

THE NEXUS BETWEEN JAIL DIVERSION AND CRISIS SERVICES

A TTI SUMMARY REPORT

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INTRODUCTION

People with serious mental illness represent between 17–34% of justice involved individuals¹, many times the rate in the general population. The Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC) 2017 report to Congress noted that “Poor social supports, unemployment, comorbid medical problems, and addiction challenges abound. We have continued to defer to law enforcement services, criminal justice systems, hospital services, public education systems, and homeless services as the primary solutions, overtaxing these services and systems while contributing to poor outcomes such as unnecessary incarceration and long waits in hospital emergency departments”.² Racial and ethnic minorities are particularly hard hit. While people of color comprise 30 percent of the U.S. population, they constitute 57 percent of the prison population.³ Recent social movements calling attention to inequities in justice outcomes and behavioral health access have galvanized communities to find less injurious and more effective ways to improve public safety and public health for everyone, regardless of their neighborhood, socioeconomic status, gender identity, sexual orientation, race, or ethnicity.

Over the past 30 years, the courts, mental health, corrections, and law enforcement agencies have established programs to reduce the involvement of people with mental illness in the justice system. To facilitate common understanding among these groups and identify opportunities to intervene, Mark Munetz and Patty Griffin created the sequential intercept map⁴ (SIM) (Figure 1) that charts the flow of individuals from apprehension, through courts and corrections to community reentry. Hundreds of communities and many states have convened mental health agencies, law enforcement, and other stakeholders to map, design, and implement successful diversion programs using SIM. Specialized mental health courts, jail and pre-trial diversions proliferated as Congress authorized funding for jail diversion programs through SAMHSA and DOJ’s Bureau of Justice Assistance (BJA). Most communities applying for SAMHSA’s jail diversion grants in the early 2000s sought to establish diversion after arrest where candidates could be carefully screened, and court involvement could be used to manage risk and leverage compliance with ordered treatment. These interventions include post-arrest diversion, drug and mental health courts, prison or jail treatment services, re-entry programs, and community supervision.⁵

¹ U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. (2015). Screening and Assessment of Co-occurring Disorders in the Justice System. (HHS Publication No. PEP19-SCREEN-CODJS). Rockville, MD: Substance Abuse and Mental Health Services Administration.

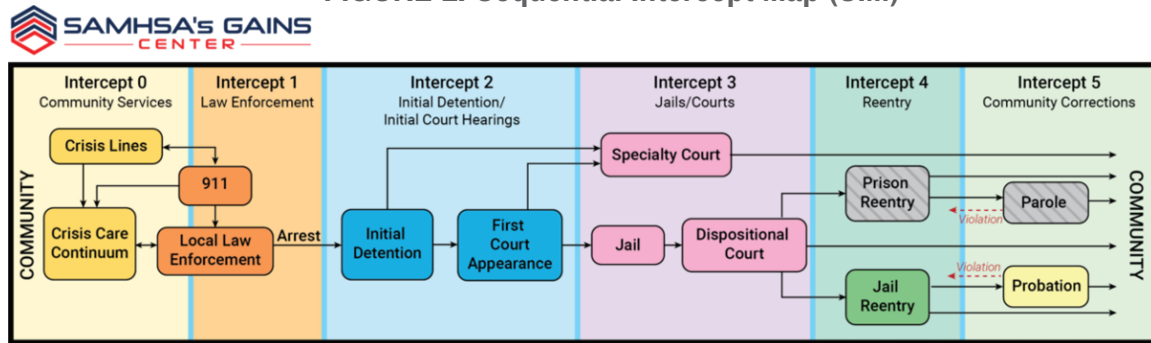
² U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. (2017). The Way Forward: Federal Action for a System That Works for All People Living with SMI and SED and Their Families and Caregivers – Full Report (HHS Publication No. PEP17-ISMICC-RTC). Rockville, MD: Substance Abuse and Mental Health Services Administration

³ U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. Office of Minority Health, Justice, and Health Initiatives <https://www.minorityhealth.hhs.gov/omh/Content.aspx?ID=11383&lvl=2&lvlid=12>

⁴ Munetz, M.R., & Griffin, P.A. (2006). Use of the Sequential Intercept Model as an approach to decriminalization of people with serious mental illness. *Psychiatric Services*, 57(4), 544–549.

⁵ Pfefferle, S., Steverman, S., Gault, E., Karon, S., and Swan, H. 2019. US Department of Health and Human Services, Assistant Secretary for Planning and Evaluation. Approaches to early jail diversion: Collaborations and innovations. https://aspe.hhs.gov/sites/default/files/migrated_legacy_files/190131/EarlyJail.pdf

FIGURE 1: Sequential Intercept Map (SIM)



Abreu, D., Parker, T. W., Noether, C. D., Steadman, H. J., & Case, B. (2017). Revising the paradigm for jail diversion for people with mental and substance use disorders: Intercept 0. *Behavioral Sciences & the Law*, 35(5-6), 380-395. <https://doi.org/10.1002/bsl.2300>
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With some exceptions crisis response and jail diversion programs are conducted by local mental health, law enforcement, and corrections agencies and courts. States support diversion efforts by convening partners, enabling legislation, policy and funding initiatives, training provision, and securing federal funding through grants and waivers. A recent survey of states⁶ by the NASMHPD Research Institute (NRI) reported that 37 states have crisis response services such as crisis intervention teams and embedded co-responders within a local law enforcement agency; 36 have mental health courts; and 31 support reentry programs for individuals returning to the community from jail (community) or prison (state).

Behavioral health emergencies make up 5-15% of 911 calls.⁷ Whether it is due to a concern for public safety or a lack of behavioral health resources, law enforcement is most often dispatched to 911 behavioral health calls. Behavioral health conditions are not always immediately apparent when police are summoned or encounter suspicious behavior, particularly in cases that threaten one's

sense of safety – the isolated senior calls law enforcement to complain about being followed, the shop owner calls law enforcement to report a destitute man loitering outside the store and upsetting customers, or a driver calls to report a car driven erratically down the road (by a veteran with PTSD). In each instance, police are the first responders. Encounters often lead to arrest⁸ and in worst-cases, become volatile and sometimes turn tragic. Individuals in emotional crises accounted for approximately a quarter of all fatal police shootings nationwide during 2015.⁹

To improve the outcomes of these encounters, police departments have established Crisis Intervention Teams (CIT) programs that involve building strong relationships between public safety and mental health agencies and specialized training for law enforcement officers. SAMHSA's Early Diversion grants and BJA's Justice and Mental Health Collaboration program attest to a national movement towards avoiding arrest and transferring individuals with mental illness from law enforcement to behavioral health agencies. In 2018, SAMHSA's GAINS Center added the "Intercept 0" to the SIM map, signifying

⁶NRI. 2021. Criminal Justice Diversion Programs For justice-involved Adults with Mental Illnesses, November 2021. Retrieved from <https://www.nri-inc.org/our-work/nri-reports/criminal-justice-diversion-programs-for-justice-involved-adults-with-mental-illnesses-november-2021/>

⁷Cited in Balfour, M.E., Hahn Stephenson, A., Winsky, J., & Goldman, M.L. (2020). Cops, Clinicians, or Both? Collaborative Approaches to Responding to Behavioral Health Emergencies. Alexandria, VA: National Association of State Mental Health Program Directors. from page 6

⁸U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. (2020) Executive Order Safe Policing for Safe Communities: Addressing Mental Health, Homelessness, and Addiction Report. Rockville, MD: Substance Abuse and Mental Health Services Administration. <https://www.samhsa.gov/sites/default/files/safe-policing-safe-communities-report.pdf>

⁹Kindy K, Elliott K: 990 people were shot and killed by police this year: here's what we learned. *Washington Post*, Dec 26, 2015. <https://www.washingtonpost.com/graphics/national/police-shootings-year-end/>

preventive measures to justice involvement through a comprehensive crisis care system.

When law enforcement officers suspect a behavioral health disorder, they may transport the individual to a hospital emergency department to await an inpatient bed for hours, days, even weeks.¹⁰ A statewide study of North Carolina Emergency Department data for adults from 2009 to 2016 estimated the police transport to hospital rates by primary diagnoses and compared county transport rates by rurality. Of the patients transported by law enforcement during the study period, 43.1% had a mental health diagnosis and 22% of all visits were for involuntary commitments. The median transport rate in rural counties was 2 times that of large metro counties.¹¹

As the country advances towards a nationwide 988 crisis call line, state behavioral health agencies are taking advantage of this unprecedented opportunity to revisit programs that are designed to help people resolve behavioral health crises and reduce the involvement of law enforcement. Funding through Substance Abuse and Mental Health Services Administration's (SAMHSA) block grant set aside, the American Rescue Plan, as well as 988 Planning grants, have provided the resources to support a shift from repressive detentions whether in a holding cell or a hospital emergency department to less intrusive and disruptive community-based crisis care. This is an enormous task that requires not only reorganizing and building crisis response infrastructure but revising how society defines and reacts to behavioral health emergencies.

When is a behavioral health crisis a public safety concern? How are states and communities redesigning crisis systems? The projects described in this report represent a small sample of the

variety of efforts at state and local levels to reduce justice involvement and improve access to crisis care for people with SMI without sacrificing public safety.

SAMHSA'S TRANSFORMATION TRANSFER INITIATIVE

To assist states in transforming their mental health systems of care, the Substance Abuse and Mental Health Service Administration (SAMHSA) and its Center for Mental Health Services (CMHS) created the Transformation Transfer Initiative (TTI). The TTI provides, on a competitive basis, flexible funding awards to states, territories, and the District of Columbia (DC) to strengthen innovative programs. Through the National Association of State Mental Health Program Directors (NASMHPD), CMHS approved 40 awards of \$150,000 to 28 states, territories, and DC under three topics:

- **Bed Registries** – to establish and expand comprehensive crisis psychiatric bed registry programs;
- **Diversion from Jail** – to use the SAMHSA's 2020 National Guidelines for Crisis Care – A Best Practice Toolkit¹² as a model of comprehensive crisis care to develop or expand state or territorial diversion programs;
- **Improving Mental Health Services within Jails** – to expand or develop better services within correctional facilities and enhance their coordination between behind the walls treatment and transitioning back into the community.

¹⁰ U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. (2020) Executive Order Safe Policing for Safe Communities: Addressing Mental Health, Homelessness, and Addiction Report. Rockville, MD: Substance Abuse and Mental Health Services Administration.

¹¹ Rosen DL, Travers D. Emergency department visits among patients transported by law enforcement officers. *PLoS One* 2021;16: e0244679.

¹² SAMHSA. (2020). National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit. Retrieved from <https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf>

NASMHPD supported TTI projects throughout their implementation and expansion efforts with technical assistance. Due to its expertise, NRI provided technical assistance to projects involving bed registries and jail diversion and prepared brief descriptions of their projects. This report describes projects to develop or expand diversion from jail.

SUMMARY OF TTI JAIL DIVERSION PROJECTS

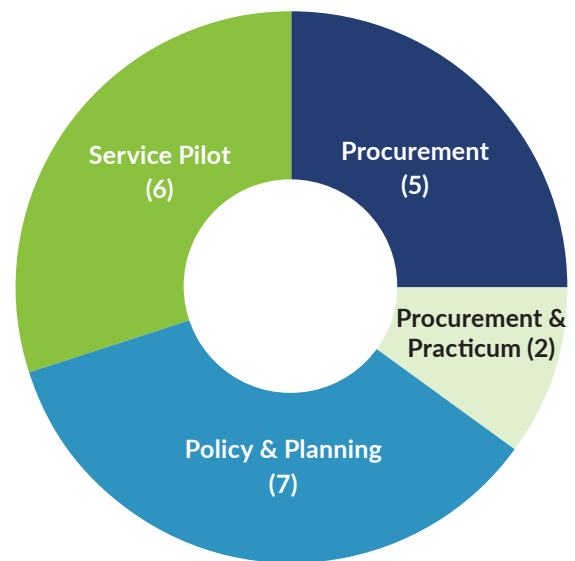
During the spring of 2022, NRI interviewed directors of the 20 projects funded for diversion from jail to prepare brief descriptions of each project that follow this summary. The brief descriptions were used to summarize commonalities and differences in how projects used TTI funds to help states and communities to reduce the justice involvement of people with serious mental illness and engage them into treatment.

How were TTI Funds Used?

Projects used TTI funds in a variety of ways, mainly to produce training programs and surveys of technical assistance needs, to support planning and policy development and to deliver services. Half of the projects involved introducing or expanding peer support services in forensic and crisis services.

- **Service Pilots:** Five of the six service pilots featured the introduction of peer services for diversion efforts in mobile crisis teams or at crisis stabilization units. One projects focused on pre-trial diversion.
- **Procurement:** Three of five projects procured training (one for peers, one for 911 dispatchers, and one for police officers). One project equipped a short term Crisis

FIGURE 2: TTI Funding Use



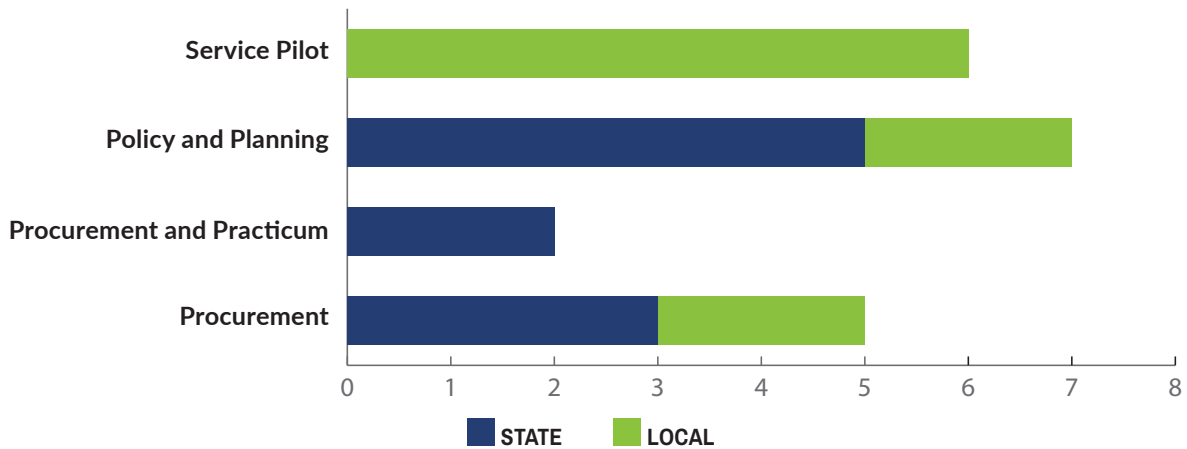
Stabilization Unit (CSU) and one project purchased consultation for system design.

- **Procurement and Practicum:** Two project developed training for peers to deliver crisis and forensic peer support and provided practicums in crisis settings.
- **Policy and Planning:** Six projects used TTI funds to launch or expand existing stakeholder groups to develop policies and improve coordination and delivery of crisis services and/or prevent or reduce SMI justice involvement. One of the projects reserved positions in a state behavioral health agency to assist in coordinating Community Forensic Liaison Teams (CFLT) in each of the six regions of the state.

Statewide or Local?

With this funding opportunity, states were able to bring together public safety and public health agencies to collaborate on how best to redirect individuals in crisis from potential justice system involvement to behavioral health recovery and support services. Half (50%) of the projects were conducted statewide. Projects conducted at the local level were often used to pilot the

FIGURE 3: Location of Funds Used



implementation of new services, such as the use of peer support in crisis and justice settings.

- Six service pilots were conducted in municipalities including one in which state police officers diverted individuals in specific municipalities they were responsible to patrol.
- Five policy and planning projects were statewide and two funded the development of community oversight boards.
- Two procurement and practicum projects were executed at the state level with practicums supervised in community settings.
- Three procurements for training, technical assistance surveys, and/or policy development were statewide. One procurement equipped a local CSU and one provided local training.

