"Decriminalizing Mental Illness" Conference

May 16 – May 17, 2017
Tuscon, Arizona

Welcome

Ellen Wheeler, J.D.

Assistant County Administrator

Pima County

PIMA COUNTY

Justin Volpe, CRPS-A

Certified Peer Support Specialist

Florida Criminal Mental Health Project

Jail Diversion Programs

PIMA COUNTY

Justin Volpe

A Personal Journey to Recovery

My Story

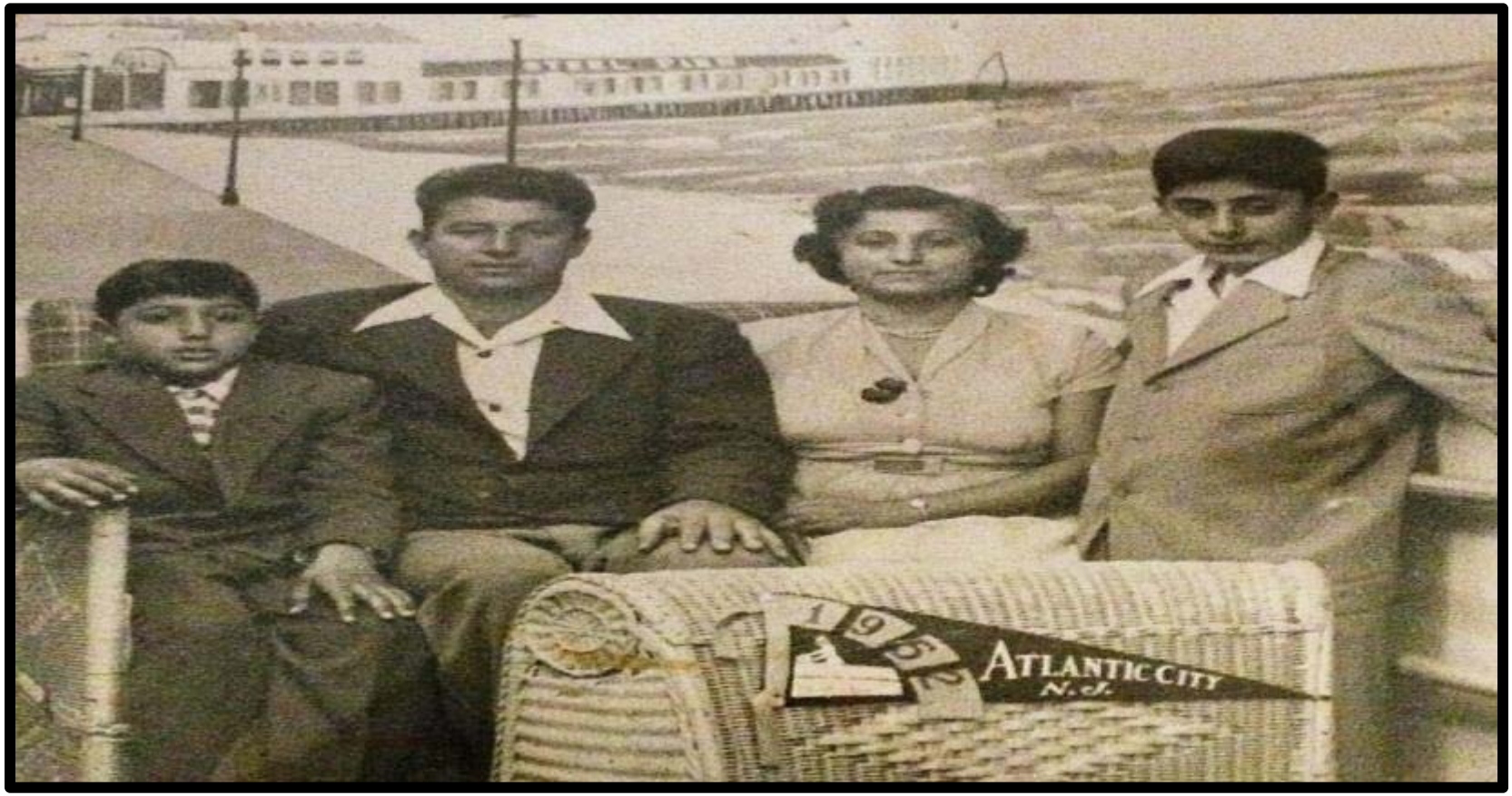
Journey to Recovery

Accomplishments :

- Employment at Miami-Dade County Jail Diversion Program through SFBHN
- Certified Recovery Peer Specialist
- WRAP Facilitator
- Consultant for SAMHSA
- CIT Training with Miami-Dade Officers
- Washington Post, NY Times, Miami Herald

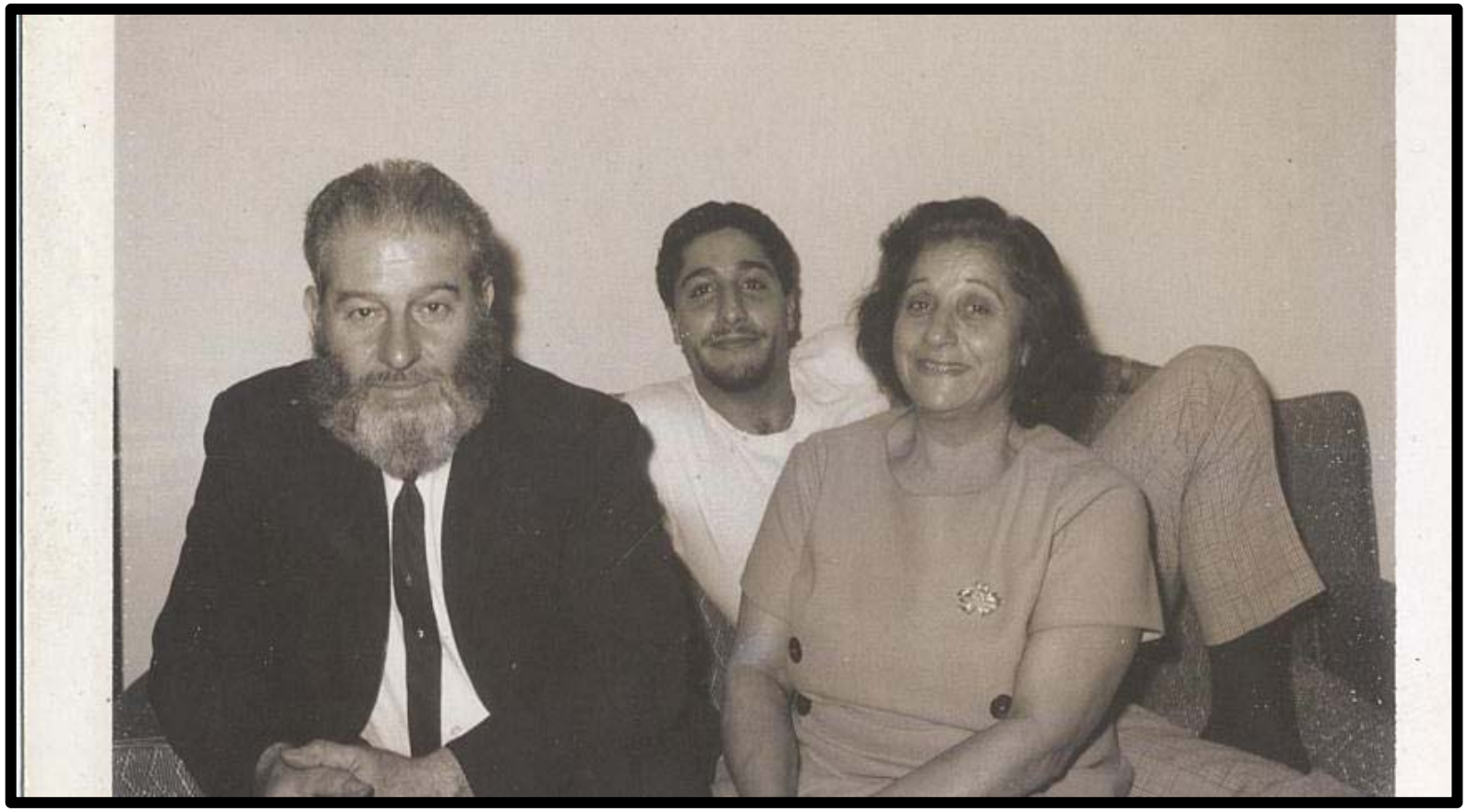
PIMA COUNTY

Atlantic City, Circa 1952



PIMA COUNTY

From the beginning…(1968)



PIMA COUNTY

My Father and Brother 1973

PIMA COUNTY

1983 My Mother

PIMA COUNTY

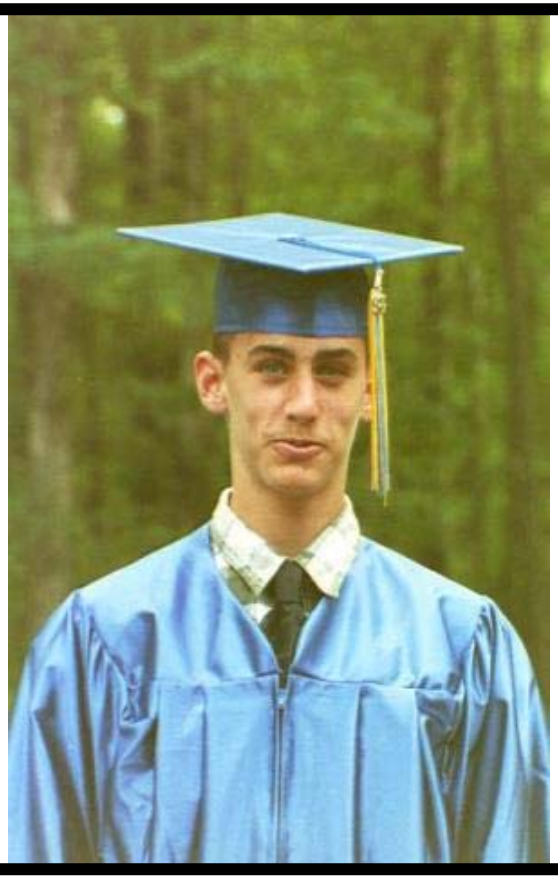
My First Friend out of the Group…

PIMA COUNTY

1995 Before Accident

PIMA COUNTY

3-6-99 Passing of Dan



PIMA COUNTY

Grandfather Passed

An 'immortal' leader has a very mortal end

Staff file photo by Vernon Ogrodnek

Leo Volpe, at age 73, was directing members of the Restored Israel of Yahweh in editing a new book in February 1990.

