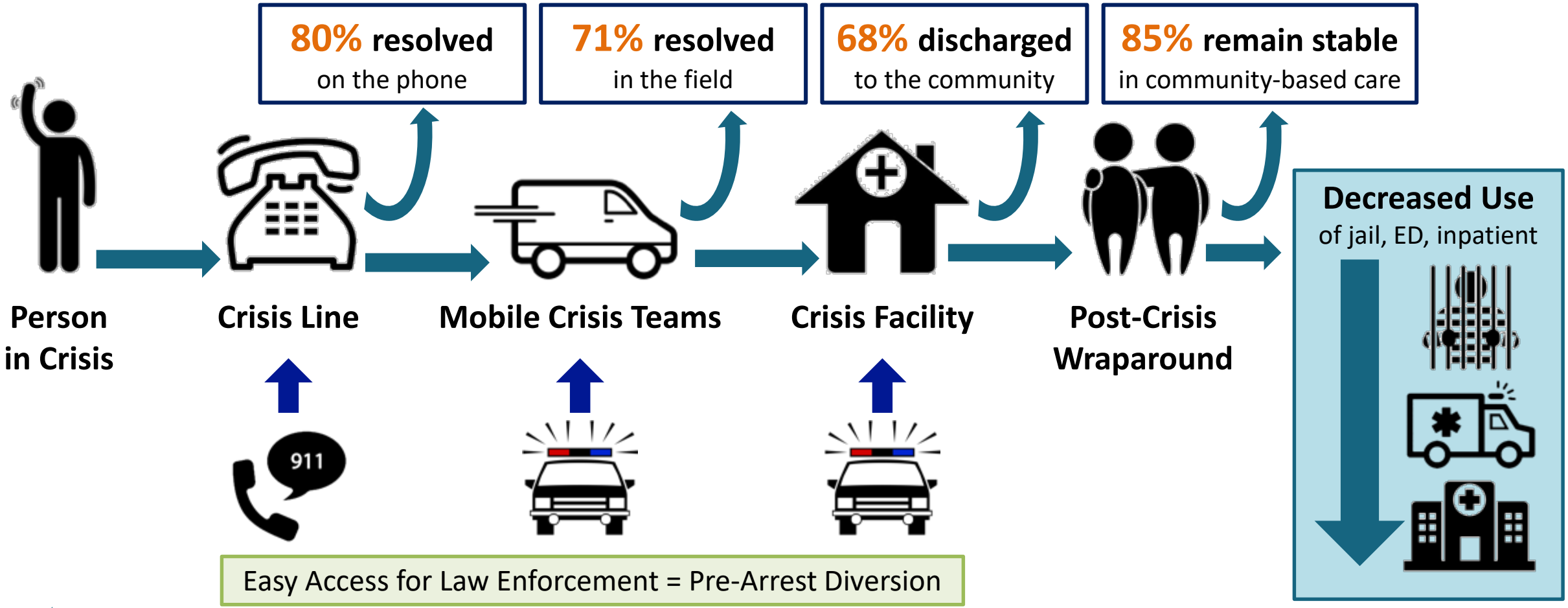
MOBILE TEAMS

- **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

The Crisis Continuum



Schematic designed by Margie Balfour, Connections Health Solutions. Data courtesy Johnnie Gaspar, Arizona Complete Health
Data applies to southern Arizona geographical service area, last updated Sep 2019

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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

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

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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

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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."

- "No wrong door"
- We take *everyone*:
  - No such thing as "too agitated" or "too violent"
  - Can be highly intoxicated
  - Can be involuntary or voluntary
- Fewer medical exclusionary criteria than many inpatient psych hospitals
- Law enforcement is never ever turned away
- 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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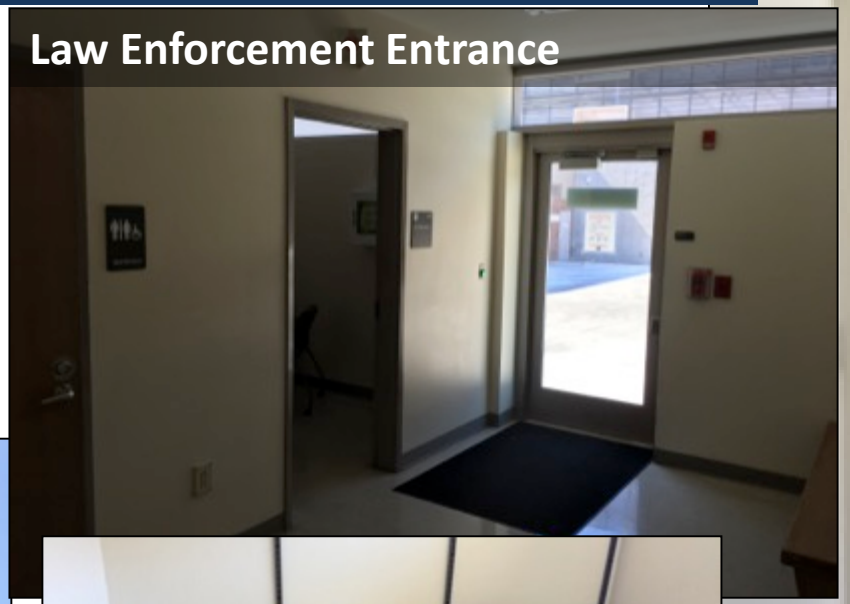
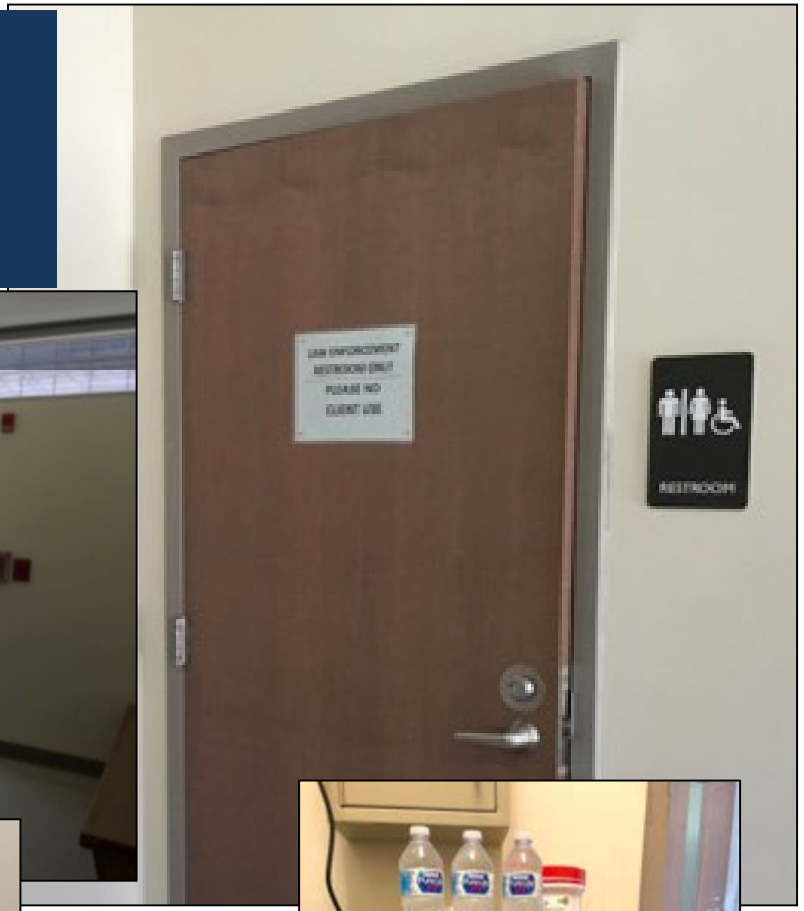
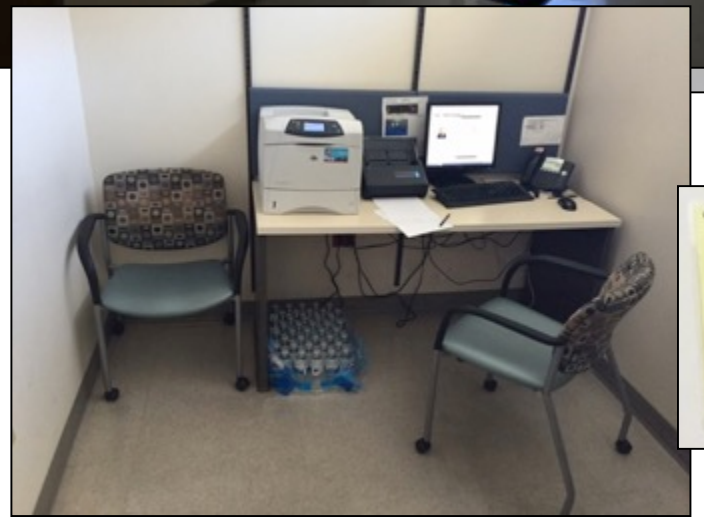
Easy Access for Law Enforcement so we are the preferred alternative to drop off at jail or ED


Law Enforcement Entrance




Gated Sally Port
Crisis Response Center - Tucson AZ



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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

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23-Hour Observation Unit

- Interdisciplinary Teamwork
  - 24/7 psychiatric provider coverage (MD, NP, PAs)
  - Peers with lived experience, nurses, techs, case managers, therapists, unit coordinators
- Early Intervention
  - Median door to doc time is ~90 min
  - Interventions include medication, detox/MAT, groups, peer support, safety planning, crisis counseling, mindfulness
- Aggressive discharge planning
  - Collaboration and coordination with community & family partners
- ***Culture shift: Assumption that the crisis <u>can be</u> resolved***