How Did Crisis Services and Jail Diversion Interface?

TTI projects reflected the transition from sole dependence on law enforcement to the collaboration with mental health agencies to

respond to behavioral health crisis calls and encounters. Projects included diverting 911 calls from police response, coordinating and expanding the use of mobile crisis teams and crisis stabilization units, and engaging individuals in post crisis care. In the course of their work, law enforcement officers may engage different components of the mental health system including outpatient, mobile crisis teams and crisis stabilization units. Likewise, clinician and peers may come in contact with multiple components of the justice system including CIT training, co-responding to 911 calls with law enforcement, and embedded roles in jail and courts and reentry support. Based on its primary objective, each project was assigned to a sequential intercept and crisis intervention. The assignments were superimposed on a graphic representation of a comprehensive crisis system found in Balfour et al.¹³ The number of each type of TTI project is superimposed in the figure on the next page.

- Two projects were mainly focused on directing crisis calls to behavioral health agencies to access treatment more quickly. One was a 911 dispatcher training and the other a statewide call system redesign.

¹³ Balfour, M.E., Hahn Stephenson, A., Winsky, J., & Goldman, M.L. (2020). Cops, Clinicians, or Both? Collaborative Approaches to Responding to Behavioral Health Emergencies. Alexandria, VA: National Association of State Mental Health Program Directors. from page 6.

**FIGURE 4: TTI Funded Projects:
Crisis System and Diversion Nexus**

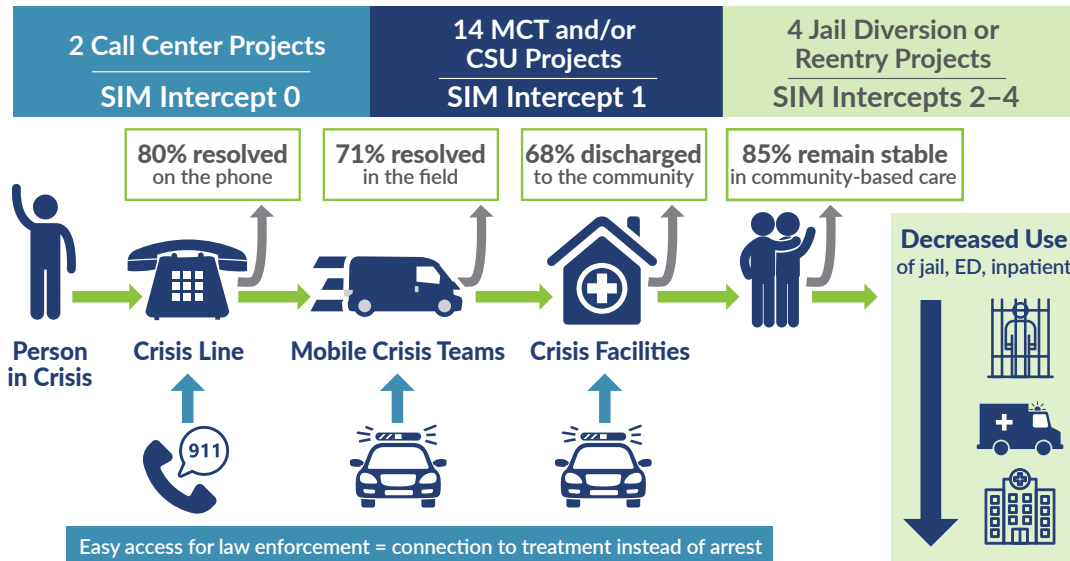


Figure 4 adapted from Balfour, et. al 2020

- Four projects delivered support and post crisis wrap around care. One project created a pretrial diversion program, one project supported reentry, one project established a municipal criminal justice coordinating council, and one project enabled policy and legislative fixes to improve competency evaluation and restoration processes.
- Most (14) of the TTI funded projects focused on services at the point of crisis and collaboration between law enforcement and mental health agencies. Two funded training and technical assistance for law enforcement; five service pilots expanded mobile crisis teams (MCTs) and crisis stabilization units (CSUs) including peer support, two focused on peer training and services, and four were policy and planning processes at local or state levels. While the principal focus is to deliver services at the point of crisis, MCTs and CSUs, particularly peer staff, continue to provide engagement through post crisis care.

What Data Were Collected?

Of 12 projects that supported training, policy, and planning, five collected no data, two collected data on training participation, one collected survey results, and four are collecting data on the impact of infrastructure funding.

- New York’s TTI based in a suburban county reported that as a result of dispatcher training, calls diverted from 911 to call centers have tripled from 6 in December 2021 when the project was implemented to 19 in March 2022.
- Delaware reported that because of state police diversions, mental health teams were able to make contact with about half (51%) of the people referred and more than half (57%) of those contacted (23% of total referrals) agreed to engage with the care managers. Most (89%) of those who engaged (20% of total referrals) enrolled in treatment.
- New Jersey reported that 13 consumers were screened and released from a crisis

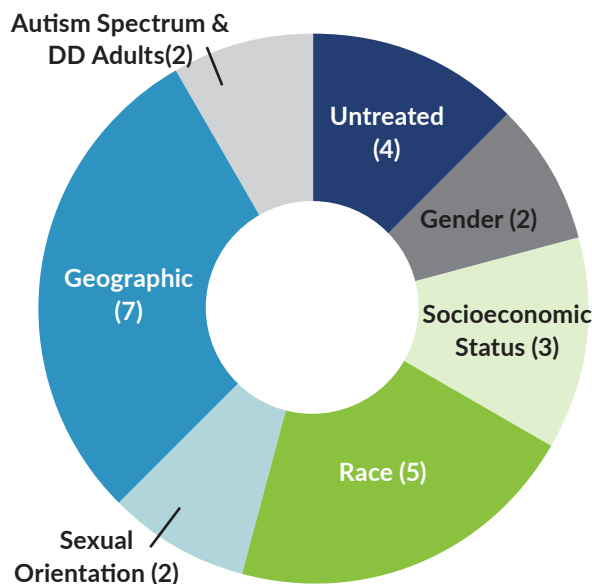
center with follow-up support by the crisis peer support specialist (CPS) and 4 of them were successfully linked to mental health and support services. CPS made three contacts in the emergency department/medical floor of local hospitals. • From March 2021 through June 2022, the Oklahoma County Jail project has screened 1960 defendants and while many of their cases are awaiting disposition, 796 have been diverted from prison to participate in some level of programming and 34 cases have been dismissed.

How Did Projects Improve Behavioral Health Equity?

A major factor driving behavioral health calls that involve law enforcement is untreated behavioral health conditions. More than a third

(35%) of adults with SMI do not receive mental health treatment. This rate is even higher, at 42%, among young adults, aged 18–24.¹⁴ A key component of every project funded under TTI was the recognition that crisis response must not only assist individuals to resolve crises but reduce their recurrence by improving access to behavioral health care. Although applicants for TTI awards were not required to specify disadvantaged groups, projects were motivated to improve behavioral health equity for subsets of state populations. Behavioral health equity is defined as “the right to access quality health care for all populations regardless of the individual’s race, ethnicity, gender, socioeconomic status, sexual orientation, or geographical location. This includes access to prevention, treatment, and recovery services for mental and substance use disorders.” <https://www.samhsa.gov/behavioral-health-equity>.

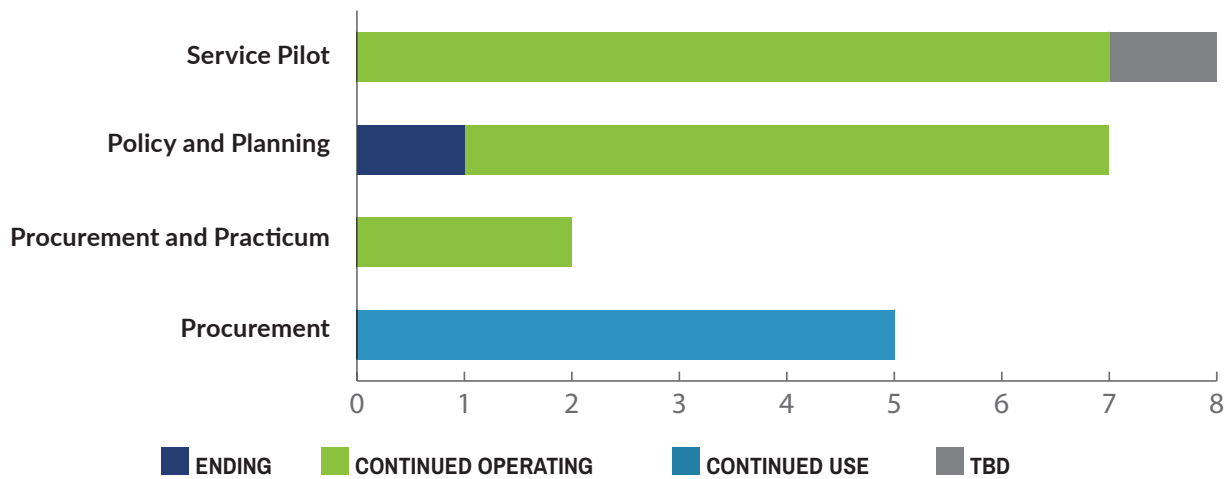
FIGURE 5: Reducing Barriers to Health Equity



Project directors identified one or more populations that would benefit from their projects. As illustrated in Figure 5, projects most commonly sought to overcome geographic barriers to quality crisis care whether they were in poor inner-city neighborhoods or rural parts of the state. Many project directors cited racial, ethnic, gender, and socioeconomic impediments to care. Several introduced services including peer support into crisis services to engage individuals who had rejected treatment in the past. Recognizing the over-representation of people with developmental disabilities in justice systems, some projects invited representative participation in planning and service delivery and purchased special equipment for crisis stabilization. Projects also partnered with agencies that specialized in behavioral health treatment to ensure access to quality care for ethnic and LGBTQ+ populations.

¹⁴ U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (2021). Key substance use and mental health indicators in the United States: Results from the 2020 National Survey on Drug Use and Health (HHS Publication No. PEP21-07-01-003, NSDUH Series H-56). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. Retrieved from <https://www.samhsa.gov/data/>.

FIGURE 6: Project Sustainment



Will Services And Products Continue After TTI Funds End?

Nearly all the projects will be sustained after TTI funding ends as illustrated in Figure 6. Excluding procurements, 87% of the policy and planning groups and service pilots report that they will continue operating after TTI funds have been expended.

SERVICE PILOTS: Funding has been secured to continue seven of the eight service pilots after TTI funding ends. One state is waiting to gather more data (listed as TBD in Figure 6) before recommending that the state continue funding.

POLICY AND PLANNING: Policy and planning projects will continue after TTI funding ends for six of seven policy and planning projects that were established using TTI funds. These include a wide array of planning efforts: a learning collaborative of crisis stabilization centers, a statewide technical assistance center, a statewide crisis system design group of stakeholders, a citywide justice coordinating council, and a neighborhood citizens’ accountability board. The policy positions reserved for peers at one state mental health agency were not expected to be funded after TTI funds are expended.

PROCUREMENT AND PRACTICUM: Two projects combined procurement of training modules with funded service practicums for forensic peer support services. The training modules were completed and are made available to peer staff in their states. The field practicums will continue to be funded after TTI funding ends.

PROCUREMENT: All five of the products planned for procurement were completed and will continue to be used. One of the procurements equipped a short-term crisis stabilization unit, one project purchased consultation for system design, one created a virtual training module for peer support, one created a decision tree and training module for 911 dispatchers, and one procured CIT training for officers and Train the Trainer certification for CIT officers.

What Impact Have TTI Projects Had on Systems?

States used TTI funds in a variety of innovative ways to improve crisis response and minimize justice involvement. They come at a time in which communities want to move away from their reliance on law enforcement, courts,

and corrections to deal with behavioral health crises and their aftermath. TTI projects provide state agencies with a flexible tool to import and implement best practices; experiment with new solutions; and convene current and new stakeholders to develop policies and standards that are needed to shepherd emerging programs, practices, and technologies. This round of TTI projects:

- Piloted innovative practices and introduced peer support services in crisis and jail diversion services;
- Established statewide consortia to design new approaches to crisis services, competency evaluation and restoration, and technical assistance to police;
- Supported local consortia to design and oversee community-based diversion and crisis response systems;
- Supported training for law enforcement officers and 911 dispatchers; and
- Created training and practicums for peers to specialize in crisis and forensic services.

Products developed with TTI funding that are available to others are accessible as attachments or electronically through hyperlinks in project briefs.

Common Themes

EARLY ENGAGEMENT OF STAKEHOLDERS.

Directors of both planning and service projects most often cited the development of a strong relationship between mental health and law enforcement agencies as critical to their success. Despite different roles and responsibilities, these agencies recognized their common aim to build and support healthy and safe communities. Their continuing and meaningful engagement prepared

them to take advantage of opportunities, such as TTI funding, to improve community response to individuals experiencing a behavioral health crisis. This is such an important factor that one state based its selection of diversion sites on the strength of pre-existing relationship between agencies evidenced by the number of law enforcement CIT referrals to treatment that mental health agencies had received.

ORGANIZATION EMPATHY. Statewide projects to establish training and technical assistance recognized that to truly engage, they must empathize with the demands and frustrations of the organizational members with which they work. Surveys of law enforcement officers, for example, that were co-designed by mental health and law enforcement leaders and endorsed by their associations, not only yielded a high response rate, but more honest appraisals of barriers to diversion.

PEER SUPPORT IN CRISIS AND DIVERSION SERVICES.

Peer support services played a prominent role in most of the TTI projects and may account in part for projects' success and sustainability. In most projects, peers were relied upon to reach out and provide follow-up care after crises have been resolved because of their remarkable ability to engage individuals in treatment. Peers interviewed for this report indicated that they experienced little or no stigma from clinicians with whom they worked or from law enforcement officers they encountered when co-responding to crisis calls. They cited instances, for example, in which officers sought their input and made no distinction between clinicians and peers. Unfortunately, as demand increases for peer support, availability appears to be lagging. Many projects cited difficulty in recruiting peer support staff as contributing to delays in project implementation.

Vision

In 2020, the Alabama Legislature appropriated substantial state funds to begin a crisis system redesign to include crisis diversion centers; rural mobile crisis teams (mobile crisis services); and the Alabama Stepping Up Initiative (jail diversion and community engagement) which will continue expansion efforts into all 67 counties over the next two years with state and local matching funds. The vision driving this effort is to significantly reduce the number of people with behavioral health disorders in jail and incidents of housing in hospital emergency departments while waiting for care. Alabama Department of Mental Health (ADMH) adopted SAMHSA's National Guidelines for Behavioral Health Crisis Care; Best Practice Toolkit as its model for crisis redesign of infrastructure, settings, and policies and to coordinate fragmented services. ADMH brought together stakeholders including policy makers, members of the 9-8-8 Study Commission (created in Act 2021-359), health officials, state Medicaid, provider organizations, law enforcement and emergency medical technicians, Lifeline operators, NAMI – Alabama, Recovery Networks, and emergency management services (911) to collaborate on its crisis system redesign.

Jail Diversion Approach

Alabama's Crisis System of Care approach includes the development of a Crisis Center in every region of the state. These crisis intervention and stabilization centers are for individuals in crisis, with an average length of stay less than 24 hours and no longer than 7 days. Crisis centers are staffed by an array of mental health and medical clinicians who provide

FIGURE 7: Alabama Crisis System of Care



first responders with an alternative to arrest and incarceration or the emergency room for individuals in behavioral health crisis. Each Crisis Center serves as the hub of crisis care for its region.

