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A Community Guide for Development of a Crisis Diversion Facility

A Model for Effective Community Response to Behavioral Health Crisis

Prepared for Arnold Ventures
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Health Management Associates (HMA) is an independent national research and consulting firm specializing in publicly funded healthcare and human services policy, programs, financing, and evaluation. HMA provides technical assistance, resources, decision support and expertise and works across disciplines to put our knowledge to work supporting clients in addressing healthcare's challenges.

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Arnold Ventures is a philanthropy dedicated to tackling some of the most pressing problems in the United States. AV invests in sustainable change, building it from the ground up based on research, deep thinking, and a strong foundation of evidence. AV drives public conversation, crafts policy, and inspires action through education and advocacy.

AV is headquartered in Houston with offices in New York and Washington, D.C. The philanthropy's work focuses on four key issue areas: Criminal Justice, Education, Health, and Public Finance. Their work is guided by Evidence-Based Policy, Research, and Advocacy.

Effective Response to Individuals in Crisis: An Opportunity for Communities and States

Communities across the country are increasingly challenged by pressures on their healthcare and criminal justice systems from high volumes of persons experiencing behavioral health (BH) crises arising from mental health, addiction, and related unresolved needs.[4] People suffering from substance use and mental health challenges, or both, often have limited access to health care and face other barriers, contributing to increased utilization of emergency criminal justice and health services.[5]

Mental illness and substance use drive a disproportionate number of avoidable emergency department (ED) and, at the same time, are recognized as contributing to repeated involvement with the criminal justice system, 911/ emergency response, and other safety net systems.[6, 7]

While the number of people presenting at the ED with mental health emergencies has increased, the number of psychiatric inpatient beds has dropped, with the result that EDs often serve as a holding facility for transition to inpatient psychiatric care; a practice known as psychiatric boarding.[8] EDs are intended for acute medical care and typically are not equipped to effectively respond to psychiatric emergencies. A recent survey of emergency physicians indicated that only about 17% of EDs had an on-call psychiatrist.[9] A significant number of people who are currently admitted could have their treatment needs addressed with more appropriate interventions and in a more appropriate setting.[10]

In addition to high rates of mental health conditions, as many as two-thirds of people in correctional settings have a diagnosable substance use disorder.[11] And, increasingly, homelessness and other social determinants of health are recognized as contributing to criminal justice system and ED encounters.[12] People in jails with mental health and/or substance use conditions are most likely to be there due to low-level offenses like jaywalking, disorderly conduct, or trespassing.[13] Concerns about these trends, and mounting pressures on jail capacity, have led to efforts to generate solutions that are both more cost effective and more conducive to effective treatment.

Involvement in the criminal justice system compounds the challenges faced by people with behavioral health issues, interrupting their access to benefits, treatment relationships, and routines and other sources of support and stability, and making them vulnerable to trauma.[14] At the same time, EDs, which provide screening and triage for acute medical conditions, are not the best treatment option for individuals whose crisis state is driven by mental illness and or substance use that could be more effectively addressed in a specialized setting.

To address this reality, the criminal justice system has developed alternatives to booking and incarceration for people whose primary reason for law enforcement encounters is their mental illness or addiction. Programs such as specialized law enforcement training, screening in the field by officers with

From 2006 to 2014 the overall number of ED visits for all reasons in the US increased 14.8% while the increase in the rate for mental health/ substance abuse-related ED encounters was over three times that at 44.1% during this same period.[1]

A 2017 study found that almost half of inmates were diagnosed with a mental illness (48%), of whom 29% had a serious mental illness and 26% had a history of a substance use disorder.[2]

As many as two-thirds of people in correctional settings have a diagnosable substance use disorder.[3]

diversion to assessment, and specialty courts that connect individuals to treatment for their mental health or substance use condition are growing in number across the country and demonstrating positive results. Communities have fostered these alternatives to address concerns about jail capacity and to better serve individuals who are in the criminal justice system because of their circumstances, not because they pose a risk to public safety.

Lack of coordination across the multiple points of community response to BH crisis leads to fragmentation and gaps despite best efforts of providers and responders and considerable investment of safety net dollars. These system gaps ultimately contribute to potentially avoidable ED and criminal justice system encounters. The development of a crisis services model with timely interventions at the least restrictive level of care is increasingly recognized as the emerging standard. This approach not only results in better outcomes for persons served but also contributes to reduced costs. Community-based crisis services offer an alternative to costly acute care at hospitals and emergency safety net services, i.e. Emergency Medical Services (EMS), which too often are the response system to behavioral health crisis.[15]

A Promising Model: The Crisis Diversion Facility

The ***crisis diversion facility*** is among emerging community-based strategies to engage and better serve this population. The crisis diversion facility model can be a core component of a coordinated, systemic response, bringing health and service sectors together with law enforcement and first responders in a central facility, providing comprehensive care, reducing reliance on the public safety net and emergency and acute care, and better supporting and stabilizing vulnerable community members.

The crisis diversion facility is a physical hub for a community's crisis continuum of care. This model effectively prevents and responds to BH crises and supports engagement in ongoing mental health and substance use disorder treatment and support services for long term stability. Coordinated BH crisis services are:

- ***24-hour Crisis Lines*** with assessment, screening, triage, preliminary counseling, and information and referral services;
- ***Walk-in Crisis Services*** that offer immediate attention and services to the community on a walk-in basis and drop-off centers for law enforcement to reduce unnecessary arrests;
- ***Mobile Crisis Teams***, available to provide 24/7 community-based screening and assessment in conjunction with law enforcement, crisis hotlines, and hospital emergency personnel;
- ***Crisis Stabilization Units (CSUs)***, sometimes referred to as Extended Observation Units for stays less than 24 hours, are inpatient facilities of less than 16 beds for people in a mental health crisis that serve as a hospital alternative for those whose needs cannot be met safely in residential service settings.

Each of the multiple stakeholders involved in community crisis response and jail diversion, including law enforcement, the judiciary, crisis and community-based providers, and city and county officials, has a specific role within the response system. The crisis diversion facility is based on a common mission and culture of stakeholder collaboration that supersedes individual roles and agendas to inform comprehensive efforts that help people in crisis gain recovery and stability in the community.

Crisis diversion facilities build upon community assets to improve the health and wellbeing of individuals with behavioral health and other challenges, with the result being better outcomes and cost reductions for communities.

A Guide to Crisis Diversion Facilities: What is a Crisis Diversion Facility?

The model crisis diversion facility ...

- ✔ Improves the health and wellbeing of individuals experiencing BH crisis and those with repeated criminal justice system encounters by integrating supports and health care, and law enforcement, criminal justice, and emergency agencies, to improve access to services that reduce reliance on emergency health and public safety response;
- ✔ Is a coordinated community approach by stakeholders with key roles and responsibilities in the system of care that leverages multiple funding streams and community investment;
- ✔ Is developed in alignment with best practices and evidence-based models for driving a service delivery system that is trauma-informed, person-centered, and recovery-oriented.

Arnold Ventures commissioned a study to provide a profile of current promising practices in crisis diversion facilities in the U.S. This report offers a model for BH crisis diversion facilities based on a literature review of strategies for BH crisis and criminal justice diversion in the United States and case studies of four established crisis diversion facilities with promising results. Criteria for the model include:

- Development driven by collaboration and stakeholder input;
- A structure for community governance that includes systematic data sharing and analysis;
- A business case for initial capital expenses and sustainability; and
- A collaborative integrated service delivery system leveraging partnerships and evidence-based practices (see *Detailed Model Framework* included as **Appendix A** of this document).

This Guide is intended to help those who are considering developing a crisis diversion facility with information compiled and lessons learned from successful implementations of such facilities.

Key Elements of Success

The following factors are key elements in developing and sustaining an effective BH crisis diversion facility:

The crisis diversion facility model intentionally addresses and overcomes fragmentation and gaps in the service delivery system with alignment and integration. The model crisis diversion facility does not exist in a vacuum. It serves as the hub for the crisis continuum of care and structured care coordination with community-based services to support recovery and stability. Historically in the American BH service delivery system, mental health and substance use services are separated by funding streams, regulations, and divergent treatment cultures. As conventional wisdom and the evidence base grow to support integrated whole-person care, the crisis diversion facility presents not only the opportunity, but the imperative to integrate mental health and substance use disorder services.

The model crisis diversion facility incorporates standardized screening, assessment, and provision of evidence-based substance use treatment to address the high number of co-occurring mental illness and substance use conditions among the population relying on the safety net, as well as rampant instance of opioid and other substance use disorders leading to crisis. Model facilities have the capacity to provide a full continuum of Medication Assisted Treatment and other evidence-based SUD services on site or have a robust referral partnership that includes warm hand offs and transportation to assure persons served are effectively linked with SUD services.

Making the Case • The visions and goals of the community form the foundation for investment in the crisis diversion facility. Questions like *Why is it important we do this? How will it benefit persons served; key partners; the public? How will we know we are being successful?* are the basis for developing measures and outcomes that tell the story of the facility's progress to generate initial, and continued, investment and support.

Leverage Existing Efforts • Building on iterative efforts and scaling up strategically is an effective way to build both key relationships and the case for larger scale investment. Leaders use their experience in, and results from, other initiatives to develop relationships, foster a culture supporting community response to mental health and addiction, and to inform the business case for a comprehensive crisis diversion facility.

Relationships • Champions for developing a crisis diversion facility build on existing relationships to engage partners and unite the community. These champions share a common vision and commitment to improve their community's ability to respond effectively and compassionately to individuals with mental illness and addiction. They occupy formal roles such as Sheriff, Mayor, District Attorney, Judge, Chief of Police, Chief Executive Officer or Executive Director of primary behavioral health or community agency, County Commissioner or Supervisor, and County Manager, that positions them to have the credibility and authority to drive positive change.