■ Lionel 'Leo' J. Volpe, the self-proclaimed prophet and leader of the Restored Israel of Yahweh, said he was immortal. But he died on April 13 at Shore Memorial Hospital in Somers Point. With his death, the secretive group has become even more elusive.

By ELAINE ROSE
Staff Writer, (609) 272-7215

EGG HARBOR TOWNSHIP — The Restored Israel of Yahweh believed their leader was immortal. Lionel "Leo" J. Volpe was said to be the resurrected biblical prophet Jeremiah, who would lead them and the rest of the world into God's kingdom.

They were wrong.

Volpe died on April 13 at Shore Memorial Hospital, according to his death certificate filed with the city of Somers Point. He was 83.

Volpe suffered a stroke in late 1992 and was sent home after a brief hospital stay, former group members said. The men in the Restored Israel of Yahweh set up a rotation schedule to nurse him around the clock.

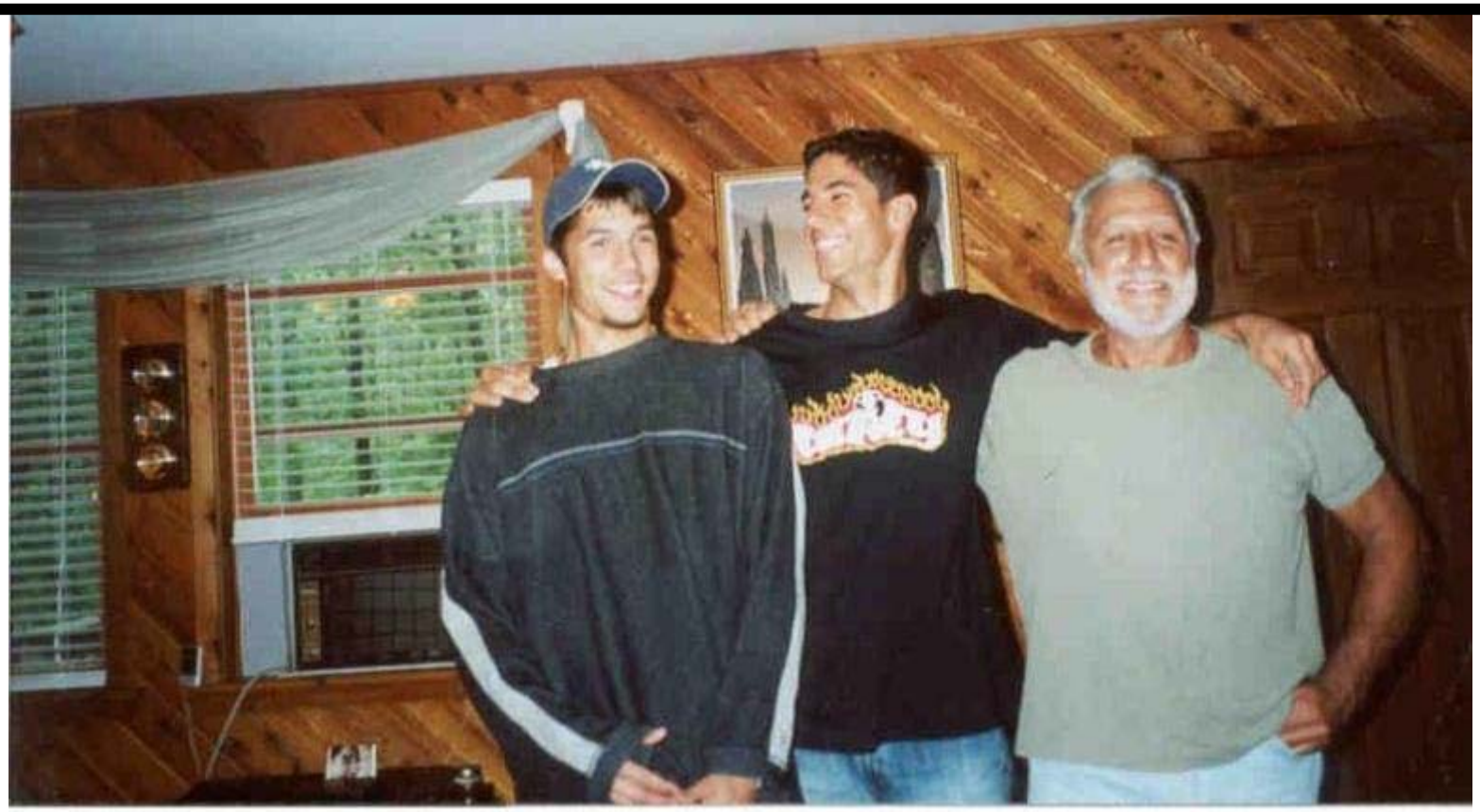
The group was visible in the 1970s, 1980s and early 1990s as they set up pickets on the Atlantic City Boardwalk and other locations around southern New Jersey. In recent

See Volpe, Page A6

CALL 272-1010 FOR HOME DELIVERY OF THE PRESS IN ATLANTIC COUNTY

PIMA COUNTY

2000ish…



PIMA COUNTY

2001 Varsity Basketball

past Buena in opener

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Staff photo/Charles Olson

Buena's Justin Volpe (13) attempts to block Millville's Daryl Loatman during Saturday's game.

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PIMA COUNTY

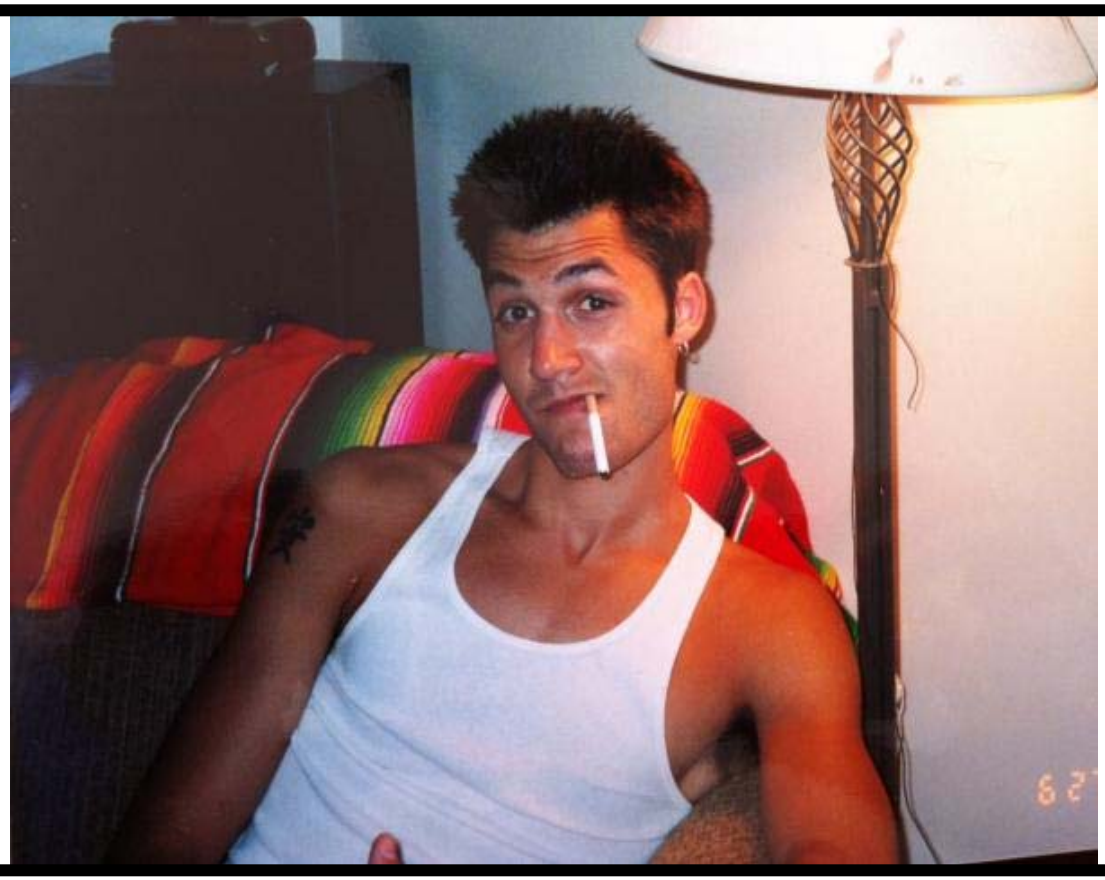
Moved to South Beach 2003

PIMA COUNTY

First apt on Beach

PIMA COUNTY

2003 South Beach



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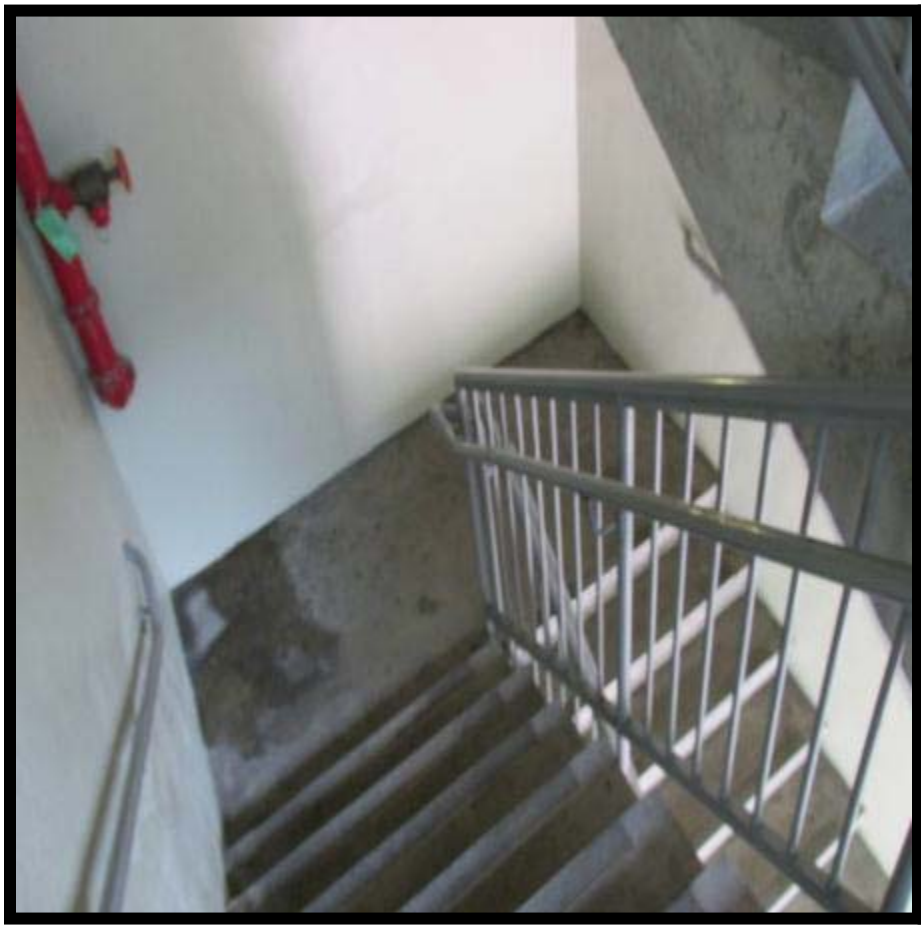
Southgate Towers (2004)

