Roadmap to the Ideal Crisis System: Lessons from Arizona

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Access to behavioral healthcare is a social justice/civil rights issue

“Mental health & addiction are often left in the shadows of our health care system and treated in a separate & unequal way. They never get reimbursed the same; there’s never the same professional esteem for those who are delivering the care for mental health and addiction. And there’s never the respect for patients who are suffering from chronic illness and who need the same care as if they were suffering from diabetes but are denied that care out of stigma and bigotry.”

- Former US Congressman Patrick Kennedy


Shows failures to deliver parity in mental health & substance-use disorder benefits & supports more enforcement of the law

“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*

Deaths per Million:

- **White**
- **Black**
- **Hispanic**
- **Other**

The 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.


Jails Are The New Asylums

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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

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Office of National Drug Control Policy

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


Office of National Drug Control Policy
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

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.

Implementing 988 without an effective crisis system could create increased demand on emergency departments, worsening existing problems like psychiatric boarding.
A behavioral health crisis is a potentially fatal health emergency.

BH emergencies require
A systemic response with the
same quality & consistency
as we expect for other health emergencies like
heart attacks and strokes.

WHERE’S THE PARITY?

Having siblings be like
988: The new Nationwide 3-digit number for behavioral health emergencies

- Replaces the current National Suicide Prevention Lifeline 1-800-273-TALK
- Phone, Text, and chat functions
- National standards
  - SAMHSA oversight
  - single national administrator
  Vibrant Emotional Health: www.vibrant.org

- People with BH emergencies now have an alternative to calling 911
- More info: https://www.samhsa.gov/988
988: What happens after the call?

States have less than a year to implement a new 988 number for mental health emergencies.

Communities will need a crisis system with mobile teams & crisis stabilization facilities to provide the care callers need.

(Just like 911 callers needed a system of ambulances and trauma centers to be built.)

Is your community ready?

Learn more at CrisisNow.com & CrisisRoadmap.com

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ONE DOES NOT SIMPLY
IMPLEMENT 988 WITHOUT A CRISIS SYSTEM THAT CAN PROVIDE THE CARE CALLERS WILL NEED

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

By Kyle Coward | March 19, 2021

In order for the shortened 988 suicide hotline to be a success when it rolls out in 2022, community stakeholders at various levels must do a better job helping individuals experiencing behavioral health crises, according to a new report published by the National Council for Behavioral Health.
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.
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.
Key Feature: Systems Thinking
Systems Thinking

A crisis system is more than a collection of services.

In a crisis **SYSTEM**, the services work together to achieve common goals.

The system is more than the sum of its parts.

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

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

- **Person in crisis**
- **Community support**
  Crisis system support to families, police and first-responders, schools, etc.
- **Clinical best practices**
  Engagement, assessment, safety, clinical interventions, evidence-supported treatment, peer support, coordination and continuity of care
- **Array of services and capacities**
  Service components, levels of care, staffing and volume capacities, special population capacities
- **System oversight and governance**
  Structure, financing, eligibility, quality metrics, customer satisfaction, performance incentives, flow and throughput, data sharing, utilization management, collaboration

www.CrisisRoadmap.com
## 3 Key Ingredients for a SYSTEM

<table>
<thead>
<tr>
<th>Accountability</th>
<th>Collaboration</th>
<th>Data</th>
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<tr>
<td>• Who is <em>responsible</em> for the system?</td>
<td>• Broad inclusion of potential customers, partners, &amp; stakeholders</td>
<td>• Are we achieving desired outcomes?</td>
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<td>• Governance and financing structure</td>
<td>• Alignment of operational processes &amp; training towards common goals</td>
<td>• Performance targets &amp; financial incentives</td>
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<td>• System values and outcomes</td>
<td>• Culture of communication &amp; problem solving</td>
<td>• Continuous quality improvement</td>
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<td>• Holding providers accountable</td>
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<td>• Data driven decision making</td>
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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
Alignment of crisis services toward common goals
care in the least restrictive (and least costly) setting

**Easy access for police = Connection to care instead of arrest**
(Sequential Intercept Model 0 and 1)

Person in Crisis → Crisis Line 988 → Mobile Crisis → Acute Crisis Facilities

- **80% resolved** on the phone
- **70% resolved** in the field
- **60-70% discharged** to the community

**Inpatient**

**Community & Residential Care**
- Post-crisis wraparound
- Crisis Residential & Crisis Respite

- **85% remain stable** in community-based care > 45 days

**LEAST Restrictive = LEAST Costly**

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.