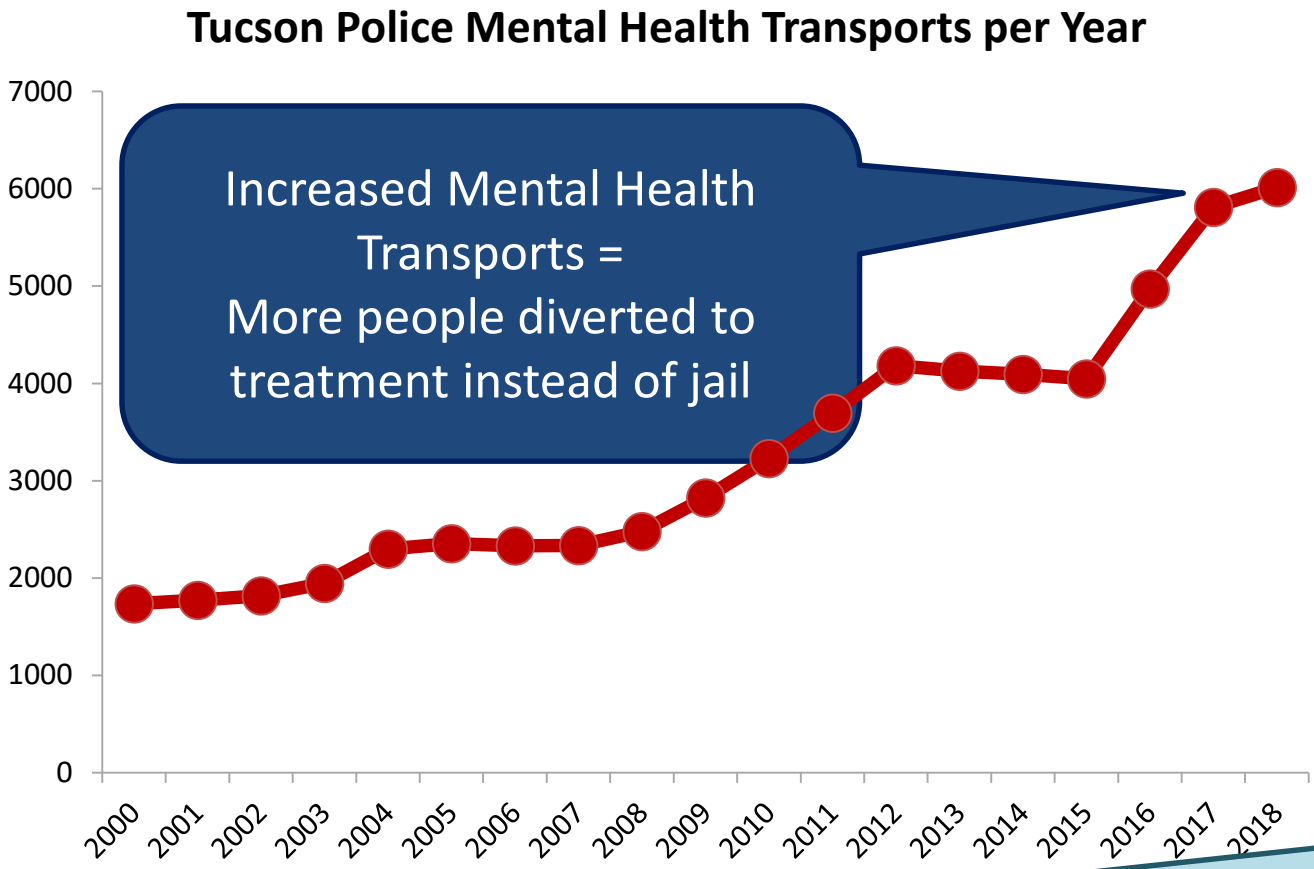
60-70% discharged to the community the following day

Avoiding preventable inpatient admission, even though most met medical necessity criteria when they first presented

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

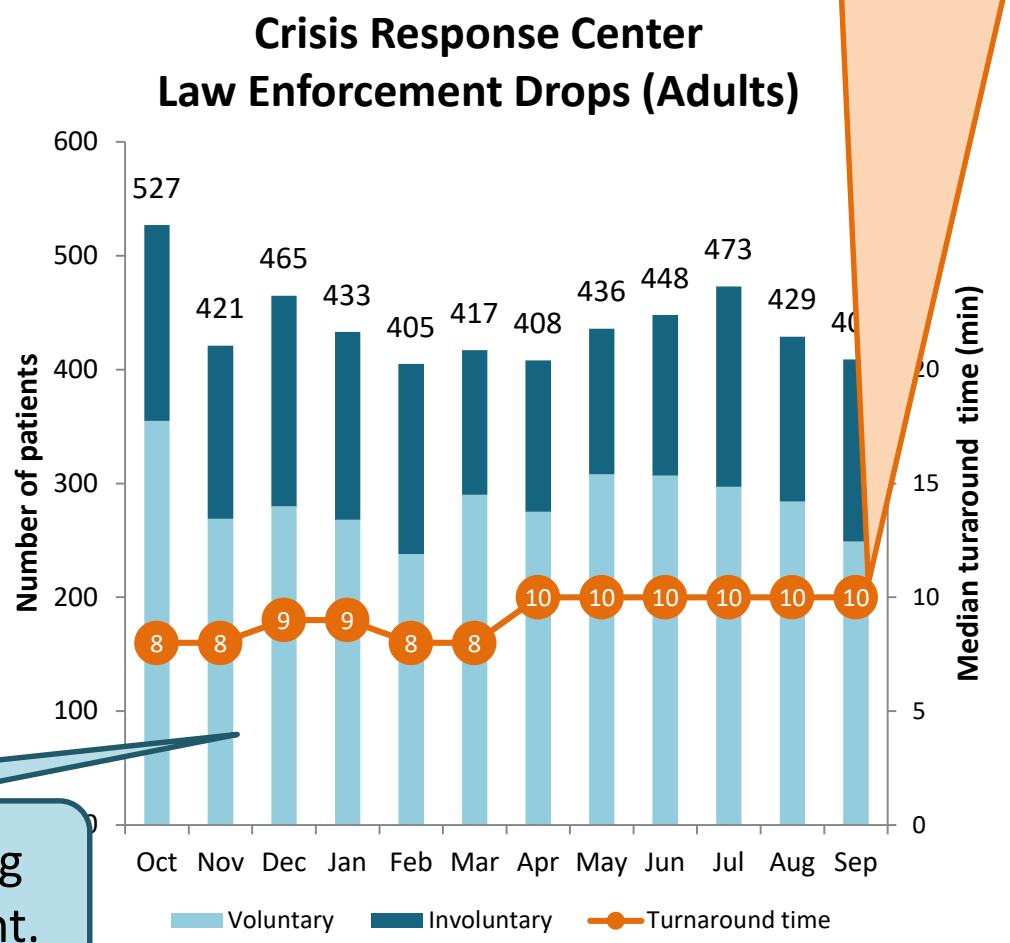
"I came in 100% sure I was going to kill myself but now after group I'm hopeful that it will change. Thank you RSS members!"