PIMA COUNTY

One of many jobs…(2004)

PIMA COUNTY

Security detail in the garage



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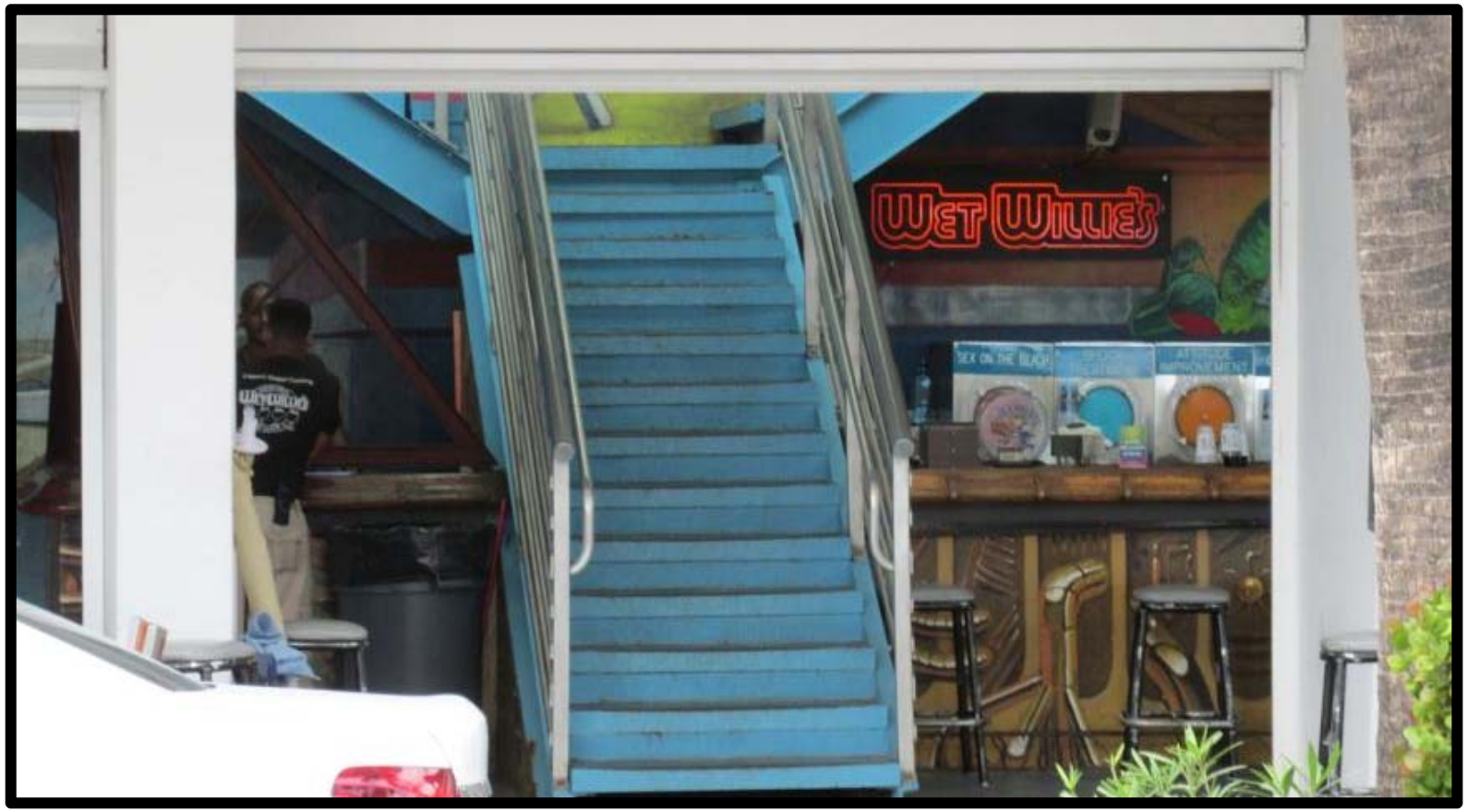
9th Floor Jumper

PIMA COUNTY

2005 Wet Willies



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4th and Jefferson

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My alley….

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Same Name as the Address (2006)

PIMA COUNTY

Current View (2017)

PIMA COUNTY

Where I Spent Most My Time…

PIMA COUNTY

Walgreens….