Vision and Goals: • A common vision and goals among the champions and leaders is essential. A vision for serving community members with mental illness and substance use disorders drives establishment of goals aligned with the community's priorities. Priorities vary by community, but common themes are a recognition of the high volume of individuals with mental

- The crisis diversion facility is informed by a common vision that has been cultivated through respect for and incorporation of each partner's organizational culture and priorities.
- The crisis diversion facility model intentionally addresses and overcomes fragmentation and gaps in the service delivery system with alignment and integration.
- The model incorporates standardized screening, assessment, and provision of evidence-based substance use treatment to address the high number of co-occurring mental illness and substance use conditions among the population relying on the safety net, as well as rampant instance of opioid and other substance use disorders leading to crisis.

illness and substance use disorders in the jail and on the streets, and the correlation between these behavioral health conditions and frequent contact with 911/emergency response, law enforcement, EDs, and jails. Communities have a common goal to develop a system that better serves their vulnerable residents who experience BH crisis.

Culture: • The organizational culture, perspectives, and agendas of each of the key partners in the coalition is incorporated to create and build a crisis diversion facility. The facility plan is built from the partners' shared vision to provide effective, efficient response and services to community members. The facility's infrastructure supports processes that align with and maximize the roles, responsibilities, and positive impact of each partner.

Person-Centered Care • A commitment to ***person-centered care that is respectful, compassionate, and based on evidence-based and emerging best practice*** is central to planning. Sites use evidence-based models for criminal justice system diversion and deflection and behavioral health community response such as CIT and assisted outpatient treatment; adopt a crisis model based on provision of care in the least restrictive setting possible; and commit to data driven decision-making and continuous quality improvement.

Criminal Justice System Engagement: • Alignment and collaboration with law enforcement and the criminal justice system is critical to effective community response centered in a crisis diversion facility. The Sequential Intercept Model (SIM) is a framework of the SAMHSA GAINS Center that "provides a conceptual framework for communities to organize targeted strategies for justice-involved individuals with behavioral health disorders.[16] Within the criminal justice system there are numerous intercept points — opportunities for linkage to services and for prevention of further penetration into the criminal justice system" and the SIM can be used by communities and states "to assess available resources, determine gaps in services, and plan for community change." [17]

The six intercept points in the Sequential Intercept Model can be examined alongside the movement of people with BH conditions to understand how people come into contact with the criminal justice system and various services within the care continuum. This supports planning for strategic partnerships and allocation of resources to develop effective responses. Crisis diversion facilities are especially well-positioned to support responses at:

- **Intercept 0:** Community Services – In the field, mobile crisis outreach teams, emergency departments, and law enforcement divert to community-based interventions and treatment.
- **Intercept 1:** Law Enforcement – Specialized training for dispatchers and law enforcement officers and specialized police response teams can support diversion to community-based interventions and treatment.
- **Intercept 2:** Initial Detention / Initial Court Hearings - Creating a site to support screening, assessment, and provision of care as a diversion to booking and incarceration and with mental health warrants.
- **Intercept 3:** Jails / Courts - Crisis diversion facilities can play a role in partnering with the judicial system to provide treatment and support to individuals in therapeutic court programs.
- **Intercept 4 and 5:** Reentry and Community Corrections - Support post-incarceration re-entry to the community by improving access to treatment and support services.

Knoxville, Tennessee's Behavioral Health Urgent Care Center (*Figure 1*) and Salt Lake City, Utah's Receiving Center (*Figure 2*) provide examples of the strategic alignment of crisis diversion centers with those communities' sequential intercept systems.

Partnerships, Roles, and Relationships

The crisis diversion facility leverages the roles and strengths of each collaborative partner. Key partners for effective behavioral health crisis diversion are:

- Policy makers and public entities that develop, fund, and contract for services;
- Law enforcement and first responders;
- The courts and judiciary;
- Behavioral health and other community-based providers;
- Hospitals; and
- Community members and stakeholders of the partners listed.

Culture has been described as "how we do things around here." The organizational culture of a behavioral health agency is different from a police department, for example. Project champions develop the crisis diversion facility plan from a common vision incorporating the culture, capabilities, and contributions of each key partner. Essentially, the "people" part of the plan must be in place before the technical and infrastructure development occurs. This shared vision is critical to create an efficient and effective model facility

Key Partners and Roles

Law Enforcement

The primary role of law enforcement is public safety. The crisis diversion facility supports the critical role of law enforcement as first responders to BH crisis, with services that facilitate officers' rapid disposition of individuals in BH crisis. The warm handoff lets officers return to the street in a matter of minutes and provides an alternative to time spent transporting individuals in BH crisis to an emergency department or inpatient facility and waiting for screening and disposition.

Having a "customer centric" perspective for law enforcement officers is essential when planning a facility. As "customers" of the crisis diversion facility, law enforcement officers and deputies benefit from several features of a model facility:

- **Timeliness:** Model facilities have a standard of no more than 15 minutes for an officer to complete a warm handoff of an escorted individual.
- **Convenience:** A dedicated law enforcement entrance and access to a dedicated kiosk for completing paperwork, restrooms, and snack machines: all without the officer being required to disarm.
- **"No Wrong Door":** A common concern of law enforcement is being told upon arrival that an admission is not eligible. If officers are turned away from a facility for eligibility restrictions, they are less likely to use the facility and to go instead where they can count on getting a disposition, in most cases an ED. Model crisis diversion facilities have a "no wrong door" policy to maximize the use of the facility by officers to meet the community's goal of easing the pressure on both the criminal justice system and ED.s.

In Knoxville, Tennessee, the D.A. and law enforcement leaders have established nine charges that are eligible for law enforcement officer disposition to Knoxville's crisis diversion facility, the Behavioral Health Urgent Care Center.

Other First Responders

Emergency Medical Services (EMS) is also on the "front line" with BH crises. Like police officers and sheriff's deputies, EMS has a responsibility to support public safety with the specific charge to provide urgent and emergent health care response whenever and wherever there is a need in the community. EMS uses algorithms and protocols based on prevailing medical standards to identify and respond to all health conditions presenting among the populace. However, mental health and substance use conditions are often co-occurring with medical conditions – acute or chronic – and at the same time mental health and substance use disorder conditions themselves can be co-occurring. The complexity of this presentation combined with the primary role of EMS to perform acute health care triage and transportation has historically resulted in all such cases being transported to an ED, even when the EMS technician suspects that the primary presenting concern is due to mental illness or substance use. Crisis diversion facilities offer a viable alternative for EMS where the patient is determined by established algorithms to not be medically urgent or emergent but requires specialized mental health and/or intoxication assessment that can be effectively provided at the crisis diversion facility instead of an ED. An example of an EMS protocol integrated with a crisis diversion facility can be found in Rhode Island's BH Link Policy Manual.

Criminal Justice and Judicial System

Individuals with a history of BH crisis often also have legal involvement with the criminal justice and judicial system. They may have multiple citations or charges for offenses resulting in outstanding warrants, repeat detentions or incarcerations, or other legal involvement that results from — and contributes to — their instability in the community while also creating a burden on the enforcement system. Specialty courts, District Attorneys, and Public Defenders can partner with law enforcement, providers, and other system stakeholders to develop treatment alternatives for individuals with behavioral health crises that address their core mental illness and/or substance use in lieu of criminal justice actions. Crisis diversion facilities contribute to diversion models by enhancing access of specialty courts to timely assessment and mental health and substance use treatment, and provide an effective institutional link between the criminal justice system and care for individuals impacted by BH challenges.

Community-Based Behavioral Health and Social Services Providers

Agencies offering mental health and substance use disorder services, and those who meet the need for housing, employment, transportation, food, and other social determinants of health, have a critical role in the safety net. Community members in need often also struggle to access routine medical care, leading to chronic conditions that limit their ability to be stable in the community. The model crisis diversion facility views each person through a multidimensional lens that incorporates all these needs. Individuals who frequently encounter safety net services, law enforcement, and first responders may have developed a mistrust of the system due to previous experiences where they felt that they were not treated respectfully or where response failed to resolve their needs. Crisis diversion facilities incorporate the following elements to effectively engage and serve persons in crisis:

- Trauma-informed: Focus on the needs of the individual in an approach and environment that promotes a feeling of safety and security.
- Recovery-oriented: Support individuals experiencing mental disorders and substance use disorders in a process of change through which they improve their health and wellness, live a self-directed life, and can reach their full potential.
- Person-centered: See and deliver services through the eyes and experience of the person served to align services and resources to best meet the individual's goals for recovery.
- Integrated: Coordinate mental health, addiction, health, and social services, resources, and supports in a seamless approach that provides effective individualized response.

BH and social services providers in the crisis diversion facility engage community members to conduct screening and assessment, and follow up services, in a crisis stabilization unit or with outpatient care that support resolution of crisis without relying on acute care facilities.

City, County and State Administrators and Elected Officials

City, county, and state governments and elected officials are stewards of dollars for critical infrastructure and safety net services and have a responsibility to implement policy that meets the needs of constituents and preserves the public trust. The crisis diversion facility offers public officials and leaders an opportunity to invest in a model that transcends the traditional silos of safety net services and delivers improved outcomes and reduced costs. Policy makers and funders can play a strong role in driving and supporting alignment across the system's variety of agencies and entities that must work together to provide coordinated BH crisis response.

- Through the leadership of the governor's office, Rhode Island developed a crisis diversion facility, BH Link. Sustainability of ongoing operations is supported by implementation of a Medicaid case rate for individuals served at BH Link. This rate "bundles" services offered at BH Link into a payment model alternative to the traditional fee for service model. Such case rates are developed to reflect the value driven by better coordinating care in a defined service model that improves outcomes and reduces costs.
- In Tennessee, state funding for jail diversion initiatives funded the development of and will support ongoing operations at the Behavioral Health Urgent Care Center in Knoxville.

State policy can play a critical role in incentivizing cross system coordination through rewards, penalties, and contract standards. See the "Funding" section for additional details on these initiatives.

Hospitals

Hospitals and other acute health care facilities provide assessment and treatment of individuals experiencing acute medical conditions, including those co-occurring with or caused by BH conditions. The crisis diversion facility model offers an alternative to ED and other hospital encounters. Model crisis diversion facilities offer mental health and substance use disorder screening and assessments, immediate stabilization services, including those for psychiatric crisis stabilization and substance use withdrawal, and can triage and stabilize minor medical conditions. Law enforcement officers and EMS technicians can divert from EDs and inpatient care to an appropriate lower level of care. Hospitals can save resources for acute care that can only be provided in a hospital to better meet community emergency health needs.