Result: Decreased Use of jail, ER, hospital


(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

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

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

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

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

**Crisis Response Canines**

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

**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

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

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

**CODAC @380**
- 24/7 MAT Clinic

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

<table>
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<tr>
<th>CRISIS LINE</th>
<th>MOBILE TEAMS</th>
<th>CRISIS CENTERS</th>
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| • Some 911 calls are warm-transferred to the crisis line  
• Dedicated LE number goes directly to a supervisor | • 30 minute response time for LE calls (vs. 60 min routine)  
• Some teams assigned as co-responders (cop + clinician) | • 24/7 crisis facility  
• Quick & easy drop-off for law enforcement  
• No wrong door – LE is never turned away |
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
A Solution to the “Divert to What?” Question
Connections Culture of Treating LE as a “preferred customer”

CIT Recommendations for Mental Health Receiving Facilities¹

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

Studies show this model:
- Critical for pre-arrest diversion²
- Reduces ED boarding³,⁴
- Reduces hospitalization³,⁴

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
  - Involuntary or voluntary
  - Without using security guards

¹. Dupont R et al. (2007). Crisis Intervention Team Core Elements. The University of Memphis School of Urban Affairs and Public Policy
Quick and Easy Access for Law Enforcement so that we’re the preferred alternative to the jail or ED

Police officers don’t like
• Waiting
• Being turned away
• Taking their guns off
• Parading people through the waiting room

Dedicated law enforcement entrance with secure gated sally port and workspace
Crisis Response Center - Tucson AZ
23-hour observation: Interdisciplinary care starting with the assumption that the crisis CAN BE resolved

**Interdisciplinary Teamwork**
- 24/7 psychiatric provider coverage (MD, NP, PAs)
- Peers with lived experience, nurses, techs, case managers, therapists, unit coordinators

**Early Intervention**
- Door to doc time
- Interventions include medication, detox/MAT, groups, peer support, safety planning, crisis counseling, mindfulness

**Proactive discharge planning**
- Collaboration and coordination with community & family partners

Most discharged to the community the following day
Avoiding preventable inpatient admission, even though they met medical necessity criteria when they first presented
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%).
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

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

Tucson Police MHST Model: A Preventative Approach
Dedicated Mental Health Support Team

**Officers** focus on **service & transport**.
- Locate and transport individuals with civil commitment pickup orders
- Hundreds 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
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.

### Outreach & Follow-up

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

#### Collaborative

*Dedicated LE specialty teams working with community-based peers*
- Follow-ups after OD or SUD deflection
- Public safety risks: investigations & f/u
- Homeless outreach

#### Clinician-Only

*BH System is responsible*
- "Second responders"
- Case management
- Timely access to needed care

### Acute Response

#### 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*
- Crisis Line/988
- Mobile Crisis Teams
- Transport to CRC/crisis facilities

### Breaking the Crisis Cycle

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

### 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.
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*

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Data courtesy Sgt. Jason Winsky at Tucson Police Department
Cops like quick turnaround time (10 min) so that it’s easier to bring people to treatment instead of jail.

**MORE People Taken to Treatment...**

**CRC Law Enforcement Drops (Adults)**

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

**Tucson PD Mental Health Transports**

More people diverted to treatment instead of jail.
... 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.

TPD “Nuisance Calls” Per Year

TPD SWAT Calls for Suicidal Barricade

Each one costs $15,000!
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)
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.

