Evolution of a Comprehensive & Collaborative Crisis System: The Tucson Story

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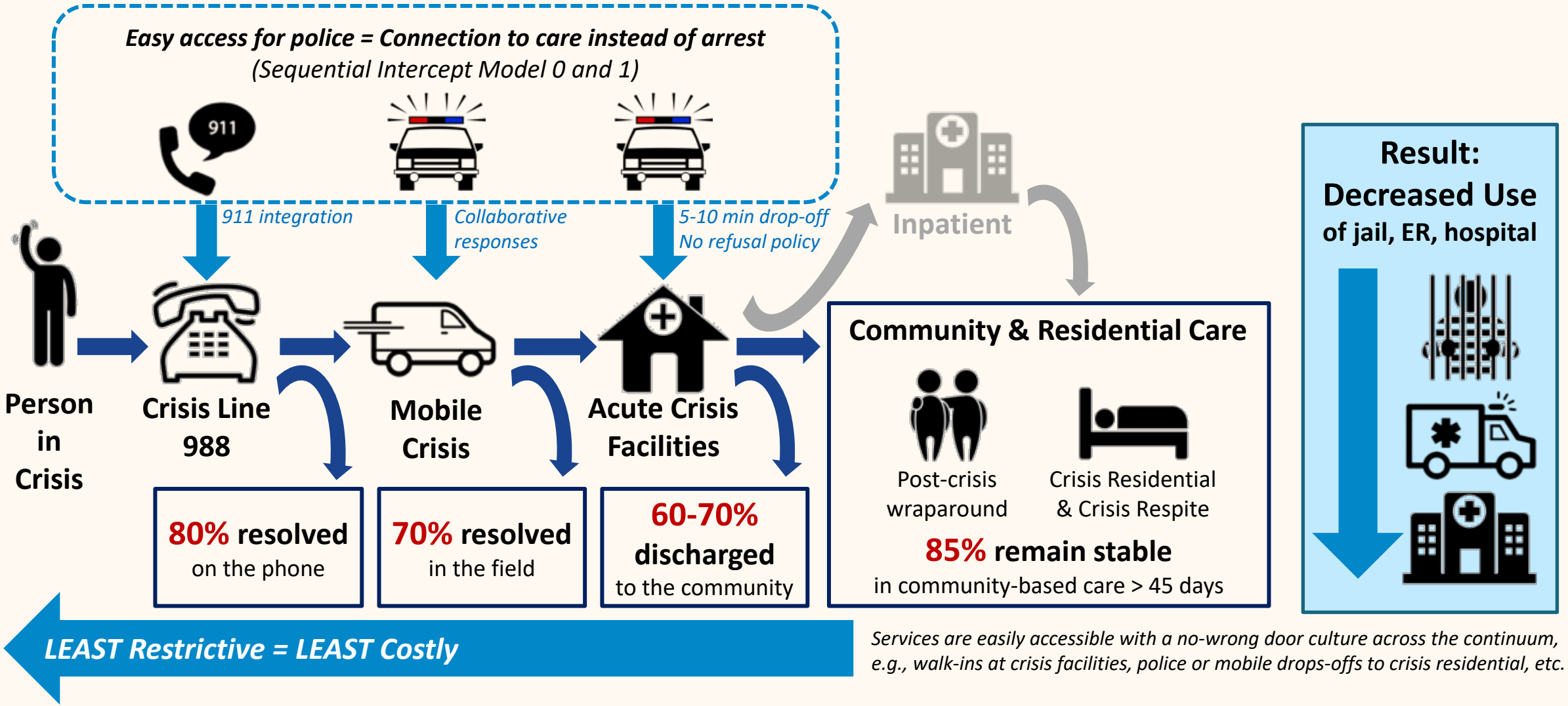
Arizona Crisis System: Alignment towards common goal of care in the least-restrictive (and least-costly) setting



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.

Balfour ME, Hahn Stephenson A, Delaney-Brumsey A, Winsky J, & Goldman ML. Cops, Clinicians, or Both? Collaborative Approaches to Responding to Behavioral Health Emergencies. *Psychiatric Services*. 2022 Jun;73(6):658-669. https://doi.org/10.1176/appi.ps.202000721

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

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< City (Tucson) MH Court

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< Peers in the Jail

< Crisis Response Center opens Aug 2011

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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 anyone regardless of payer.**

A single **"accountable entity"** creates the structure for strategic planning & oversight.

