More Than Emergency Response:
The Tucson Model's Preventative Approach to Crisis and Public Safety

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Tucson Police Department
Mental Health Support Team

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Cenpatico Integrated Care
Supervisor, First Responder Services
Agenda for today

1. Overview of the Problem
2. The Tucson Model: A Unique System Spanning Collaboration
   – Sgt. Jason Winsky
     Tucson Police Dept. MHST Team
3. Being a Good Partner to Law Enforcement
   – Margie Balfour, MD, PhD
     Connections Health Solutions
4. Panel discussion and Q&A
   – Polly Knape
     Cenpatico Integrated Care
When mental health and criminal justice collide…

It can get ugly.
“I’m having chest pain.”

“I’m suicidal.”
Officer-involved shootings

Washington Post Nationwide Database of Police Fatalities

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.

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

Related story Distraught people, deadly results: Officers often lack the training to approach the mentally unstable, experts say

https://www.washingtonpost.com/graphics/national/police-shootings-2016/
The path to jail

- Officers want the person to get treatment
- But they don’t know where else to take them except the ED
- Where they have to wait.
- Cops are busy and have crimes to fight.
- So they take the person to jail instead.

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

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### Prevalence of Mental Illness

<table>
<thead>
<tr>
<th></th>
<th>Jail</th>
<th>US Adults⁵</th>
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<tbody>
<tr>
<td><strong>SMI³</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Men</td>
<td>17.1%</td>
<td>4%</td>
</tr>
<tr>
<td>- Women</td>
<td>34.3%</td>
<td></td>
</tr>
<tr>
<td><strong>Any mental disorder⁴</strong></td>
<td>76%</td>
<td>18%</td>
</tr>
<tr>
<td>+ Co-occurring substance use⁴</td>
<td>49%</td>
<td>3.3%⁶</td>
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Impact of incarceration\textsuperscript{1,2}

- Jails and prisons lack the policies and trained staff to deal with this population.
- 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.

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.\textsuperscript{3}

For review see:
3. Office of National Drug Control Policy
https://www.whitehouse.gov/ondcp/in-custody-treatment-and-reentry
The Sequential Intercept Model

A Continuum of Solutions: Behavioral Health System

A CONTINUUM OF CRISIS INTERVENTION NEEDS

- **EARLY INTERVENTION**
  - Crisis Respite
  - Outpatient Provider
  - Family & Community Support
  - Crisis Telephone Line

- **RESPONSE**
  - 23-hour Stabilization
  - Mobile Crisis Team
  - CIT Partnership
  - EMS Partnership
  - 24/7 Crisis Walk-in Clinic
  - Hospital Emergency Dept.

- **PREVENTION**
  - WRAP
  - Crisis Planning
  - Housing & Employment
  - Health Care

- **POSTVENTION**
  - Integration/Re-integration into Treatment & Supports
  - Peer Support
  - Non-hospital detox
  - Care Coordination

**TRANSITION SUPPORTS**
- Critical Time Intervention, Peer Support & Peer Crisis Navigators
A Continuum of Solutions: Law Enforcement

A CONTINUUM OF CRISIS INTERVENTION NEEDS

- Early Intervention
- Response
- Prevention
- Postvention

CIT (Memphis Model)
Mental Health Co-Responder Team
Mental Health Co-Responder Teams
The Tucson Mental Health Support Team Model

A preventative approach to crisis and public safety

Sgt. Jason Winsky
Supervisor
Mental Health Support Team (MHST)
Tucson Police Department
Typically Police Have to Balance the two...
MHST (Mental Health Support Team) seeks to find solutions to both.
MHST is a Preventative Approach

• Tucson already had one of the oldest and most respected CIT programs in the nation.
• Yet people still fell through the cracks with tragic results.
• The wave of mass shootings and the increased mental health related calls served as a catalyst for taking a fresh look at law enforcement’s approach to mental illness.
  – CIT provided the tools to help officers respond to a person in behavioral health crisis as in the Glenn case.
  – But perhaps with a different approach we can prevent some crises and related threats to public safety altogether.
Purpose of MHST

MHST Mission:

- Community Service
- Public Safety
- Risk Management

- Decrease risk to officers and deputies
- Decrease risk to community
- Decrease risk to persons with mental illness
- Decrease waste of taxpayer dollars
- BREAK THE CYCLE