Measuring Progress

There are limited data being collected currently as the crisis centers develop. One measure involves police wait times when they transport an individual to the crisis center. They examine other data, such as length of stay, to determine how best to deploy staff and resources. Other measures will be standardized as ADMH develops a data dashboard.

Integration With Crisis System

Crisis Centers coordinate crisis services for their regions. By contract with the state, each Crisis

“All of these initiatives are interrelated and their stakeholders are often the same people. Networking has got us thinking outside the box.”

—Anthony Reynolds, Crisis Care Program Director

Center must detail how it will work with mobile crisis teams, hospital emergency departments, emergency medical technicians, and law enforcement. Two current lifeline call providers, along with newly onboarded lifeline call providers, will become the state’s 988 call centers in July 2022. The determination of the primary and back-up call takers will be determined at the regional level through established agreements.

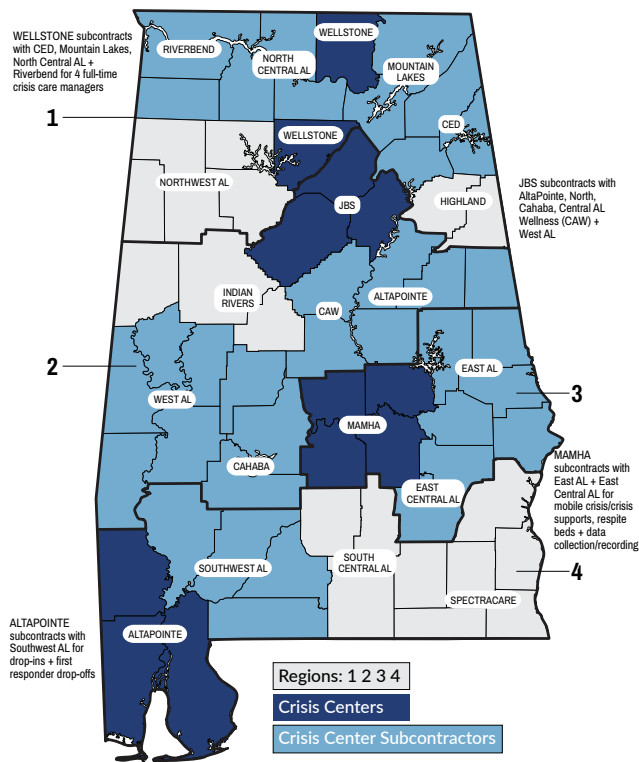
Behavioral Health Equity

ADMH is committed to integrating every community into its statewide crisis system of care to ensure equal access to “right care, right time, right place” including in rural communities. Crisis Centers are the service hubs in each of their respective regions, coordinating crisis care with mobile crisis teams and case managers in communities through either written agreements or subcontracts. Community Mental Health Centers (see Figure 8) are in the process of developing and incorporating mobile crisis teams, which may include a co-response with law enforcement and emergency medical personnel, crisis peer support, crisis case management, regional call centers, and respite options.

Project Legacy

The result of this project has been the formulation of a crisis system design that integrates 988 crisis call centers. The crisis system provides individuals with alternatives to long waits in hospital emergency departments or involvement in the justice system when they are undergoing a behavioral health crisis.

FIGURE 8: Map of State Crisis Coverage



What Has the Crisis System Redesign Process Taught Us?

Staff recognize that many of the participants on the 988 Study Commission were involved in similar initiatives such as the 988 State Implementation Coalition that seek to bring about a new and more comprehensive vision of the crisis system, including how services can be sustained. The group was particularly useful in understanding the diversity of rural and underserved communities. In part, because of their input, crisis centers have some flexibility in how they engage mobile crisis teams, coordinate with law enforcement, and deploy staff.

For further information about this project, contact Ada Katherine van Wyhe at ada.wyhe@mh.alabama.gov.

CONNECTICUT

Vision

The vision of the enhanced mobile crisis team project is to provide more accessibility to police responding to calls involving individuals who are in crisis. In 2020, Connecticut passed the Police Accountability Bill that permitted law enforcement officers to be sued for injury endured during “use of force” and required police departments to study the feasibility of using social workers in some capacity to respond to mental health calls. The Bill sparked conversations between police and mental health agencies to collaborate on new approaches to reduce hospitalizations and arrests involving people with behavioral health disorders. The Sequential Intercept Map’s Intercept “0” outlines strategies for collaboration between mental health clinics and law enforcement agencies to prevent justice involvement. What began as a conversation between the East Haven police chief, BHcare (the local mental health authority of six shoreline communities), and the Connecticut Department of Mental Health and Addiction Services (DMHAS) led to submission and award of this TTI funded project.

Jail Diversion Approach

With TTI funding, BHcare’s existing Mobile Crisis Team expanded services to 24/7 coverage, enhanced after hours clinical care, and added video conferencing by smart phone available to law enforcement officers. When a police officer encounters an individual in a behavioral health crisis, officers can use this feature to facilitate a virtual crisis assessment between the individual and the mobile crisis team. The officer can also directly consult with the mobile crisis team. DMHAS anticipates that police will spend less

time responding to behavioral health calls and arrest fewer people in a behavioral health crisis.

Measuring Progress

The project was launched in November 2020 and has collected data on a number of important outcomes including:

- ▶ Diversions from jail;
- ▶ Diversion from hospitalization;
- ▶ Time spent by officers responding to calls;
- ▶ Recidivism and incarceration rates;
- ▶ Persons outreached and engaged in treatment;
- ▶ Number/types of services provided;
- ▶ Number of repeat calls to the same location;
- ▶ Trust between law enforcement and mental health crisis team.

In addition to these outcome data, both mobile crisis teams and police officers are automatically prompted to complete a brief survey about their perception of the project when they submit case reports on the behavioral health call response. Data is expected to be analyzed during 2022.

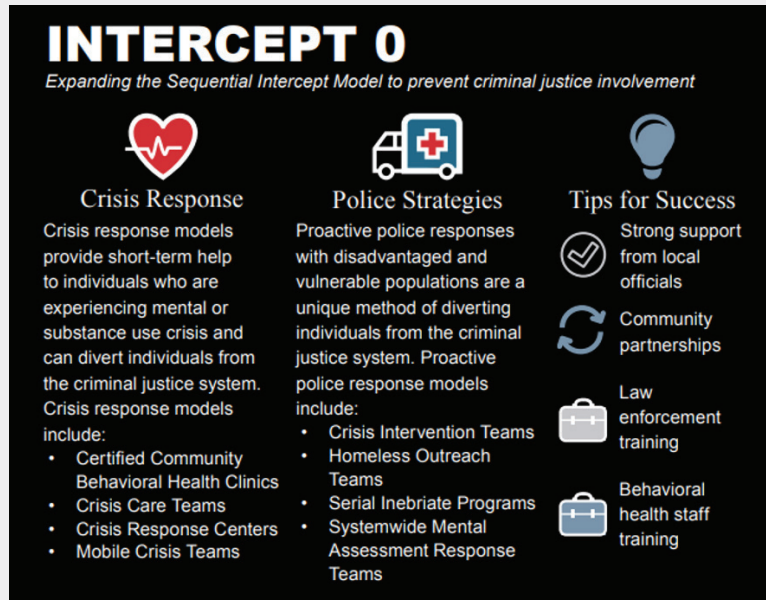
Integration With Crisis System

Connecticut employs a “no wrong door” approach to crisis calls. The United Way operates the state’s

“Monthly meetings between police and clinicians have been helpful in processing interactions, making improvements and clarifying roles in responding to behavioral health crises.”

—Dana Begin, Project Director

FIGURE 9: (From the) SAMHSA Sequential Intercept Map Brochure



211 information line, the ACTION line (the centralized call center for adults in crisis) and is a National Suicide Prevention Lifeline provider, soon to become the 988 call center for the state. Calls are screened and appropriately routed to an adult Mobile Crisis team for clinical assessment and a mobile in-person response as needed. Callers requiring further assistance are referred to the mobile crisis teams in the callers' vicinity. Connecticut has two publicly accessible crisis bed registries that include treatment beds for mental health and addiction services. There are currently no crisis stabilization settings in the state. Locally, the project benefits from integration with police departments in the area. Police departments and the mobile crisis team meet monthly to address problems and find solutions.

Behavioral Health Equity

Crisis care is not simply a “one and done” event and is a critical portal to recovery. The project intends to collect data on gender, race, and ethnicity.

Project Legacy

This is a pilot project among many different models of police and mental health collaboration

across the state. The enhanced elements of the project, including telephonic connectivity with police and the availability of clinical staff 24/7, are likely to be maintained after TTI funding is expended.

What Has an Enhanced Mobile Crisis Team Taught Us?

After years of calling on mobile crisis teams mainly to evaluate individuals who are in acute crisis and in need of hospitalization, police officers need training, encouragement, and positive experiences to fully utilize the telephonic and in-person resources of an enhanced mobile crisis team. Monthly meetings between police departments and mobile crisis teams are an effective way to improve relationships between the two agencies and resolve problems.

For further information on this project, contact **Dana Begin, Director of Evidence-Based Practices and Grants**, at Dana.begin@ct.gov.

Vision

State police were frustrated that many of the people they encountered had an untreated substance use or mental health condition. These encounters often resulted in continuing a cycle of arrest and incarceration. Working with state police and the state attorney general's office, the Division of Substance Abuse and Mental Health braided funds from a State Opioid Response grant and a TTI award to launch a pre-arrest diversion program with the goal of providing another gateway to behavioral health care when the individual is most in need and most open to accepting it. Three of nine state troops (districts) participated in this initiative as pilot sites.

Initially, officers could refer individuals suspected of committing certain low-level offenses to treatment as an alternative to arrest and incarceration. A handful of misdemeanor crimes were pre-approved by the attorney general's office for consideration under this program. Individuals who agree to the terms of the program are referred to on-site two-person team consisting of a clinician and a peer who can receive warm handoffs during business hours or visit the individual the next business day.

As officers became more familiar with the program, they have referred other individuals that they encounter who need treatment regardless of arrest status.

Jail Diversion Approach

Police often want to deflect or divert individuals to treatment because arrest and detention take officers away from their duties to monitor and ensure public safety. Repeatedly arresting and

“Adding peer support was the secret sauce to make the program successful.”

—Glenn Owens, Director of Crisis Intervention Services, Division of Substance Abuse and Mental Health (DSAMH)

detaining the same person with a behavioral health disorder may seem futile and does little to improve public safety and wellbeing. Police diversion practices can prevent justice involvement and may reduce the number of people with behavioral health disorders in jail.

Measuring Progress

Data collection was planned before the program began one year ago. The program expanded from a pre-arrest diversion model to one that supports police to refer anyone they encounter who might need behavioral health treatment. Participating troopers now commonly refer individuals that they encounter who have survived an opioid overdose (“defined as “overdose response”) or those they encounter during other types of calls, such as domestic disturbances (defined as “social contact/co-occurring mental health). Police have also referred several individuals that they did arrest but met the criteria to be diverted to care managers. Approximately one year since the program launch, state police have made 784 referrals to the case managers; pre-arrest diversion cases made up only .3% of these referrals, overdose response 25%, and social contact 75% of these referrals.

The team were able to make contact with about half (51%) of the people referred and more than

half of them (57% of those contacted, 23% of total referrals) agreed to engage with the care managers. Most of those who engaged (89% of those engaged, 20% of total referrals) enrolled in treatment.

Integration With Crisis System

This project is operated by DSAMH in collaboration with its Crisis Intervention Services and fills a void for police to refer individuals who may have a behavioral health disorder but do not need immediate crisis treatment. Participation in the program may prevent crises by engaging individuals in treatment as early as possible. Police contact mobile crisis teams or escort individuals to crisis stabilization units when they encounter individuals in need of crisis care.

Behavioral Health Equity

Over- or under-representation by race and ethnicity is difficult to characterize because the referrals were limited to the people that police encounter. 68% of referrals were male, 32% were female, 64% were white (69% in 2020 Census), 21% (22% in 2020 Census) were black and 15% were other. The majority of the referrals were for adults between the ages of 26–45 (60%), with smaller percentages for those aged 18–25 (10%), 46–55 (17%) and over 55 (13%). Due to data collection efforts, the program can track referral rates by gender, race, and age, by troop location, and observe them over time for trends.

Project Legacy

The project will continue using blended funding from the Delaware Criminal Justice Council and State Opioid Response grants. As officer and commander confidence has grown, the project has expanded from three troop districts to six in 2022.

What Can Delaware's Pre-Arrest Police Diversion Program Teach Us?

While there are administrative hurdles to hiring peer support staff with criminal justice involvement histories, their lived experience in the justice system carries credibility to consumers who are involved or at risk of involvement. Officers have expressed their surprise and admiration for peers that they once knew as troubled that have become case managers and able to persuade individuals to engage in treatment. The success of the project can be attributed to the early partnership among DSAMH, Delaware State Police and the Department of Justice. Each partner saw value in the program to give officers another tool to improve public safety and DSAMH another portal to engage people into treatment. The trust developed between partners allowed the program the flexibility to expand referrals and reach more people in need of treatment.

For further information about this project contact Rick Urey at Richard.urey@delaware.gov.

Vision

The Department of Children and Families' Office of Substance Abuse and Mental Health (SAMH) coordinates Community Forensic Liaison Teams (CFLT) in each of the six regions of the state. Teams are responsible for improving regional outcomes for adults with behavioral health conditions that are justice involved, reducing health and social disparities, and strengthening collaboration between mental health and justice systems. While peers are involved in providing direct services in their respective regions, peer voice has been missing at the state level. SAMH used TTI funds to hire three persons with lived experience to participate in regional and statewide coordination, problem solving, development of standards and policies, and training and technical assistance. Figure 10 underscores the collaboration required by all stakeholders, including persons with lived experience, in developing successful jail diversion approaches.

Jail Diversion Approach

Forensic peer liaisons working within the SAMH Community Forensic Liaison program provide oversight to SAMH's forensic community-based systems of care that impact all points of intercept including diversion and reentry in the state. Forensic peer liaisons were assigned to:

- Assume a leadership role in the newly formed Statewide Forensic Peer Specialist Workgroup.
- Develop statewide specialized curriculum for Forensic Peer Specialist certification.

“Peers bring a fresh perspective to solving old problems.”

—Leah Compton, former Project Director

- Work with the Florida Certification Board to adapt specialized Forensic Peer Specialist curriculum for certification.
- Develop and deliver statewide training specifically for peer specialists working with law enforcement crisis intervention teams, state hospitals, emergency rooms, jails/prisons, courts/specialty courts, mental health providers, and other community settings.
- Develop inventory tool/database and track Forensic Peer Specialists specifically working in the criminal justice/behavioral health/substance abuse field.
- Develop a statewide strategy to enhance Forensic Peer Specialist networking, training, support, and collaboration.

Measuring Progress

Three peers were hired as forensic peer liaisons and assumed leadership of the Statewide Forensic Peer Specialist Workgroup. The COVID-19 Pandemic shifted duties from their planned assignments as states scrambled to implement risk reduction measures and deal with reduced capacity at state facilities. Forensic peer liaisons assisted by case managing the backlog of forensic patients (those hospitalized for competency restoration and Not Guilty by Reason of Insanity status) in state hospitals awaiting release. During this period, they also

FIGURE 10: Collaboration is Key to Successful Jail Diversion Programs



developed a forensic peer specialist training curriculum that was piloted and approved. The training will be conducted on a quarterly basis.

Integration With Crisis System

SAMH Community Forensic Liaisons did not provide direct services.

Behavioral Health Equity

Due to Department prohibitions against employing individuals with arrest histories, peers with justice system lived experience could not be

hired. Although every effort was made to recruit peers of color, none were available to hire. The positions paid \$38,000 (plus \$10,400 in benefits) placing them within second quartile of average salaries in Florida.