Data and Analysis

The stories told by communities about how and why they want to better respond to community members with mental health and substance use conditions give rise to the crisis diversion facility that fulfills the community's vision.

Data that reflect the community's issues and challenges help make the case for the imperative to support a model facility to better serve people with BH conditions. The data paint the picture of the need which in turn ignites community members' compassion and commitment to developing solutions. Some data points communities have used to make the case for a crisis diversion facility include:

- Jail bed census compared to jail capacity
- Numbers of persons in jail with a diagnosed BH condition
- Recidivism rate of individuals with a diagnosed BH condition
- Number of MH warrants served and where individuals under warrant receive crisis intervention
- Law enforcement officer/deputy response to BH crisis
  - Number of responses
  - Average time spent until disposition of BH crisis
- Costs associated with
  - Jail bed days, including for one:one – or – individual observation for detainees with high risk BH conditions
  - Booking costs for individuals with BH conditions
  - Law enforcement officer BH crisis response time

The Data-Driven Justice Playbook outlines a multi-step strategy for the use of data to engage and inform a community effort to develop a criminal justice diversion system: [18]

- Use data to tell the story of challenges your community faces;
- Use data to show that change is needed;
- Establish agreements for sharing data; and
- Integrate data across systems to understand the magnitude of cross-system utilization and key characteristics of cross-system utilizers.

> To further tell the story, community members developing a crisis diversion facility must ask the question, "Who will be served at the crisis diversion facility?"

This question is best answered by considering the community's pain points where people in BH crisis intersect with the criminal justice and emergency response systems. The population of focus is typically people with BH conditions with multiple police encounters for low-level offenses (criminal trespass, failure to appear on citations for jaywalking, panhandling) or due to community complaints requiring law enforcement response; those who frequent the ED with issues due to their BH condition but not requiring acute-level care; and frequent 911 utilizers with, again, issues that could be resolved without the involvement of emergency response services.

As community leaders develop their data story, the following elements are important in planning:

- Include experts in information technology and data analytics such as the CIO, Privacy Officer, Finance/CFO, and Database Administrators from participating agencies in the planning process for data collection. These subject matter experts can assist with identifying data sources and plan how to systematically collect information to make the case for the facility and to profile the population to be served. They can also resolve concerns regarding privacy and other aspects of data sharing. The Data-Driven Justice Playbook outlines key steps to build consensus and document the specific uses for sharing data, identifying the minimum types and amounts of data needed to achieve the established purpose, while offering ongoing opportunities to inform individuals and the public about how their data are being used to gain trust, and building privacy, security, and civil liberty protections into the design of the data sharing systems.[19] To guide development efforts, the U.S. Department of Health and Human Services (HHS) provides answers to many of the common questions and misperceptions regarding HIPAA. [20]
- Develop the framework for ongoing data collection to support clear actionable milestones, data-sharing, and data-driven process improvement. Communities and organizations often fail to do this initial work to determine what data is needed to prove the positive impact of their facility and how the data will be collected and monitored. Not doing this work upfront means a lost opportunity to build a strong "business case" for the facility that attracts investment from varied partners and supports sustainability through continued funding support. Funders of all types and at all levels — private and public; individual, city, county, state, and federal – are most likely to financially support facility development efforts and ongoing operations that are represented by a data-based proof of concept and evaluation model. This guide's companion report profiles four crisis diversion facilities and includes examples of community data "stories", with examples from these, and other sites, summarized below.

Rapid City, Pennington County, South Dakota

Rapid City in Pennington County South Dakota is the site of The Care Campus, a facility that opened in September 2018 offering a single point of entry to the community for, and law enforcement disposition of, behavioral health crisis with co-located programs in one location. The Care Campus is a partnership of the Pennington County Sheriff's Office; Pennington County Health and Human Services; the City of Rapid City; and the Crisis Care Center operated by Behavior Management Systems, a private provider under the oversight of the Pennington County Sheriff's Office. The Care Campus includes a full continuum of co-located services addressing the crisis stage of mental health and substance use disorders and support services to assist Care Campus clients with attaining recovery and maintaining stability in the community. Services at the Care Campus are documented in the same electronic record that is used for the Rapid City Police Department, Pennington County Sheriff, Pennington County Jail and Juvenile Detention Center. This creates a coordinated view of individuals served in the Care Campus with their history in the criminal justice system, while also supporting the ability to analyze and report on a shift in costs from jail to services provided at the Care Campus.

Knoxville, Knox County, Tennessee

The Behavioral Health Urgent Care Center (BHUCC) in Knoxville, Tennessee, is a collaborative effort of leaders from county and city government, the District Attorney, Knoxville Police Department, Sheriff, and the Helen Ross McNabb Center, a private behavioral health agency. The BHUCC, which opened in March 2018, provides a full continuum of crisis services and drop off disposition for law enforcement. Nine misdemeanor charges have been standardized for which law enforcement can automatically divert individuals who appear to have behavioral health issues to the BHUCC unless deemed violent, or for other exclusions based on risk. They are assessed and offered voluntary admission in lieu of charges being filed. The BHUCC staff, law enforcement, and DA's office track the following measures to support ongoing quality and utilization monitoring of the BHUCC. See Table 1 for more detail.

Table 1. Highlighted Data from BHUCC (March 19, 2018 - September 30, 2018)

Measure	Data		
Population by Sex	Female: 24%	Male: 76%	Other: 1%
Housing Status: Adults Reporting Homelessness (Yes); Not Reporting Homelessness (No)	Yes: 60%	No: 40%	
Referrals to Post Discharge Treatment (Yes); Client Refused (No)	Yes: 88%	No: 12%	
Post Discharge Initial Appointment Status: Initial Appointment Kept (Yes); Initial Appointment not Kept (No)	Yes: 74%	No: 26%	
Return to BHUCC: Returned (Yes); Did not Return (No)	Yes: 21%	No: 79%	

San Antonio, Bexar County, Texas

The crisis diversion facility, the Restoration Center, is situated within the larger crisis response and jail diversion system in Bexar County and includes a full continuum of care for BH crisis and law enforcement disposition. Comprehensive data sharing and analytics include: the Community Medical Directors Roundtable, a community collaborative forum of stakeholders that reviews and responds to a set of data/metrics on a monthly basis (a sample of the monthly CMDRT report is provided as Appendix B); MEDCOM, a community initiative that includes real time communications between law enforcement and hospitals for disposition of BH crisis/emergency detentions; and Signify Community, a population health technology platform that identifies and supports a comprehensive response to system high utilizers coordinated among county hospitals, the local mental health authority, and EMS.

The Restoration Center uses data collected to show positive impact on expenditure of county tax dollars and utilization of city resources by correlating data from its operations with data such as:

- Average number of open beds per night at Bexar County Jail;
- Number of jail bookings; and
- Estimated value of getting officers back on the street by quickly diverting public inebriates to the Center instead of detention facilities, or injured prisoners to the Center's on-site minor emergency clinic instead of hospital ER.

Table 2. Public Funding Sources for Crisis Services in Texas

State	Crisis Services Provided	Services Infrastructure and Collaboration	Funding Sources Reported
Texas	**Emergency Service Centers** • Provide extended observation and jail diversion services **Residential Crisis Services** • Crisis Stabilization Units • Crisis Respite • Crisis Stabilization Beds • Mobile Crisis Teams • Outpatient Crisis Services • Crisis Hotline	In 247 counties, the state delegates a community mental health center with the responsibilities of a mental health authority which ensures the provision and continuity of services for individuals with mental illness, including crisis services. NorthSTAR, a behavioral health service system, through which mental health and substance abuse services are provided to eligible consumers, serves seven counties.	• State General Funds • Medicaid Funds • Medicaid Rehabilitation Option • Medicaid 1915(b) Waiver • Medicaid 1115 Waiver • Mental Health Block Grant • Local Government Funds • Emergency Management Agency (FEMA) Funds

Tucson, Pima County, Arizona

The Crisis Receiving Center (CRC) in Tucson is physically connected to Banner University Medical Center offering co-located access to emergency and inpatient psychiatric care for individuals presenting at or receiving treatment at the CRC who require acute levels of care. The CRC is a county-owned facility operated by Connections, a private behavioral health provider. Law enforcement accesses the CRC through a dedicated entrance with a firm "no wrong door" policy and benefits from rapid disposition of individuals experiencing behavioral health crisis.

> The Crisis Receiving Center (CRC) operates within a robust data sharing and analytics framework and quality improvement culture.

Until 2018 when Arizona Medicaid, Arizona Health Care Cost Containment System (AHCCCS) restructured and re-procured its Medicaid contract, there was one payor in Pima County, Cenpatico (now Arizona Complete Health, (ACH)), and patient data sharing and review was conducted systemically. These processes continue with ACH, and CRC leadership is working on scaling them with Medicaid payors now operating in Pima County. Payor reports are integrated into CRC existing operations and reporting workflows as much as possible. Utilization management staff at the CRC reviews all inpatient charts to conduct concurrent reviews and to glean meaningful data for quality improvement purposes. On a monthly basis, the following data is reviewed:

- Return to CRC within 72 hours resulting in an admission to the inpatient unit;
- 30-day readmissions to inpatient unit; and
- As time permits, all other 72-hour return visits.

See Figure 3 – Draft Crisis System Dashboard for Pima County and Southern, AZ.

Salt Lake City, Salt Lake County, Utah

The Intermountain LDS Hospital Behavioral Health Access Center serves patients experiencing a mental health crisis and engages providers and community partners in fostering a provider network for community members with BH conditions served at the Access Center. The Center tracks scheduled appointments with outpatient BH providers, along with diversions from inpatient admissions (see Table 3 for additional data). The University Neuropsychiatric Institute operates the Receiving Center for assessment and interventions and short-term crisis resolution. These crisis diversion facilities operate within a community criminal justice system diversion system built from multiple public and private entities, including The Utah Department of Public Safety's Highway Patrol, Salt Lake City (SLC) Police Department which is a united city and county law enforcement, Salt Lake County and City elected officials, and Salt Lake County BH Department.