PIMA COUNTY

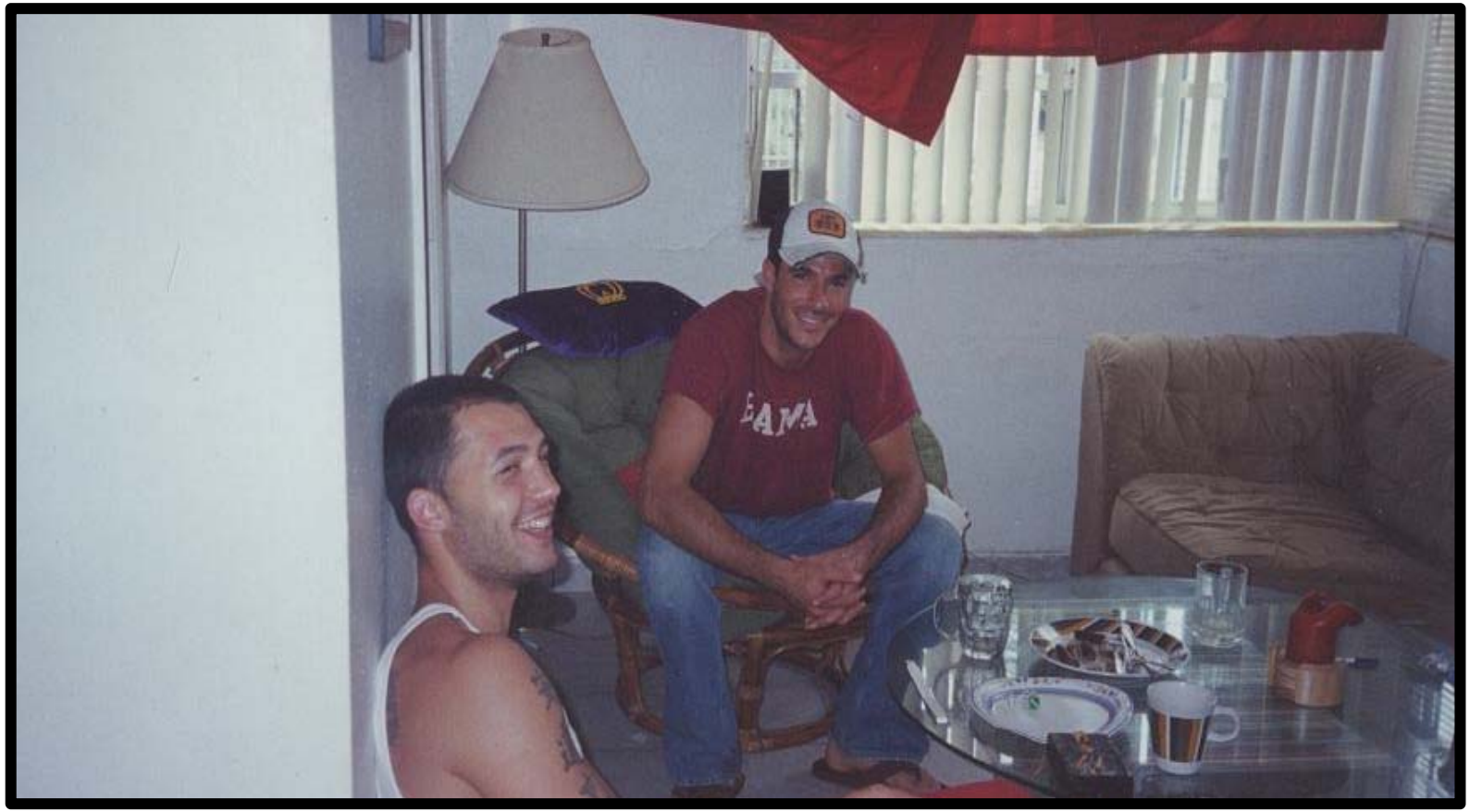
The Trash Trucks

PIMA COUNTY

Signals from the Ships…

PIMA COUNTY

Room with a View



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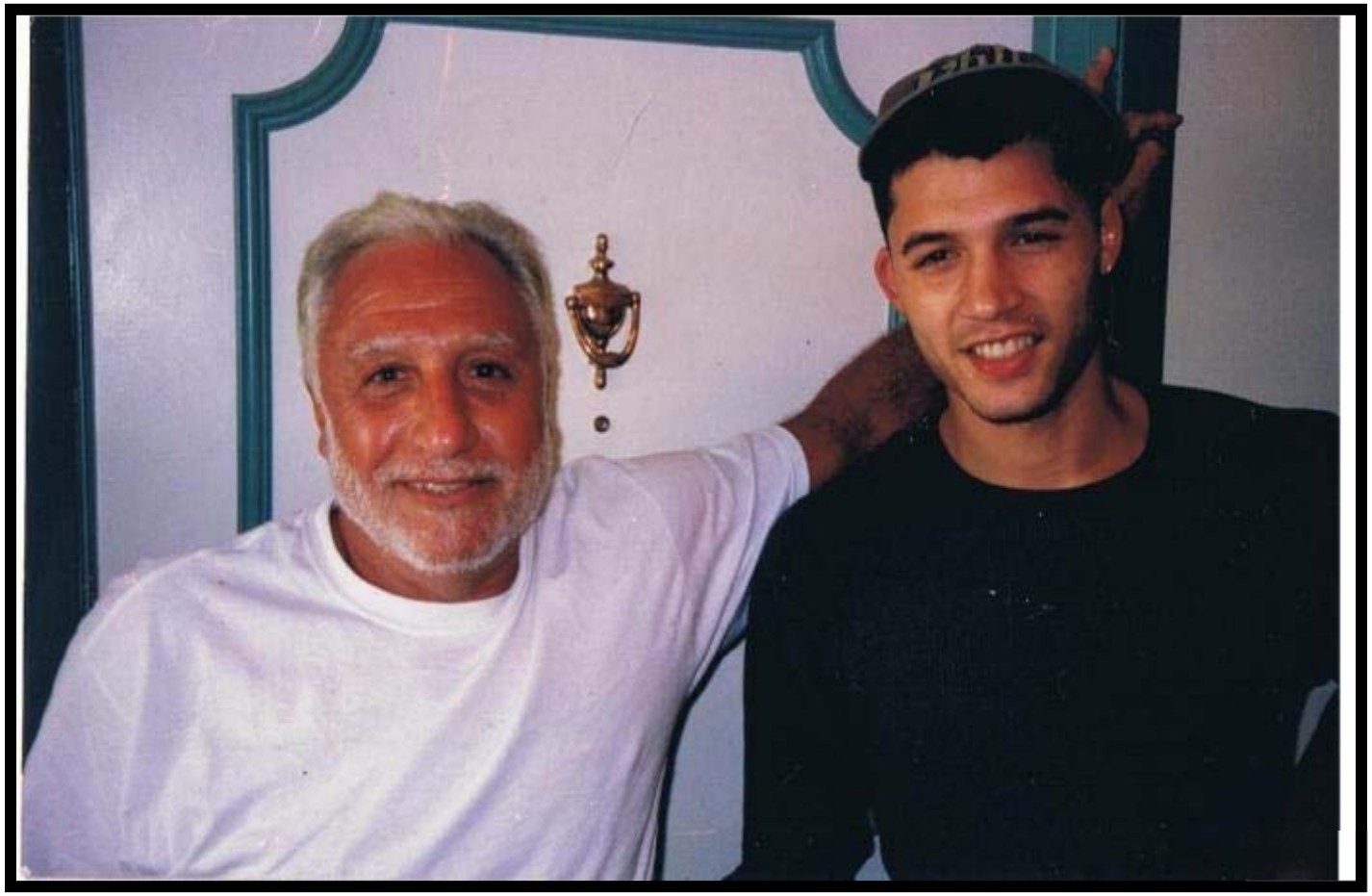
South Beach Diet
(Days before rehab) August 2006



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Flamingo Park

October 2006 Trip to NJ

PIMA COUNTY

Dade County Jail

PIMA COUNTY

Booking Photo April 11, 2007

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Jail Diversion Program (2016)

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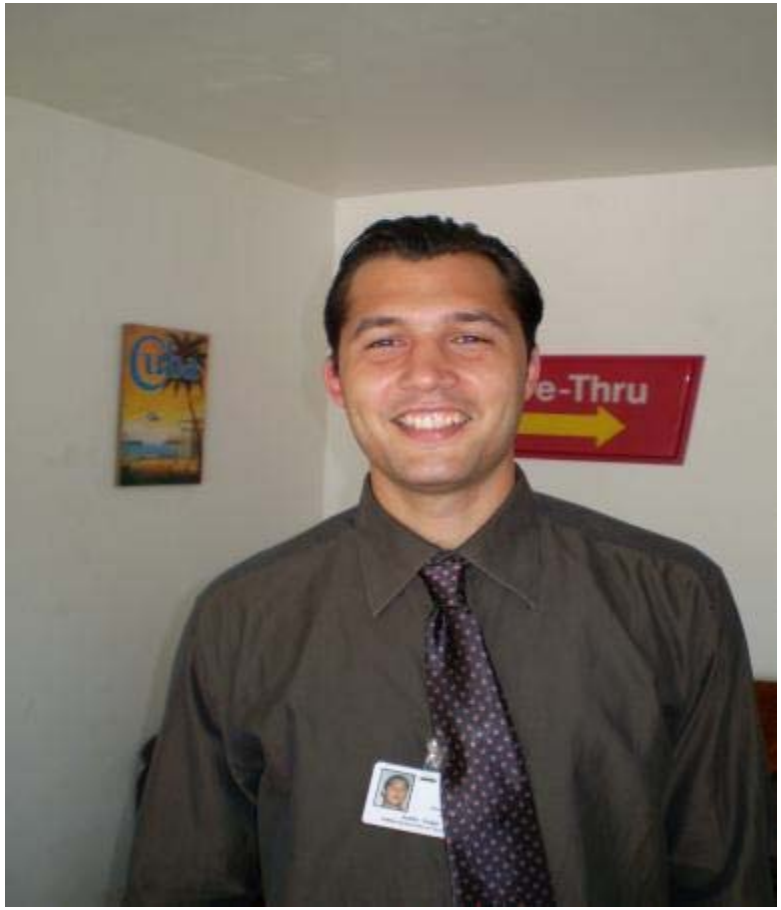
ALF in Miami Gardens

PIMA COUNTY

Liberty City

PIMA COUNTY

New Life November 2007



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Met my girl June 2008

PIMA COUNTY

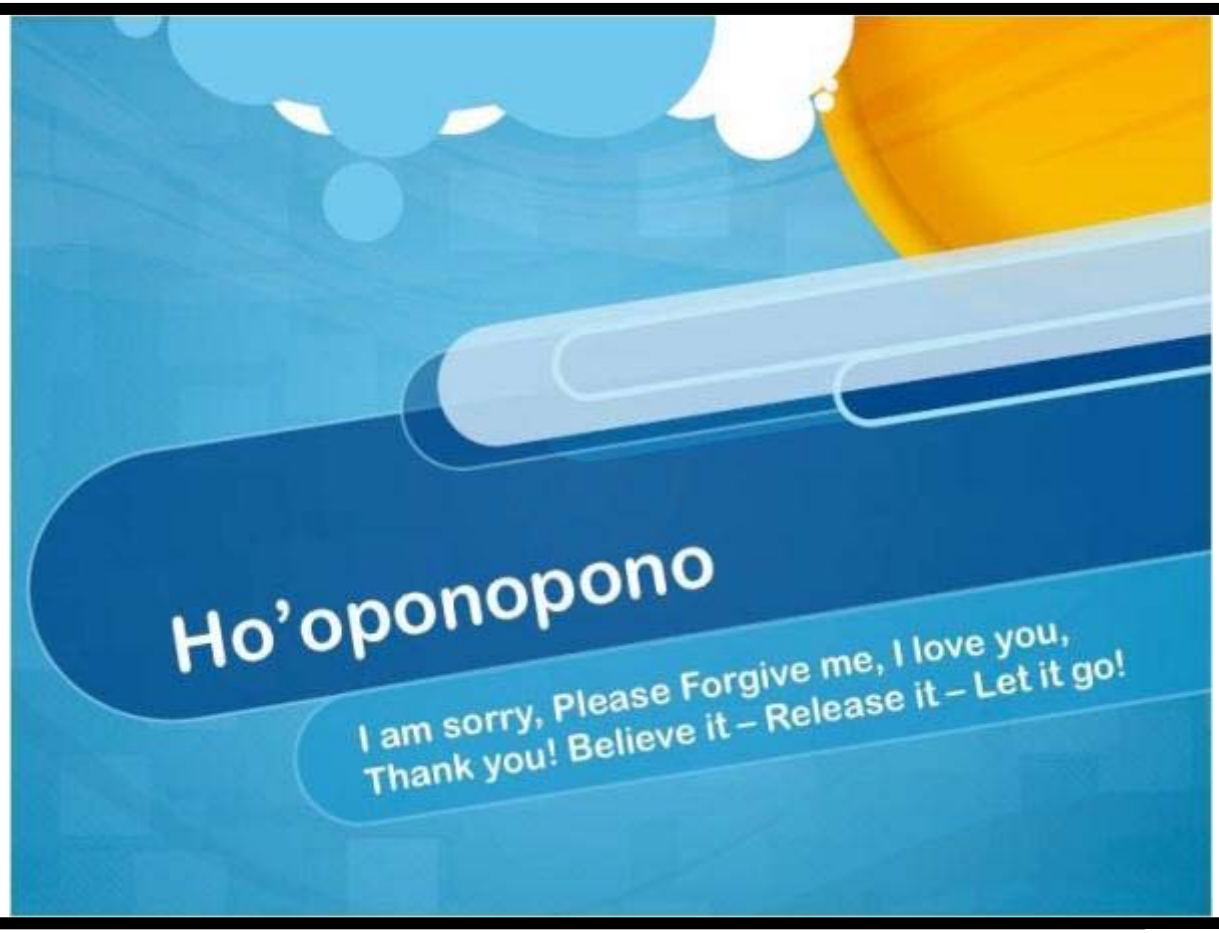
Wedding December 2009

PIMA COUNTY

2010 Trauma Therapy

PIMA COUNTY

Forgiveness



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My new therapy

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Alcohol Free since 2012!

PIMA COUNTY

Weight Loss

PIMA COUNTY

Home Owners 2014 !!

PIMA COUNTY

NY Times Article

"All the News That's Fit to Print"

The New York Times

Washington Edition

VOL. CLXIV ... No. 56,774 WEDNESDAY, FEBRUARY 11, 2015 $2.50

THE NEW YORK TIMES NATIONAL WEDNESDAY, FEBRUARY 11, 2015 A19

Jails Have Become Warehouses for the Poor, Ill and Addicted, a Report Says

By TIMOTHY WILLIAMS

Jails across the country have become vast warehouses made up primarily of people too poor to post bail or too ill with mental health or drug problems to be equitably sent for treatment, according to a report issued Wednesday.

The study, "Incarceration's Front Door: The Misuse of Jails in America," found that the majority of those incarcerated in local and county jails are there for minor violations, including driving with suspended licenses, shoplifting or evading subway fares, and have been jailed for longer periods of time over the past 30 years because they are unable to pay court-imposed costs.

The report, by the Vera Institute of Justice, comes at a time of increased awareness in many in-carceration policies that have swelled prisons and jail populations around the country. This week in Missouri, where the fatal shooting of an unarmed black man by a white police officer caused months of racial tension not seen in the town of Ferguson, 14 people used this city and another suburb, Bridgeton, alleging that the cities created an unconstitutional modern-day debtors' prison, jailing impoverished people behind bars in overcrowded, unlawful and penalizing conditions.

While many reform efforts, including early releases and the elimination of some minimum mandatory sentences, have been focused on state and federal prisons, the report found that the disparate rules that apply to jails is also in need of reform.

"It's an important moment to take a look at our use of jails," said Nancy Fishman, the project director of the Vera Institute's Center on Sentencing and Corrections and an author of the report. "It's a huge burden on taxpayers, on our communities, and we need to decide if this is how we want to spend our resources."

The number of people housed in jails on any given day in the country has increased from 223,000 in 1983 to 731,000 in 2013 — nearly equal to the population of Charleston, S.C. — even as violent crime nationally has fallen by nearly 50 percent and property crime has dropped by more than 40 percent from its peak.