Project Legacy

Although they demonstrated their flexibility and value to maintaining essential services during the Pandemic, forensic peer liaisons were re-assigned from their primary mission for much of the TTI funding period. The legacy of their involvement in policy development is still being shaped. Ongoing funding for the positions has not been identified.

What Has Bringing Peer Voice to State Coordination Of Forensic Services Taught Us?

While hiring peers into state agency policy positions is not an uncommon or radical act, it is still subject to misunderstanding and the political exigencies and priorities of changing government administrations. Creating opportunities for staff to know and work with peers can change attitudes and make more permanent reforms possible.

For more information on this project, contact Asta Trinh at asta.trinh@myffamilies.com.

Vision

Despite large expenditures of funds on correctional services in Hawaii, recidivism remains high. About two thirds of persons who serve their maximum sentence recidivate, and nearly one in ten of them reoffend within two years. Hawaii has been developing resources to increase peers (people with lived experience with mental illness and/or substance abuse) to work in correctional and justice settings on Maui, Kauai, Hawaii Island, and Oahu islands. Peers serve as the critical key to a successful transition from institution to housing as well as the connection to housing, SSI/SSDI, health insurance, treatment, and other community support resources. Using TTI funding, Hawaii's Adult Mental Health Division of the Department of Health (AMHD) is training certified peer specialists in forensics and culturally competent care and providing practicums for graduates to apply these competencies. Because of the great distances between islands that make in-person training both expensive and time consuming, selected peer specialists receiving this training will also be prepared to train others on their home islands.

Jail Diversion Approach

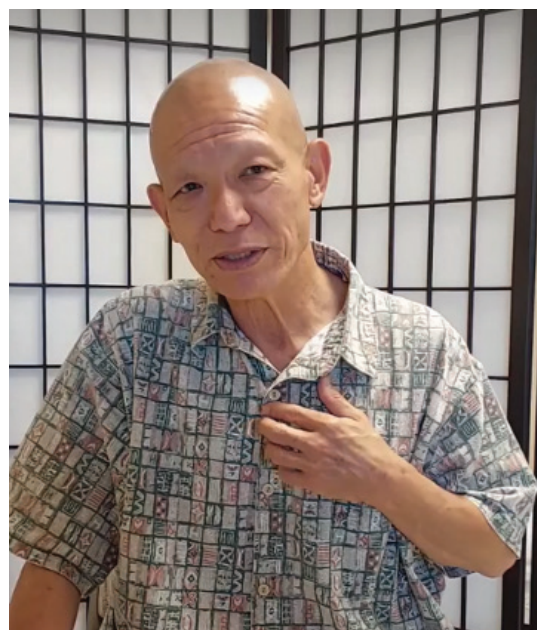
Hawaii recently enacted ACT 26 allowing law enforcement to divert non-violent misdemeanor cases to the state mental health system for treatment and to make recommendations on case disposition. Crisis stabilization units provide law enforcement a place to divert individuals with behavioral health disorders from arrest and detention. The crisis stabilization unit in Oahu also serves as a transitional setting for individuals who are being released from the state hospital

forensic unit. Forensic peer specialists (FPS) graduates were placed in crisis stabilization units to support individuals who were diverted and those transitioning from forensic hospitalization. The students have demonstrated their ability to establish rapport with them while they remain at the Oahu crisis stabilization unit and eventually gain consent to enroll them in wrap around services.

Measuring Progress

Measures of the TTI funded training program focus on trainee enrollment, course completion, internship placement, permanent placement, and number of consumers engaged by training program graduates. All seven trainees completed the course and were placed for internships.

**FIGURE 11: Derwin Teranishi,
Forensic Peer Specialist (FPS)**



“Peer support services can be life changing. One of our clients had been homeless for 17 years. She’s been out of jail and in the community for over four months and is now housed and in treatment thanks to the peer specialist.”

—Amy Naylor, Project Director

Integration With Crisis System

Forensic peer specialists have been placed in a newly opened crisis stabilization unit that is one component of Hawaii’s overall crisis continuum. The project collaborates with community mental health providers, AMHD’s housing support programs, hospitals, the Honolulu and Maui Police Departments, and Maui, Hawaii, Kauai, and Oahu courts.

Behavioral Health Equity

This program is designed to make peer support available to populations that have been underserved in the community and overrepresented in the justice system. Among these populations, Native Hawaiians and Pacific Islanders are more likely to get a prison sentence, receive a longer prison sentence, and receive longer probation terms than other groups. Hawaii also has a disproportionate number of Native Hawaiian women compared to women of other ethnicities in prisons (<https://www.ojp.gov/ncjrs/virtual-library/abstracts/disparate-treatment-native-hawaiians-criminal-justice-system>). Training emphasizes a cultural understanding of Island life that is crucial to forming rapport. The project has made special efforts to recruit women with lived experience to enroll in peer training and internships and has recruited and graduated twenty-one women, out of thirty-two graduates.

Project Legacy

The project had originally planned to place students at the jail or at the state hospital. At the jail, the

nurses’ station that had been planned to house FPS services were moved to an administrative office area that contained sensitive records prohibiting entry to non-jail staff. Protocols at the state hospital to reduce the risk of COVID-19 transmission removed the opportunity for peers to make face to face contact with patients when they first arrived and reduced contact opportunities during their stays. Students were instead placed in crisis stabilization units. FPS demonstrated their flexibility and value in helping individuals in crisis stabilization units on their journeys of recovery. AMHD has arranged for the FPS program to continue in the long term. The train the trainer model effort from this grant will continue to multiply the number of trained FPS and federal block grant funds will continue to support internships of trainees. Contracts with community mental health providers support the hiring of forensic peer specialists and billing for their services.

What Have Forensic Peer Specialists Taught Us?

FPS are remarkable at engaging consumers in services, particularly as they transition from institutions and when they first arrive at the stabilization unit. Contact with peer specialists during that transition can mean the difference between recovery and recidivism. Maintaining relationships with individuals is just as important and often more challenging as consumers move through behavioral health systems. Work is still needed on developing programs that allow for FPS to follow individuals through the forensic process until they become stable in the community.

For further information on this project, contact Yara Sutton at yara.sutton@doh.hawaii.gov.

Vision

When judges doubt a criminal defendant's ability to understand the nature and consequences of the court process, they may order the defendant's competency to be evaluated and if found wanting, restored. Requests for competency evaluation has grown annually having reached 60,000 cases nationwide.¹⁵ Many requests must await an opening in state hospitals where competency evaluation and competency restoration (CECR) are most often conducted. Figure 12 depicts the process of CECR. Defendants can wait days, weeks, and months for CECR, in some cases, exceeding the time they would have to serve if found guilty.

Moreover, while CECR prepares defendants to understand and participate in their trials, it does not necessarily address a range of clinical and social needs, such as co-occurring substance use challenges, housing needs, occupational needs and supports, and other important related issues.¹⁶ To reduce wait times and integrate treatment, the Behavioral Health Division of the Kansas Department for Aging and Disability Services (KDADS), is moving towards conducting CECR in other settings including jails and community outpatient settings for low-risk defendants. KDADS developed a multipronged approach to reduce demand for CECR by preventing arrests that lead to involvement with the justice system, diverting involved individuals before trial, and conducting CECR in the community for those so ordered. To establish the infrastructure needed to implement these approaches, KDADS engaged community and

state partners in planning, informed enabling legislation, established department policy changes, and secured funding for community agencies to deliver community CECR and diversion services.

Jail Diversion Approach

KDADS identified three opportunities to divert individuals who are at risk of CECR mainly through its expansion of Certified Community Behavioral Health Clinics (CCBHCs). CCBHCs establish liaisons with local jails and law enforcement agencies that open pathways for diversion, CECR, and treatment to people with behavioral health disorders who are at risk or involved in the justice system. KDADS has established a Stepping Up Technical Assistance Center to support local collaboration between agencies including courts that serve as exemplars on pre-trial diversion, community based CECR, and specialized courts. In areas of the state in which it is available, Assisted Outpatient Treatment (AOT) is being offered to defendants undergoing community based CECR.

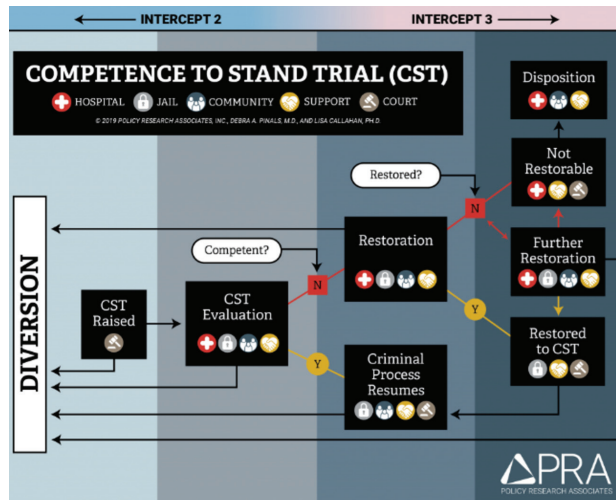
“We are working towards a robust statewide system where people with mental health issues are able to have them resolved without having to stand trial, or if needed, competency evaluation and restoration services that allow them to have fair and speedy trials.”

—Andrew Brown, Commissioner, KDADS

¹⁵ Competency Restoration for Adult Defendants in Different Treatment Environments. Graham S. Danzer, Elizabeth M.A. Wheeler, Apryl A. Alexander, Tobias D. Wasser. *Journal of the American Academy of Psychiatry and the Law Online* Feb 2019, JAAPL.003819-19; DOI: 10.29158/JAAPL.003819-19

¹⁶ Evaluation and Restoration of Competence to Stand Trial: Intercepting the Forensic System Using the Sequential Intercept Model. Debra A. Pinals and Lisa Callahan. *Psychiatric Services* 2020 71:7, 698-705

FIGURE 12: Competence Process Flowchart Depicted By Policy Research Associates



Measuring Progress

Process measures include the number of partners engaged in the planning process, the number of policy changes, and the amount of funding appropriated to diversion and to jail and community based CECR strategies.

KDADS intends to use the CECR state hospital waitlist and days waiting by municipality to measure the impact of implementation.

Integration With Crisis System

Tying the expansion of mobile crisis teams to CCBHCs, KDADS has submitted a state plan amendment to CMS to fund CCBHC services. KDADS has certified 9 CCBHCs and expects to certify 16 more in the next few years that will provide coverage to all areas of the state. CCBHCs are also integrated with 988 and provide crisis response and back-up for calls. Kansas has short term crisis stabilization units and crisis intervention centers (CICs). CICs can safely detain individuals up to 72 hours for psychiatric evaluation. Both facilities accommodate individuals transported there by police and have qualified staff on duty to assess medical needs.

Behavioral Health Equity

While CECR was instituted to safeguard an individual’s right to understand the nature of the charges and evidence against them, long waits may violate their right to trial without unnecessary delay. Lengthy waits for CECR can have a devastating impact on people’s lives and may disproportionately affect those who are black and brown, poor, and alone. A meta-analysis of CECR studies over the past 15 years found several common characteristics of people more likely to be found incompetent as unemployed, receiving social security disability income, unmarried, older aged, and non-white.

Project Legacy

The multipronged approach funded by TTI has resulted in several favorable advances that will have a long-lasting impact including:

- Community-based CECR was authorized and funded by state legislation.
- Mental health center budgets have been increased to accommodate grants and contracts for forensic services, and
- The state’s Chief Justice held a statewide conference on pre-trial diversion and CECR.

What Has Building An Infrastructure For CECR Taught Us?

Although the project’s intent was to make internal policy and funding changes to support community based CECR, its impact is felt beyond the mental health system. External stakeholders, especially the courts, must be consulted early in the process, not only to improve legislation and expand its base of support, but to improve its implementation.

For more information on this project, contact Andy Brown at Andrew.brown@ks.gov.

Vision

As Kentucky's largest city, Louisville has been riddled by the opioid epidemic, the COVID pandemic, and tremendous racial strife resulting from the deaths of Breonna Taylor and David McAtee at the hands of law enforcement.

Protests across the city, exponential increases in calls to the local behavioral health crisis call/text lines and a rise in psychiatric crises point to increased demand for behavioral health crisis response and linkages to treatment. The Kentucky Department of Behavioral Health, Developmental and Intellectual Disabilities (DBHDID) used TTI funds to engage community members, Louisville officials, and Seven Counties Services (the community mental health provider), convened by Spalding University to explore the feasibility of a community designed behavioral health crisis response model as an alternative to law enforcement response to mental health calls.

The participation of community members exceeded expectations resulting in a community designed response model and the establishment of a Community Accountability Board to oversee the project.

Jail Diversion Approach

Community members and partners in the projects sought to prevent justice involvement before law enforcement is engaged. They designed an approach that relies on mobile crisis teams that respond to crisis calls independently from police and a crisis respite setting in the community.

“The community is the source of strength and innovation.”

—Shannon Cambron, Ph.D., Spalding University,
Community Engagement Facilitator

Measuring Progress

The voices of the community members were sought in this project for their unique perspective and new ideas. The engagement of community members, government and provider agencies as co-equal partners resulted in a co-created crisis response design. The success of community partnership ultimately led to the implementation of a new diversion approach funded by the City of Louisville.

Integration With Crisis System

In addition to community leaders, the project engaged local government, law enforcement, mental health providers, and state officials involved in designing systems to respond to behavioral health crises. Collectively, they represent the current crisis continuum of the city. Through this collaboration, mobile crisis teams are now enabled to co-respond with police to 911 calls and a crisis respite center has been established on a hospital campus.

Behavioral Health Equity

Conservative estimates suggest that at least 1 in 4 fatal law enforcement encounters involves an individual with serious mental illness. The statistics are even more pronounced among

FIGURE 13: Headline ©2022 LEO Weekly, Louisville, KY, May 12, 2022

NEWS

Louisville's 911 Diversion Program is Expanding into the West End and Other Neighborhoods

indigenous and people of color and underscore the urgency to reduce law enforcement involvement in behavioral health crisis response systems. The project engaged a primarily black and brown community to design such a system to reduce justice involvement, injury, and trauma associated with police response to behavioral health crises.

Project Legacy

The project demonstrates the value of engaging community members, not just providers, in service design efforts even amid periods of social upheaval. Although consensus was reached on the program design, political and contractual exigencies prevented the full implementation of the group's recommendations. With the success of this project, DBHDID is considering replicating this approach to engage other community members in designing crisis response models that are unique to them and their needs.

What Can Exploring the Feasibility of Community Designed Crisis Response Models Teach Us?

Service programs that are designed with the input of stakeholders often have greater political

momentum and lead to improved effectiveness and sustainability. In addition to stakeholders, this project engaged community members directly to obtain different perspectives and new ideas to solve an entrenched problem that has had traumatic and even tragic consequences. The most direct way to know what communities need to reduce police involvement in crisis response models is to ask them. This project demonstrated that consensus among service providers, community members, and government officials on an effective, non-police involved crisis response model is achievable.

For further information on this project contact Vestena Robbins, PhD at Vestena.Robbins@ky.gov.

Vision

The Louisiana Department of Health (LDH) entered into an agreement with the United States Department of Justice in 2018 to transform services for adults aged 21 and older with Medicaid. The agreement stemmed from their investigation of individuals 18 years and older with serious mental illness unnecessarily residing in nursing homes. Several requirements were included in the agreement related to the state's behavioral health service system including the development of a comprehensive crisis system of care. The vision for this system is to ensure individuals in crisis and their families experience treatment and support that is compassionate, effective, resolution-focused, and delivered by a crisis system that is coordinated, responsive and efficient. LDH used TTI funds to conduct research and identify options for designing the crisis call center component of a comprehensive system. To arrive at an approach that would work for Louisiana, the study included an assessment of state service gaps and resources, surveyed stakeholders, and reviewed best practices in other states. Based on the report, LDH will soon issue a request for proposals to establish crisis call hubs to serve as the primary point of entry to crisis services. The hubs will receive crisis calls directly from the community and from 988 and will coordinate with provider agencies to dispatch mobile crisis teams, access walk-in and crisis stabilization facilities, and deliver follow up care after crises are resolved. Based in part on this report and its comprehensive crisis system blueprint, LDH is in the process of standing up additional mobile crisis teams and crisis stabilization units.