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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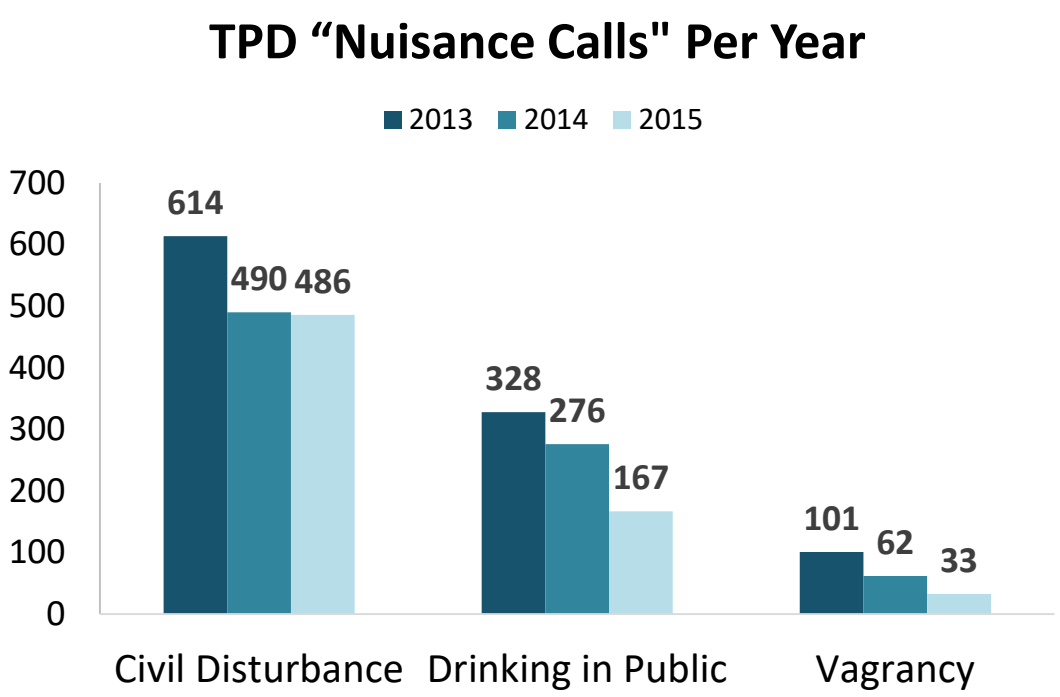
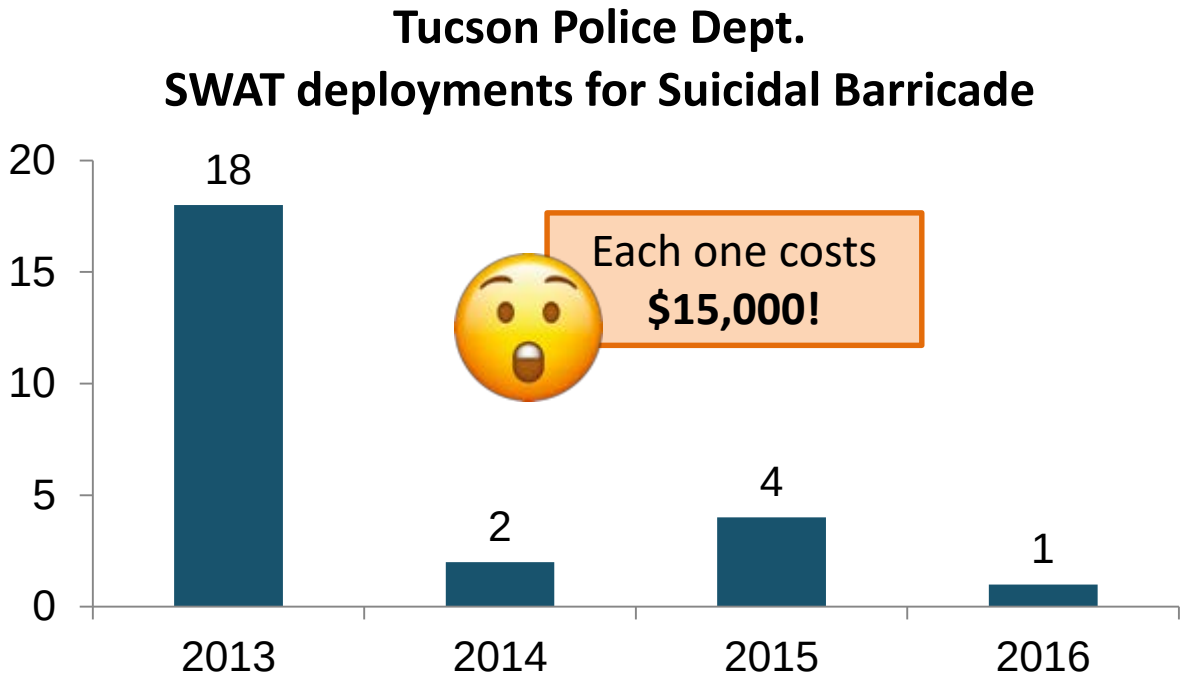
… and LESS Justice Involvement

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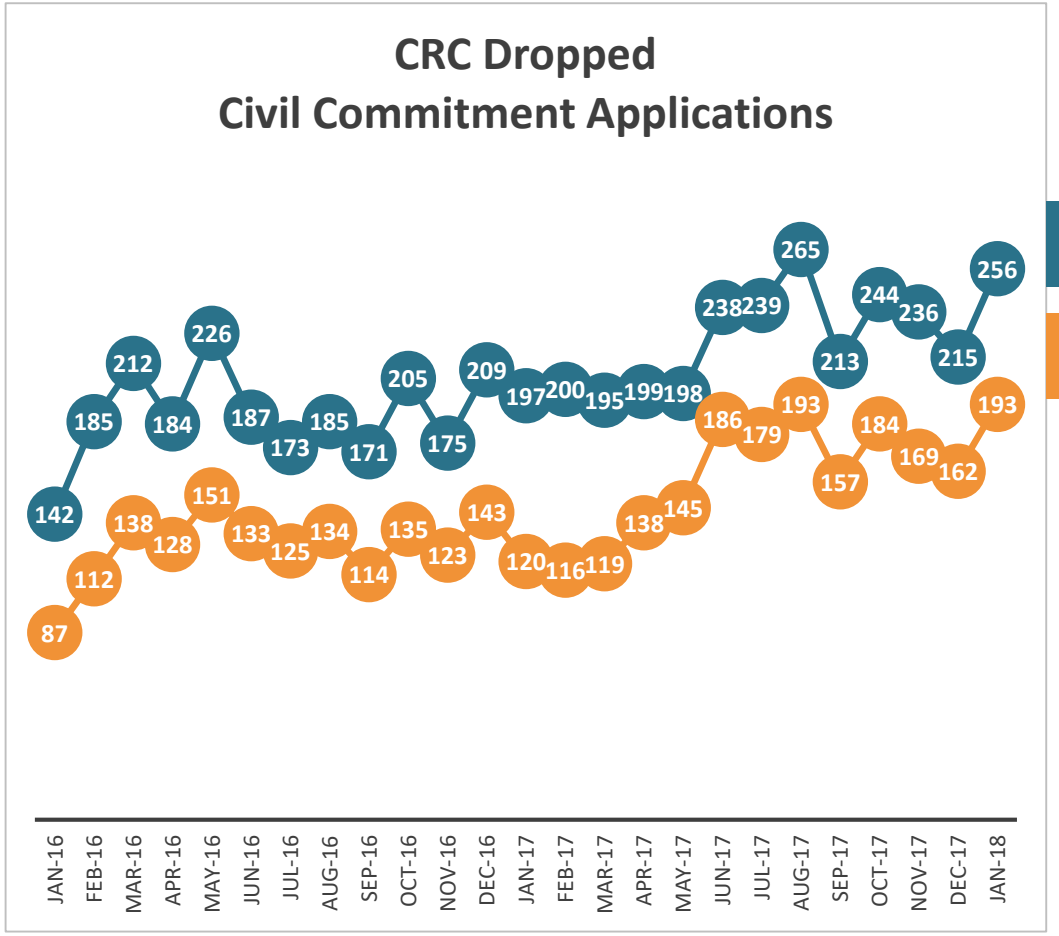
Crisis Stabilization Aims for the **Least-Restrictive** (and least costly) Disposition Possible

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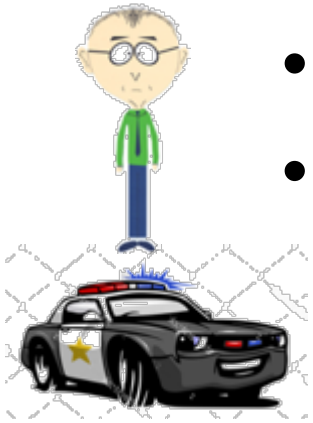
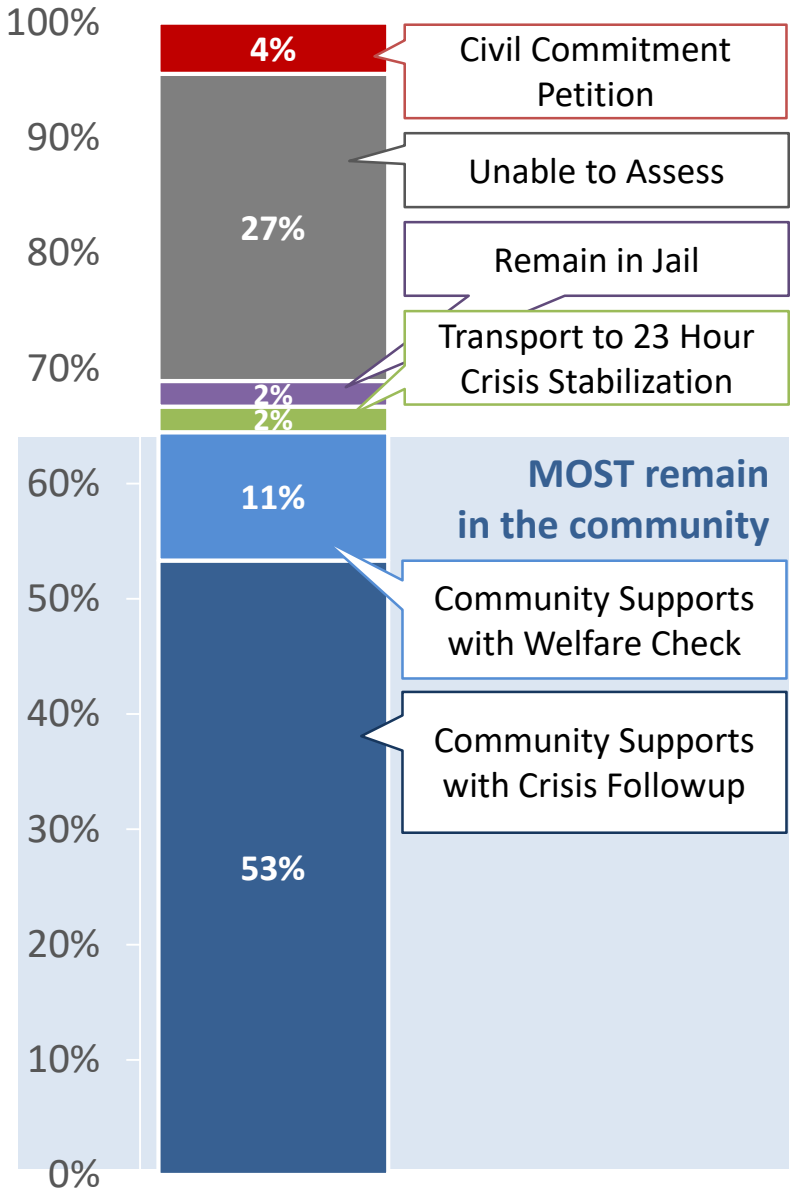
Co-Responder Innovations:
Increasing connection to care while **minimizing** involuntary treatment and/or arrest