In 2017 Salt Lake City was facing a serious problem in a small concentrated downtown area with up to 2,000 individuals congregating or camping with open drug use and sales, prostitution, and interpersonal violence occurring, creating a threat to public safety and disrupting businesses in the area. Operation Rio Grande (ORG), a partnership between the Utah Department of Public Safety Highway Patrol, SLC Police Department, and Workforce Services Workforce Development was launched to mitigate the situation. ORG deployed multiple strategies, including outreach and engagement, coordinated connection to services, and arrest sweeps to get the situation under control. One of ORG's strategies focuses on 20 non-violent offenders with more than 500 low-level misdemeanor bookings over the past 10 years. On average these individuals spend six days in jail and have cost Salt Lake County over a half million dollars in incarceration costs alone. These individuals are diverted to and served through the Community Connections Center (CCC) rather than being booked into jail with the goal to interrupt the churning through the CJ system and support stability in the community.

Table 3. Sample of Year-to-Date LDS Access Center Statistics

Criteria	Amount
Patients Seen	1,771 patients
Patients Treated in Observation	552 patients
No Diverted Admissions with Use of Observation	436
Patients Discharged from Access Center	1,381 (78%)
Average Time to Follow Up Appointment	6 days
Patients Transferred from Local ED	489 patients
Patients Presenting with BH Primary Concern	82%
Patients Presenting with SUD Primary Concern	18%
Reduction in Psychiatric Transfers out of LDS	25%

New York City, New York

In 2017, New York City invested nearly $90 million for two new diversion centers scheduled to open in 2020. These centers will be able to divert approximately 2,400 people annually who would otherwise be arrested on low-level charges. The diversion centers are part of the Mayor's Action Plan on Behavioral Health and the Criminal Justice System.

> The centers offer a range of clinical and non-clinical services, including overnight shelter and basic need services, such as food, laundry and showers.

Clinical services include health and behavioral health assessments, counseling, advocacy, peer-to-peer engagement services, medication, medically supervised substance use stabilization and withdrawal management services, and naloxone training and distribution. The City committed $90 million over 10 years to operate two Health Diversion Centers and reviewed data including precinct-level arrests for low-level drug possession and public health indicators to determine which neighborhoods had the greatest need, which were determined to be the Bronx and East Harlem. These programs will also receive State funding and programmatic support from the State Office of Alcoholism and Substance Abuse Services and the State Office of Mental Health, with each Health Diversion Centers estimated to 1,200 people a year.

Rhode Island

BH Link, this state's crisis diversion facility, is administered by The State Departments of Behavioral Healthcare (DBH) and Developmental Disabilities and Hospitals. DBH recently implemented a new database which has modernized the Department's process of tracking ED utilization for persons with SUD with a hospital and treatment resource census function (for tracking utilization such as inpatient detox) which is updated daily and provides estimates on BH system capacity. DBH also participates in the RI360 database, a program which compiles a number of the state's data sources and integrates the data for the purpose of analysis and can trace an individual's "journey" through different state services. While this tool provides invaluable context for an individual's care and allows providers and care managers to identify an individual's interactions with historically siloed departments in the state (i.e., Department of Justice, Department of Behavioral Healthcare), the RI Department of BH is still working on integrating this tool in the day-to-day operations of its staff. The Rhode Island data that includes de-identified data from the Medicaid data ecosystem offers a full view to an individual's experience in continuum of care, which is operated with limits in regard to patient consent requirements as outlined in 45 CFR 164.514, and other relevant regulations for uses and disclosure of protected health information. The tool is in the early stages of implementation but the goal is to provide the State with considerable insight on program impact when fully realized.

Linked is a sample manual of policies and procedures from BH Link.

Funding

Funding of crisis diversion facilities must be considered at two stages: capital funding for initial planning and development and operational funding for ongoing service delivery and sustainability. While funding innovative BH services can be a challenge, potential funding opportunities exist at different levels of government and in collaboration with other funding partners. Many funding streams from public sources are tied to specific populations (i.e. youth; persons with serious mental illness; individuals with developmental disabilities). In addition, the current payment structures in Medicaid and commercial insurance typically do not reflect the full-service array and cost of providing effective care that gets positive outcomes with the population served at crisis diversion facilities. And, in many settings, especially in states where Medicaid has not been expanded, the majority of persons targeted for services at crisis diversion facilities does not have a direct benefit source.

A comprehensive national overview of the funding strategies used by each locality or even each state to fund behavioral health crisis services does not exist, which causes difficulty in comparing funding approaches across the nation to identify the best strategies for replication when implementing a BH crisis diversion program. Additionally, factors unique to each community, such as a community's demographics (i.e., race, ethnicity, gender, and/or age), access to transportation, socio-economic conditions, and the political environment will impact considerations of the array of appropriate services to provide and will lead to further variations in funding needs and approaches. Communities can leverage a number of existing funding structures that have been used in communities to support robust BH crisis diversion facilities.

While funding innovative BH services can be a challenge, potential funding opportunities exist at different levels of government and in collaboration with other funding partners. Many funding streams from public sources are tied to specific populations (i.e. youth; persons with serious mental illness; individuals with developmental disabilities).

Collaborative Funding for Behavioral Health Crisis Intervention

Collaborative funding, which includes both blended and braided funding, is a strategy for combining funding sources that enables organizations and states to address behavioral health crises. Braided funding consists of multiple funding streams, brought together to pay for more services than any one stream can support, that are tracked separately to report to funders. In blended funding,

multiple funding sources are used for a single program or array of services but lack requirements to track individual funding streams for reporting. Many funding sources for BH crisis services are restricted to the provision of care for a specific population. Typically, programs offering BH crisis services need to pool available funds, as funding allocated for a single population is often insufficient to fully sustain comprehensive services.

Federal Funding

Federal agencies that provide funding for crisis services include the Substance Abuse and Mental Health Services Administration (SAMHSA) which funds formula-based block grants and discretionary grant programs; Health Resources and Services Administration (HRSA) which provides funding for community health centers; Centers for Medicare & Medicaid Services (CMS) which administers Medicaid and Children's Health Insurance Program (CHIP); and the Department of Veterans Affairs (VA) and Department of Defense (DOD) which provide mental health benefits within their delivery system. The majority of funding for BH crisis services is from Medicaid and the federal government. In the current BH crisis system, private insurance has not typically provided reimbursement for BH crisis services, though there is increasing awareness of the impacts of social determinants on health outcomes.

> The low percentage of individuals with commercial insurance coverage served in the BH crisis system, and the nature of a crisis episode – which makes obtaining benefits information challenging – preclude this being a viable funding source for sustaining a crisis diversion facility.

Federal Grants

SAMHSA block grants — Community Mental Health Services Block Grants (MHBGs) and Substance Abuse Prevention and Treatment Block Grants (SABGs) — are an important source of funding for many crisis services providers. The MHBG program operates in every state and the District of Columbia. Administered through state mental health agencies, these grants are typically used to finance services for low-income adults and children. Some states leverage MHBG funds to create a reliable and sustainable source of reimbursement through Medicaid for services to augment BH crisis response. Using this, Michigan created and sustains a network of Assertive Community Treatment (ACT) teams, an evidence-based model for addressing the needs of individuals with complex BH needs. Historically, SABG has been used as the primary funding source for substance use treatment services and prevention. These funds are administered by the state agency responsible for substance use treatment and are focused on services for specific populations, such as intravenous drug users.

State Funding

Many states use state general revenue to "fill in gaps from other funding sources" or for services for which there are no other funders such as BH crisis services.[21] Examples of services that might be under this financing umbrella include crisis services for Medicare beneficiaries; mobile crisis programs (unless these programs are covered by Medicaid); and other services for the uninsured. These funds have also been used by states for staff payroll in states where personnel are state employees and to pay for infrastructure such as facilities for crisis services.[22] In Massachusetts four of the 21 Emergency Services Programs are staffed with state personnel. At these facilities, which provide 24/7 crisis assessment, intervention and stabilization services, and salaries for state employees are paid with state funds while Medicaid-eligible services are billed to Medicaid.

Augmentation of Medicaid

According to SAMHSA's review of crisis services in eight states, "the most frequently reported funding sources for crisis services are state and county general funds and Medicaid waivers."[23] Medicaid waivers are submitted by individual states for CMS approval and allow states the opportunity to apply Medicaid funds to broaden service coverage for specific populations. Common waivers used for behavioral health services include 1915(i) waiver for home and community-based services which can cover alternative living arrangements in the community. Another option is the 1115 waiver for broadening service coverage for specific subgroups, which allows states to improve care for populations that do not typically receive services via Medicaid. Utah offers an example of a Medicaid waiver to support improvement of services to adults with BH conditions, including those experiencing homelessness.

Salt Lake County, Utah: Targeted Adult Medicaid Extension (TAM)

As part of a robust Salt Lake County community response to individuals experiencing BH conditions, homelessness, and criminal justice system involvement, Salt Lake County Behavioral Health leadership played a role in efforts in the state to pass House Bill 437 in the 2016 General Session. HB 437 established a plan for a Utah-specific approach to reduce the number of uninsured adults in the state through an application for an 1115 Demonstration Waiver to CMS to expand Medicaid coverage to adults: The Targeted Adult Medicaid Extension (TAM). The bill directed the Utah Department of Health (UDOH) to expand Medicaid coverage and created three new eligibility groups of adults without dependent children. UDOH submitted an 1115 Demonstration Waiver to CMS for TAM which was approved on November 1, 2017 to provide Medicaid coverage for adults without dependent children with household income up to 5% of the federal poverty level (FPL) who are: chronically homeless; involved in the justice system through probation, parole, or court ordered treatment; and needing substance abuse or mental health treatment.

Expanding Medicaid in a previously non-Medicaid expansion state can increase the population covered for behavioral health crisis services, increasing reimbursement to providers and systems providing services.