Inmates have subsequently been spending more time in jail awaiting trial, in part because of the growing reluctance of judges to free suspects on their own recognizance pending trial dates, which had once been common for minor offenses.

As a result, many of those arrested — misdemeanants — who are often poor — are unable to pay bail as low as $100.

Traced with the rebirth of the Vera Institute report, the Macfor that Foundation announced Wednesday that it would invest $75 million over five years in 20 jurisdictions that are working to reverse its sending large numbers of people to jail. The jurisdictions, which could be cities, counties or other versions that run local jails, will be announced this spring.

Nationwide, the annual number of jail admissions is 20 times higher than the number of those sent to prison, and has nearly doubled since 1983, from about 6 million to 11.7 million. A significant number are repeat offenders, the report said.

In Chicago, for instance, 21 percent of the people sent to local jails from 2007 to 2012 accounted for 50 percent of all jail admissions.

In New York City, the figures were even starker: From 2000 to 2013, about 400 people were sent to jail on at least 20 occasions each, which accounted for more than 30,000 jail admissions and 300,000 days in jail.

The study found that the share of people in jail accused or convicted of crimes related to illegal drugs decreased from 8 percent in 1983 to about 15 percent in 2014, and that they were disproportionately African-Americans.

And the study said that about 68 percent of jail inmates had a history of abusing drugs, alcohol or both. Jail-based drug treatment programs had been underfunded.

Justin Volpe, 31, a peer recovery specialist in Miami for the Dade County courts, said he spent 45 days in jail in 2007 after being arrested on a petty theft charge. Mr. Volpe, who was homeless, addicted to drugs and suffering from an untreated mental illness at the time of his arrest, said drug treatment and a court-mandated diversion program that included counseling and medication had probably saved his life.

"It was the extra push I needed," he said.

But Mr. Volpe said there were too few drug and alcohol treatment programs available to those in jail, where there is a close correlation between drug addiction and mental illness.

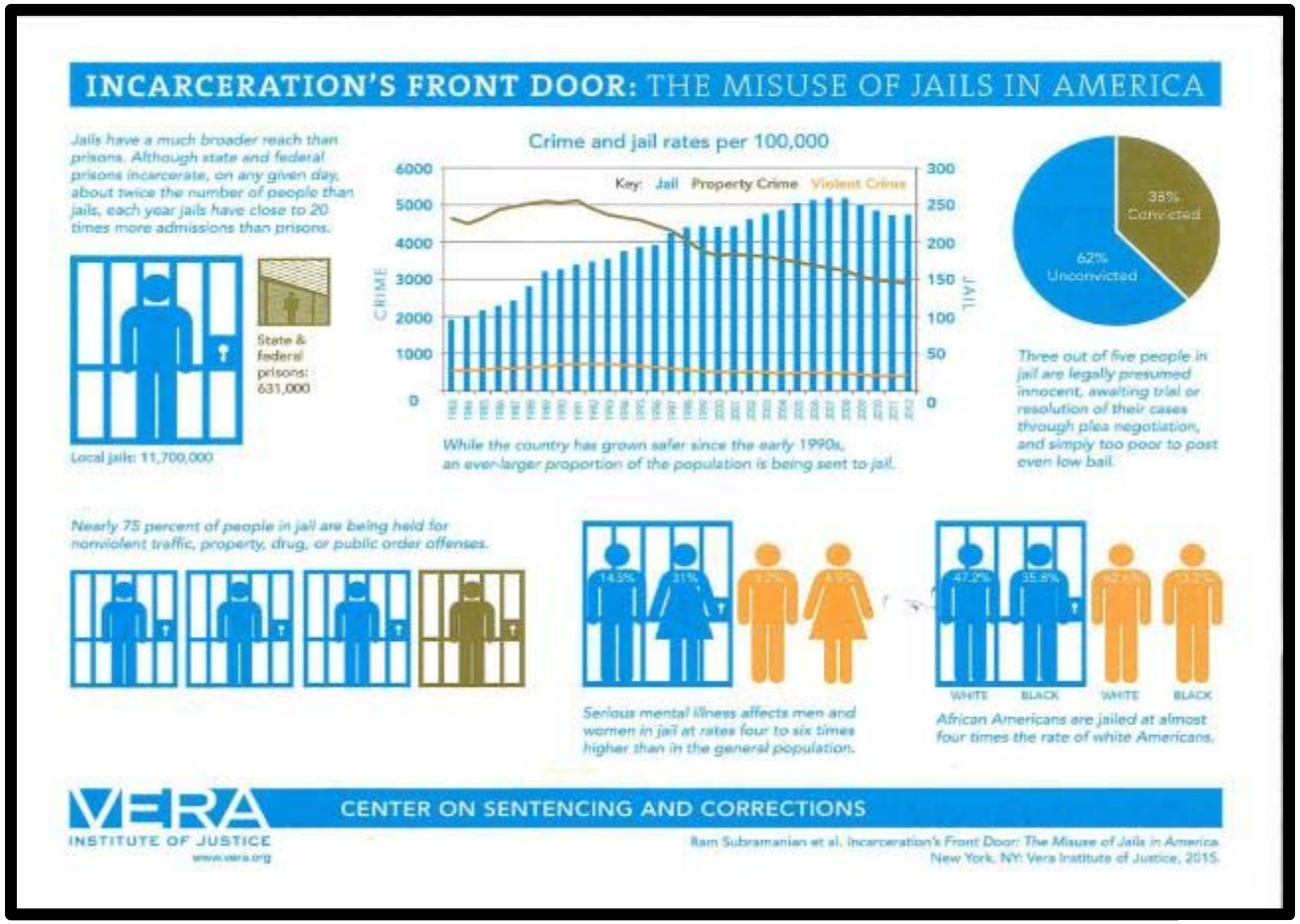
The Vera Institute report, for instance, found that more than four of five inmates with a mental illness were not treated in jail and that 24 percent of those with mental illness in jail had been using drugs at the time of their arrest, compared with 18 percent of the rest of the jail population.

Still, seeking mental health services sometimes would bring an stayer in jail, the report said. In Los Angeles, those seeking help spent more time later in court than those in court who did not seek help — 45 days compared with 18 days.

Three seeking mental health services in Los Angeles jails stayed more than twice as long as others, the Vera Institute said.

PIMA COUNTY

Misuse of Jails



PIMA COUNTY

Washington Post

PIMA COUNTY

Work in the Community

PIMA COUNTY

A Lifelong Battle…

PIMA COUNTY

Recovery is Real

PIMA COUNTY

Special Thanks from our Family!

PIMA COUNTY

Contact Information

- **EMAIL**: JVOLPE@JUD11.FLCOURTS.ORG
- **LINKEDIN**: www.linkedin.com/in/volpejustin
- **OFFICE**: **305-548-5147**

In the media

- **Al Jazeera Story**: http://alj.am/rflb
- **NY Times Article**: http://nyti.ms/1MbtDGA
- **Washington Post**: http://wpo.st/9B-D1
- **Miami Herald: https://t.co/tutvz7Z1eT**

PIMA COUNTY

Panel Discussion

Experiences from the Community

Panelists

Sally Hueston
Certified Peer Support Program Coordinator
Hope, Inc.

Michele Keller
Certified Recovery Specialist & BH Technician
US Camp Wellness & Pima County CRC

Manny Mejias
Freedom Management Coach & Reentry Coordinator
Choices Holistic Resource Network &
Fortaleza Reentry Collaborative

PIMA COUNTY

Danna Whiting, M.S.

Behavioral Health Administrator

Pima County

PIMA COUNTY

Danna Whiting
Pima County Behavioral Health Administrator

Good morning.

I'm excited to talk to you today about some of the things we do in Pima County Behavioral Health. We work mostly behind the scenes to support many important County functions. We are fortunate to be invited to participate in and support many of the programs and initiatives that involve Behavioral Health, like this one.

The first program I'd like to highlight is Title 36 Court-ordered evaluation. If you've ever petitioned someone for Title 36 Court ordered evaluation, you know that the County Attorney's office, the office of mental health defense, Pima County Superior Court and law enforcement are all involved in the legal process of court-ordering someone to treatment. Pima County Behavioral Health makes sure the hospitals get paid for performing those evaluations along with costs associated with the process. We have high standards for payment…we look at every petition to ensure compliance with the statutes. We monitor the crisis system to ensure a balance between patient rights and a fair process for those held in the hospital against their will. We create and execute contracts with three local hospitals who perform these evaluations on the County's behalf. Our staff go into the hospitals, review records, perform audits and collect data. We are constantly watching the crisis system to ensure efficiency and equal access to care. On average, we review about 160 new evaluation cases every month, about 80% of which are performed by Banner at the Behavioral Health pavilion. The rest are provided by our other hospital partners, Sonora and Palo Verde. COE services are a vital tool for both treating those who are unable or unwilling to seek treatment voluntarily, and for public safety.

Another responsibility of Pima County Behavioral Health is indirect oversight of the service deliverables at the crisis response center and the Behavioral Health Pavilion. The Sheriff and the Police Chief told you how law enforcement officers love the CRC. I hear that all the time…especially because they can drop people off through a secure sally port and be back out on the street in less than 10 minutes. Somewhere around half of all law-enforcement drop-offs are voluntary. Most jurisdictions I talk to are still only dreaming about a central drop off point for their law enforcement, while ours has been a reality for about six years. Ours began with overwhelming support by the voters in Pima County through bond elections which funded the CRC, BHP, call center, sally port, and new emergency department on the Kino campus.

Pima County Behavioral Health oversees the leases for these facilities because, well, our leases are unique in that they cover the usual language about the maintenance and upkeep of the buildings, but they also include phrases like "no wrong door", "best practices", "equal access to care" and "first responders return to duty". Yep, that 10 minute drop off is impressive- and also an expectation. Pima County leadership made sure that the philosophy of the CRC and BHP would remain intact regardless of operator by including operational expectations and philosophies right in the lease. It's our job to ensure that these and other service deliverables are met.

And we have been fortunate to have awesome partners in Banner and Connections Arizona, which makes this task fairly easy. You're about to hear more about the CRC from Dr. Margie Balfour. I echo the sentiments from a couple of the speakers yesterday in saying she's awesome.

Another area where we are involved is the Pima County Adult Detention Center and the Pima County Juvenile Detention Center. I've heard a couple of folks say that our jail is the largest mental health facility in southern Arizona. That's absolutely true. And we would know because we are the people in your government who make sure the medical vendor at the adult and juvenile facilities is providing appropriate care to detainees. Pima County Behavioral Health oversees both the adult and juvenile contracts, performs quality audits, works with the vendor, the sheriffs department and juvenile detention to ensure compliance with contract deliverables.