But also…
It’s the right thing to do.
MHST Areas of intervention

• Many people suffering from mental health issues fall between the cracks of the system
• They always become the burden of law enforcement
MHST: A New Approach
MHST Functions

Support/Transport

• Officers
• Focuses on patients already in the civil commitment system
• Centralized tracking and specialized training

Investigative

• Detectives
• Prevent people falling through the cracks
• Recognizing patterns and connecting people to services
MH Support/Transport: Out With The Old

Old Way

- Patrol Officers Serving COE Orders
  - Court Ordered Evaluations orders served before expiring = 30%
- Patrol officers would look for the quickest, easiest solution to a situation with a mental health nexus
  - Often resulting in arrest and incarceration

New Way

- Approaching 100% service rate on mental health orders
- Mental health facilities and providers communicating with law enforcement
- One central location for patrol to go to for answers to problems
- Law enforcement talking to law enforcement
- **ZERO** uses of force serving mental health orders
Civil Commitment Pickup Orders 2014-2016

- **Total Orders:** 926
- **Success Rate:** 93%
- **Uses of Force:** 0

In 2016, the success rate was 98%.

- **Served by MHST Team:** 580
- **Served by Patrol:** 152
- **Quashed:** 125
- **Not Served:** 69
SWAT Calls for Suicidal Barricade

- **Number of incidents**
  - 2013: 18
  - 2014: 2
  - 2015: 4
  - 2016: 1

- **Percent of all SWAT calls**
  - 2013: 20%
  - 2014: 10%
  - 2015: 50%
  - 2016: 10%
Time Saved by MHST Jan-Jun 2017

- Following up with individuals: 44\%
- Serving Mental Health Orders: 78\%
- Meeting with Community Stakeholders: 90\%
- Patrol Assist: 100\%

Cumulative Percent
MHST Investigation

- Adjudication or mental health diversion
- Presentation to Prosecutors
  - Start of criminal investigation
  - Criminal Investigation

- Long term care, medication
- Presentation to evaluating provider
  - Start of the mental health investigation
  - Mental Health Investigation

- Initial Call
Collaboration with the mental health system is key to success

• But it was challenging at first.
• MHST had to make a concerted effort to engage and form partnerships with the mental health system.
• Suspicious at first
  – “I’m not going to help you get my patient arrested.”
  – COMBATIVE PATIENTS

<table>
<thead>
<tr>
<th>Words</th>
<th>Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>• We’re sorry that we have been missing before now.</td>
<td>• Showing up</td>
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<tr>
<td>• We want to be helpful.</td>
<td>• Developing a dedicated team to devote attention and resources to this population</td>
</tr>
<tr>
<td>• We want to share data with you, not receive it.</td>
<td>• Investment in training</td>
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Tucson Training Model: CIT vs. MHFA

All officers receive basic mental health training (Example: MHFA)

- De-Escalation & Crisis Intervention
- Mental Health Basics & Community Resources

Some officers receive intermediate training (CIT)

- Voluntary Participation
- Aptitude for the Population

Specialized Units – Advanced Training

- SWAT Negotiators
- MHST Teams
WHO is trained?

CIT training is voluntary by design.

- Hostage Negotiators: 100%
- SWAT: 100%
- First Responders and 911 call takers: 78%
- Field Services Bureau: 57%
Regional Training Center of Excellence

- Provides training to a dozen local and federal agencies across Southern Arizona
- Helping other departments set up mental health teams
- Most content delivered by mental health system partners
Lessons Learned

• A mental health team should be comprised of Officers, Detectives, and Sergeants

• *Dedicated*, not designated

• Partnership and engagement with local community mental health professionals

• Access to crisis services (crisis centers, psychiatric urgent care, walk-in clinics, etc.) as an alternative to incarceration.