- 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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Newest Innovations

Co-Responder Teams

- Mobile crisis clinician assigned to MHST detectives
- Focus on followup and investigations
- Increased community stabilization (vs transport to facility or civil commitment petitions)

Deflection Program

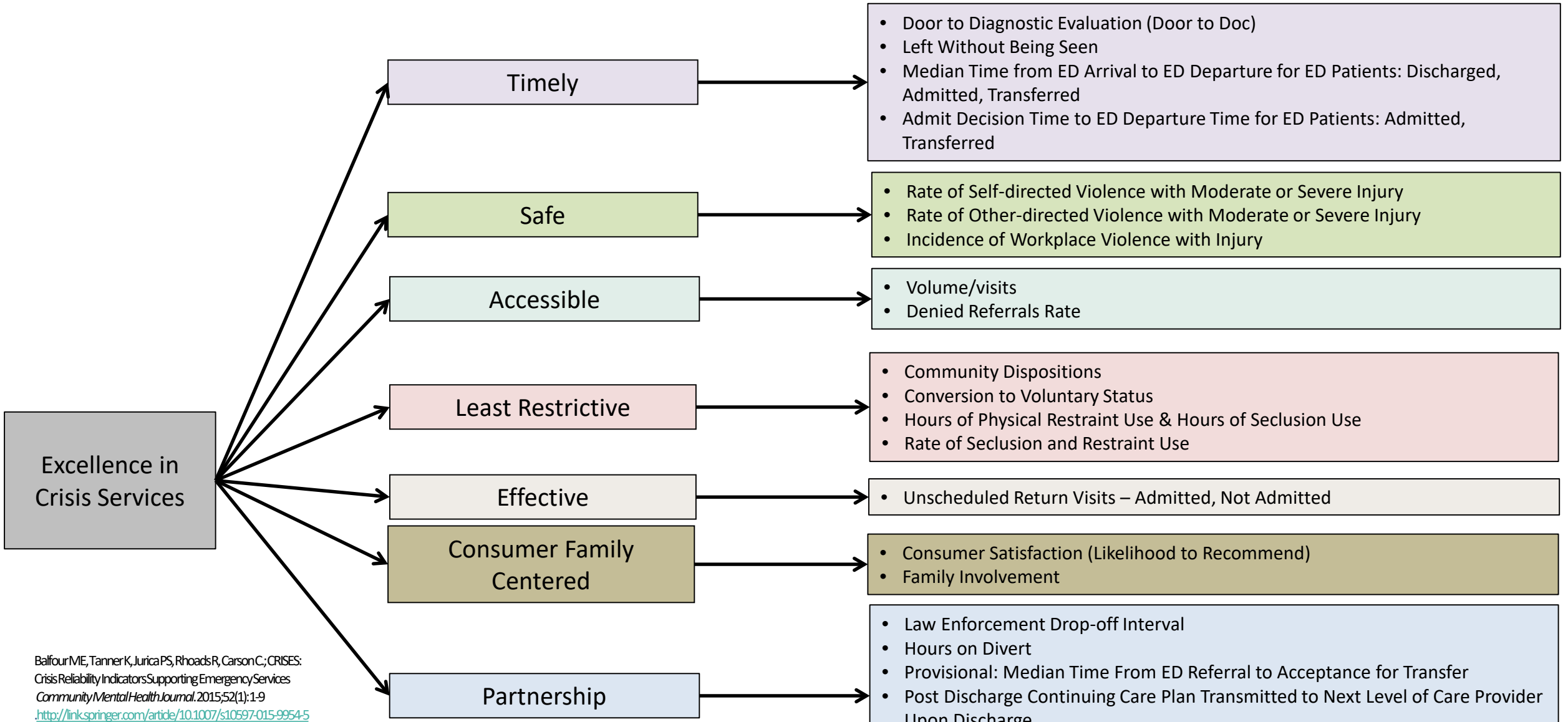
- Peer co-responders focused on SUD and overdoses
- Option not to arrest for possession of small amounts of illicit substances
- Connection to treatment instead
- 24/7 access to treatment

Homeless Outreach

- Increased outreach to people experiencing homeless in the community
- Identify and engage people needing services
- Collaboration with community stakeholders
- Focus on housing first models

Using data to improve care

Outcome metrics for facility-based crisis services



Balfour ME, Tanner K, Jurica PS, Rhoads R, Carson C.; CRISES: Crisis Reliability Indicators Supporting Emergency Services *Community Mental Health Journal*. 2015;52(1):1-9 .http://link.springer.com/article/10.1007/s10597-015-9954-5

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Connections Crisis Facility KPIs

Metric	Outcome	Relevance
Urgent Care Clinic: Door-to-Door **Length of Stay**	**< 2 hours**	Patients get their needs met quickly instead of going to an ED or allowing symptoms to worsen.
23-Hour Obs Unit: **Door-to-Doctor Time**	**< 90 min**	Treatment is started early, which results in higher likelihood of stabilization and less likelihood of assaults, injuries and restraints.
23-Hour Obs Unit: **Community Disposition Rate** (diversion from inpatient)	**60-70%**	Most patients are able to be discharged to less restrictive and less costly community-based care instead of inpatient admission.
Law Enforcement Drop-Off **Police Turnaround Time**	**< 10 min**	If jail diversion is a goal, then police are our customer too and we must be quicker and easier to access than jail.
Hours of **Restraint Use** per 1000 patient hours	**< 0.15**	Despite receiving highly acute patients directly from the field, our restraint rates are 75% below the Joint Commission national average for inpatient psych units.
Patient Satisfaction Likelihood to Recommend	**> 85%**	Even though most patients are brought via law enforcement, most would recommend our services to friends or family.
Return Visits within 72h following discharge from 23h obs	**3%**	People get their needs met and are connected to aftercare. A multiagency collaboration addresses the subset of people with multiple return visits.

Standard Crisis Scorecard Across the Southern Arizona Region

The **Regional Behavioral Health Authority** requires the other 23h crisis facilities to use this framework.

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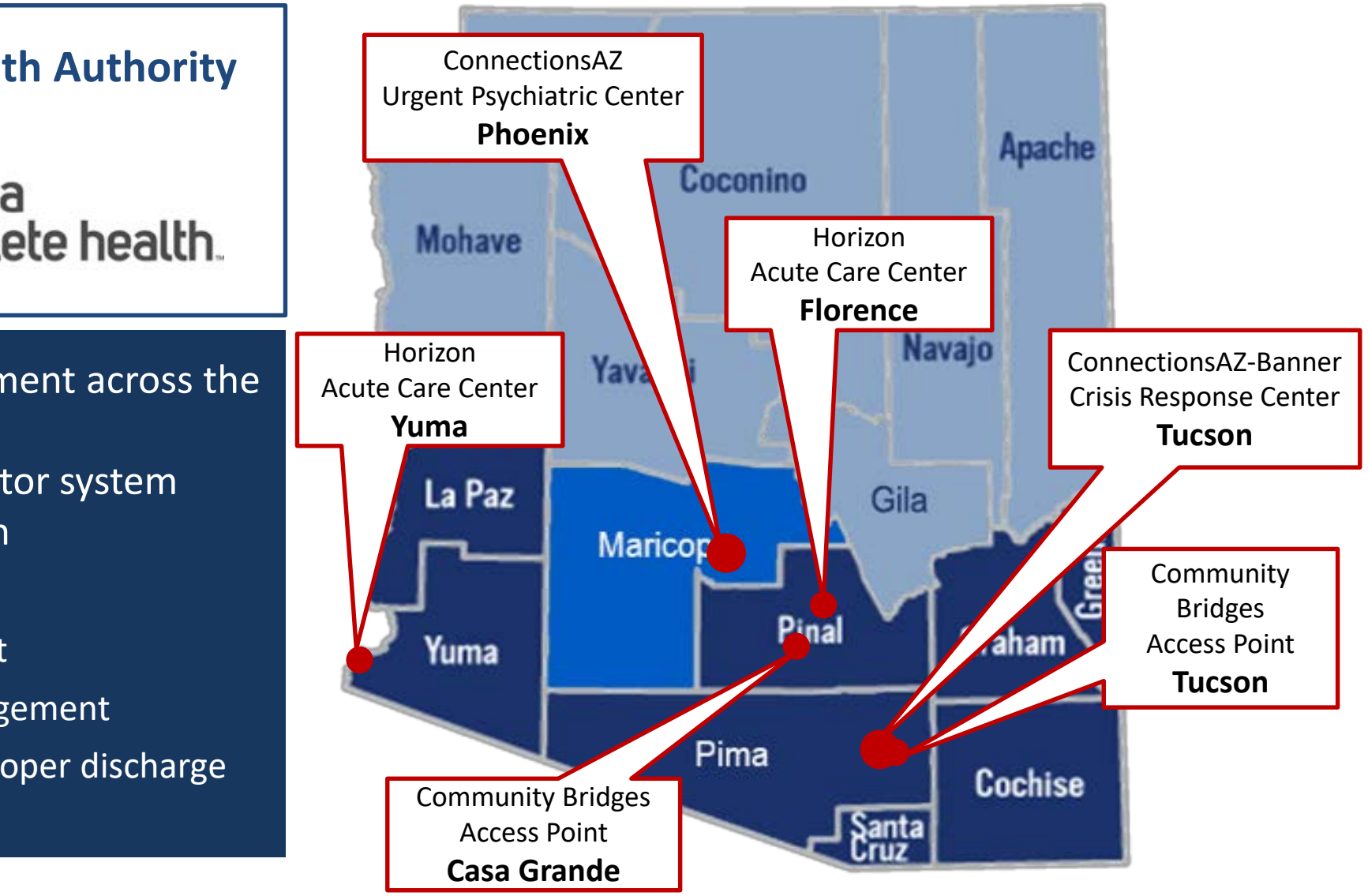
- Consistent outcome measurement across the Southern AZ network
- Monthly data reviews to monitor system performance across the region
  - Insight into volume trends
  - Bed capacity and throughput
  - Community acuity and engagement
  - Ensure accountability and proper discharge planning



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Systems Approach: 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.