Jail Diversion Approach

While the stimulus for this system change was to ensure individuals with mental illness are provided services in the most integrated setting appropriate to their needs, a comprehensive crisis system will divert individuals from unnecessary institutionalization, whether in medical settings or correctional settings. The model maximizes the use of voluntary treatment and reduces the need for law enforcement involvement.

Measuring Progress

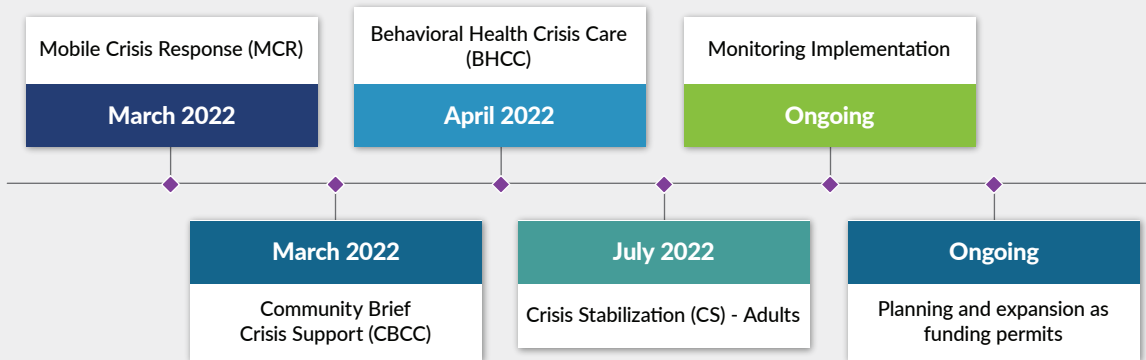
A number of measures are under consideration for the crisis call hubs that include:

- Availability of crisis line services;
- Availability of adequate staff to meet service demand within timeliness requirements;
- Answer rate time and location;
- Call abandonment rate;
- Call handle time;
- Percent of callers assessed for suicide;
- Percent referred to services; and
- Percent of callers who receive follow-up services.

“Crisis is self-defined and can best be labeled as ‘need help now’ determined by the individual.”

—The 2019 Louisiana Coordinated Crisis Plan

FIGURE 14: Medicaid Adult Crisis Services Implementation Schedule for Louisiana



Integration With Crisis System

LDH is seeking to build a comprehensive crisis care system. The crisis call hubs will serve as the single point of entry to the crisis system, resolving crises when possible and coordinating community resources for ongoing care as they are needed. In addition to establishing crisis call hubs, LDH is growing mobile crisis teams from 4 to 8 of its 10 health regions in the near future. Crisis stabilization units are in 4 of the state’s health regions and their numbers will likely grow as services to Medicaid recipients can be billed.

Behavioral Health Equity

Regions of the state vary not only geographically, but culturally as well. As crisis systems are developed, access and availability must match the needs and resources of localities. The selection of service providers will be based in part on their ability to identify and address the specific needs of diverse ethnic communities in Louisiana, such as Acadians or Vietnamese Americans and innovate solutions to service impediments such as language and transportation barriers.

Project Legacy

This project funded a review and recommendations for establishing a crisis call center that served as a blueprint for a comprehensive crisis system in Louisiana. More

than just another report that sits on the shelf, its recommendations were adopted, and system build-out has begun. The keystone of the system, the crisis call hub is in process for procurement and expansion of mobile crisis teams and crisis stabilization units are on the horizon.

What Has Designing a Crisis System Taught Us?

A major catalyst to the crisis system redesign, due in part to the DOJ settlement agreement, is the recognition that crisis services are critical supports to help people live and thrive in the community. LDH found the review of best practices of crisis call systems in other states extremely helpful. The surveys and interviews of crisis call centers in the state, Managed Care Organizations, and Lifeline centers informed an assessment of the system’s readiness to align services with SAMHSA’s National Guidelines for Behavioral Health Crisis Care – A Best Practice Toolkit helped LDH determine next steps. Input from a workgroup of MCOs, advocates, people with lived experience, nursing homes, and other stakeholders responsible for implementing the DOJ settlement agreement to the report’s helped LDH determine how to proceed.

For more information on this project, contact Ann Darling at ann.darling@la.gov.

MASSACHUSETTS (WESTERN)

Vision

Behavioral Health Network (BHN) is the regional behavioral health authority for 29 cities and towns including and surrounding Springfield in western Massachusetts. In addition to a crisis call center, a peer-run Living Room model crisis walk-in center, crisis stabilization units, and mobile crisis teams, BHN works with police departments to dispatch behavioral health clinicians to co-respond to behavioral health related 911 calls. TTI funding is being used to augment the co-response program by adding peer support specialists and expand efforts to divert individuals from hospital emergency departments and jails. Peer specialists can provide the additional support people need to remain in the community and help them receive the level of care they need to succeed.

Jail Diversion Approach

Six behavioral health clinicians are embedded in police departments in the region and co-respond to 911 calls. Augmenting clinicians, peer support specialists may accompany them to co-respond to calls assisting in de-escalation, assessment, and referral to care. Peers are uniquely equipped, based on their lived experience, to persuade individuals in crisis to participate in treatment. Peer support specialists also contact individuals the next day, whether or not they responded to the initial 911 call, to offer on-going support and connection to care. They develop rapport with individuals and may refer them to other services that they need to live in the community, such as housing and food assistance. In some cases, individuals served by this program have called the peer support specialist instead of 911 to prevent

or resolve a new crisis, averting the potential for arrest or hospital emergency department use.

Measuring Progress

As reported in the application this project is seeking to reduce the overuse of 911 and hospital emergency departments. The project proposed to measure the number of behavioral health related 911 calls that are repeatedly from the same location, and the number of interactions that peer support specialists have during each shift, including follow up contacts.

Integration With Crisis System

BHN has integrated this project into its crisis response system (as illustrated in Figure 15). Peer support specialist co-responders make and receive referrals across crisis services and systems including a crisis line, a peer run Living Room walk-in center, crisis stabilization units, and mobile crisis teams.

Behavioral Health Equity

For some people, particularly those with limited access to quality health care, encounters with law enforcement because of untreated behavioral health disorders can lead to incarceration

“Peer support exists to help people find their voice — to say what they want and need to thrive in the community.”

—Candace Lafever, Peer Support Specialist

FIGURE 15: BHN Crisis Services

24/7 Crisis Line

Contact BHN Crisis Services 24 hours per day for help: Call (413) 733-6661 or walk in: 417 Liberty Street, Entrance B, Springfield MA 01104

BHN's Crisis Program provides 24/7 front line response to individuals of all ages who are experiencing a behavioral health crisis, regardless of insurance. BHN provides services on a mobile basis, including home and community-based settings or in an emergency department when needed.

The Living Room
Provided at no-cost, The Living Room connects those in crisis with peer mentors at the onset of a crisis, often helping to avoid an emergency.
[Information](#)

Stabilization Services
Short-term, out-of-home placements offer stabilization in a home-like, supervised environment.
[Information](#)

Crisis Intervention
A solution for immediate help to the person in crisis and their family. BHN assists callers in deciding next steps for the individual in crisis.
[Information](#)

or involuntary detention. Co-responding with law enforcement, clinicians and peer support specialists can change the course of those encounters by providing alternatives to hospitalization or arrest, and engaging individuals in treatment. To welcome them, BHN has recruited a diverse peer workforce that looks like the people that they serve.

Project Legacy

Due to the success of this project, peer support specialists will continue to augment clinicians in co-responding to 911 crisis calls and providing follow up support. The peer embedded crisis co-responder program is viewed as another important component of the crisis response system and providing an additional gateway to care.

What Has Embedding Peer Support In a Co-Responder Diversion Program Taught Us?

The addition of peer support specialists to the co-responder model has been relatively seamless,

owing to the strong collaborative relationship already established between BHN and police departments. Peer support specialists have mostly experience respect and appreciation from police during co-responder calls and have had little to no resistance. Individuals who are accustomed to calling 911 when they are in crisis are encouraged to call the peer support specialist instead. Peer support specialists report that they receive more calls as rapport develops.

For more information on this project contact Robert Walker at Robert.Walker@Massmail.state.ma.us.

MISSISSIPPI (NORTH CENTRAL COUNTIES)

Vision

As law enforcement and mobile crisis teams encountered individuals in distress, it became apparent to them that some individuals needed somewhere to go for a few hours – to leave a stressful setting, to decompress, talk to a crisis clinician or peer support specialist, and consider treatment options. The Mississippi Department of Mental Health partnered with Communicare, the community mental health center for north central counties of Mississippi, to establish a Crisis Service Center (CSC) that could provide “someplace to go” for people who are in crisis and need a safe alternative setting for a few hours to recover. TTI funds supported certification training of peer support staff and furnishing the CSC, including a sensory kit that enables them to serve individuals with cognitive disabilities and autism spectrum disorders. The CSC is on the main campus of Communicare and is staffed as needed by the mobile crisis team for short periods (less than 24 hour stay) to help individuals recover from their crises. Law enforcement also bring individuals in crisis that they encounter to the CSC after consulting with the mobile crisis team.

Jail Diversion Approach

The CSC is a living room model¹⁷ crisis stabilization unit (less than 24-hour stays) operated by the mobile crisis team, consisting of a clinician and certified peer support specialist. The team may bring a person with a behavioral health condition to CSC with or without police

“The key to making programs like this work is to not say ‘no’.”

—Melody Madaris, Project Director

involvement and stay with that person while they recover. The CSC provides law enforcement with an alternative to arrest or hospital emergency department evaluation. Many of municipal law enforcement agencies participate in this and other behavioral health programs although smaller agencies in rural areas are too short staffed to spare officers for Crisis Intervention Team training.

Measuring Progress

Between May 2021 and June 2022, 46 people were admitted to the CSC, typically remaining for 3–4 hours (one person remained for 12 hours). Of those admitted, 3 had a developmental or adult spectrum disorder; 4 had a substance use disorder, 37 had serious mental illness, and 5 had co-occurring mental health and substance use disorders. Police referred and transported 19 individuals to the CSC. Most, 26, returned to the community the same day and 20 were voluntarily admitted to inpatient care. None went to jail and none were involuntarily committed. There were 20 males and 26 females ranging in age from 15 to 71, most in their 20s and 30s. Most were white (29) or African American (13), reflecting census data for the area.

¹⁷ The Living Room model is a community crisis center that offers people experiencing a mental health crisis an alternative to hospitalization. Living Rooms embrace the Recovery Model and offer people experiencing mental health crises a calm and safe environment. https://smiadviser.org/knowledge_post/what-is-the-living-room-model-for-people-experiencing-a-mental-health-crisis

FIGURE 16: Crisis Stabilization Unit With Sensory Kit



Integration With Crisis System

The CSC is a short-term crisis setting. Individuals typically stay a few hours with the longest stay of 17 hours thus far. Communicare can provide psychiatric evaluation on site as needed. Individuals in need of longer-term crisis care are transported to crisis stabilization centers located in regions that border Communicare's service area. Residential substance abuse services in the area also provide ambulatory detoxification services.

Behavioral Health Equity

Among the renovations on one of their buildings to establish a living room model crisis center, Communicare included a "sensory kit" to create a safe and comforting space for people with developmental disorders and adult spectrum disorders (ASD), conditions that are significantly over-represented in the justice system. According to a 2016 report from the Bureau of Justice Statistics, about a quarter of inmates in state prisons reported a cognitive disability <https://bjs.ojp.gov/content/pub/pdf/drpspi16st.pdf> and a 2012 study found the rate of adult spectrum

disorders in the incarcerated population was four times greater than the rate in the general population.¹⁸ Diversion programs such as this one can reduce the overall incarceration of people with mental illness in the justice system including people with autism spectrum and developmental disorders.

Project Legacy

Certified peer support specialist staff mobile crisis teams and the CSC. The CSC will continue to be used and staffed on an as-needed basis and equipped to address the crises of people with developmental disorders and ASD.

What Has As-Needed Staffing of a Living Room Model Crisis Center Taught Us?

Partnerships between law enforcement and mental health agencies are often built upon mutual goals to improve both public health and public safety. They recognize a mutual responsibility to not say "no" to someone who is struggling with a mental health or addictions problem and needs help to avoid detention. Partnerships can often take advantage of funding opportunities like the TTI program to develop innovative practices that meet the community's need without breaking tight budgets or overwhelming existing resources.

For more information on this project contact Brent Hurley at Brent.hurley@dmh.ms.gov.

¹⁸ Fazio, Rachel & Pietz, Christina & Denney, Robert. (2012). An estimate of the prevalence of autism-spectrum disorders in an incarcerated population. Open Access Journal of Forensic Psychology. 4. 69-80.

Vision

The lack of a cohesive, evidence-based crisis system had become evident to the Montana Addictive and Mental Disorders Division (AMDD) and to stakeholders in communities across the state. People in behavioral health crises were often detained in jail or hospitals after encounters with law enforcement. Sequential Intercept Mapping workshops convened in municipalities had repeatedly identified the need for receiving centers (crisis stabilization units) as alternatives to emergency rooms and jails. Hospitals reported that behavioral health visits accounted for 30–40% of emergency department visits, more than double the national average of 15.7%.¹⁹ Communities were struggling to shift from a rigid reliance on emergency departments and detention and move to a model of care that utilizes community-based alternatives. Three counties in western Montana: Lewis and Clark, Missoula, and Cascade agreed to participate in a regional crisis stabilization planning and implementation process to advance system innovations for diverting individuals from the Montana state hospital, jails, and hospital emergency departments. The state provided support to convene stakeholder groups, map resources, collect and analyze data, and develop a strategic plan. Throughout the process, they encouraged stakeholders to design and implement a “no wrong door” approach to crisis care including crisis care facilities such as peer respite, short term residential, 23-hour urgent and longer-term crisis stabilization units. At AMDD’s request, NASMHPD provided technical assistance

to the three counties through a contract with WICHE (Western Interstate Commission for Higher Education). WICHE consulted the three counties on consensus building within their communities and effective crisis and diversion models.

Jail Diversion Approach

The project encourages stakeholders in three counties to establish crisis diversion facilities (crisis stabilization units) that will accept anyone that law enforcement transports there due to a behavioral health crisis.

Measuring Progress

Both the communities receiving TTI funds and WICHE prepare and submit quarterly reports on their progress to AMDD. The volume of hospital emergency department behavioral health visits will continue to serve as a measure of progress. A sub-goal of the project is to develop a data dashboard that can reflect the level of utilization of crisis diversion centers and their integration with other crisis services.

Integration With Crisis System

Counties have mobile crisis teams and with the implementation of 988, will have 24/7 access to call centers. The third component of the continuum, crisis stabilization units, are not easily accessible to rural and frontier areas of the state

¹⁹ QuickStats: Emergency Department Visit Rates Related to Mental Health Disorders, by Age Group and Sex – National Hospital Ambulatory Medical Care Survey, United States, 2016–2018. *MMWR Morb Mortal Wkly Rep* 2020;69:1838. DOI: <http://dx.doi.org/10.15585/mmwr.mm6948a13externalicon>.

“A crisis system has to be inclusive and serve everyone rather than a small subset of people.”