Expanding Medicaid in a previously non-Medicaid expansion state can increase the population covered for behavioral health crisis services, increasing reimbursement to providers and systems providing services. The TAM was a key component to improve access to needed treatment for individuals with complex BH needs in Salt Lake County, and results there helped build the case for larger statewide expansion of Medicaid to serve adults in similar circumstances. State Medicaid expansion passed on the Utah state ballot in the November 2018 general election. Access to Medicaid reimbursement improves sustainability for BH providers along the continuum, especially those operating to serve the crisis and other complex care populations. *See Figure 4 for more detail on Salt Lake County Department of Behavioral Health services and funding.*

State Medicaid Managed Care Contracts

Many states use Medicaid Managed Care for the provision of their Medicaid programs. In fact, a majority of all beneficiaries nationally receive most or all of their care from managed care organizations (MCOs).[24] In Medicaid managed care, states contract with MCOs for the delivery of Medicaid health benefits and additional services for a set per member per month (capitation) payment for these services. States can expand the current array of covered services for Medicaid beneficiaries by adding services to the covered services listed in the Medicaid Managed Care contracts.

Florida

Florida included provisions in its contract that MCOs must reach out to plan enrollees to help them avoid, when possible, future inpatient services or their deeper involvement in the criminal justice system. Outreach focuses on people who are homeless or at risk of involvement in or already engaged with the criminal justice system to improve access to care. As part of this outreach, MCOs must use prevention measures, including connecting people to pre-booking sites that perform screenings and assessments, and then link them to behavioral health treatment.

Rhode Island

As Rhode Island developed BH Link, its crisis diversion facility, it considered how to support its ongoing sustainability. The goal for the BH Link was to close the gaps in care to reduce opioid-related deaths and other adverse outcomes, linking people to needed services and treatment along the continuum, including when experiencing crisis. Recognizing that individuals likely to be most in need at the intersection of mental illness, substance use and addiction, and/or homelessness require an array of services for intervention to be effective, the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals developed a special "BH Link" Medicaid rate. To set the rate, the department estimated what they thought would be a typical interaction and set of interventions to be effective with this complex population. For example, they considered that intervention times would vary and that not all services would require the services of a psychiatric medical provider. The proposed rate formulation allows RI to start this effort and evaluate both outcomes and costs as the program progresses (*see Table 4 BH Link Triage Center Medicaid Rate Composition*).

Table 4. BH Link Triage Center Medicaid Rate Composition

Service	Rate/Unit	Duration of Unit	Projected Avg # Units	Projected Total	Cost
Crisis Assessment	—	60 min	1	60 min	—
Nursing	—	5 min	24	120 min	—
Case Management	—	15 min	7	105 min	—
Psychiatrist — Evaluation and Management	—	25 min	1	—	—

Health Homes

Since 2012, Missouri has operated health homes for two populations of high need, high cost beneficiaries: those who have been diagnosed with serious mental illness and those who have multiple chronic conditions. The state Medicaid and mental health agencies utilize the health home model within Medicaid managed care which has produced lower health care costs and improved care for these complex populations by streamlining care management and data sharing, providing effective care for beneficiaries, and supporting providers within the health home system.

> 2016 data shows that the establishment of health homes resulted in $52 in Medicaid savings, per beneficiary, per month.

The state has taken a proactive approach to identifying potential health home beneficiaries. Three times a year, the state reviews enrollment data to identify beneficiaries who may be eligible for the health home program. This hands-on approach is not limited to beneficiaries; the state is actively involved in providing supports to health care providers such as coaching, training, data management, and IT assistance. MCOs collaborate with health homes by sharing data such as automated notifications when beneficiaries have been admitted to the hospital.

The targeted enrollment of beneficiaries, provider supports, and holistic care provided in the health home has culminated in a highly efficient and effective system. 2016 data shows that the establishment of health homes resulted in $52 in Medicaid savings, per beneficiary, per month. The overall health of the populations also improved. The beneficiaries in both the physical and behavioral health "cohorts" saw an overall decrease in emergency department visits as well as a decrease in instances of preventable hospitalization.[25]

Coordinated Care Organizations

Oregon received approval from CMS in 2011 to establish Medicaid accountable care organizations (ACOs) called Coordinated Care Organizations (CCOs).[26] More often associated with use in Medicare programs, Oregon's Medicaid CCO model allows the state to apply the same strategy of coordinating care and collaborating with community organizations to its Medicaid population. Oregon's CCOs were established via a federal Section 1115 Waiver and state legislation by HB 3650.[27, 28, 29] Dubbed Oregon's health system transformation legislation, HB 3650 established the Oregon Integrated and Coordinated Health Care Delivery System in which the 16 regional CCOs operate.

In tandem with the newly stable Health Care Delivery System, CMS provided $1.9 billion to assist with the transition of most Medicaid enrollees to the CCOs.[30] The CCOs are managed within a fixed global budget, defined in HB 3650 as "a total amount established prospectively by the Oregon Health Authority to be paid to a coordinated care organization for the delivery of, management of, access to, and quality of the health care delivered to members of the coordinated care organization."[31] This patient-centered approach leverages primary care homes and health information technology to improve an individual's overall health and to reduce health disparities. Initial research confirmed that after the first two years, Oregon's CCOs were associated with improvements in utilization, access, and quality including a reduction in ED and primary care visits; and improvements in acute preventable hospital admissions.[32, 33]

Collaborative Public Funding

In addition to seeking opportunities to tap into expanded Medicaid funding, cities, counties, and states have collaborated to combine funding to support their BH crisis initiatives. Examples of this type of funding are described below.

Bexar County, Texas

The Bexar County jail diversion model since its inception has subscribed to the proof of concept model, using available funding sources to achieve positive outcomes to demonstrate results and accountability, which in turn attracts additional funding and supports scaling up and addition of needed services. At the crisis diversion facility in Bexar County, the Restoration Center, multiple funding streams support the array of services and programs housed there, with a total operating Budget of $36 million. The crisis services are contracted with the Texas Health and Human Services Department of State Health Services (DSHS) within a state funding and regulatory system structured for the local mental health authorities (LMHSAs) to provide crisis services in their respective catchment areas. The Center for Health Care Services (CHCS) is the LMHA for Bexar County. DSHS has specific contracts with CHCS for various substance use disorder (SUD) services offered at the Restoration Center. The Medication Assisted Treatment (MAT) services are funded by a cost reimbursement contracted with Texas Health and Human Services Commission (HHSC) and billing of third-party payors. The county/safety net hospital, University Health System (UHS), also contracts with CHCS for cost reimbursement for a number of unfunded individuals. HHSC funds suboxone treatment for 600.

At the crisis diversion facility in Bexar County, the Restoration Center, multiple funding streams support the array of services and programs housed there, with a total operating Budget of $36 million.

A specialty program for pregnant and parenting opioid-addicted women (the "Mommies" program) was initiated under a SAMHSA grant and has been continued through collaborative funding when the grant expired. UHS contracts with CHCS to serve individuals in this program, and HHSC has funded a pilot addressing Neonatal Abstinence Syndrome (NAS) that includes funding for treatment and services at Restoration Center and 16 residential beds at a separate location. SUD outpatient treatment is funded through a combination of billing third party payors; HHSC cost reimbursement contracts; contracts with Bexar County through the court/diversion system; and through UHS's CareLink, the County's health insurance program. Restoration Center is licensed for and contracted with HHSC for 28 medical detox beds, with cost reimbursement and UHS-Carelink combining as funding sources.

HHSC also contracts with CHCS for several specialty programs, including the Co-Occurring Psychiatric and Substance Use Disorders Program (COPS-D) program; and recovery support programs: DSHS Recovery Support – a pilot to develop and provide a model for recovery support; and Recovery Support team which supports integrated treatment program at the supported living dorm at the adjacent Haven for Hope homeless transformation services campus.

The Sobering and Injured Prisoner Triage Clinic at Restoration receives funding from the City of San Antonio as the sole payment source. This operation is dedicated to supporting local law enforcement in responding to public intoxicants and individuals in BH crisis with a warm handoff so officers and deputies can quickly return to the streets.

State-Level Grants

State-level grants may support initial services for BH crisis or criminal justice system diversion within a community that then require other sources of funding for the services to be sustainable. In 2013 Tennessee introduced Senate Bill 180/House Bill 174 which addressed the release of defendants who lacked the mental capacity to proceed with trial. The bill set a time limit for the length of time that a misdemeanor charge can remain pending against a defendant deemed incompetent to stand trial. Building on the success of this program, in the FY18 budget, the governor and General Assembly provided $15 million in non-recurring funding for pre-arrest diversion infrastructure. Grantees competitively bid for the state funding and a key aspect of applications was leveraging local funding to sustainably support the state's funding. Local partners committed $4 million in supplementary funding to augment the state's funds for developing infrastructure to divert individuals with behavioral health needs away from jail and to community-based treatment; implement community strategies to serve individuals in crisis while reducing incarceration and reducing related costs; and demonstrate a coordinated system of care that incorporates not only law enforcement but also behavioral health providers.

In Florida, the Florida Criminal Justice, Mental Health, and Substance Abuse (CJMHSA) Reinvestment Grant by the Florida state legislature in 2007 awarded funding to counties to support the planning, implementation, or expansion of programs that aim to reduce the number of individuals with mental illness or substance use disorders who are in the criminal justice or juvenile justice systems. Since then Florida has continued to build on this strategy with additional state funding and strategies to further build out the BH crisis and criminal justice diversion system.

Community Supported Initiatives: Bonds and Sales Tax Initiatives

County Bond: Pima County, Arizona

The Crisis Receiving Center (CRC) in Tucson was established in 2011 to complement and expand services to the existing psychiatric care facilities at Banner University Medical Center's South Campus. The CRC has its origins in advocacy efforts by and leadership of the County Administrator and Board of Supervisors who championed a solution for transitioning the existing County Hospital to a newly configured system that would meet the needs of Pima County residents challenged by behavioral health crisis. At the same time, these County officials, along with law enforcement leaders from the Tucson Police Department and Pima County Sheriff, drove a community dialogue and development effort that included mental health and medical providers and other stakeholders to develop a vision, design, and plan that would ultimately create "no wrong door" for people in behavioral health crisis. County leaders responded to community and stakeholder interest in improving options for and response to individuals with mental illness and substance use disorders with a bond initiative in 2006 to support development of a new psychiatric hospital and psychiatric urgent care center: $36 million in bond funding supporting development of the psychiatric hospital and $18 million in bond funding for the psychiatric urgent care center. This provided additional inpatient psychiatric beds and supported the development, on the same campus, of the Crisis Receiving Center (CRC.)