*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)

BIA presentation at SMSICC (2017), Madison, Wisconsin data

34

Slide courtesy www.crisisnow.com
ADVOCACY ALERT!

BH Crisis Expansion Act
SB 1902/HB 5611

Bipartisan federal legislation that requires most insurance plans to cover crisis care.
Connections CRISES Framework: Quality metrics for facility-based crisis services

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<tr>
<th>High Quality Crisis Services</th>
<th>Timely</th>
<th>Safe</th>
<th>Accessible</th>
<th>Least Restrictive</th>
<th>Effective</th>
<th>Consumer &amp; Family Centered</th>
<th>Partnership</th>
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<td></td>
<td>• Door to Diagnostic Evaluation (Door to Doc)</td>
<td>• Rate of Self-directed Violence with Moderate or Severe Injury</td>
<td>• Volume/visits</td>
<td>• Community Dispositions Rate</td>
<td>• Consumer Satisfaction (%Likelihood to Recommend, NPS)</td>
<td>• Law Enforcement Drop-off Time</td>
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<td></td>
<td>• Left Without Being Seen</td>
<td>• Rate of Other-directed Violence with Moderate or Severe Injury</td>
<td>• Denied Referrals Rate</td>
<td>• Conversion to Voluntary Rate</td>
<td>• Family Involvement: % with Collateral</td>
<td>• Hours on Divert</td>
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<td>• Median Time from Arrival to Departure (Discharge, Admit, Transfer)</td>
<td>• Incidence of Workplace Violence with Injury</td>
<td>• Hours of Physical Restraint Use &amp; Hours of Seclusion Use (per 1000 patient-hr)</td>
<td>• Median Time from Dispo Decision to Departure: Discharge, Admit, Transfer</td>
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<td>• Median Time From ED Referral to Acceptance for Transfer</td>
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<td>• Post Discharge Continuing Care Plan Transmitted to BH Provider at Discharge</td>
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Progress towards national standards

**Connections Standard**

The Regional Behavioral Health Authority requires the other 23 health crisis facilities to use the same framework for quality measurement.

**Arizona Standard**

**National Standard**

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"Maybe stories are just data with a soul."

- Brené Brown

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.
Using Data to Solve Complex Problems

Example:
Repeat revocations to the CRC for individuals on COT (outpatient civil commitment)

Who are these people?

CRC Emergency Revocations

- Mean: 1.5
- Median: 1.0
- Mode: 1.0

Number of Visits

Frequency
Where are these individuals coming from?

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

Courtesy Sgt. Jason Winsky, Tucson Police Dept.
“The Group Home Guy”
Multiagency QI Process to reduce repeat civil commitment orders

A “Swim Lane” diagram shows how each agency plays a role in making the new process work.

- Group Home
- Crisis Line
- Mobile Crisis Team
- Outpatient Clinic
- Crisis Response Center
- 911 Communications Center
- Law Enforcement

Courtesy of Amy Devins, Arizona Complete Health
Key Ingredients

- Systems approach
- Underlying governance & financing structure that supports
  - A robust continuum of crisis services
  - Oversight & accountability
  - Alignment towards common goals & clinical outcomes
- Culture of communication, collaboration and problem solving
  - “Figure out how to say YES instead of looking for reasons to say NO.”
- Data-driven decision-making

Roadmap principles create a strong foundation for collaboration & innovation.
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**: < Mobile Crisis Teams < Jail Based > Restoration to Competency
- **2004**: Felony > MH Court
- **2006**: Bond passes > to build crisis facility
- **2007**: Jan 8 2011 shooting > at Congress On Your Corner
- **2008**: 2001 CIT Program started
- **2009**: 2001 CIT Program started
- **2010**: < Pima County Office of BH Administrator < DTAP Program Drug Treatment Alternative to Prison
- **2011**: < Peers in the Jail < Crisis Response Center opens Aug 2011
- **2012**: < Rural MH Courts < Law Enforcement MH Support Teams < PCSO TPD >
- **2013**: < MH First Aid Training for law enforcement begins
- **2014**: 2001 CIT Program started
- **2015**: 2001 CIT Program started
- **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**: 2001 CIT Program started
- **2019**: < 911/crisis line co-location < CoMPaSS Court Consolidated misd. problem-solving court < Drug Deflection UMATTER program < Homeless Outreach Team
- **2020**: < Learning Site designation by Dept of Justice < STEPS Court pre-adjudication diversion
- **2021**: < MHFA Impact Award National Council for BH < Repeat Jail Detainees Task Force < Homeless Outreach Team
Getting There...