—Wyatt McAlpine, Project Director

and not fully utilized where they are accessible. Through this process, AMDD is working with community stakeholders to determine how to improve their utilization and where best to locate them.

Behavioral Health Equity

Since launching the TTI project, four more communities have been added that represent rural and frontier areas of the state including the Blackfeet Indian Reservation of Montana. American Indians and Alaska Natives represent about 6.5% of the population of Montana and reservations comprise 9% of its land. According to SAMHSA's TIP 61: Behavioral Health Services for American Indians and Alaska Natives²⁰ “American Indians and Alaska Natives have consistently experienced disparities in access to healthcare services, funding, and resources; quality and quantity of services; treatment outcomes; and health education and prevention services. Availability, accessibility, and acceptability of behavioral health services are major barriers to recovery for American Indians and Alaska Natives.”

Project Legacy

Based on the progress of this TTI funded effort, AMDD sought and was awarded additional funds from a CMS planning grant to support expansion of mobile crisis services.²¹ As project funds to support community development and implementation end and plans are completed, the ADMM anticipates supporting community implementation of regional crisis diversion centers designed by and for the communities that they serve.

What Has State Level Support For Community Diversion Centers Taught Us?

Community stakeholders are not all at the same level of readiness to embrace change that challenge conventional structures and procedures. Projects such as this one provides support to communities as they build consensus and design more flexible, community-based approaches to crisis care that best fit their environments. AMDD is finding that engaging community stakeholders early in the design and implementation of crisis systems has encouraged adoption of community-based crisis care and led to growing consensus and action.

For more information on this project, contact Wyatt McAlpine at wyatt.mcalpine@mt.gov.

²⁰ TIP 61: Behavioral Health Services for American Indians and Alaska Natives 2019 <https://store.samhsa.gov/product/TIP-61-Behavioral-Health-Services-For-American-Indians-and-Alaska-Natives/SMA18-5070>

²¹ More information on CMS planning grants can be obtained at <https://www.medicaid.gov/medicaid/benefits/behavioral-health-services/state-planning-grants-for-qualifying-community-based-mobile-crisis-intervention-services/index.html>

NEW JERSEY

Vision

New Jersey's Division of Mental Health Services (DMHS)'s established designated screening centers (DSCs) as the gateway to in-person crisis services. DSCs provide emergency psychiatric care in every county, including mobile crisis team dispatch, screening and assessment, short term crisis services, peer support, and referral to longer term treatment. Law enforcement often transport individuals in distress that they encounter to DSCs. While DMHS has a system-wide Justice Involved Services program for individuals with mental illness who are involved in the justice system, they were missing a significant group that were frequently encountered by police and either transported to DSCs or arrested, booked, and released without arrangements made for treatment, medication, and other necessary care. This project bridges the gap between crisis and justice-involved services by placing crisis peer specialists (CPSs) in DSCs to engage and provide follow-up to consumers who have been brought in by police, particularly those who have a history of repeat police calls and/or frequent admissions to crisis services. The CPS may also work in police departments, hospital emergency departments and medical floors to provide follow-along services in the community when the consumer is released from crisis or hospital settings.

Jail Diversion Approach

CPSs develop rapport with consumers who are transported to DSCs by police and maintain contact with them after they've been released. Follow up contact is a critical step to connect and maintain consumers in treatment services.

The approach not only completes the diversion process, but by enrolling in treatment and engaging in community supports, consumers may avoid future involvement with law enforcement.

Measuring Progress

The COVID-19 pandemic and the concurrent "Great Resignation" contributed to recruitment difficulties and delayed the project launch for the two counties in which the project was piloted. One of the two reported the following data for the first quarter of 2022.

- 13 consumers were screened and released with follow-up support by the CPS
- 3 contacts were made by the CPS in the emergency department/medical floor
- 4 screened and released consumers were successfully linked to mental health and support services with assistance of the CPS
- 0 episodes of CPS's deployment to a police department at the request of police
- 1 readmission for emergency services for consumers receiving CPS services

“We piloted the project in counties that demonstrated a historically strong relationship between county behavioral health providers and law enforcement.”

—Steve Fishbein, Project Director

Integration With Crisis System

DSCs were established in every county in New Jersey beginning in 2008 and serve as the county hub for crisis services. They provide emergency psychiatric care including mobile crisis team dispatch, screening and assessment, short term crisis services, peer support, and referral to longer term settings. Individuals can remain up to 72 hours to recover from their crises, while others are transferred to a longer-term crisis stabilization unit, peer-run respite setting, or inpatient unit in a local hospital. About 40% are involuntarily hospitalized at a state hospital. The BEDS crisis bed registry system assists DSCs to best utilize crisis and respite settings. Planning to integrate 988 into the crisis system continues.

Behavioral Health Equity

A major rationale for this project is to reach out to individuals involved with the justice system with untreated conditions to provide them access and care. The project seeks to enroll, engage, and support them in continuing services after their crisis has been resolved.

Project Legacy

The first quarter report from one of the two counties suggests that engagement and follow up services provided by peers may be both successful and cost-effective in reducing consumers' involvement with police and engaging them in treatment. The project director will make recommendations to DMHS's chief financial officer based on the continued performance of the pilot projects.

What Has Follow Up and Engagement of Justice Involved Consumers After Crisis Intervention Ends Taught Us?

The project director selected the DSCs to participate in the pilot based on the strength and positive relationship that they already had with local law enforcement. Indicators of that relationship included their involvement in police training, the number of CIT officers in the county, the number of referrals to treatment from county prosecuting attorneys, and the number of diversions by police. DMHS has supported CIT training of some 5000 officers in New Jersey since 2008.

The growing number of projects involving forensic peer support in New Jersey is having a synergistic impact on services and simultaneously straining resources. Partnerships between law enforcement and mental health agencies are developing more innovative approaches and increasingly leaning on peer service for diversion programs resulting in an increased demand for a limited supply of peer support staff. On the other hand, this growing demand is leading state agencies to discuss procedures and codes that could allow providers to bill for peer services in expanded contexts such as crisis services.

For more information on this project, contact Steven Fishbein at Steve.Fishbein@dhs.nj.gov.

Vision

New Mexico's Behavioral Health Services Division (BHSD) was looking for ways to support the development of existing and emerging crisis stabilization units (called crisis triage centers or CTCs) in the state to build its crisis continuum of care and prepare for 988 implementation. The purpose of the grant was to convene a learning collaborative of CTC operators and their stakeholder organizations including consumers, law enforcement, and emergency responder agencies to develop a CTC implementation strategy and uniform set of outcome data.

As they met to outline implementation strategies, the learning collaborative focused on operational challenges, some unique and some common, to communities in this geographically and culturally diverse state. CTCs offered one another ideas to navigate implementation barriers to state regulations through acceptable alternatives. One developing CTC for example, was stymied by a requirement for fully certified kitchen. Another developing CTC shared that they navigated this requirement by coordinating with another state agency to import hot meals rather than spend many months and thousands of dollars to build a commercial kitchen. Over the course of the past year, BHSD's expectations for this process evolved from a uniform implementation strategy and data set to an endorsement of operational themes. For example, though the aspiration for the state in implementing CTCs was to emulate "no wrong door," it was recognized that resource constraints and some state laws may prevent that from currently being fully attainable. Instead, the focus should be on helping CTCs be as accessible as possible in the short-term, while collaborating with the State to fully implement "no wrong door" in the long-term. These themes allow CTCs the flexibility to work closely with local partners including law enforcement, emergency responders, and consumer organizations while integrating within the larger statewide crisis systems. Two CTCs came on-line during the year, due in part to the advice and support of the learning collaborative.

Jail Diversion Approach

CTCs minimize the involvement of law enforcement and justice agencies with individuals experiencing

a mental health crisis by making crisis services immediately available. Anyone can walk-in to CTCs to request help with a crisis without the involvement of law enforcement.

If law enforcement encounters an individual experiencing a mental health crisis, they can transport them to a CTC voluntarily as an alternative to arresting them or taking them to an emergency room for psychiatric evaluation. This allows for individuals in behavioral health crisis—but who are not in need of coerced care or detention for public safety—to have their needs more appropriately met. Often overlooked and yet critically important to ending a repeated cycle of police encounters and incarcerations, CTCs provide follow-up case management and referral to ongoing treatment.

Measuring Progress

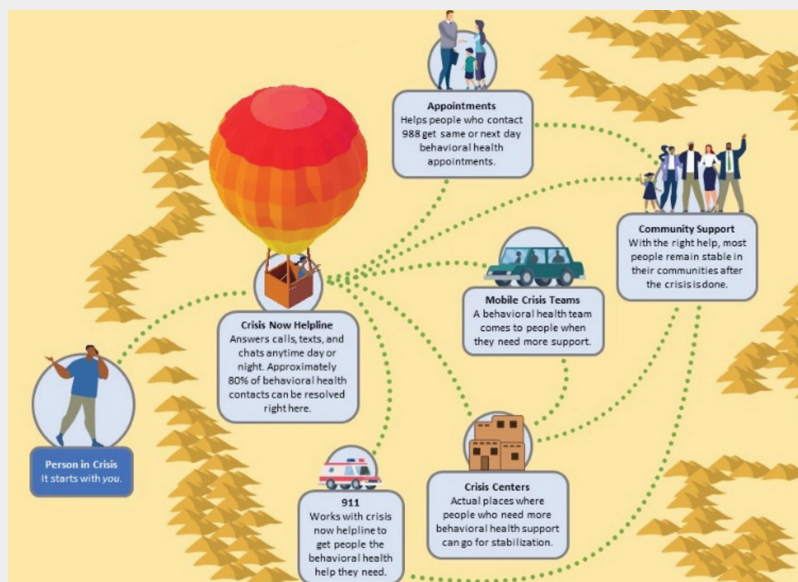
The project measured its progress in achieving collaboration and consensus across CTCs. While the desired outcome of the learning collaborative shifted from adopting uniform strategies to identifying common principles, participants expressed satisfaction with meetings and level of engagement. A second outcome was that participants engaged stakeholders outside of meetings and were able to elevate their concerns to appropriate individuals on the State level who could help them navigate implementation issues in the short-term and work towards long-term revision of policies that might allow CTCs to better serve the needs of New Mexicans.

BHSD expected that the learning collaborative would recommend a single set of CTC measures. CTCs were already capturing performance and outcome data, such as the number transports and time spent by law enforcement to transfer custody of individuals to the CTC. While the project outlined these and other metrics, the learning collaborative focused more on helping CTCs to identify the data most important to their own community and in building a business case for their development, continuance, and/or expansion.

“It is extremely useful to behavioral health policy makers to involve providers to figure out how to make state policies work locally.”

—Jaymes Fairfax-Columbo, Project Co-Director

FIGURE 17: New Mexico's Crisis Now Continuum of Care



Integration With Crisis System

The CTCs invite representatives from their consumer peer community, law enforcement, and first responders to learning collaborative meetings. Other stakeholders and subject matter experts attend as needed. The learning collaborative has served as a platform to coordinate activities with other related efforts.

The project has integrated with an overall statewide continuum of crisis care by serving as the conduit between CTCs and state crisis systems. The learning collaborative has met with Open Beds, a bed registry operator that BHSD will seek to increasingly utilize in coming years. Mobile crisis teams in the state work closely with CTCs and in some cases are operated by the same provider. New Mexico's primary crisis call center (soon to become a 9-8-8 operator) regularly attends learning collaborative meetings. CTCs report working regularly with hospital emergency departments to make referrals, and several are co-located with ambulatory detox settings.

Some CTCs have medical staff that can “medically clear” individuals for admission. Other CTCs are social model programs that must have clients medically cleared by other providers prior to accepting them at the center. Still others have capacity to triage individuals to appropriate level of care if the CTC is not able to meet the individual's medical or psychiatric needs. All CTCs in the state are located on or close by to a medical facility that can address medical issues.

Behavioral Health Equity

CTCs provide an early gateway to mental health care in New Mexico. Whether individuals arrive on their own or they are transported by first responders, they will have the same access to care and follow up services. Two impediments continue to challenge

BHSD in achieving equity. Individuals without cars in rural areas have difficulty getting to CTCs. The learning collaborative has proposed a less intensive “CTC-lite” model for frontier areas to bring them closer to people in need, as well as are working to identify transportation alternatives that might allow for CTCs to be more accessible to these individuals. Native Americans' reluctance to seek mental health care based on past experiences and distrust of state services may also impede BHSD's efforts to improve health equity.

Project Legacy

CTCs and their stakeholders want to continue the learning collaborative after TTI funding ends. BHSD plans to continue to act as convener for the group. As CTCs continue to evolve and as community awareness of their services grow, the project anticipates that there will be a reduction in arrests and psychiatric detentions and fewer overdoses.

What Have CSU Learning Collaboratives Taught Us?

Policies developed at the state level do not address every contingency nor meet the needs of every community. The learning collaborative served as a platform to solve problems and overcome obstacles to implementing policies and integrating systems. It also supplied an opportunity for the State to learn the unanticipated consequences of policies from providers. Ultimately, the learning collaborative provided a framework for the State and providers to learn from each other, identify the critical issues that underscore policies to make crisis care accessible and effective.

For further information on this project, contact Jenny Felmley, PhD, at jenny.felmley@state.nm.us.

NEW YORK (WESTCHESTER COUNTY)

Vision

Following the death of George Floyd at the hands of law enforcement in 2020, New York State asked its municipalities to develop and recommend police reforms. Westchester County established and coordinated five major initiatives that would enable alternative responses to behavioral health crisis calls that had typically resulted in police dispatch: preparing for the national 988 crisis call line, training EMS on psychological first aid, increasing CIT training and community partnerships, expanding mobile crisis teams by eight, and training 911 dispatchers to screen and divert emergency calls from police to behavioral health resources. TTI funds were used to design a screening protocol, modified from a Los Angeles Police Department protocol, and train 911 call takers to assess and divert appropriate calls to behavioral health resources rather than dispatching law enforcement based on the caller's risks and needs. Westchester County has 31 public safety answering points (911 sites) managed by municipal agencies and 8 sites covered by state police. Figure 18 is a version of the decision tree used for training.

Jail Diversion Approach

Calls to 911 are screened for imminent danger including suicide and behavioral health concerns using the screening protocol illustrated in Figure 18 – Diversion Risk/Responsivity Guide. The guide provides guidance to determine level of risk and appropriate action. Calls that are determined to pose no threat to public safety are diverted to crisis call lines, warm lines, or mobile crisis teams.

Measuring Progress

The project involved training call takers in 31 municipal public safety answering points (911 call centers). 426 call takers have participated in the training. 911 call centers diverted six calls in December 2021 when the project was implemented. Diversions had steadily grown to 19 in March and appeared on track to reflect further increases.

Integration With Crisis System

The success of this project is dependent upon the other prongs of police reform underway in Westchester County including expanded capacity of mobile crisis teams and 988 call centers to take on calls diverted to them by 911. In addition to hospital emergency departments, Westchester County has a Living Room model walk-in crisis center.

Behavioral Health Equity

Among the Westchester County communities most engaged in expanding CIT officers and

“Police officers do not have to be the first responders to every 911 call every time. Firefighters respond to fires, EMS respond to medical emergencies — why can't crisis counselors respond to behavioral health emergencies?”