• Partnership with organizations
  – National Alliance on Mental Illness
  – Crisis Intervention Training International
The Tucson Model

• A transformational shift: in policy, in practice, in thinking about responding to persons in crisis

• Saving time

• Saving resources – proactive versus reactive

• Engaging with the community before there’s a crisis
Being a good partner to law enforcement

Strategies for crisis providers

Margie Balfour, MD, PhD
VP for Clinical Innovation & Quality, ConnectionsAZ
Chief Clinical Officer, Crisis Response Center
Assistant Professor of Psychiatry, University of Arizona
Overview of the Arizona Behavioral Health System

AHCCCS: Arizona Health Care Cost Containment System (Arizona Medicaid)

Regional Behavioral Health Authorities (RBHAs) Cenpatico Integrated Care

Providers
What this means for collaboration

• Centralized **planning**
• Centralized **accountability**
  – Performance metrics and payment systems that promote desired outcomes
• Coverage for all individuals in crisis regardless of insurance
• Crisis Team includes liaisons for various stakeholders:
  – law enforcement, fire, DCS, Hospital/EDs, etc.
RBHA goals for the crisis system

- **Decrease** preventable interactions with
  - Law Enforcement
  - The Criminal Justice System
  - Emergency Departments

- **Increase** rates of community stabilization
  - Availability of services to assist in stabilization
  - Ongoing support of members in the community
  - Collaboration with community partners
Example Collaborations

• 24/7 Crisis Line + 11 Crisis Mobile Teams
  – Can assist law enforcement with assessment, stabilization, connection to services, and welfare/follow-up checks
  – Some 911 calls warm-transferred to the crisis line

• Law enforcement as a preferred customer:
  – Dedicated LE number goes directly to a supervisor
  – CMTs have 30 minute response time for LE calls (vs. 60 min for community initiated calls)
  – Some teams co-located in police substations for faster deployments
  – Some teams assigned as co-responders
Community Crisis Intervention for Persons on COT – Pima County

Advisors: 09/19/2016 v 1.0 FINAL DRAFT

Out of Home Placement

START
Person on COT in Crisis at Out of Home Placement
Call NW

CMT advises Out of Home Placement Facility of crisis plan and member remains in group home

NurseWise

NW triages call

CMT dispatched to scene to assess
Person Can Be Stabilized at Out of Home Placement?

Yes
CMT completes crisis assessment & crisis plan

No
CMT consults with ICCA

ICCA recommends revocation?

No

Yes

CMT calls CRC intake coordinator at 520-301-2156 with brief case staffing including Name of ICCA doc granting revocation

CMT - ICCA

CRC completes internal paperwork documenting verbal revocation
CRC calls TPD Commander (520-791-5059) requesting LE for Verbal Revocation Transport

END

CRC

CRC responds with CMT member name and authorizing doc name

TPD - LE Communications

Commnu gathers: member name, location of pick up & authorizing (AMA revoking) doc name

Based on Jurisdiction, TPD Commnu will alert appropriate LE Agency / Sheriff’s Commnu

Law Enforcement

LE responds, verifies with CMT, member name and authorizing doc name

LE transports verbally revoked member to CRC
The Future: Cross County Development & Expansion

CIT
(Crisis Intervention Team)

MHFA
(Mental Health First Aid)

Co-Responder
(Clinicians in Cop Cars)

Treat and Refer
(first stop is the right stop)

For more info about the co-responder program:

Thursday 4PM Grand Ballroom F
Ripples in the Pond: Strategies for CIT and Co-Responder Program Expansion
The Crisis Response Center

- Built with Pima County bond funds in 2011 to provide an alternative to jail, ED, hospitals
  - 12,000 adults + 2,400 youth each year
- Law enforcement receiving center
- 24/7 urgent care, 23 hour observation, and short-term inpatient
- Space for community clinic staff
- Adjacent to
  - Crisis call center
  - Mental health court
  - Inpatient psych hospital for COE
  - Emergency Department (ED)
- Managed by Connections since 2014
- Licensed by Banner since 2015
The Crisis Response Center
“We address any behavioral health need at any time.”

• Referrals from:
  – Law enforcement
  – Crisis Mobile Teams
  – Walk-ins
  – Transfers from EDs
  – Foster Care

• Studies show this model:
  – Critical for pre-arrest diversion
  – Reduces ED boarding
  – Reduces hospitalization

CIT Recommendations for Mental Health Receiving Facilities

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
“It’s easier to get into heaven than a psychiatric facility.”
Low clinical barriers to access

• “No wrong door”
• We do our best to take everyone:
  – No such thing as “too agitated”
  – Can be highly intoxicated
  – Can be voluntary or involuntary
• Fewer medical exclusionary criteria than many inpatient psych hospitals
• Law enforcement is never turned away

Otherwise, where would these patients go?
The CRC provides safe environment where people can be under **continuous observation** and **lack the means** to hurt themselves or others, while being as comfortable and welcoming as possible.
Law Enforcement is a "Preferred Customer"

Gated Sally Port
Crisis Response Center, Tucson AZ
Easy access for law enforcement

Crisis Response Center
Tucson AZ
23-Hour Observation Unit

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

"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."
What should we be striving towards?