The Canary in the Coal Mine
for what's NOT working in the community

Crisis Center

"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."

"These meds aren't working."

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

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

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

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

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

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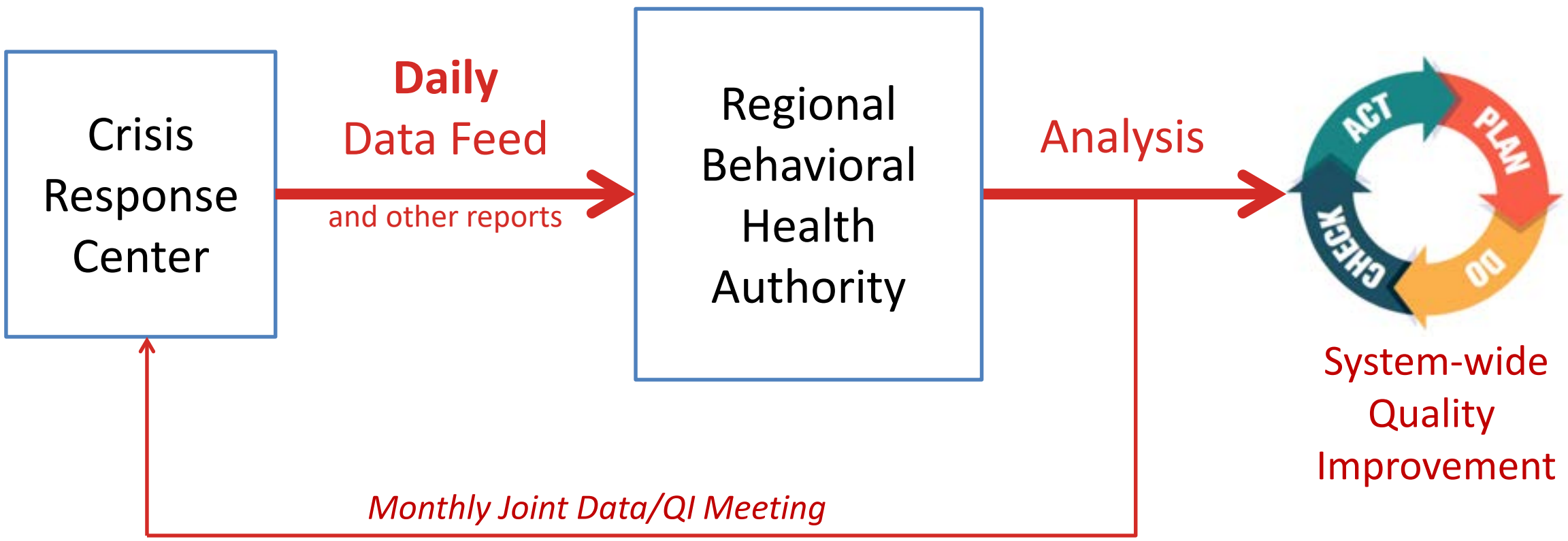
CRC-RBHA Data/QI Partnership



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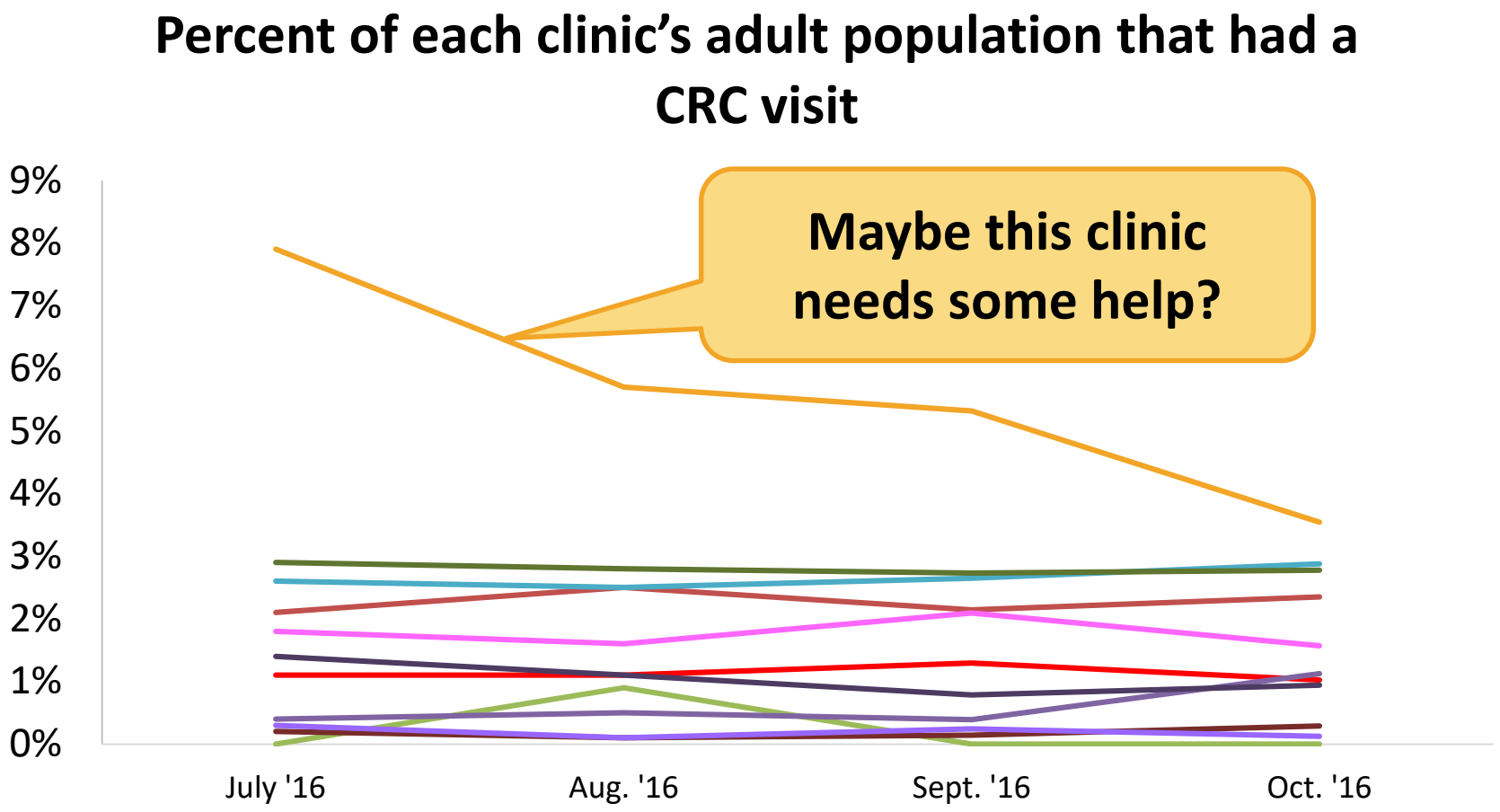
The power of collaboration: Crisis utilization by clinic



CRC has the NUMERATOR

RBHA has the DENOMINATOR

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Operationalizing Data Sharing

- Automated feed sent daily from the CRC to RBHA
- Additional consents are not required since RBHA is the payer. (Non-RBHA patients are removed before any data is sent.)
- We try to integrate reports into our existing workflows.
- UM staff abstracts charts of patients readmitted to the subacute unit

Daily Data Feed

Last Name	First Name	DOB	Admit Date	ICC	CIS Client ID	Discharge Date	Disposition
			6/6/17	MHC Healthcare		6/7/17 16:56	Home with Comm Referrals
			6/6/17	Declined		6/7/17 16:10	Home with Comm Referrals
			6/5/17	LA FRONTERA		6/7/17 11:20	Group Home
			6/6/17	Arizona Children Association		6/7/17 23:15	Sonora Hospital
			6/7/17	CODAC		6/7/17 3:18	Home with Comm Referrals
			6/6/17	COPE		6/7/17 15:25	Level 2 Facility

- **List of all discharges (23 hour obs and inpatient)**
- **Key demographic and patent-level info**
- **Sent daily each morning to**
  - **RBHA for data analysis**
  - **Responsible clinic for QI/feedback**
  - **Crisis Line for followup/aftercare tracking**

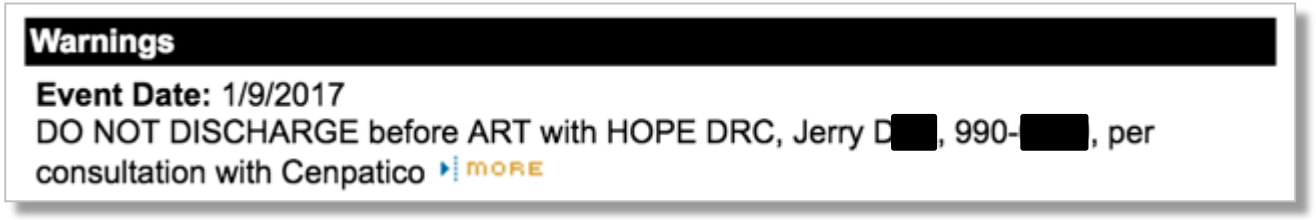
Adults: “Familiar Faces” QI Plan

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

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.