Among the gaps noted was the increasing volume of behavioral health issues in adults being responded to by police officers due to the absence of a local treatment center.

Sales and Use Tax: Larimer County, Colorado

Larimer County Colorado passed a sales tax initiative in the 2018 general election that will fund development of a BH crisis diversion facility and expand and enhance behavioral health services overall in the County. The measure was developed and endorsed by an advocacy group, Citizens of Larimer County for Mental Health Matters, which is composed of county employees, members of the public, and the Larimer County Commissioners.

The original 2016 measure called for a $0.25 sales tax — 25 cents for every $100 spent — implemented for 25 years which failed by a margin of 52.1 percent to 47.9 percent. Advocates for the measure returned to the voters in 2018 with a 20-year implementation proposal which passed by a margin of 67%.

Advocates for the measure actively sought community input and conducted a gap analysis of the current BH treatment system to inform the plan for the initiative. Among the gaps noted was the increasing volume of behavioral health issues in adults being responded to by police officers due to the absence of a local treatment center. The plan calls for a three-pronged approach: expand and enrich local BH services across the County; facilitate connections between community-based services and services/providers in a centralized facility to provide a stronger care coordination system, and building transition bridges across providers and services in and outside of the facility; and build a regional behavioral health facility to provide coordinated care and crisis services.

The Promise of Recovery

Community efforts to develop crisis diversion facilities are spreading, with the promise that people experiencing crisis will receive the individualized compassionate response that supports their recovery, while communities benefit from an increase in the well-being and productivity of their citizens and reduced costs for public safety net services and health care.

Figures

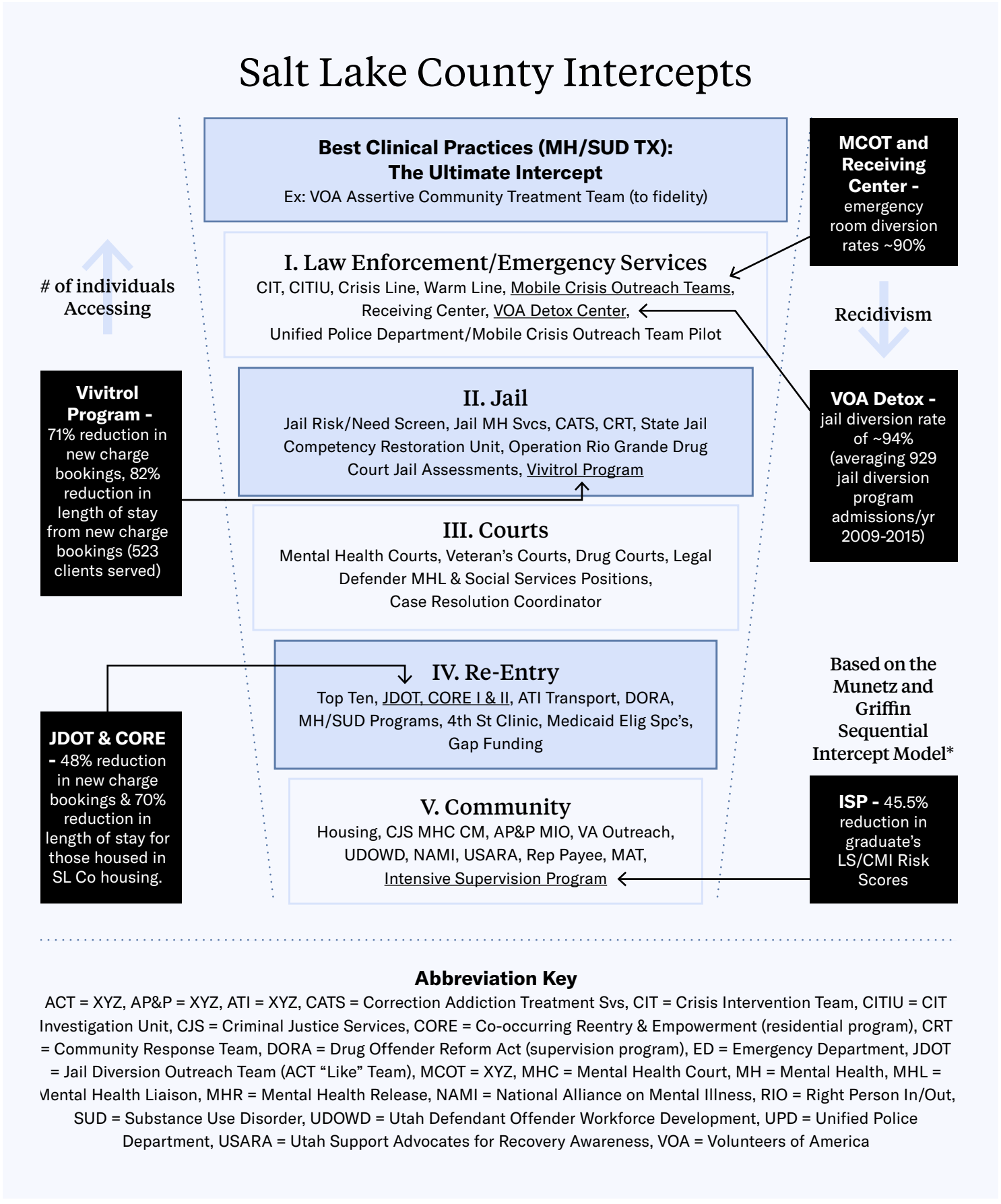
Figure 1. Programs by Sequential Intercept Point - Knoxville, Tennessee

Intercept 0 **Community Services**	*Intercept 1* **Law Enforcement**	*Intercept 2* **Initial detention/ Initial court hearings**	*Intercept 3* **Jails/Courts**	*Intercept 4* **Re-Entry**	*Intercept 5* **Community Corrections**
Mobile Crisis Unit	Behavioral Health Urgent Care Center – Avenue A*	Behavioral Health Urgent Care Center – Avenue B**	Release planning for mental health and addiction services in the jail system	Criminal Justice Mental Health Liaison Program, including case management and peer services	Medication Assisted Treatment Group Therapy – Anger Management and Cognitive Behavioral Therapy
Crisis Stabilization Unit	Knoxville Early Diversion for Sex Workers		Local recovery courts and veterans recovery courts		
Crisis Intervention Training (CIT)	Knoxville Early Diversion Co-Response Team		Tennessee Recovery Oriented Compliance Strategies Docket		

**Avenue A = Avenue A is the main path of referral to the BHUCC. Referral is made by law enforcement officers in the field who arrest an individual with one of the nine misdemeanor charges approved for referral.*

***Avenue B = Avenue B is set aside as a special path for individuals whose charges fall outside the nine approved misdemeanor charges, but whom the District Attorney General believes would benefit from entry into the BHUCC after an initial appearance in court.*

Figure 2. Salt Lake County Diversion System



Abbreviation Key

ACT = XYZ, AP&P = XYZ, ATI = XYZ, CATS = Correction Addiction Treatment Svs, CIT = Crisis Intervention Team, CITIU = CIT Investigation Unit, CJS = Criminal Justice Services, CORE = Co-occurring Reentry & Empowerment (residential program), CRT = Community Response Team, DORA = Drug Offender Reform Act (supervision program), ED = Emergency Department, JDOT = Jail Diversion Outreach Team (ACT "Like" Team), MCOT = XYZ, MHC = Mental Health Court, MH = Mental Health, MHL = Mental Health Liaison, MHR = Mental Health Release, NAMI = National Alliance on Mental Illness, RIO = Right Person In/Out, SUD = Substance Use Disorder, UDOWD = Utah Defendant Offender Workforce Development, UPD = Unified Police Department, USARA = Utah Support Advocates for Recovery Awareness, VOA = Volunteers of America