We write the contract language and manage the process to select service providers. There are approximately 32,000 people booked at the adult jail every year. The average daily census is around 1800 people. Every single person gets a medical assessment at booking. So, you might be wondering why would this contract live in Behavioral Health...I mean, we mostly provide medical services at our jails, right? Absolutely not. The majority of services performed are not medical, they are behavioral. At the adult jail about 70% of the contract deliverables are for Behavioral Health services, and for the juvenile corrections facility it's closer to 90%. 60% of our monthly medication costs at the adult jail are for psychotropic medications - that's about $65,000 per month. Think about that…that cost is for short term incarceration in many cases. That's a lot of psych meds. So, I think this is another illustration that we have too many folks suffering from mental illness in our jail and it's time to look at alternative strategies.

Another program in our department is Pima County's Restoration to competency program. The in-custody program sees approximately 150 cases every year. Our restoration rate is about 85%. While this is not necessarily a measure of program success, it is an indicator we use to gauge overall performance by removing any artificial barriers to competence. We know that by emphasizing best practices, applying no artificial timelines for opinion (some jurisdictions force doctors to opine at around 60 days regardless of circumstances - we don't do that), and we have no formulary restrictions for psychotropic medications. We set benchmarks and constantly review our program to find new ways of applying evidenced-based strategies. I can say, without hesitation, that our program has become the best in the state. And we serve many other jurisdictions, as well. We currently provide restoration services to Cochise, Santa Cruz, Greenlee and Graham counties. We work closely with Superior Court to provide the best restoration services possible.

One of our most exciting projects is building a data analytics dashboard that uses data from multiple County departments and databases, along with data from our RBHA, Cenpatico. Our goal is to eventually link Title 36, pretrial services, adult probation, superior court and sheriffs department data to allow us to fully contemplate recidivism causes and system anomalies so that we can continue to identify focused strategies. So what makes this exciting? Well, never, ever in the history of our local government, has there been a project that pulls data from multiple silos across the County for comparison in real time using thousands of datasets.

Eventually, citizens will have access to the data, which we believe will increase community involvement and education around these issues. As I am constantly reminded by my staff, data is the future and data is cool.

We are also responsible for other things, like the contracting and funding of forensic evidence collection for sexual assault victims. We oversee and fund the data exchange known as JHIDE or the Justice Health Information Data Exchange at the adult jail between Cenpatico and our medical vendor. We provide mental health first aid training to hundreds of County employees. We educate local school districts on recognizing kids in Behavioral Health crisis. We provide training to first responders. We serve as technical advisers to other jurisdictions, including on data driven justice initiatives, crisis infrastructure, court-ordered evaluation, restoration, and community collaboration.

I don't often get to highlight the amazing work of my staff, and I'm pleased to do so today. Not many jurisdictions have a behavioral health administrator, let alone a robust behavioral health department to provide key support and oversight across multiple silos within the county. I believe this is a testament to Pima County's strong commitment to Behavioral Health initiatives. We have visionary leaders in Pima County, especially on the behavioral health front and it continues today with both MacArthur and Data driven justice initiatives.

I began my career in public Behavioral Health and what we are accomplishing today in this community we could only imagine back then. We knew change was needed on many fronts. We knew that the intersection between justice and Behavioral Health would become more significant over time and that eventually our justice system and government would see these as priorities. Back then, a client in jail was a priority for NO ONE including public Behavioral Health. I remember, as a case manager, telling my boss that so-and-so was in jail. I heard the same response over and over. “Out of sight. Out of mind. move on to someone else.” It wasn’t that we were callous or unfeeling. We had high caseloads filled with people who needed our help and we simply didn’t want to expend resources on those who were arrested. We saw it as them being in a safe place for a while. This was such backward thinking. Today, I think we all believe the opposite - or we should! And even though case managers today face similar working conditions…low pay, high caseloads and the absolute responsibility for as many as 200 lives day to day - which is incredibly stressful - our attitudes have changed. Now it’s time to shift the resources to match.

I believe today we all work together to support initiatives that make positive change for our community and It's exciting to be involved in creating and driving health policy for the County that increases access to care, improves communication and data sharing across disparate systems, and focuses resources on our most vulnerable citizens. But, we still have much work to do, and Pima County Behavioral Health is proud to be part of this amazing, forward thinking community. I wish everyone success as you return to your respective work sites and try to establish new ways of doing business and we are always here to help if you need us. Thank you.

Dr. Margaret "Margie" Balfour

VP for Clinical Innovation & Quality Connections

PIMA COUNTY

PIMA COUNTY'S CRISIS RESPONSE CENTER

BECAUSE HE'S GOT WARRANTS

That's why.

PIMA COUNTY

911: WHAT'S YOUR EMERGENCY?

"I'm having chest pain."

"I´m suicidal."

PIMA COUNTY

The path to jail

For psych emergencies, first responders are often the police instead of EMS

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

- There are over 2 million jail bookings of people with serious mental illness (SMI) each year.[1]
- Nearly half of people with SMI have been arrested at least once.[2]

Prevalence of Mental Illness		
	Jail	US Adults[5]
SMI[3] -Men -Women	 17.1% 34.3%	4%
Any mental disorder[4]	76%	18%
+ Co-occurring substance use[4]	49%	3.3%[6]

1. Steadman HJ et al. (2009) Prevalence of serious mental illness among jail inmates. Psychiatric Services. 60(6):761-5.
2. 44%. Hall LL et al. (2003) TRIAD Report: Shattered Lives: Results of a National Survey of NAMI Members Living with Mental Illnesses and Their Families.
3. Includes PTSD. Excluding PTSD rates are 14.5% for men and 31.0% for women. Steadman HJ, Osher FC, Robbins PC, Case B, Samuels S. (2009) Prevalence of serious mental illness among jail inmates. Psychiatric Services. 60(6):761-5.
4. Glaze LE, James DJ. (2006) Mental Health Problems Of Prison And Jail Inmates. Bureau of Justice Statistics.
5. NIMH Statistics https://www.nimh.nih.gov/health/statistics/index.shtml
6. SAMHSA (2015). Behavioral Health Trends in the United States: Results from the 2014 National Survey on Drug Use and Health.

If they do make it to an ED…

Psychiatric boarding = long waits for beds with little/no treatment

- 84% of EDs report boarding of psychiatric patients
- Increased risk
  - Assaults, injuries, self-harm
- Increased cost
  - Sitters, lost revenue
  - Unnecessary inpatient admits
- Poor patient experience
  - Non therapeutic environment with untrained staff

Table 1 Examining Recent Data

The table below describes data from recently published studies on boarding times for psychiatric patients in the ED setting:

Study	Setting	Boarding time for adult patients*
Baraff et al 2006[1]	California	7 hr (average)
ACEP 2008[2]	National	≥4 hr (60% of EDs) ≥8 hr (33% of EDs) ≥24 hr (6% of EDs)
Tuttle 2008[3]	Georgia	34 hr (average)
Chang et al 2011[4]	Massachusetts	6.8 hr (median, to other facility) 2.5 hr (median, to in-house unit)
Stone et al 2012[4]	California	10.05 hr (average)

*Time from decision to admit until discharge from ED.

Sources: Adapted from: Zeller S, et al. *West J Emerg Med.* 2013 Jun 11 [Epub ahead of print]. Available at: http://escholarship.org/uc/item/01s9h6wp. Other referenced studies: 1. Baraff LJ, et al. *Ann Emerg Med.* 2006;48:452-452. 2. ACEP. *ACEP Psychiatric and Substance Abuse Survey.* 2008. 3. Tuttle GA. Council on Medical Service, American Medical Association, 2008. 4. Weiss AP, et al. *Ann Emerg Med.* 2012;60:162-171.e165. 5. Stone A, et al. *West J Emerg Med.* 2012;13:51-56.

American College of Emergency Physicians (2014) http://newsroom.acep.org/download/ACEP+Polling+Survey+Report.pdf
Zeller et al (2014) https://dx.doi.org/10.5811%2Fwestjem.2013.6.17848

PIMA COUNTY

What's the REAL prevalence of mental health and substance use in the ED?

National estimates say 12 million, or 12.5% of total ED visits, were related to mental health and substance abuse.

However…

Highest Volume for Adult Outpatient Emergency Department Encounters

Highest Volume	1	2	3	4	5
All	Low Back Pain	Hypertension	Pain/Aching of Joints	Chronic Bronchitis	Asthma
Insured	Low Back Pain	Hypertension	Pain/Aching of Joints	Chronic Bronchitis	Asthma
Medicaid	Low Back Pain	Pain/Aching of Joints	Asthma	Chronic Bronchitis	Depression/ Anxiety
Medicare	Low Back Pain	Hypertension	Chronic Bronchitis	Pain/Aching of Joints	Diabetes
Uninsured	Low Back Pain	Pain/Aching of Joints	Hypertension	Asthma	Diabetes

International Association for Healthcare Security and Safety (2015) http://ihssf.org/PDF/foundationbhpatientboarding.pdf
DFW Hospital Council Foundation (2012) TX 1115 Medicaid Waiver RHP 9 Community Needs Assessment
http://www.texasrhp9.com/main/community-healthneeds-assessment.aspx

PIMA COUNTY

A Better Way: Dedicated Crisis Facility

- 24/7 on-demand access
- A safe and welcoming environment
- Rapid triage and assessment
- Treatment and Crisis Stabilization:
  - Via counseling, medications, peer groups, family engagement, etc.
- Connection to community resources

Studies show this approach reduces:

- ED boarding[1,2]
- Inpatient hospitalization[1,2]
- Arrest[3]

1. Little-Upah P et al. (2013). The Banner psychiatric center: a model for providing psychiatric crisis care to the community while easing behavioral health holds in emergency departments. Perm J 17(1): 45-49.
2. Zeller S et al. (2014). Effects of a dedicated regional psychiatric emergency service on boarding of psychiatric patients in area emergency departments. West J Emerg Med 15(1): 1-6.
3. Steadman HJ et al (2001). A specialized crisis response site as a core element of police-based diversion programs. Psychiatr Serv 52:219-22

The Crisis Response Center

- Built with county bond funds in 2011 to serve the community
  - 12,000 adults + 2,400 youth each year
- Alternative to jail, ED, hospitals
- Serves as the law enforcement receiving center
- Co-located crisis call center
- Space for community clinic staff and other partners
- Adjacent to
  - Mental health court
  - Inpatient psych hospital providing the bulk of the court-ordered evaluations
  - Emergency Department (ED)

ConnectionsAZ/Banner University Medical Center Crisis Response Center in Tucson, AZ

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The Crisis Response Center

CIT Recommendations for Mental Health Receiving Facilities[1]

1. Single Source of Entry
2. On Demand Access 24/7
3. No Clinical Barriers to Care
4. Minimal Law Enforcement Turnaround Time
5. Access to Wide Range of Disposition Options
6. Community Interface: Feedback and Problem Solving Capacity

"We address any behavioral health need at any time."