Values-Based Outcomes and Services

- Start by defining core values
- A Critical-to-Quality (CTQ) tree can be used to translate values into desired outcomes
- Then create processes that are designed to achieve these outcomes

Outcomes: Police Turnaround Time

Half of our patients arrive via law enforcement. They are an important customer and quick turnaround time is critical to providing a viable alternative to jail.

(Our Phoenix facility achieves similar results with twice the volume.)
## CRC Outcomes

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<thead>
<tr>
<th>Metric</th>
<th>Outcome</th>
<th>Relevance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Urgent Care Clinic: Door-to-Door</strong></td>
<td>&lt; 2 hours</td>
<td>Patients get their needs met quickly instead of going to an ED or allowing symptoms to worsen.</td>
</tr>
<tr>
<td><strong>Length of Stay</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>23-Hour Obs Unit: Door-to-Doctor Time</strong></td>
<td>&lt; 90 min</td>
<td>Treatment is started early, which results in higher likelihood of stabilization and less likelihood of assaults, injuries and restraints.</td>
</tr>
<tr>
<td><strong>23-Hour Obs Unit: Community Disposition Rate</strong></td>
<td>60-70%</td>
<td>Most patients are able to be discharged to less restrictive and less costly community-based care instead of inpatient admission.</td>
</tr>
<tr>
<td><strong>Law Enforcement Drop-Off Turnaround Time</strong></td>
<td>&lt; 10 min</td>
<td>If jail diversion is a goal, then police are our customer too and we must be quicker and easier to access than jail.</td>
</tr>
<tr>
<td><strong>Hours of Restraint Use per 1000 patient hours</strong></td>
<td>&lt; 0.15</td>
<td>Despite receiving highly acute patients directly from the field, our restraint rates are 75% below the Joint Commission national average for inpatient psychiatric units.</td>
</tr>
<tr>
<td><strong>Patient Satisfaction: Likelihood to Recommend</strong></td>
<td>&gt; 85%</td>
<td>Even though most patients are brought via law enforcement, most would recommend our services to friends or family.</td>
</tr>
</tbody>
</table>
The best measure of effective collaboration...
I don't often post about my job, but I can't resist sharing this story. Yesterday, my team received a judge's order to transport a 67 year old woman to a local mental health facility. We discovered that the woman was living in her car (which doesn't run) in a church parking lot for the last ten years. Every day, she works in the church garden and is generally self sufficient. When we met with her, my team was somewhat confused as to why this woman needed to be transported to a mental hospital, but with a judge's order, our hands were tied.

When we told the woman she had to go with us, she became very upset. Pointing to her car, she told us "my whole life is in that car." She just wouldn't leave her car, and we didn't blame her. We knew that she would likely stay in the hospital overnight, leaving her car vulnerable. After trying many other options, suddenly I realized: let's just bring her car with her to the hospital. Easier said than done, since the car didn't run and she had no money for a tow.

With a few phone calls, the Tucson community I love so much rallied to support this woman. Andrew Cooper and Shaun McClusky pointed me to Barnett's towing, who referred me to Gavin Mehrhoff, owner and operator of East Side towing. I talked to Gavin, and he quickly agreed, at NO cost, to tow the woman's car to the hospital, and when she's done there, tow it back to the church.

But the kindness didn't stop there. Working with the always awesome Doctor Margaret Balfour and the folks at ConnectionsAZ was amazing, not only did their hospital security team agree to watch the woman's car, they even promised to help find a room at the hospital where she could SEE her car.

When the woman saw what we had done, the relief in her face was obvious and she agreed to go with us to the hospital. I want to thank my team, especially Darrell Hussman and Todd for being so patient and compassionate, Margaret Balfour who runs the best crisis center in the country, and Gavin at East Side towing for making a small but critical difference in this woman's life. I love my job!
Questions?

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- margie.balfour@connectionshs.com
- Pknape@cenpatico.com