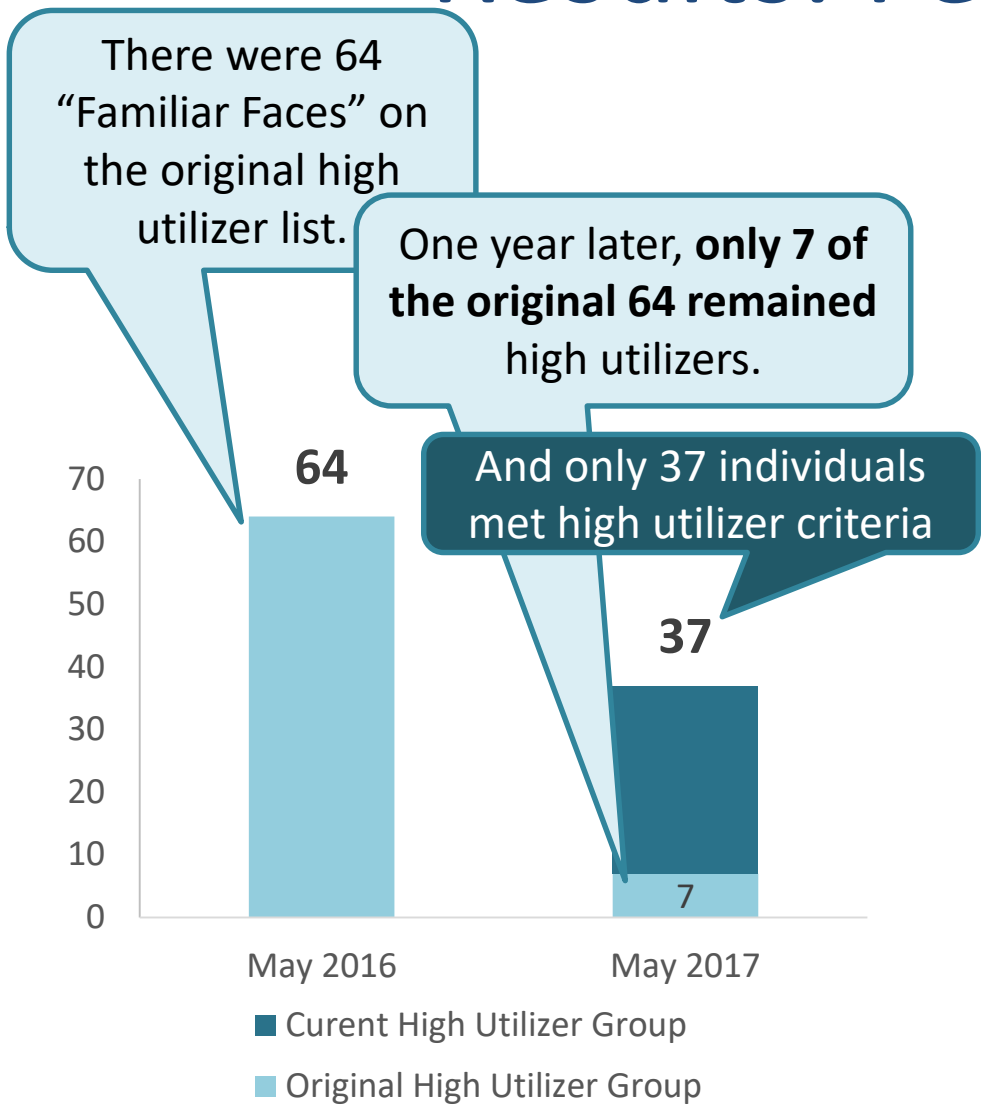
3. **CHARTS FLAGGED** at the CRC with information about the new crisis plan and who to contact so that the new plan can be implemented.



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

connections HEALTH SOLUTIONS

Results: Fewer "Familiar Faces"



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

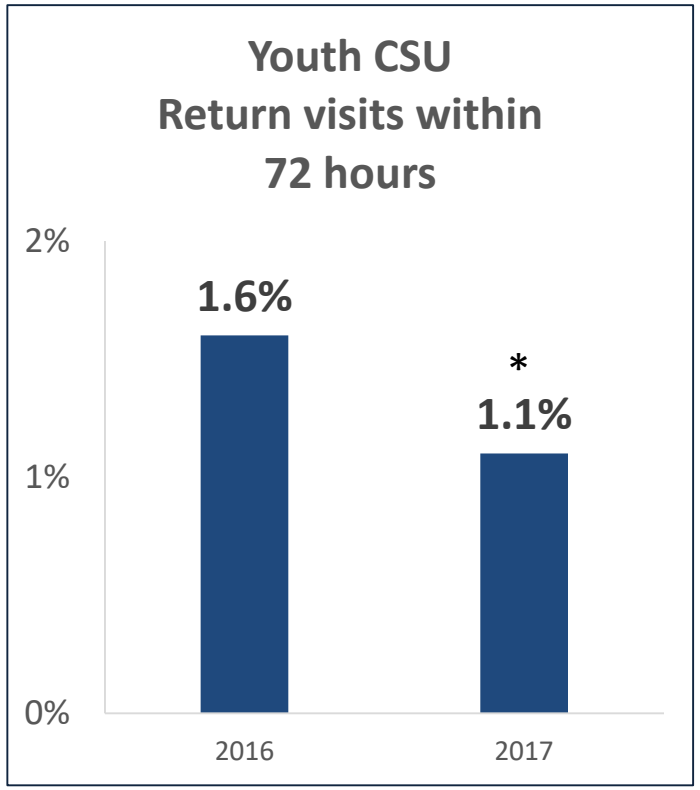
14 in Q1 2016 to

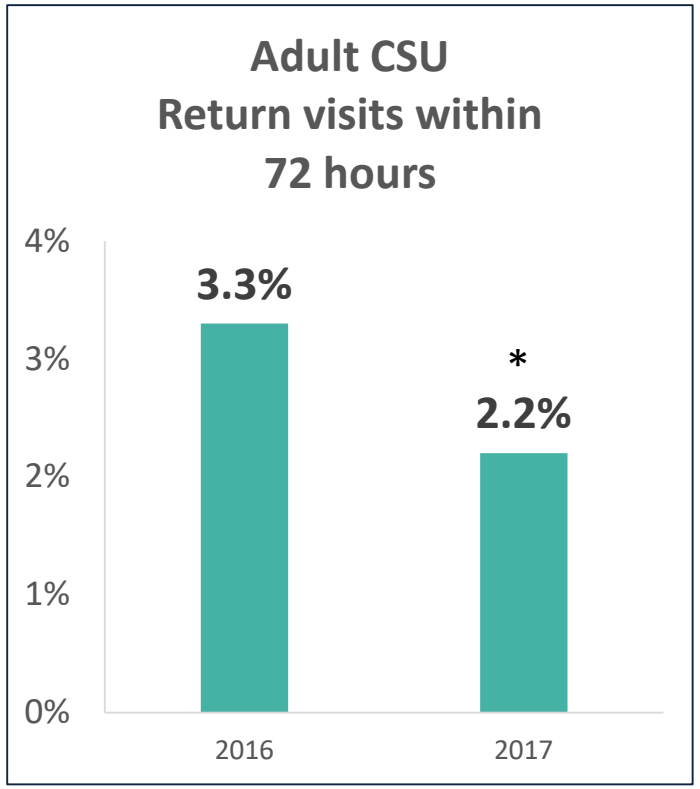
1 in Q1 2017.