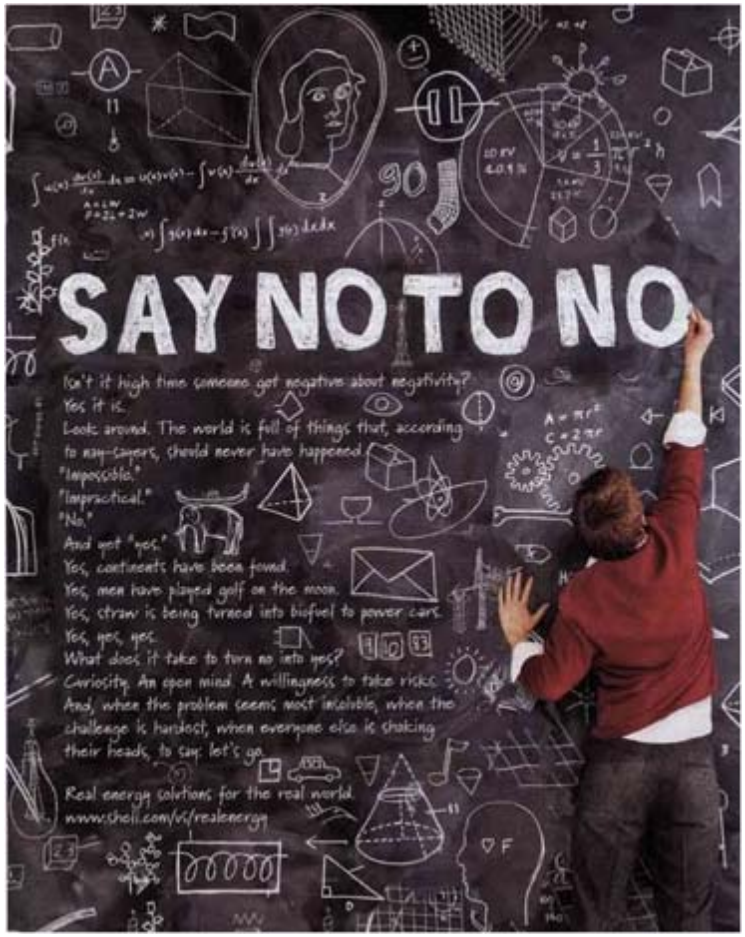
Dupont R et al. (2007). Crisis Intervention Team Core Elements. University of Memphis School of Urban Affairs & Public Policy

"It's easier to get into **heaven** than a **psychiatric facility**."

Low clinical barriers to access

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

Otherwise, where would these patients go?



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The CRC provides safe environment where people can be under **continuous observation** and **lack the means** to hurt themselves or others, while being as comfortable and welcoming as possible

Crisis Response Center, Tucson AZ

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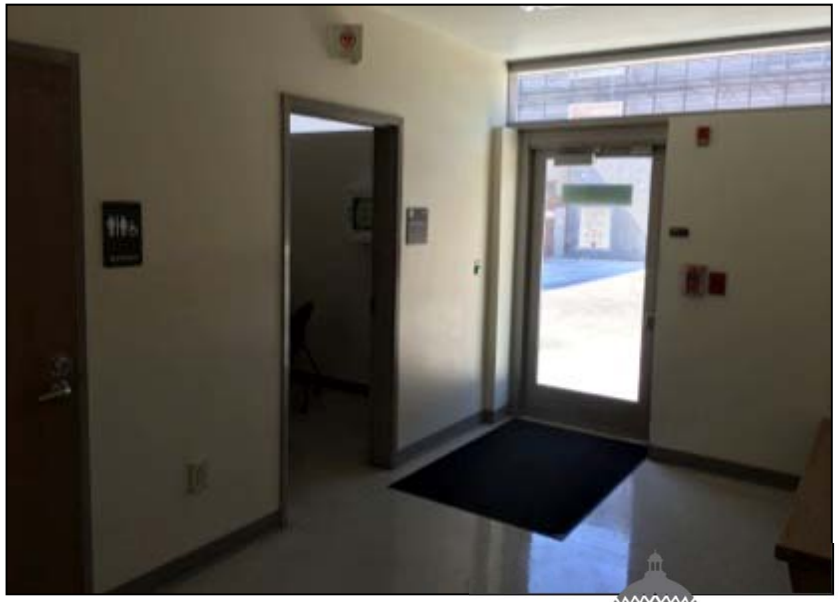
Law Enforcement is a "Preferred Customer"

Gated Sally Port
Crisis Response Center, Tucson AZ



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Easy access for law enforcement

Crisis Response Center
Tucson AZ

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23-Hour Observation Unit

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

"I came in 100% sure I was going to kill myself, but now (after group) I'm hopeful that it will change. Thank you, RSS members."

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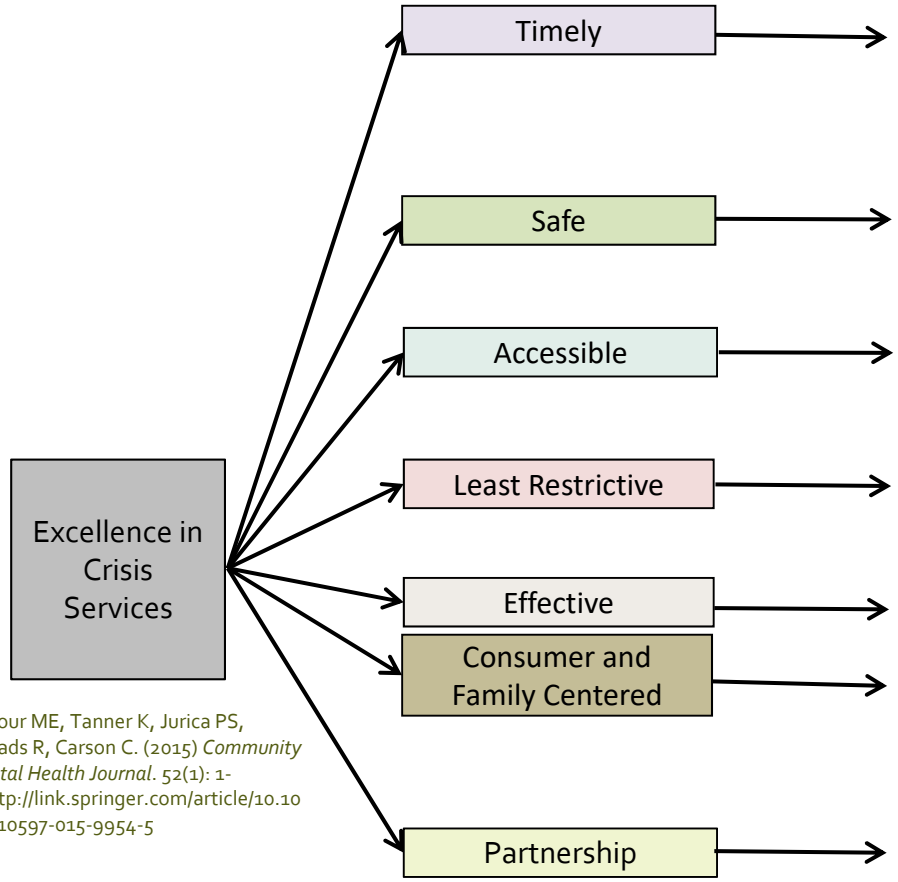
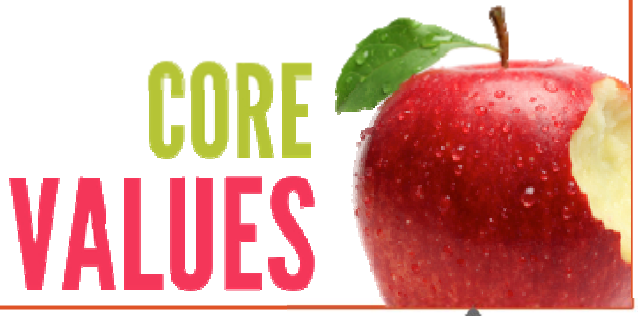
What should we be striving towards?



Balfour ME, Tanner K, Jurica PS, Rhoads R, Carson C. (2015) *Community Mental Health Journal*. 52(1): 1-9.http://link.springer.com/article/10.1007/s10597-015-9954-5

Values-Based Outcomes and Services

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



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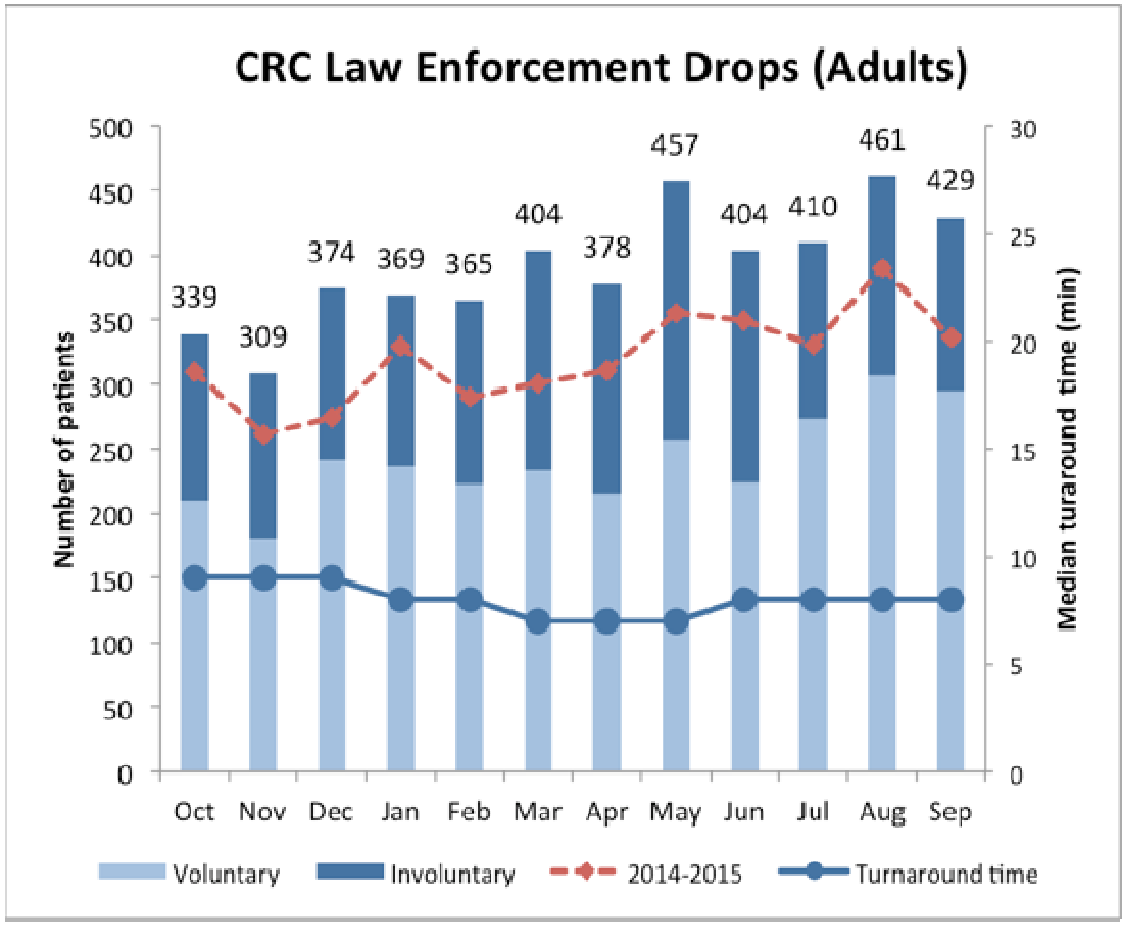
Outcomes: Police Turnaround Time



Half of our patients arrive via law enforcement.