Contracted services are aligned towards common goals that are both clinically desirable & fiscally responsible:

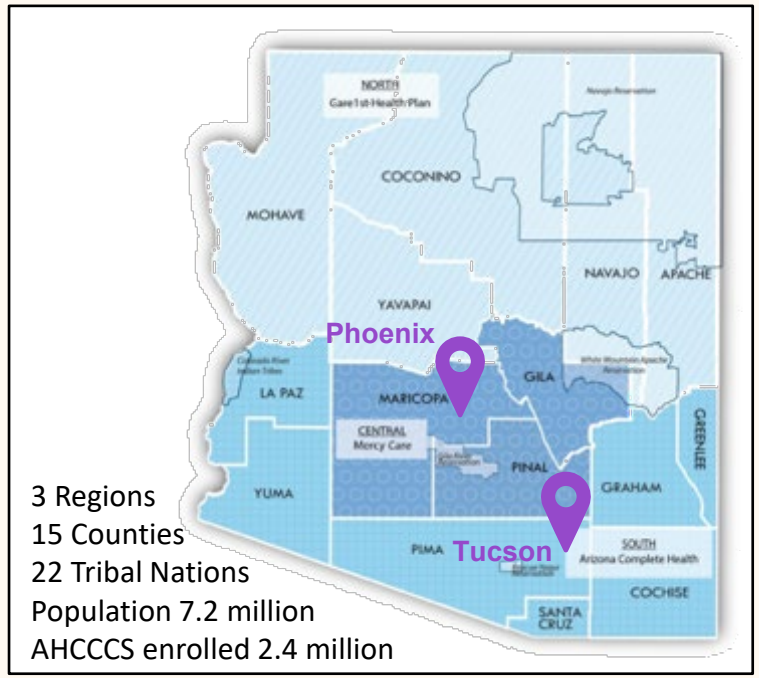
DECREASE use of ER, Hospital, Jail
INCREASE community stabilization

AZ Medicaid
AHCCCS
Arizona Health Care Cost Containment System

- Medicaid
- Federal Block Grants
- State & Local Funds

Regional Behavioral Health Authority (RBHA)

Contracted Crisis Providers



3 Regions
15 Counties
22 Tribal Nations
Population 7.2 million
AHCCCS enrolled 2.4 million

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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
- 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

A Solution to the "Divert to What?" Question

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 Police Turnaround Time**
5. Wide Range of Disposition Options
6. Community Collaboration

Studies show this model:

- Critical for pre-arrest diversion[2]
- Reduces ED boarding[3,4]
- Reduces hospitalization[3,4]

These two are the hardest to do well.

It means

- **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
  - Can be Involuntary
  - Without using security guards on clinical units

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 NH holds in EDS. 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.

Crisis Response Center: Quick & Easy Access for Law Enforcement

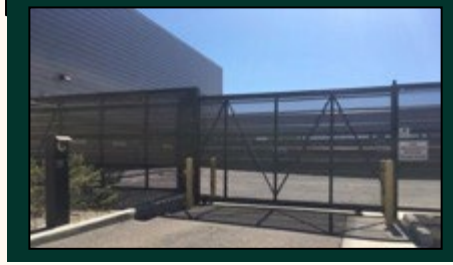
so that we're the preferred alternative to jail or the emergency room

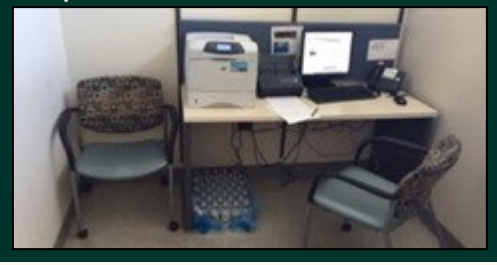
Officers don't like:

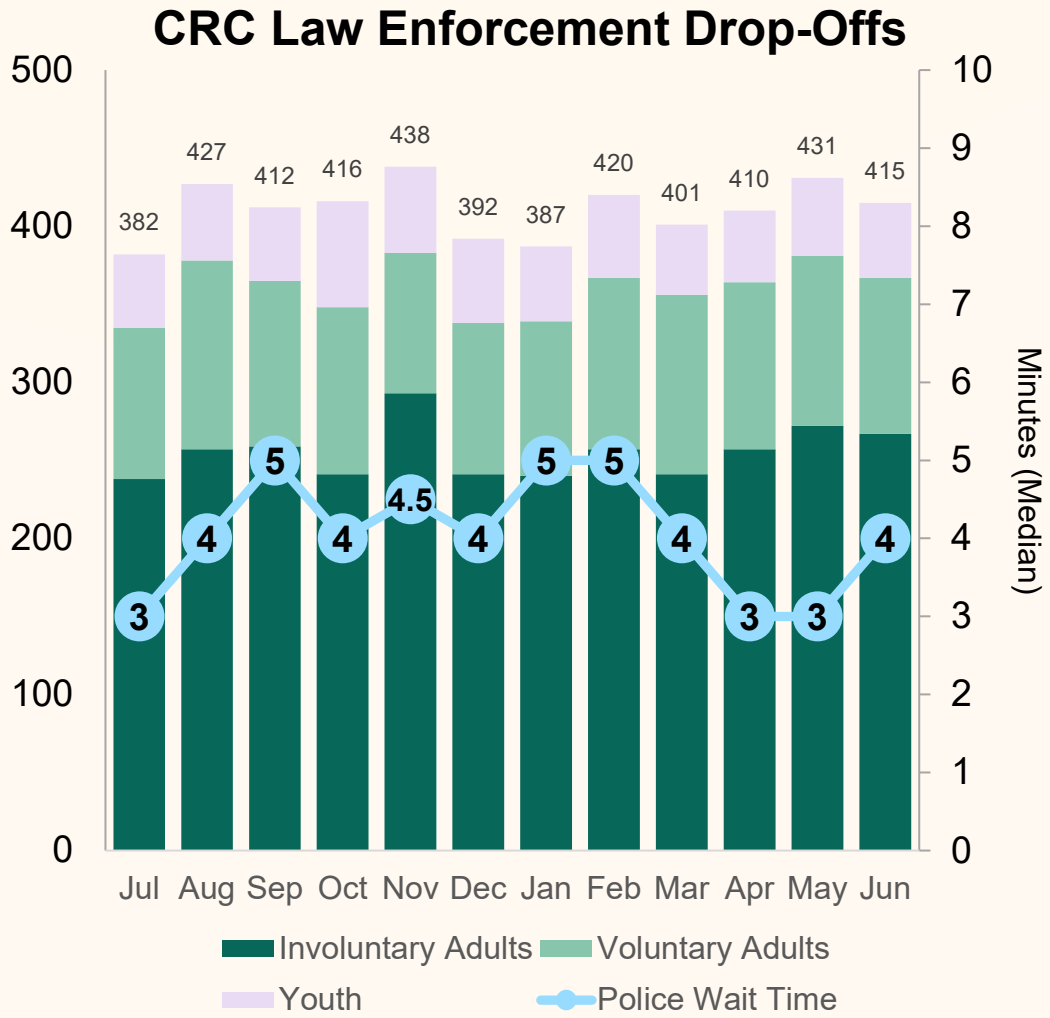
- Waiting
- Being turned away
- Taking their guns off
- Parading people through the front lobby

Dedicated police entrance with secure gated sally port & workspace

Crisis Response Center - Tucson AZ





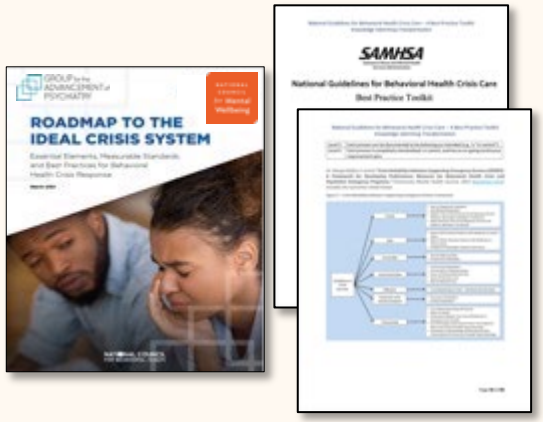


Connections CRISES Framework:

Quality metrics for facility-based crisis services

High Quality Crisis Services

- **Timely**
  - Door to Diagnostic Evaluation (Door to Doc)
  - Left Without Being Seen
  - Median Time from Arrival to Departure (Discharge, Admit, Transfer)
  - Median Time from Dispo Decision to Departure : Discharge, Admit, Transfer
- **Safe**
  - Rate of Self-directed Violence with Moderate or Severe Injury
  - Rate of Other-directed Violence with Moderate or Severe Injury
  - Incidence of Workplace Violence with Injury
- **Accessible**
  - Volume/visits
  - ~~Denied Referrals Rate~~
- **Least Restrictive**
  - Community Dispositions Rate
  - Conversion to Voluntary Rate
  - Hours of Physical Restraint /Seclusion Use (per 1000 patient-hr)
- **Effective**
  - Readmissions, Return Visits (72h, 30d)
- **Consumer& Family Centered**
  - Consumer Satisfaction (%Likelihood to Recommend, NPS)
  - Family Involvement: % with Collateral
- **Partnership**
  - Law Enforcement Drop-off Time
  - Hours on Divert
  - Median Time From ED Referral to Acceptance for Transfer
  - Post Discharge Care Plan Transmitted to BH/PCP at Discharge



Adopted in national guidelines by SAMHSA and National Council

http://www.CrisisRoadmap.com

https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf

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

Contact us about sharing or duplicating these slides.