EXCITING TIMES FOR BH CRISIS CARE

SAMHSA MHBG crisis set-aside
CARES Act
ARPA Funding
COVID
ED Boarding
Value-based payment models
9-8-8 State planning grants
State funding
Social Justice Movements
BLM Police reform
Justice Reform
MH Parity
ET3 CCBHCs

Medicaid
↑ FMAP for Mobile Crisis and HCBS
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

We used to call the police when we needed mental health care.

Big changes in emergency mental health care are on the horizon. In July 2022, a new 9-8-8 number will provide an alternative to 911 for mental health emergencies and there is new federal funding for crisis services. Now it's time for state & local leaders to build the crisis system callers will need like mobile crisis teams and crisis stabilization facilities.

The future, hopefully!
**Legislation & Advocacy: Federal**

- **Passed:** American Rescue Plan and other federal legislation
  - SAMHSA MHBG increased to $757m + 5% crisis set-aside
  - Increased Medicaid federal match (FMAP)
    - 85% for mobile crisis
    - 10% increase for Home and Community Based Services (HCBS)
  - $15m for 988 and Mobile Crisis planning grants to states
  - $25m to strengthen Lifeline
  - $250m for CCBHCs

- **To do:** Lots of legislation in progress and rapidly changing
  - BH Crisis Expansion Act (HR 5611/S 1902)
  - 988 Implementation Act (HR 7116, no Senate companion bill yet)

- **Good news:** Lots of bipartisan support 😊
**BH Crisis Expansion Act**  
S-1902/HR-5611

- **Sen Cortez Masto (D-NV) and Cornyn (R-TX)**
- Directs HHS to create national definitions and standards for crisis services
- Requires all federally regulated insurance to cover crisis services (Medicare, ACA, Employer, VA, Tricare)
- Funding for technical assistance to help communities create crisis services
- Expert panel to help improve 988 and 911 coordination


**988 Implementation Act**  
HR 7116

- **Rep Tony Cardenas (D-CA), Brian Fitzpatrick (R-PA) and others, no Senate companion yet**
- Makes permanent the increases to SAMHSA MHBG ($2.235 billion with 10% crisis set aside)
- Creates and funds a Behavioral Health Crisis Coordinating Office to develop standards
- Funding for 988 infrastructure
- Increased Medicaid funding for phones, mobile, facilities
- Capital funding via HRSA for building crisis centers
- Workforce development, including loan repayment for working in crisis settings
- Exempts short-term crisis facilities from the IMD exclusion

Info:  

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.

ROADMAP TO THE IDEAL CRISIS SYSTEM

Essential Elements, Measurable Standards and Best Practices for Behavioral Health Crisis Response

March 2021

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
Preview at dev.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 news & other resources
Advocacy: Staying Up to Date

• Weekly "Crisis Jam" webinar centered around 988 implementation
  – Legislative updates
  – SAMHSA updates
  – Featured presentation each week
  – Wednesdays at noon ET
  – https://talk.crisisnow.com/learningcommunity/

• MHA Action Alerts: https://mhanational.org/issues/action-alerts

• NAMI Re-imagine Crisis Advocacy Center

• And check with your state/local chapters
Questions?

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Further Reading:

- **Cops, Clinicians, or Both? Collaborative Approaches to Responding to Behavioral Health Emergencies.**


- **Psych News overview of Tucson model:** [https://doi.org/10.1176/appi.pn.2022.1.7](https://doi.org/10.1176/appi.pn.2022.1.7)