Figure 3. Draft Crisis System Dashboard for Pima County and Southern AZ

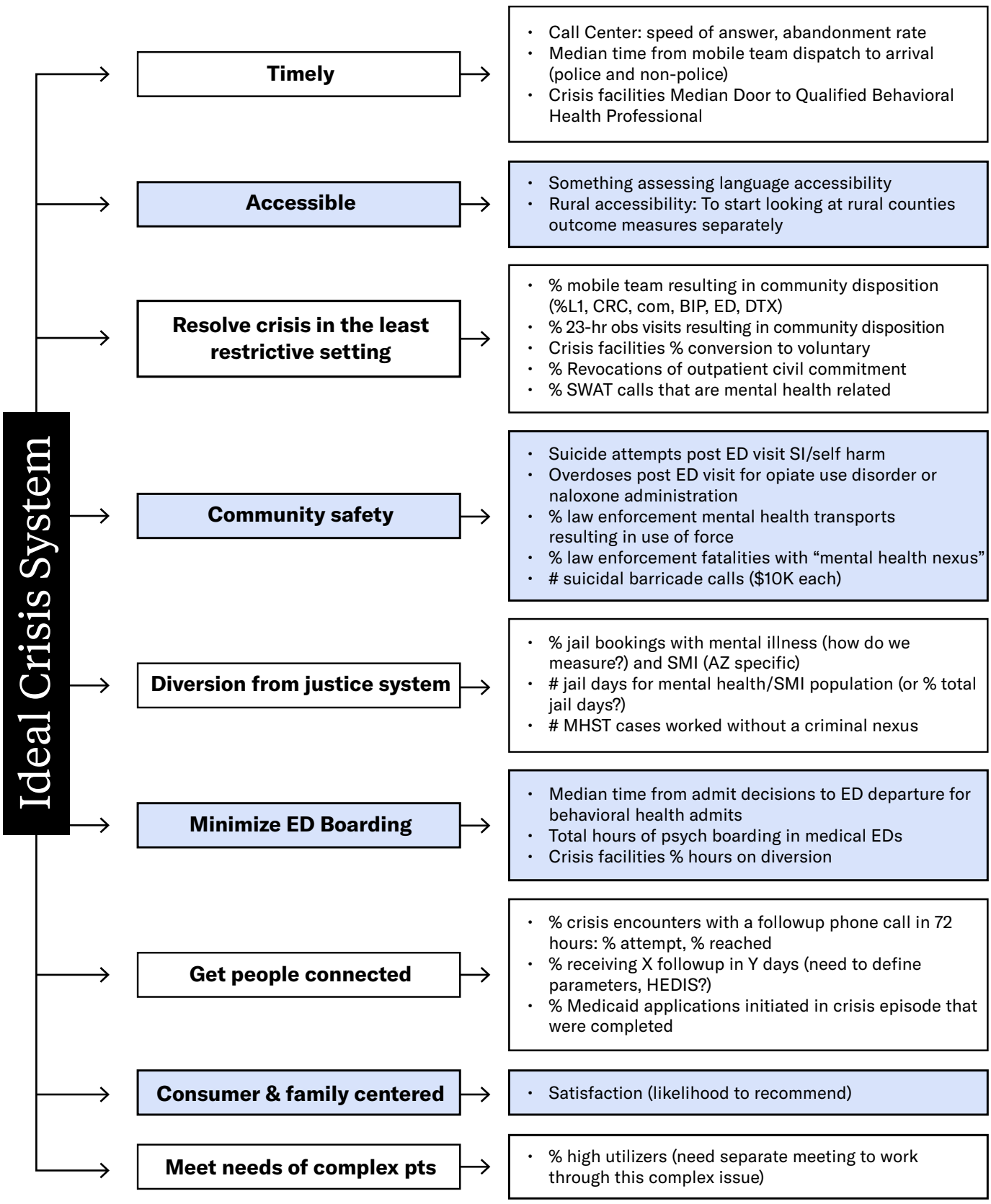
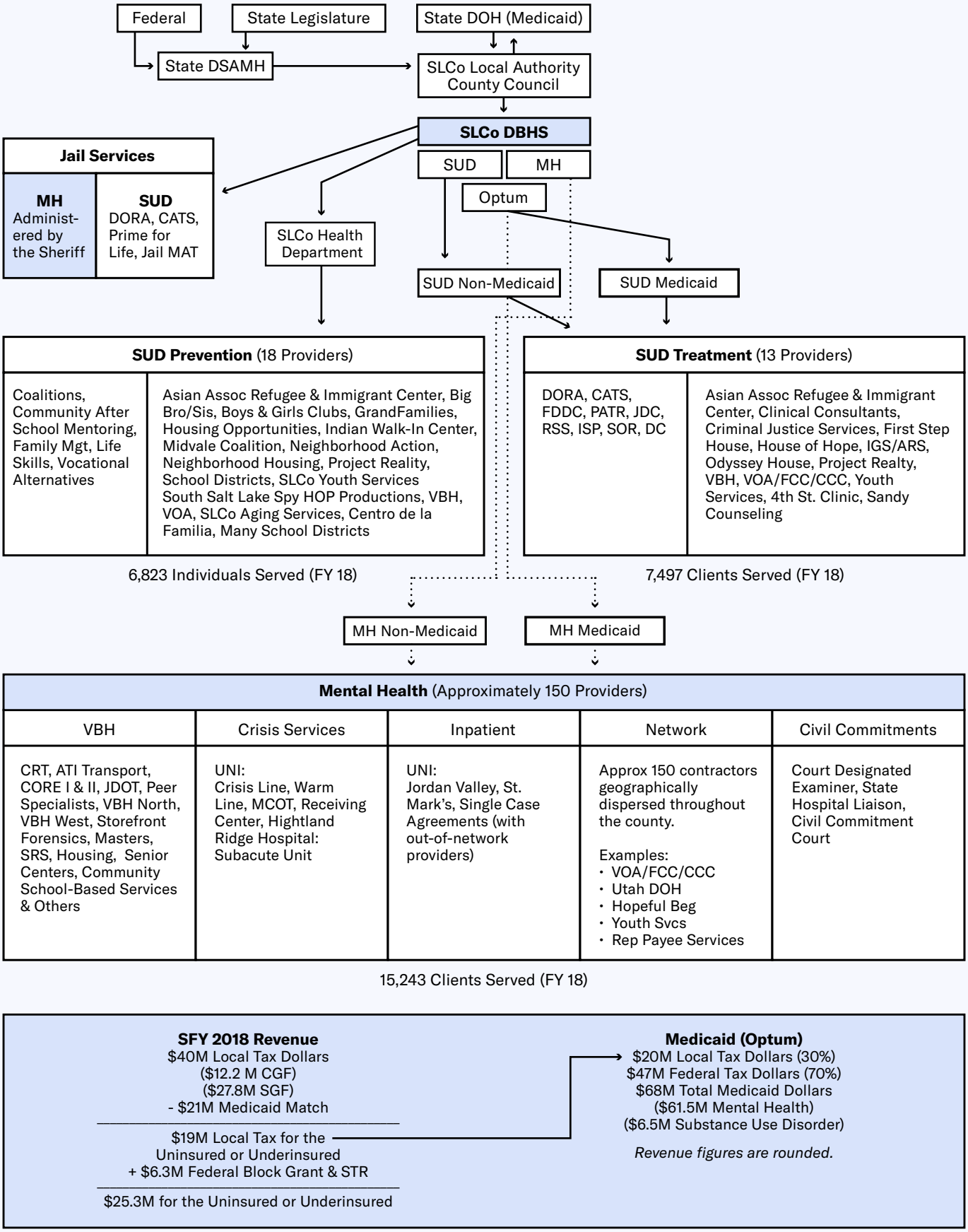


Figure 4. Salt Lake County Department of Behavioral Health Services and Funding



Appendices

Appendix A. Detailed Model Framework

Model for BH Crisis and Jail Diversion Facilities

Description: A facility created in the context of a coordinated community strategy that includes programs that: (1) improve the health and wellbeing of individuals with BH conditions leading to crisis in the community and those with involvement with the criminal justice system by increasing linkages across health, behavioral health, housing, and other social supports to improve access to needed services and outcomes and reduce the utilization rates of emergency health and public safety services; (2) is developed and sustained by a collaborative and coordinated community approach informed by stakeholders with key roles and responsibilities within the system of care, including leveraging of multiple public and private funding streams and community investment; (3) is developed in alignment with person-centered recovery, harm reduction, and trauma-informed approaches.

Community Context and Governance

I. Collaboration-Based Development and Ongoing Direction from Stakeholders that Include:

- Mayors and County Commissioners; other "champion" elected officials and representatives
- Public health and BH departments and public hospital/health system administrators
- Private leading BH and Hospital/health system administrators
- Local Federally Qualified Health Centers and Other Safety Net Clinics
- Law enforcement leaders
- Jail Directors and Jail Health Care Providers
- Judges
- District Attorneys and Prosecutors
- Public Defenders
- EMS/EMTs
- Peer Services Organizations
- Consumer Advocates
- Community Based Support Organizations to support community re-entry and tenure in the community
- Housing Authorities
- Homeless Service Organizations
- Foundations
- Faith-Based Organizations
- Local Universities
- Data Scientists/Analysts
- Local Tech Innovators

II. *Formal Governance Framework or Structured Informal Collaborative*

- Common purpose or mission statement
- Established framework for consistent and ongoing communication to continually inform process improvement toward established goals; clarification of key roles and key processes; develop and share results of working groups and committees.

Formal:

- Memoranda of Understanding (MOUs) among participating partners that formalize policies and procedures
- Designated backbone organization responsible for governance and system performance

III. *Data Sharing and Analysis Framework*

- Set clear actionable milestones: goals, objectives, benchmarks and metrics, and activities to develop and implement robust data sharing and data-driven process improvement
- Combine data sources, e.g. jail data, emergency department use, mental health service use, 911 calls
- Utilization and cost data from multiple sources — ER visits, arrests and jail bookings, homeless shelters, behavioral health services
- Identify the high-utilizer population, patterns of service use, and resulting economic impact

IV. *Funding*

- Leverage multiple funding streams in a coordinated approach
- Public: Medicaid, Medicaid/Medicare Dual Eligibility, Supplementary Security Income, Department of Veterans Affairs, Federal Block Grants; Tax Levys
- Private: Hospital/health systems; Foundations; Philanthropy

Service Delivery System

I. Sequential Intercept Model: *Individuals with BH conditions can be identified and linked to appropriate services and supports across the criminal justice continuum from the community to post-incarceration. (Focusing on community-based diversion strategies.)*

Law Enforcement (LE) and Community Response

- Crisis Intervention Training
- Field-based BH Screening Tools for LE
- Standard Diversion Protocols
- Option(s) for Rapid Response and Disposition for Positive Screening Results from LE Tools;
- Warm Hand Offs for LE
- Co-Responder Model (Field Based: LE and BH Clinicians)

Community Re-Entry: *Pre-Release coordination of services connects individuals reentering their communities with key community resources, including:*

- Enrollment in Medicaid
- Scheduling of medical appointments and other referrals to health care
  - For continuity of care for identified MH and SUD disorders:
  - Referral and introduction to mental health service providers; scheduling of appointments
  - Referral and introduction to SUD, MAT providers; scheduling of appointments
- Arranging for medical transportation
- Supportive housing
- Supportive employment /education

Crisis Response: Early intervention and linkage to community-based services

- 24/7 Crisis Hotline
- 24/7 Warm Line
- Mobile Crisis Response Teams
- Peer Crisis Programs

II. Crisis Stabilization: *Facilities that accommodate walk-in and drop-off treatment, stabilization and referral to offer appropriate community-based alternative to emergency room and inpatient services.*

- Crisis Stabilization Unit (24-72 hours)
- Psychiatric Emergency Programs (24-72 hours)
- Sobering Center
- Detoxification Services
- Community Respite (1-2 weeks)
- Peer Respite Programs

III. Service Centers: *Central hubs that connect individuals to services and supports through direct coordination, referral, or onsite services. Services may include:*