“Crisis Stabilization Units” & Facility-Based Crisis Services – An Imperfect Guide

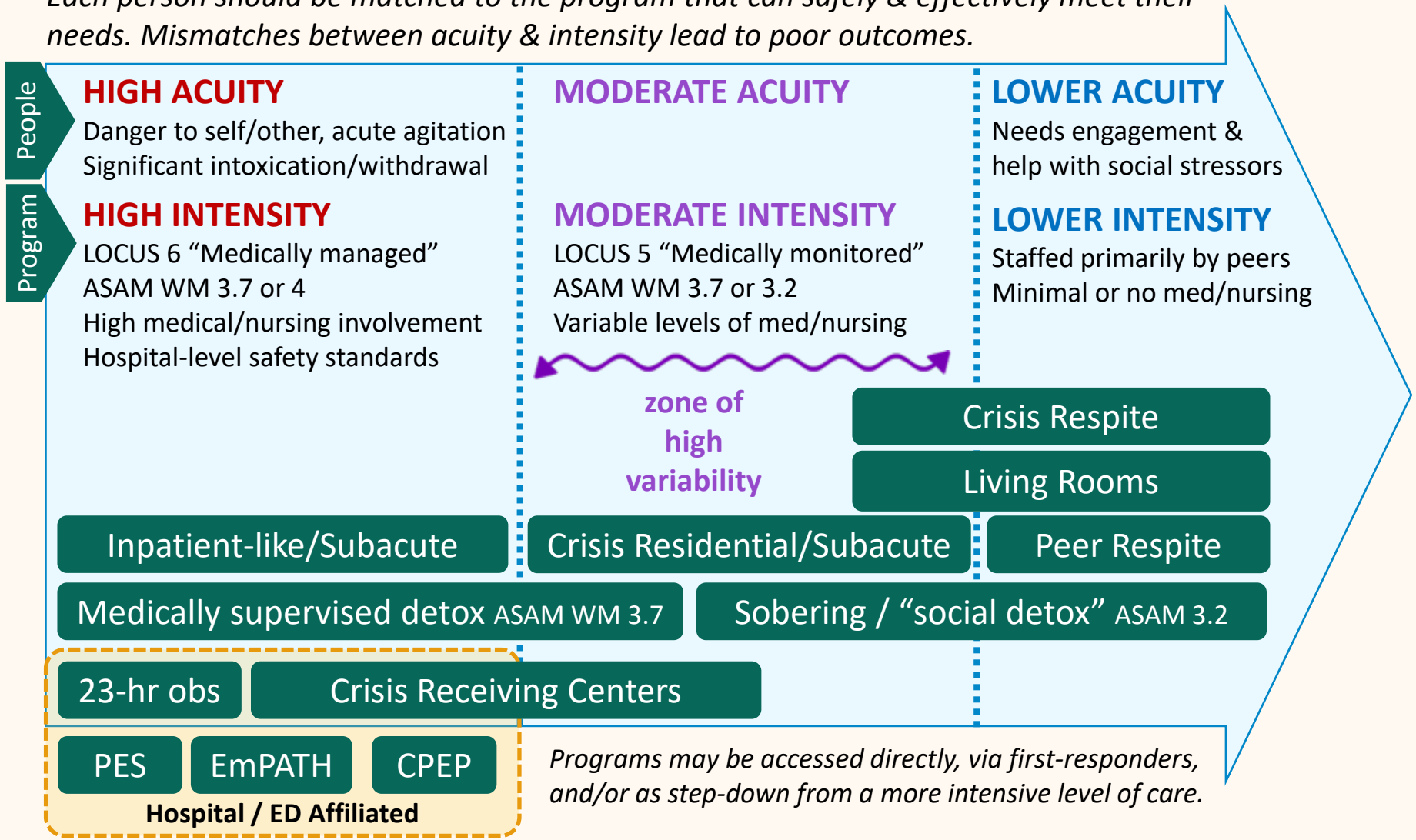
Lots of local variation in:

- Licensing
- Nomenclature
- Reimbursement
- Involuntary process
- Locked vs unlocked
- Police drop-offs
- Length of stay

But ALL should provide

- Crisis intervention/treatment *(vs holding to await transfer to another level of care)*
- Safe and therapeutic milieu
- Peer support & engagement
- Care coordination and help with social determinants of health
- Trauma-informed approaches
- Capability of addressing co-occurring MH and SUD needs

Each person should be matched to the program that can safely & effectively meet their needs. Mismatches between acuity & intensity lead to poor outcomes.