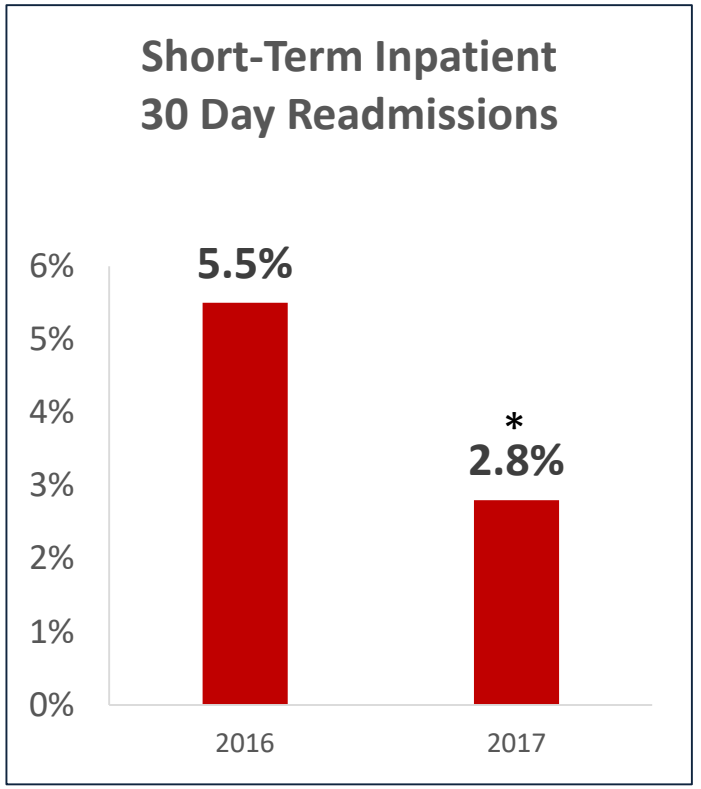
Balfour ME, Zinn T, Cason K, Fox J, Morales M, Berdeja C, Gray J; Provider-Payer Partnerships as an Engine for Continuous Quality Improvement; *Psychiatric Services;* 2018;69(6):623-625; https://doi.org/10.1176/appi.ps.201700533

Results: Reduced Readmissions

A significant reduction in readmissions in all units!



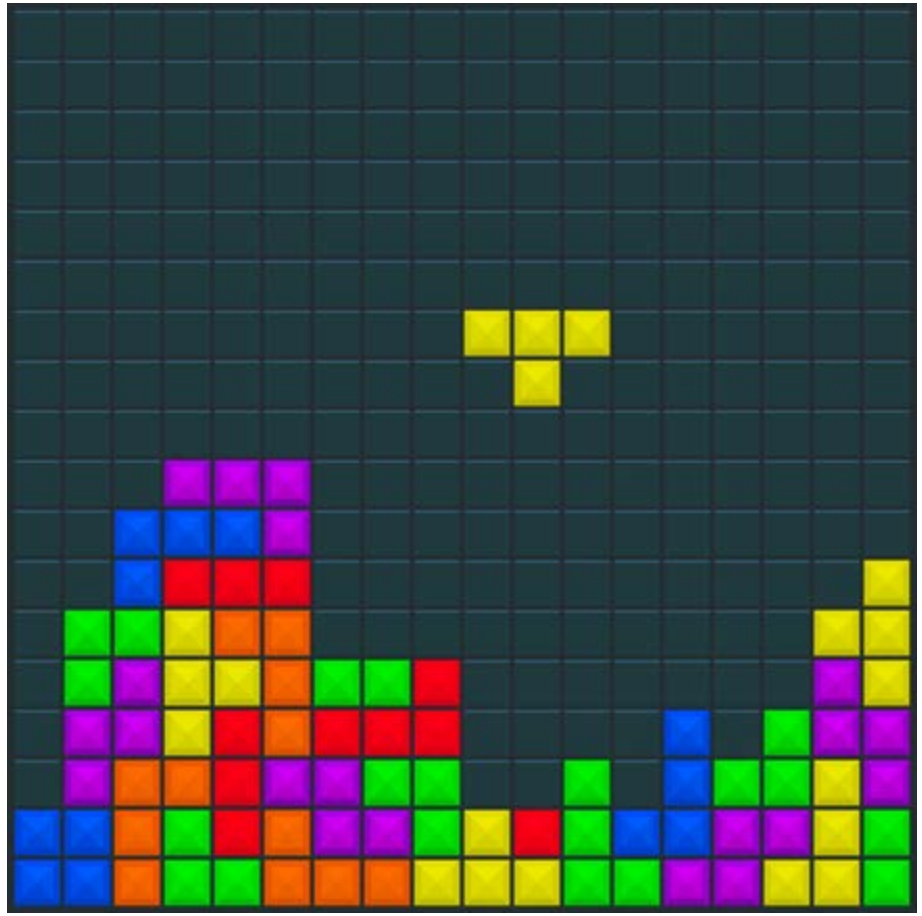




*Comparison of Q1-Q3 (Oct-June) each year. YCSU $p < 0.03$, ACSU $p < 0.02$, STIU $p < 0.01$

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

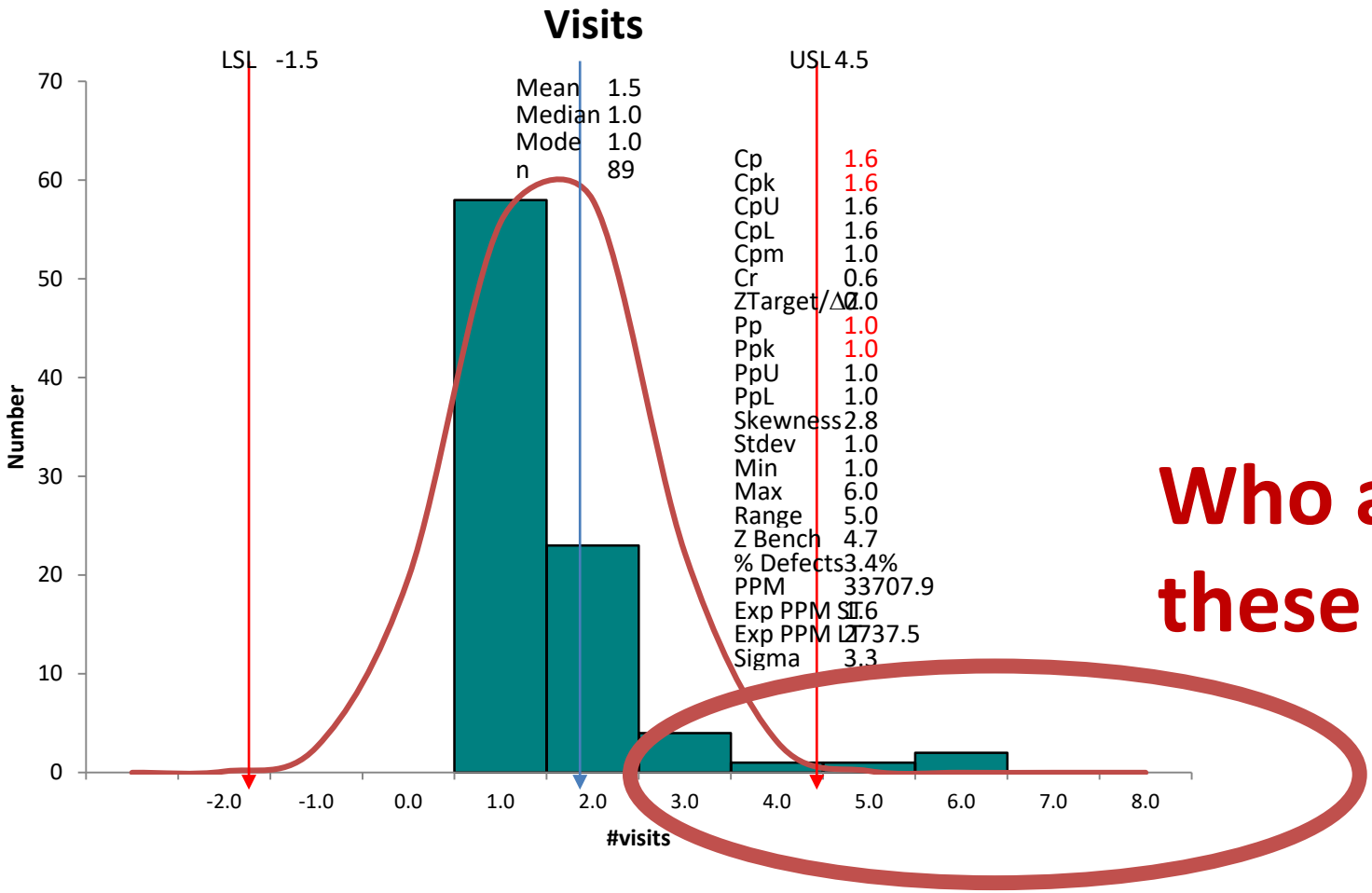
Putting it all together…



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)