- Mental health services (including crisis stabilization for short stays of 24-72 hours)
- Peer support
- Detoxification
- Intensive Outpatient SUD Services and Outpatient SUD Services
- Medication Assisted Treatment
- Supportive housing
- Employment services
- Medicaid enrollment
- Assistance with Social Security benefits – SSI/SSDI Outreach, Access and Recovery (SOAR)

Appendix B. Sample Monthly Community Directors Roundtable (CMDRT) Report

Chart Title Goes Here					
Measure	**Sept**	**Oct**	**Nov-Aug** *(data not yet collected)*	**YTD Total**	**YTD Avg.**
Admissions					
Number of Admissions (Goal: 5200 annually)	390	332		722	361
Percentage of Admissions with Admission in Past 12 Months	44%	50%		n/a	47%
Percentage of admissions who were male	87%	84%		n/a	86%
Percentage of admissions who were homeless	48%	51%		n/a	49%
Average length of stay (hours)	5:03	5:49		n/a	5:26
Referral Sources					
SAPD (percent)	66%	67%		n/a	67%
Other Law Enf. (percent)	27%	26%		n/a	27%
CHCS Detox Unit (percent)	3%	3%		n/a	3%
Other (percent)	4%	4%		n/a	4%
Substance Leading to Admission					
Alcohol	83%	86%		n/a	85%
Synthetic Marijuana	7%	5%		n/a	6%
Heroin / Opiates / Opioids	3%	4%		n/a	3%
Methamphetamine	3%	2%		n/a	3%
Other or Unknown	4%	4%		n/a	4%
Community Impact					
Percentage of public intoxicants diverted from criminal justice system	Pending SAPD			n/a	Pending SAPD
Percentage of sobering admissions admitted to Detox (Goal: 3%)	4%	5%		n/a	4%
Percentage of sobering admissions admitted to Detox who completed program (Goal: 50%)	50%	27%		n/a	38%

Minor Medical / Injured Prisoner

Measure	Sept	Oct	Nov-Aug *(data not yet collected)*	YTD Total	YTD Avg.
Admissions					
Number of Admissions (Goal: 700 annually)	54	44		98	49
Percentage of Admissions with Admission in Past 12 Months	4%	5%		n/a	4%
Average length of stay (minutes) (Goal: <30 minutes)	26	29		n/a	26
Referral Sources					
SAPD (percent)	80%	80%		n/a	80%
BCSO	11%	11%		n/a	11%
Sobering / Detox / ITP	0%	0%		n/a	0%
Other (percent)	9%	9%		n/a	9%
Community Impact					
Percent of injured prisoners diverted from ER	69%	77%		n/a	73%

Detoxification Unit

Measure	Sept	Oct	Nov-Aug *(data not yet collected)*	YTD Total	YTD Avg.
Admissions					
Number of People Screened	307	278		585	292.5
Number of Admissions	183	184		367	183.5
Percentage of Admissions with Admission in Past 12 Months	43%	58%		n/a	50%
Percentage of admissions who were male	73%	73%		n/a	73%
Percentage of admissions who were homeless	24%	25%		n/a	25%
Average Length of Stay (Days)	3.5	3.7		n/a	3.6
Substance Leading to Admission					
Alcohol	34%	38%		n/a	36%
Synthetic Marijuana	1%	3%		n/a	2%
Heroin / Opiates / Opioids	45%	38%		n/a	41%
Methamphetamine	14%	13%		n/a	13%
Other or Unknown	7%	9%		n/a	8%
Discharges					
Number of Discharges	189	184		373	186.5
Percentage completing successfully (Goal: 50%)	50%	63%		n/a	57%
Community Impact					
Bed Day Utilization Rate (Goal: 95%)	78%	82%		n/a	80%

Crisis Care Center					
Measure	**Sept**	**Oct**	**Nov-Aug** *(data not yet collected)*	**YTD Total**	**YTD Avg.**
Admissions & Discharges					
Number of Admissions	341	329		670	335
Number Placed in Observation	268	265		533	266.5
Percentage of Admissions with Admission in Past 12 Months	39%	34%		n/a	36%
Average length of stay in EOU (hours) (Goal: <48 hours)	34.5	23		n/a	28.8
Number of Discharges	340	353		693	347
Referral Sources					
MCOT (percent)	1%	1%		n/a	1%
Mental Health Warrant (percent)	3%	4%		n/a	3%
Emergency Detention (percent)	53%	45%		n/a	49%
Community Impact					
Number of Times on Diversion	46	22		68	34
Amount of Time on Diversion (hours)	201	83		283	142
Percentage of clients linked to CHCS services prior to admission	50%	38%		n/a	44%
Percentage of client diverted from hospitalization	82%	80%		n/a	81%
Percentage of clients linked to ongoing services at discharge	23%	26%		n/a	25%

Mobile Crisis Outreach Team					
Measure	**Sept**	**Oct**	**Nov-Aug** *(data not yet collected)*	**YTD Total**	**YTD Avg.**
Mobile Crisis Calls					
Total Referrals	319	341		660	335
Average Response Time (Goal: <14 hours)	5:57	5:11			5:34
Percentage of cases escalated to a higher level of care	5%	4%		n/a	5%
State Bed Authorizations	230	234		464	28.8
LOC-5: Number of people served	96	100		196	98%
Referral Sources					
MCOT (percent)	1%	1%		n/a	1%
Mental Health Warrant (percent)	3%	4%		n/a	3%
Emergency Detention (percent)	53%	45%		n/a	49%
Private Psychiatric Beds (Contract)					
Average time from assessment to intake (hours)	58	42		n/a	50
Number of admissions	114	78*		192	96

Mobile Crisis Outreach Team					
Bed Day Utilization Rate (Goal: 95%)	97%	100%*		n/a	97%
Number of discharges	115	84*		199	81%
Average Length of Stay (days)	6.6	4.8*		n/a	4.5
Crisis Line					
Number of Calls	2725	2503		5228	2614
Emergency Calls – Adults	4	6		10	5
Emergency Calls – Children	3	1		4	2
Urgent Calls – Adults	28	25		53	28
Urgent Calls – Children	11	21		32	11
State Bed Authorizations – Adults	134	100		234	117
State Bed Authorizations – Children	21	36		57	29
Non-Assessment / Info Only Calls	1992	1717		3709	1855

**Excludes Nix data*

Josephine Recovery Center					
Measure	**Sept**	**Oct**	**Nov-Aug** *(data not yet collected)*	**YTD Total**	**YTD Avg.**
Admissions					
Number of Referrals from Hospitals	53	37		90	45
Number of Admissions	39	37		76	38
Number of unfunded clients	26	29		55	27.5
Percentage of admitted clients who were unfunded	67%	78%		n/a	73%
Referral Sources					
Crisis Care Center	69%	68%		n/a	68%
Hospital	28%	32%		n/a	30%
CHCS Clinic	3%	0%		n/a	1%
Discharges					
Number of Discharges	38	46		84	42
Average length of stay (bed days)	9.6	10.4		n/a	10
Percentage of clients leaving AMA	32%	26%		n/a	29%
Community Impact					
Bed Day Utilization Rate (Goal: 90%)	78%	2503		n/a	79%
Percentage of Clients Linked to CHCS clinic at discharge (Goal: 100%)	82%	6		n/a	78%

Integrated Care Program					
Measure	**Sept**	**Oct**	**Nov-Aug** *(data not yet collected)*	**YTD Total**	**YTD Avg.**
Men's Program					
Number of Admissions (Goal: 230 annually)	18	34		52	26
Number of Discharges	21	30		51	25.5
Bed Day Utilization Rate	91%	92%		n/a	92%
Percentage of Clients Screened for Benefits (Goal: 100%)	100%	100%		n/a	1
Percentage of Clients Receiving Primary Medical Care	48%	50%		n/a	49%
Percentage of Clients Discharging to Stable Housing (Goal: 45%)	38%	57%		n/a	53%
Women's Program					
Number of Admissions (Goal: 170 annually)	28	14		42	21
Number of Discharges	21	21		42	21
Bed Day Utilization Rate	90%	92%		n/a	91%
Percentage of Clients Screened for Benefits (Goal: 100%)	100%	100%		n/a	1
Percentage of Clients Receiving Primary Medical Care	48%	76%		n/a	62%
Percentage of Clients Transitioning from a Neonatal Abstinence Syndrome Recovery Home	5%	10%		n/a	7%
Percentage of Clients Discharging to Stable Housing (Goal: 45%)	38%	57%		n/a	48%

Crisis Stabilization Unit				
Measure	**Sept**	**Oct**	**Nov-Aug** *(data not yet collected)*	**YTD Total**
Admissions				
Total Admissions	48	58		106
Total Discharges	50	59		109
Average Length of Stay (Days)	8.1	8		8.05
Wait Time (Hours)	56	42		n/a
Potential bed days	450	465		915
Utilized bed days	436	451		887
Utilization Rate (Goal: 95%)	96%	97%		n/a
Percent Emergency Detention	52%	53%		n/a
Percent Voluntary Patients	48%	47%		n/a

Crisis Stabilization Unit				
Referral Sources				
Southwest General	3	2		5
Santa Rosa- Westover Hills	2	1		3
Santa Rosa- NorthWest (Medical)	0	0		0
San Antonio Behavioral Health	0	0		0
Baptist- Downtown	8	4		12
Baptist- North Central	0	0		0
Baptist- North East	2	0		2
Baptist- St. Luke's	0	0		0
Baptist-Mission Trails	0	3		3
Methodist- Metropolitan	0	2		2
Methodist- Specialty/Transplant	1	0		1
Methodist- Stone Oak	0	0		0
Methodist- NorthEast	2	1		3
Methodist- Main	0	0		0
Laurel Ridge Treatment Center	1	0		1
SAMMC	0	0		0
University Hospital	2	7		9
NIX- Vance Jackson	0	7		7
NIX- Downtown	3	4		7
NIX- Babcock-PES	11	14		25
Crisis Care Center	13	13		26
SASH	0	0		0
Method of Arrival				
Other LEO	1	1		2
EMS	0	0		0
Walk in	2	1		3
ER Transfer	0	31		31
CCC	13	13		26
SAPD	8	12		8

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