Programs may be accessed directly, via first-responders, and/or as step-down from a more intensive level of care.

For review see: Balfour ME, Hahn Stephenson A, Delaney-Brumsey A, Winsky J, & Goldman ML. Cops, Clinicians, or Both? Collaborative Approaches to Responding to Behavioral Health Emergencies. *Psychiatric Services*. 2022 Jun;73(6):658-669. https://doi.org/10.1176/appi.ps.202000721

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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**

connections

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: Dedicated Team with a Preventative Approach

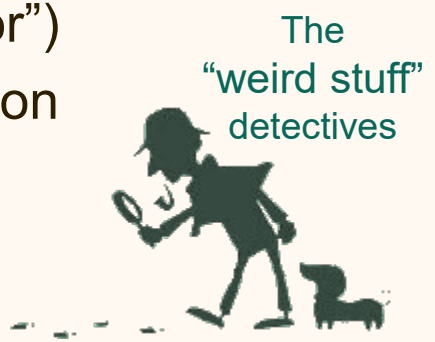
Officers: service & transport.

- Locate and transport individuals with civil commitment pickup orders
- Thousands have been transported to treatment without uses of force
- Develop relationships &recognize patterns
- Help respond to CIT calls and complex 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: prevention & safety.

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



Common Cases Referred to MHST for Investigation

- An individual is sent home/suspended from their employment for making vaguely threatening statements. They are a military veteran and known to keep firearms in the home (public safety/law enforcement use of force)
- A person presents at a gun store with clear MI and purchase is denied.
- A treatment provider calls 911 and says a client is making threatening statements over problems getting a med refill. CMT is unwilling to respond due to threats.
- A person is sending threatening emails to Mayor/their pastor/their boss/their neighborhood association/their family member. The case is referred to MHST and appears to have no MH per information available to law enforcement, but co-responder uncovers history of past treatment.

Evolution of Co-Responder Model:
Finding the right solution to fit community needs

Co-Responder 1.0: LA Model

MHST Team Officers
already employed by TPD

1 Mobile Crisis Team
already employed by mobile provider financed via RBHA/Medicaid

2 Co-Responder Teams
Cost neutral

Officer + clinician ride and respond to crisis calls together

Co-Responder 2.0

Dedicated mobile team with officers and clinicians in their own vehicles

Co-Responder 3.0

TPD MHST Officers & Detectives

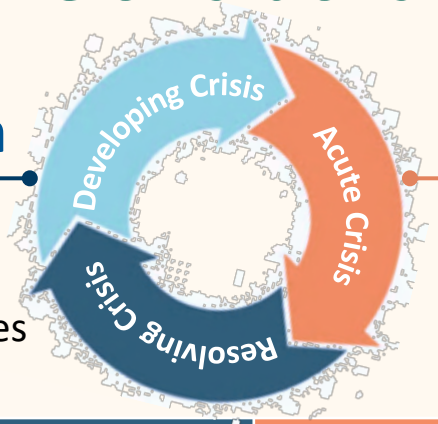
Peer Support Specialists
Employed by Connections billing case mgmt. codes

Peer follow-up and wraparound for high-risk individuals

Tucson's Police-MH Collaborative Response Model

Prevention

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



Response

- De-escalation
- Intervention
- Discrete event
- Higher urgency

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.

Health-First Response

With 911/crisis line integration, calls are **triaged to a clinician-only response as early and often as possible**, with law enforcement involvement reserved for cases with higher safety risk or criminal nexus. Responding officers are CIT-trained and can request additional assistance if needed.

Safety Risk	Outreach & Follow-up	Acute Response
	Collaborative ***Dedicated LE specialty teams working with peer co-responders*** - Follow-ups after OD or SUD deflection - Public safety risks: investigations & f/u - Homeless outreach	**Collaborative** ***CIT Trained Officer + assistance from the crisis system to fit the situation*** - CIT officer transport to CRC - Mobile crisis assist at suicidal barricades
	Clinician-Only ***BH System is responsible*** - "Second responders" - Case management - Timely access to needed care	**Clinician-Only** ***BH System is responsible*** - Crisis Line/988 - Mobile Crisis Teams - Transport to CRC/crisis facilities

Urgency

Questions?

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