—Mark Guilianno, Project Director

FIGURE 18: Modified Version of the 911 Decision Tree to Divert Calls

Westchester County 911 Diversion Risk/Responsivity Guide		
HIGH RISK 4	IMMEDIATE THREAT TO PUBLIC SAFETY (SELF/OTHERS) Is the person and other people in immediate danger?	ACTION Deploy Emergency Law Enforcement - Emergency Service Unit - Response. Stage EMS and/or Mobile Crisis Response Team if appropriate.
MODERATE RISK 3	CALLER NEEDS IN PERSON ASSESSMENT (LE/MH) Is the person themselves at risk of danger?	ACTION Deploy a CIT Officers and/or MCRT EMS may be required
LOWER RISK 2	CALLER NEEDS IN PERSON ASSESSMENT Is the person at a lower risk of danger?	ACTION Deploy MCRT Or Divert to Crisis Network Team if appropriate.
IMMEDIATE REMOTE 1	CALLER NEEDS IMMEDIATE SUPPORT VIA PHONE Does the person require immediate support but does not require an in person assessment?	ACTION Divert to a member of the CNT.
NO CRISIS 0	CALLER NEEDS SUPPORT SERVICES OR WARMLINE Does the person simply need someone to speak to or is the person in need of access to non-emergent supports?	ACTION Divert to CNT. The CNT will connect to a peer support warm-line or other supportive services as appropriate.

participating in 911 diversion are those in larger cities that have a disproportionate share of people who are Black, Latino and living in poverty. By diverting people in crisis away from law enforcement and towards behavioral health care, individuals in these communities are more likely to gain access to treatment for behavioral health disorders rather than risk injury or involvement with the justice system.

Project Legacy

The training and Risk/Responsivity Guide for 911 dispatchers are now available for continued use. A sample policy and procedure is also available for police departments to revise and employ. Efforts are underway to introduce aspects of the training into police academy program, CIT training, and annual training opportunities for officers.

What Has 911 Diversion Taught Us?

Even with the implementation of 988, people will continue to call 911 for help with a behavioral health crisis. This and similar projects in New York state indicate that dispatchers who staff 911 call centers are eager for training to better respond to behavioral health related calls and want to divert no- and low-risk calls to 988 and other crisis resources rather than law enforcement. Although it has been identified in the Sequential Intercept Map as a key issue at Intercept 1, 911 dispatch is often overlooked in developing diversion strategies.

For more information on this project, contact Tricia George, at tricia.george@omh.ny.gov.

OKLAHOMA

Vision

Oklahoma has consistently ranked among the highest of all states in prison rates for many years and despite some reform efforts, remains on a trajectory to continue incarceration growth which is socially and financially unsustainable. Although multiple jurisdictions have implemented diversion at police encounters and expanded court options there remains a significant gap through which many individuals with behavioral health treatment needs fall. They are the people with behavioral health conditions who are detained before court appearance, arrested on charges that police can't waive in lieu of diversion, but for whom existing court-based options (eg. drug and mental health court) are too intensive. These individuals descend into a repeating cycle of jail incarcerations because, once released from custody, no formal mechanism exists to connect them to the community-based network of treatment options.

Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) partnered with Oklahoma County jail to implement reentry support from initial detention to community services including behavioral health treatment and other community social supports such as housing, education, employment, and legal resources.

Jail Diversion Approach

Although the project assists in reentry, the project seeks to divert individuals in detention after arrest and booking and before a court hearing. Oklahoma County jail houses some 1200 men and women who are held in detention from a few hours to many months. The complexity involved in screening and assessing individual needs and referring to appropriate services in such a large

“Keep your big bright idea as the goal but understand that the first question should be what are the jail's barriers to doing this work and what will help you in interacting with detainees.”

—Dedra Hansbro, Project Director

secure facility is daunting. Each detainee that is screened and assessed must be escorted from their cell block by a detention officer through multiple security checkpoints to a quiet room that enables confidential consultation. The treatment staff conducting the screening makes treatment and services recommendations best suited for the detainee to the public defender's office for further case disposition. The treatment staff also coordinates with a local non-profit, Diversion Hub, to coordinate transportation and community engagement. The initial plan was to use web enabled tablets on-site to complete forms and arrange referrals during screenings. However, due to the facility design, treatment staff were unable to access wi-fi in the building.

Measuring Progress

Reentry support is based on length of stay in detention and has 5 tracks. Since its launch in March 2021 through June 2022, the project has screened 1,960 defendants within the Oklahoma County Jail. While many cases are still awaiting disposition as of June 29, 2022, 796 defendants have been diverted from prison to participate in some level of programming and 34 cases have been dismissed.

FIGURE 19: Oklahoma County Jail



Integration With Crisis System

Diversion from pre-trial detention directly engages community mental health centers, precluding the necessity of crisis services. Should they be needed, Oklahoma County has three Certified Community Behavioral Health Clinics (CCBHCs) that are required to provide mobile crisis teams. Oklahoma County also has crisis stabilization units including short term, Urgent Recovery Centers (less than 24-hours) and longer-term clinical settings.

Behavioral Health Equity

The project collects data on race, gender and ethnicity. The table below illustrates the average daily population of the Oklahoma County Jail for 2021.

Male	84.20%
Female	15.80%
White	41.50%
Black	42.70%
Asian/Pacific Islander	10.90%
Hispanic	10.20%
Middle Eastern	0.33%
Native American	4.00%

Staff utilize this data to make appropriate community and treatment referrals. For example, the Latino Community Development Agency participates in screening, referrals, and services within diversion programs of Spanish speaking

defendants. CCBHCs in the County are able to also meet the needs of multicultural clients as well as for the LGBTQ+ community.

Project Legacy

Detention officers and the Oklahoma County Jail Trust overseeing the jail are fully behind the project and their plans for a new jail facility include more accessible private spaces that enable confidential consultation and wi-fi. ODMHSAS will continue to fund on-site screenings and work with local providers to support diversion for those individuals in need of treatment and behavioral health services. Community providers will continue to work with the county jail to accept and treat referrals for behavioral health disorders. Other counties in Oklahoma have also expressed interest in this project.

What Has The County Detention Reentry Support Pilot Taught Us?

Despite efforts to divert before and during police encounters and the expansion of specialty courts, there remain a significant number of individuals with behavioral health needs detained in jails. While it is complicated by the rapid turnover of detainees and requires the active support of corrections staff, there is still a sizable population of people with behavioral health disorders that can be diverted. Approaching partners, both leadership and staff, with an understanding of their needs to maintain safety and security has facilitated work arounds to cut down transition times and allow confidential screenings. Working together, partners have located more confidential rooms and begun to schedule certain floors of the building for certain days of the week to reduce travel time through the building. Providing behavioral health screening on site has also allowed detention officers to begin viewing detainees as whole persons which helps to reduce stigma.

For further information about this project contact Nisha Wilson at NWilson@odmhsas.org.

PUERTO RICO

Vision

Among the many challenges facing people with behavioral health disorders when they leave the justice system are the lack of positive social supports and familiarity with social skills needed to succeed in employment and higher education. SAMHSA identifies peer support services among the key elements for diversion at reentry from incarceration, intercept 4 of the Sequential Intercept Model. Individuals who have gone through the transition from jail or prison to the community successfully can help people plan for reentry, identify safe housing, and learn about triggers or issues that could lead back to the justice system. The peer “support facilitators” of the Mutual Support Center see their role as creating safe spaces for consumers to form new and positive relationships and learn social skills that will help them start and keep a job or attend educational classes. Support facilitators guide and motivate consumers to develop and integrate strengths using as their model SAMHSA’s 8 Dimensions of Wellness: social, environmental, physical, emotional, spiritual, occupational, intellectual, and financial.²²

Jail Diversion Approach

Support facilitators have been active in diverting individuals with behavioral health disorders at multiple points in the justice system. They are integrated into the clinical teams of six Recovery Centers and have established support groups for persons diverted from jail. For several years, support facilitators have worked with courts

“People go back to the Justice system because they have nowhere else to go. We are here to fill that gap, to guide and motivate and to strengthen social skills.”

—Juan Velez, Project Director

to divert individuals from incarceration and into community care. Most recently, support facilitators have worked closely with police and municipal government leaders to reach out to individuals at risk of arrest and incarceration on the street in some of the poorest communities in the commonwealth to engage them in treatment. Although the project seeks to hire peers who also have lived experience in the justice system, credentialing them as certified peer specialists has required requests for special waivers. Once credentialed, corrections and the Courts have welcomed their participation on site.

Measuring Progress

Much of the information support facilitators gather is anecdotal. The Mutual Support Center has brought on an evaluator to collect data that will demonstrate the program’s impact on reducing incarceration while improving quality of life outcomes.

Integration With Crisis System

The Mutual Support Center regularly collaborates with detoxification centers, primary health care centers, the courts and the police

²² U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. (2016). Creating a Healthier Life: A Step-By-Step Guide to Wellness. (HHS Publication No. 2016 SMA-16-4958). Rockville, MD: Substance Abuse and Mental Health Services Administration

FIGURE 20: Photos from Puerto Rico's TTI Project



departments in areas in which they provide services. Several former members of the Mutual Support Center now participate in the Puerto Rico Mental Health Planning Council.

Behavioral Health Equity

Behavioral health services in the Commonwealth are much less available to women than to men. While peer support is available to either gender at the Mutual Support Center, they have made a concerted effort to hire more women and people of color.

Project Legacy

The Mutual Support Center seeks to change systems as well as the trajectory of individuals through education. Support facilitators have demonstrated to judges and correction officers that recovery is possible and have even coached

them on questions and statements that will achieve more positive results. Through the availability of other funding sources, peer support services including outreach efforts have been sustained.

What Have Support Facilitators Taught Us?

The Mutual Support Center reaches out to all communities and institutions to help them understand that recovery is possible and likely and to understand the contribution that peer support can make. They continue to work with guilds such as the association of social workers to incorporate education and training for their members and students on peer support services.

For further information on this project, contact Juan Velez Court at jvelez@assmca.pr.gov.

SOUTH CAROLINA

(RICHLAND COUNTY)

Vision

The South Carolina Department of Mental Health (SCDMH) directly delivers treatment services across all 46 counties in the state through a variety of inpatient and community settings. Its mental health agency in Richland County had been successful in founding a mental health court 17 years before and had built strong partnerships with law enforcement and the courts. These and other stakeholders are seeking to build on that foundation to establish a broader portfolio of diversion strategies. To engage and organize the county to improve public safety and community well being, Richland adopted the Criminal Justice Coordinating Council of Charleston County (<https://cjcc.charlestoncounty.org/>) as a model (see Figure 21). TTI funds were used to hire a council coordinator and a data analyst to begin to tap and present available data on justice and treatment data in the county to inform strategic planning and implementation.

Jail Diversion Approach

Criminal justice coordinating councils have been established across the country to improve the administration of justice and promotion of public safety through planning, research, education, and system-wide coordination of criminal justice initiatives. Councils are composed of elected officials, senior leadership of law enforcement, justice, corrections, and behavioral health agencies, advocacy groups, and other stakeholders who meet regularly to and address issues of mutual concern involving the law enforcement, judicial, and correctional components of the criminal and juvenile justice systems and to make recommendations to improve the efficiency and effectiveness of the systems.

“Don’t box yourself into one narrow model of diversion.”

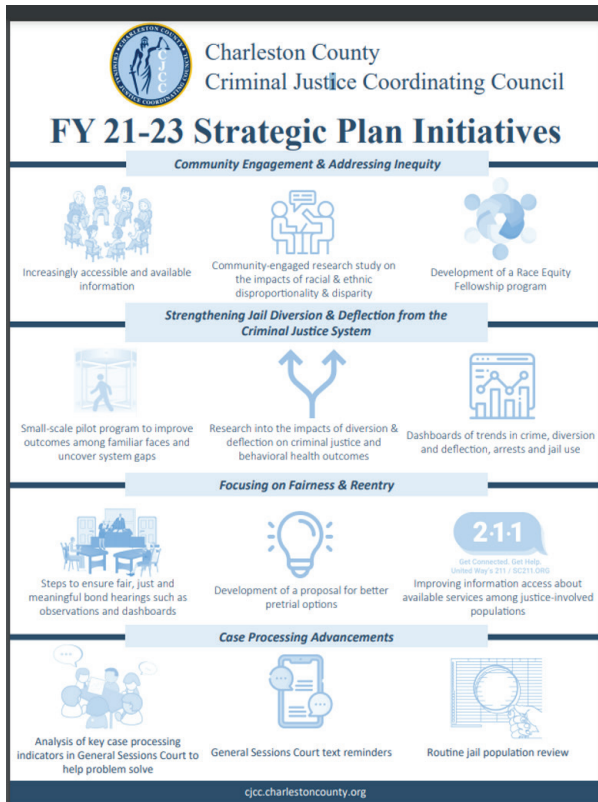
—Allison Ferrell, Project Director

The focus of the Richland Criminal Justice Coordinating Council (RCJCC) is to reduce justice involvement at the earliest possible opportunity in multiple ways. These can be as simple as instituting an automated call system to remind individuals when they will be due in court. Richland already has a mobile crisis team that is dispatched by crisis call centers in the state and has recently begun deploying a co-responder program that joins a Crisis intervention Team trained law enforcement officer with a mental health clinician to respond to 911 calls involving domestic disputes and mental health issues. SCDMH also received a second TTI award in 2020 to provide clinician services at the detention facility. This service connects detainees with mental illness to mental health services during their stay and immediately upon discharge. The RCJCC is made up of representatives of the solicitor’s office, public defenders, mental health, hospitals, judges, private attorneys, mental health, drug and alcohol treatment providers, homeless services, patient advocacy, peer support, NAMI, sheriff and police convened to think critically and plan innovatively.

Measuring Progress

The intent of this initiative is to collect data from detention, law enforcement, and mental health agencies that would inform decision makers and stakeholders about the most effective opportunities for diversion. Unfortunately, the

FIGURE 21: The CJCC Model



reduction of staffing levels due to the COVID 19 pandemic hampered the RCJCC momentum in two ways. Access to the data from all three agencies has been limited as staff were redirected to fill service gaps in these agencies. The RCJCC has convened virtually and less frequently than planned. As throughout the country, the “Great Resignation” in late 2021 has extended staffing shortages. Data will be focused on understanding those who are in detention with mental illness who have not been enrolled into mental health care and why they have not.

Integration With Crisis System

Cross system planning between mental health and first responders are conducted through the RCJCC. The state has a crisis lifeline and operates a crisis call line that is linked with 911. Richland County Mental Health, operated by the state of South Carolina, has a mobile crisis team that is dispatched through the state crisis line. Of 2500

calls from Richland County, the crisis line deployed the mobile crisis team 789 times. A living room model crisis stabilization unit (>24 hour stay) is scheduled to open during the summer of 2022 on the grounds of a local hospital. Individuals who are in need of transportation to a hospital emergency department can be transported in unmarked vehicles operated by security personnel and/or ambulance. Neither the county nor the state have a crisis bed registry.

Behavioral Health Equity

The project director reports that people of color are over-represented in the county detention facility. Data on the race and gender of detainees are among the many characteristics that will be collected, distributed, and examined by members of the RCJCC as they seek to understand barriers to care and improve efforts to deflect and divert people with mental illness from justice involvement.

Project Legacy

Despite the impact of COVID on the project’s momentum, ongoing funding for the coordinator’s position has been secured through the county solicitor’s office. Richland hopes to outshine Charleston County as a model of collaboration and community engagement, addressing racial inequities, and in effective deflection and diversion.

What Have Criminal Justice Coordinating Councils Taught Us?

Coordinating councils demonstrate the value and power of engaging the community in problem solving. No single solution or one agency can change complex programmatic, administrative, and judicial practices that result in the criminalization of mental illness and over-representation of people of color in the justice system.

For further information about this project contact Allison Ferrell at allison.ferrell@scdmh.org.