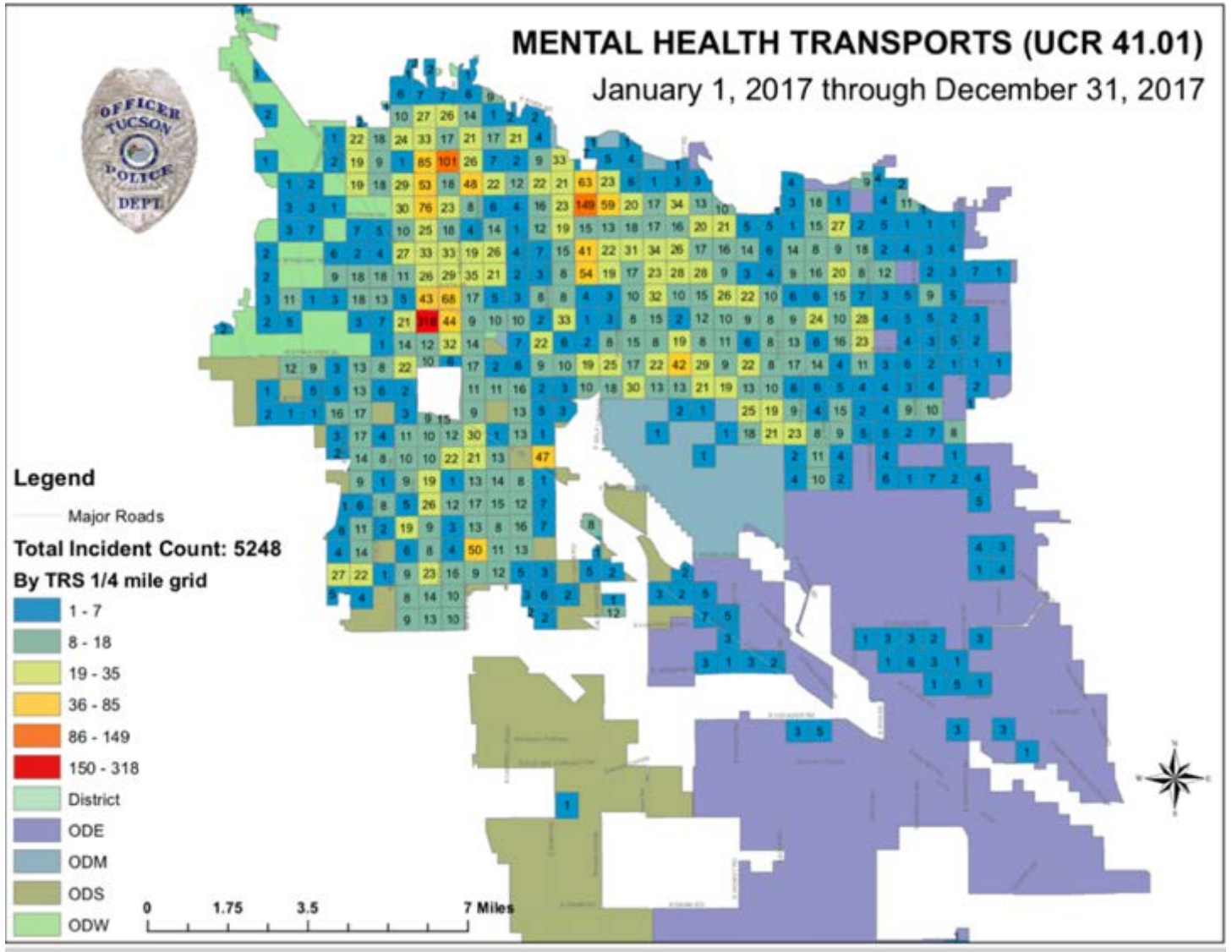


Who are these people?

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.

connections HEALTH SOLUTIONS

Multiagency QI Process to reduce T36 revocations

“The Group Home Guy”

Group Home

Crisis Line

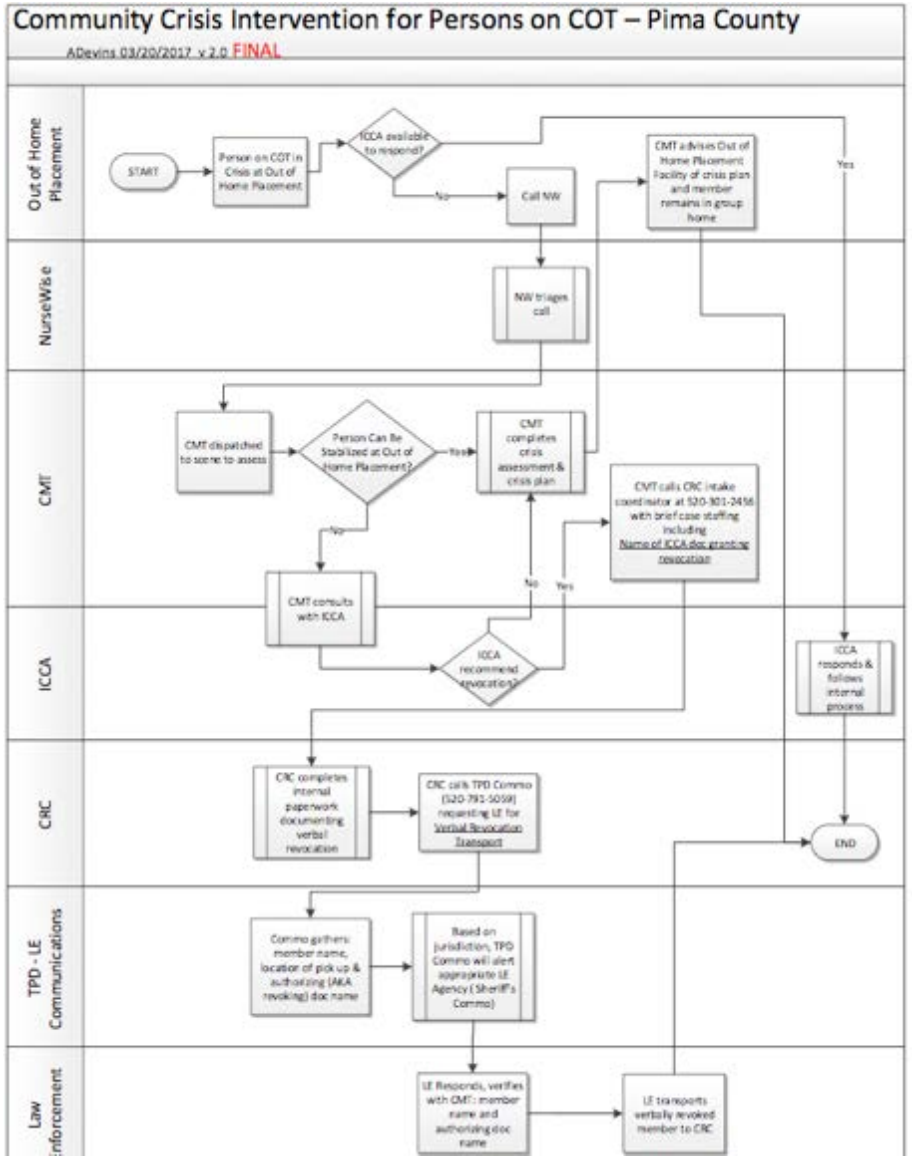
Mobile Crisis Team

Outpatient Clinic

Crisis Response Center

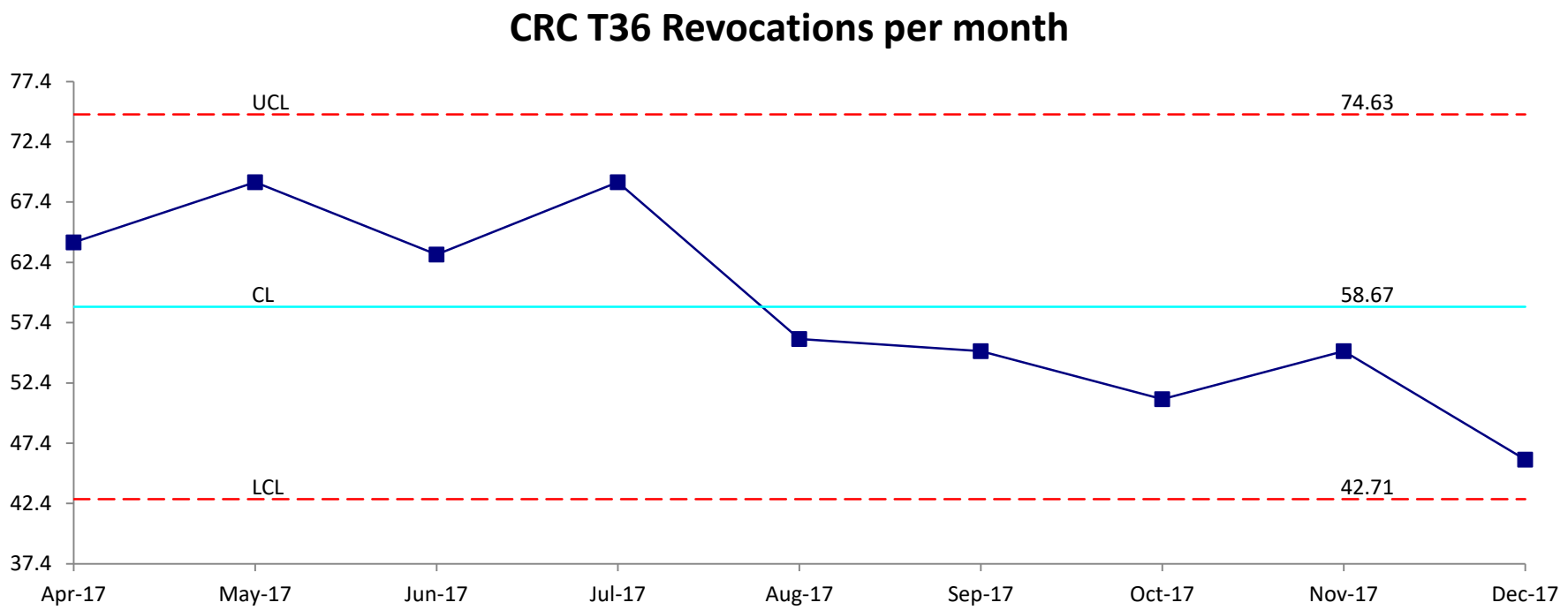
911 Dispatch

Law Enforcement



Courtesy Amy Devins, Cenpatico

Results: Reduced civil commitment revocations



connections HEALTH SOLUTIONS

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

< MH First Aid
Training for law enforcement begins

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

< Learning Site designation by DOJ/BJA

< 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

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Lessons Learned & Key Ingredients

- 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."**

Questions?

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