Vision

There were several system issues that indicated to Texas Health and Human Services Commission (HHSC) that despite state legislation enabling and encouraging jail diversion, too many people with serious mental illness (approximately 30% of inmates) were booked into county jails. At the time the project was awarded, of the 1400 jail inmates awaiting inpatient competency restoration nearly 20% had only misdemeanor charges. Many urban areas of the state have instituted diversion programs with great success. Why haven't more law enforcement agencies adopted diversion strategies in suburban and rural counties and municipalities? HHSC used the TTI funds to collaborate with law enforcement to understand barriers to diversion and devise a strategy to overcome them. HHSC, together with the Texas Police Chiefs Association (TPCA) and Sheriffs' Association of Texas (SAT) designed and administered a study of law enforcement agencies across 254 counties to better understand impediments to diversion. Based on the results, HHSC designed a technical assistance center whose content and delivery system are more attuned to suburban and rural communities. The T.A. Center has begun providing hands-on support to communities including Sequential Intercept Model Mapping Workshops (See Figure 22) and training as well as identifying best practice sites within the state for communities to visit, observe, and consult. The website to be launched in late 2022 will provide a variety of implementation guides and other resources.

Jail Diversion Approach:

The Texas Behavioral Health and Justice Technical Assistance Center (T.A. Center)

utilizes the sequential intercept model to help communities identify opportunities to divert. The model details how individuals with mental and substance use disorders come into contact with and move through the criminal justice system. Law enforcement agencies, working with local behavioral health providers, consumer advocacy groups, and other key stakeholders determine how best to use resources to divert individuals. Best practices at each intercept are illustrated in Figure 22.

Measuring Progress

A major product of this initiative is the survey of law enforcement agencies across the state. The T.A. Center received 557 unique responses from across the state with about half completed by agency chiefs. The high response was attributed to the joint design and distribution by HHSC, TPCA, and SAT. The results are still being analyzed but point to limited access to treatment as a barrier to diversion. Respondents also indicated a preference for pre-arrest diversion programs.


Integration With Crisis System

Law enforcement's understanding and use of crisis system resources is critical to diversion efforts. Although mobile crisis teams cover every region of Texas, some rural areas experience delays due to the large geographic range they must cover. Crisis stabilization units are less likely in rural areas. Through a grant program, the state funds

“There is a hunger to do things effectively using best practices.”

—Jennie Simpson, Project Director

FIGURE 22: Best Practices Are Identified At Each Intercept

Diversion Best Practices Across SIM Intercepts						
Intercept 0 Hospital, Crisis, Respite, Peer, & Community Services	Intercept 1 Law Enforcement & Emergency Services	Intercept 2 Initial Detention & Initial Court Hearings	Intercept 3 Jails & Courts	Intercept 3.5 Forensic Evaluations & Commitments	Intercept 4 Reentry	Intercept 5 Community Corrections & Community Supports
 <ul style="list-style-type: none"> • 24/7 Crisis Hotline  <ul style="list-style-type: none"> • Mobile Crisis Outreach Team  <ul style="list-style-type: none"> • Crisis Facilities • Peer Operated Crisis Respite • SUD Focused Diversion • Early Identification and Intervention of High-Utilizers 	 <ul style="list-style-type: none"> • Crisis Intervention Team (CIT) Training & Model  <ul style="list-style-type: none"> • MH Deputies • LE and MH Co-Responder Models  <ul style="list-style-type: none"> • MH and SU Drop-Off Centers 	 <ul style="list-style-type: none"> • Texas Law Enforcement Telecommunications System (TLETS) Continuity of Care Query  <ul style="list-style-type: none"> • Minimum Requirements for Texas Jails (validated screening instruments; 24/7 telepsychiatry; provides Rx meds)  <ul style="list-style-type: none"> • Pre-Trial Supervision and Diversion Programs 	 <ul style="list-style-type: none"> • Specialized Courts  <ul style="list-style-type: none"> • MH Public Defender Programs  <ul style="list-style-type: none"> • Mental Health Liaison and Diversion Coordinators  <ul style="list-style-type: none"> • Assisted Outpatient Treatment 	 <ul style="list-style-type: none"> • Alternatives to Inpatient Competency Restoration Services  <ul style="list-style-type: none"> • Active Waitlist Monitoring (See Eliminate the Wait Toolkit)  <ul style="list-style-type: none"> • Efficient Court Policies and Procedures  <ul style="list-style-type: none"> • Education and Awareness 	 <ul style="list-style-type: none"> • County Reporting and Medicaid Suspension  <ul style="list-style-type: none"> • Transition Planning by the Jail or In-reach Providers  <ul style="list-style-type: none"> • Peer Support Services 	 <ul style="list-style-type: none"> • Specialized Caseloads of people with MI or SUD  <ul style="list-style-type: none"> • Community Partnerships  <ul style="list-style-type: none"> • Access to Recover Supports

co-responder (law enforcement and mental health clinician) and mental health deputy programs in several communities across the state.

Behavioral Health Equity

The focus of this effort is to reduce the involvement of people with SMI in the justice system particularly in suburban and rural areas of the state. Time and distance to services are significant barriers for individuals to obtain care and can be disincentives to diversion for law enforcement. Technical assistance is designed to work with law enforcement agencies to develop innovative solutions to meet the unique needs of the communities they serve.

Project Legacy

The T.A. Center will continue to provide training, guidance, and resources to law enforcement agencies across Texas to divert individuals with mental illness from arrest and incarceration. Thanks to the results of its survey of officers, the T.A. Center will design and deliver technical assistance that officers will find more relevant and applicable to their jurisdictions and lead to increased diversion.

What Has The T.A. Center Taught Us?

Organizational empathy is at the core of the T.A. Center's approach, demonstrating empathy towards all stakeholders and coming to understand their needs. HHSC invited law enforcement agencies to not only consult, but shape the content of the survey, resulting in a high response rate from law enforcement executives and officers across the state.

Reducing the number of people with SMI in the justice system requires stakeholders to contribute their own viewpoint and simultaneously open themselves to the perspective of others. Organizational empathy fosters mutual trust and cultivates the new insights and innovations that are needed to implement diversion programs in rural and frontier areas.

For more information on this project contact Jennie Simpson, PhD at jennie.simpson@hhs.texas.gov.

Vision

Utah Division of Substance Abuse and Mental Health (DSAMH) is using TTI funding to establish a Forensic Peer Support Specialist (FPSS) enhancement and practicum program. Peers with lived experience, particularly those who have been incarcerated, understand the complexity and barriers to receiving care, finding jobs, and affordable housing and can navigate resources and supports that are easier to access. In February, 2020, the Utah Hospital Association released “A Roadmap for Improving Utah’s Behavioral Health System” which included the Utah Continuum of Mental Health Care (displayed in Figure 23). FPSS deployed to crisis services provide the lived experience and support needed to divert individuals from incarceration and support recovery.

TTI supported a forensic training enhancement for peer support specialists that addressed the barriers and supports specific to the needs of people who have been arrested in the past or continue to be involved in the justice system. Following the training, a 100-hour practicum was provided to six FPSS in short term stabilization units (24–48-hour stays) to individuals with behavioral health disorders brought there by law enforcement. The project was piloted in Davis County by Davis Behavioral Health.

Jail Diversion Approach

While the intent of the project is to ultimately prepare FPSS to support diversion opportunities at every sequential intercept, this project focused on diverting individuals from jail who have been arrested for minor offenses and their charges held in abeyance pending participation in treatment. FPSS provide support services to individuals when they arrive at the receiving center stabilization unit and continue to provide

follow up services including emotional support, community connection, system navigation, and referral.

Measuring Progress

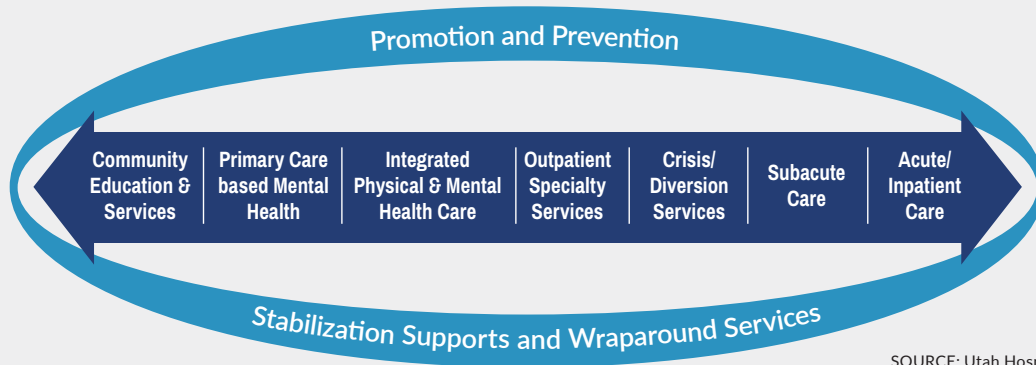
DSAMH is evaluating the impact of specialized training for FPSS on direct service outcomes including recidivism measures, treatment compliance, housing and employment through Electronic Medical Records (EMR).

The project conducted surveys of certified peer support specialists that participated in the training to identify its strengths and weaknesses. Nearly all of them had some involvement with the justice system and a little over half had experienced incarceration. Participants felt most confident with inspiring hope and change, adhering to professional, ethical and legal guidelines, assisting individuals in discovering healthy lifestyle choices, ensuring clients felt understood, and delivering person-centered trauma-informed support. They were least confident in reducing barriers to employment and housing, identifying required community and correctional programs responsible for post-release services and coordinating transitional behavioral health and forensic services. Among participants those with deeper justice involvement were more confident of relationship building with justice system employees.

“Forensic peer support specialists (FPSS) rebuild connection and access to resources while empowering individual choice. The adventure starts at the gate, the journey begins with FPSS.”

—Brian Neilson, Utah State University’s
Certified Peer Support Lead Trainer

FIGURE 23: Utah Continuum of Mental Health Care



SOURCE: Utah Hospital Association

Integration With Crisis System

Davis Behavioral Health operates a crisis call center, mobile crisis teams, three short-term crisis stabilization units (stays of 24–48 hours), and one longer term unit (stays averaging two weeks). Both short and longer stay crisis stabilization units are required by statute to include peer support services as do local hospital emergency departments. The project has a relationship to crisis call centers and warmlines. Receiving centers have nursing staff on duty 24/7 and can support most ambulatory detoxification needs. However, individuals with more medically involved detoxification needs are transferred to nearby hospitals.

Behavioral Health Equity

In addition to law enforcement, courts, correctional agencies, and consumer organizations, the project has engaged a broad array of partners representing populations that are often overlooked and underserved by behavioral health agencies. The Association of Utah/Brain Injury Council²³, LGBTQ+ Suicide Prevention Strategic Plan Committee; Sex Workers Outreach Project (SWOP), Homeless Resource Center, and the Utah Developmental Disability Council assist the project to develop more effective outreach approaches.

Project Legacy

The success of the project has demonstrated the value of FPSS for DSAMH and its project partners. Davis Behavioral Health will continue to recruit peers with histories of arrest, train them as FPSS, and deploy them to Receiving Centers

(crisis stabilization units) and other sites. The training will be expanded to an on-line format to ensure continued availability and access to rural and frontier areas of the state. Mental Health Block Grant funding will support ongoing in-person and virtual training. The Department of Corrections will continue to support placements in jails and fund supervisor and FPSS positions in half-way houses and prisons.

What Has Establishing Forensic Peer Support Specialists Taught Us?

DBH's strong relationship with law enforcement and corrections played a significant role in the success of the project. Their established trust allowed organizations to engage in innovative thinking and combine resources. When administrative barriers impeded DSAMH from hiring of a peer with an arrest record for example, a local corrections agency was able to waive restrictions and hire FPSS directly to provide peer services at the jail. Establishing effective forensic peer services in jail demonstrated the value of FPSS to law enforcement, the courts, and other correctional officers, and paved the way to expanding the project. Extensive partnerships with supported employment and supported housing agencies also played a role in demonstrating the interconnection of the people and resources with which each agency is engaged.

For more information on this project, contact Sharon Cook at sharoncook@utah.gov, Heather Rydalch at hrydalch@utah.gov, Pam Bennett at pbennett1@utah.gov, Brett Bartruff at brettb@dbhutah.org.

²³ A 2010 meta-analysis estimated the prevalence of traumatic brain injury in the overall offender population at 60.25%. (Shiroma, Eric & Ferguson, Pamela & Pickelsimer, Elisabeth. (2010). Prevalence of Traumatic Brain Injury in an Offender Population: A Meta-Analysis. *Journal of Correctional Health Care*. 16. 147-59.)


WASHINGTON

Vision

Concurrent opportunities sparked the expansion of peer support services in crisis care and with it, access to training. With Governor Jay Inslee’s announcement of a five-year plan to dramatically reshape how and where people experiencing symptoms of acute mental health conditions are treated, Washington’s Division of Behavioral Health and Recovery (DBHR) worked with community agencies to develop capacity and treatment services that deflect crises response from law enforcement to mental health agencies. Also in 2019, the Trueblood settlement was reached in a case challenging lengthy delays in competency restoration services. Lastly, DBHR is planning for a dramatic rise in referrals to care from the implementation of 988 in 2022. To meet these challenges, DBHR is enhancing crisis triage/stabilization and mobile crisis services that improve response times, increasing collaboration, providing law enforcement with opportunities to connect individuals to treatment instead of the justice system, and adding certified peer counselors. To expand and better prepare its workforce, DBHR is creating a 40-hour virtual training for peer support counselors. DBHR used TTI funds to create the prequel to that educational program — *Peer Support for Crisis Services* is a seven module, 2.5 hour, on-line virtual training that is free and accessible to anyone. The training was designed with the input of peers, peer counselors, managed care organizations, mobile crisis teams and in partnership with the Peer Workforce Alliance.

FIGURE 24: Peer Support Counselor Online

Are you ready to become a peer counselor? Take the online course and complete the training application.

Complete the application online 

Jail Diversion Approach

Peer counselors serve in a variety of settings that intersect with law enforcement, justice, and correctional systems that include mobile crisis teams, court settings, crisis stabilization units, and hospital emergency departments. Understanding the linkage between these different settings and their services enable peer counselors to consider alternatives to prevent or reduce justice involvement.

Measuring Progress

Peer Support for Crisis Services launched in early 2022. In this short time, 300 peers have registered and 53 have completed the modules. 123 are in the process of completing the course.

Integration With Crisis System

Peer counselors are integral to crisis systems in Washington. Working in community mental health centers, they assist consumers to prevent problems from growing into crises.

“Being there and connected, peer counselors know when someone is going into a crisis. They can help consumers resolve problems before they become crises.”

—Maureen Bailey, Project Director

Peer counselors work in crisis response settings including hospital emergency departments, mobile crisis teams, and crisis stabilization units in every region of the state and operate a statewide warmline. Two peer run crisis respite settings are opening in 2022 that will provide more alternatives to hospital emergency departments and inpatient settings.

Behavioral Health Equity

DBHR recognized the homogeneity of peer counselors in the state and is encouraging broader recruitment efforts to bring on more black, indigenous, and people of color. *Peer Support for Crisis Services* encourages peer counselors to see each individual as unique and to avoid making cultural assumptions based on preconceptions. Peers are trained to ask questions about how they can best support individuals in their recovery. The free virtual training platform has made this training available to people in every part of the state.

Project Legacy

Peer Support for Crisis Services will continue to be available to anyone whether in or outside the state to orient users to crisis system as well as the role of peer support counselors in those settings. It also provides the critical orientation to the full 40 peer support counselor certification training that is in development.

What Can We Learn From Washington’s Peer Support For Crisis Services Training?

The training was designed with input from many people with lived experience. Those who participated and were not representing an agency could request compensation for time and travel. Many withdrew from the process after initial focus groups and brainstorming sessions, particularly youth, whose perspective may have been missed. In projects like this that require broad representation over the long term, staff will invite even greater participation and plan for attrition as the time and work required towards completion become more demanding.

For more information on this project contact Melodie Pazolt at Melodie.pazolt@hca.wa.gov.

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