They are an important customer and quick turnaround time is critical to providing a viable alternative to jail.

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

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Outcomes: Urgent Care Clinic

Patients are able to walk in and quickly get their needs met without going to an ED (med refills, connection to services, etc.)

A. Clinic door-to-door dwell time

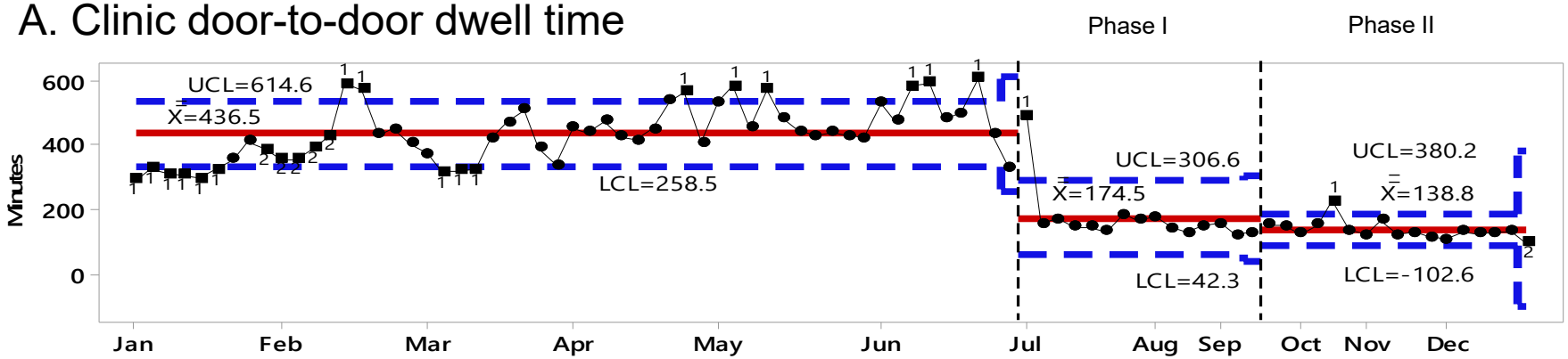


Table 1. Comparison of Phase I Outcome Variables: Pre- vs. Post-implementation and Pre- vs. One Year Post Implementation

	Pre (Jan-Jun 2014)	Post Phase I Implementation (Jul-Dec 2014)				One Year Post Implementation (Jan-Dec 2015)			
			Difference (vs. pre)	95% CI	*p*		Difference (vs. pre)	95% CI	*p*
Clinic Door-to-Door Dwell Time (median in minutes)	343	118	-225	(-224, -208)	<0.0001	99	-244	(-241, -229)	<0.0001

Balfour ME, Tanner K, Jurica JS, Llewellyn D, Williamson R, Carson CA. (2017) Using Lean to Rapidly and Sustainably Transform a Behavioral Health Crisis Program: Impact on Throughput and Safety. *Joint Commission Journal on Quality and Patient Safety*. Epub ahead of print. http://dx.doi.org/10.1016/j.jcjq.2017.03.008

Outcomes: Door to Doctor Time

Early assessment and treatment is critical to avoiding hospitalization and preventing adverse outcomes such as restraints and assaults.

B. Observation unit door to doctor time

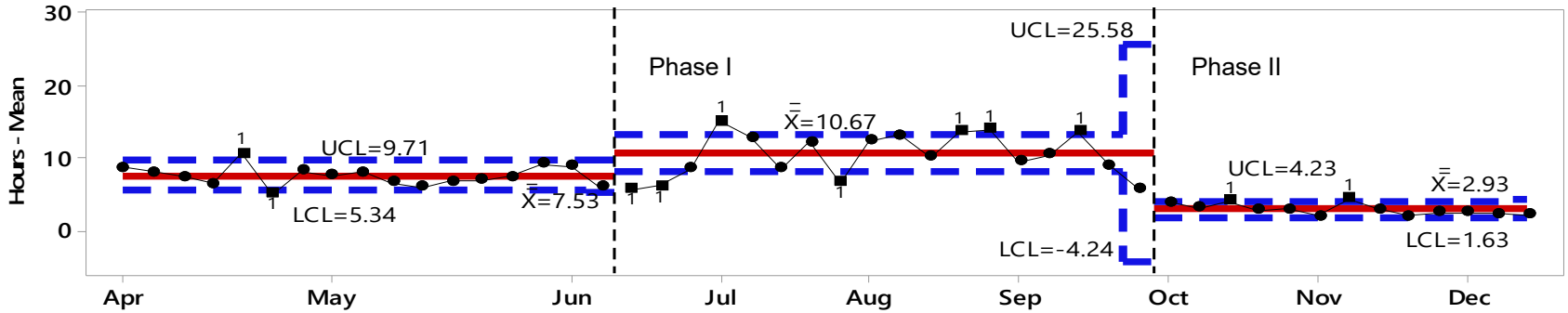


Table 2. Comparison of Phase II Outcome Variables: Pre- vs. Post-implementation and Pre- vs. One Year Post Implementation

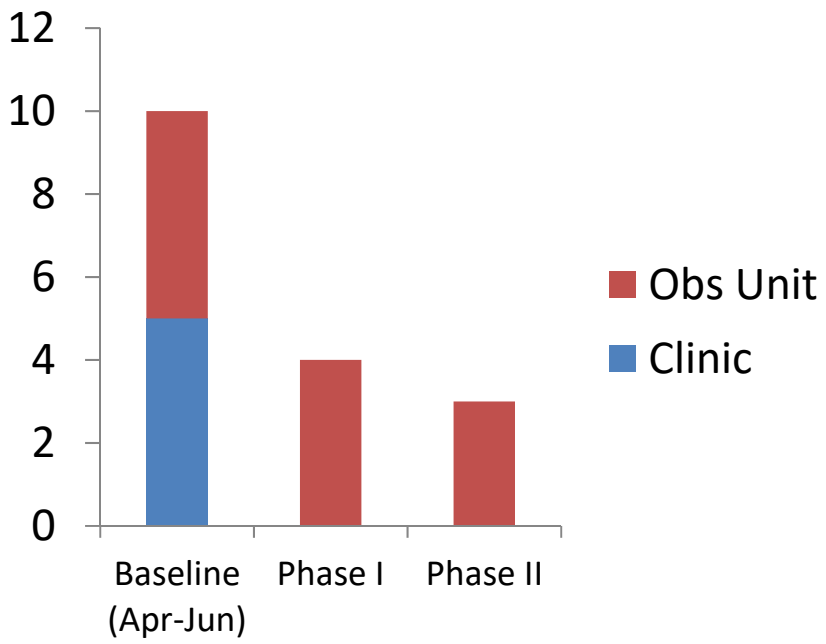
	Pre* (Jul-Sep 2014)	Post Phase II Implementation (Oct-Dec 2014)				One Year Post Implementation (Jan-Dec 2015)			
			Difference (vs. pre)	95% CI	*p*		Difference (vs. pre)	95% CI	*p*
Observation Unit Door-to-Doctor Time (median in hours)	8.2	1.6	-6.6	(-6.1, -5.1)	<0.0001	1.4	-6.8	(-6.3, -5.5)	<0.0001

Balfour ME, Tanner K, Jurica JS, Llewellyn D, Williamson R, Carson CA. (2017) Using Lean to Rapidly and Sustainably Transform a Behavioral Health Crisis Program: Impact on Throughput and Safety. *Joint Commission Journal on Quality and Patient Safety*. Epub ahead of print. http://dx.doi.org/10.1016/j.jcjq.2017.03.008

Outcomes: Safety measures

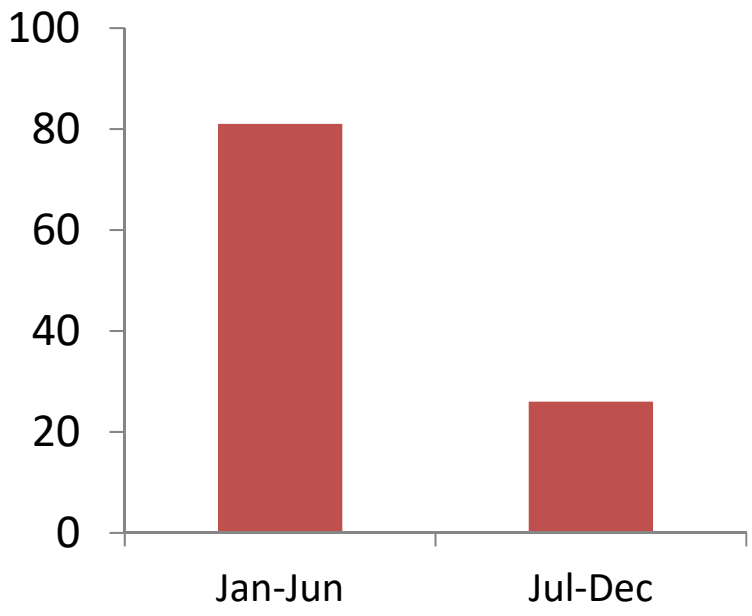
Staff Injuries

There are fewer assaults to staff.



Calls to Security

There are fewer calls to security for behavioral emergencies.



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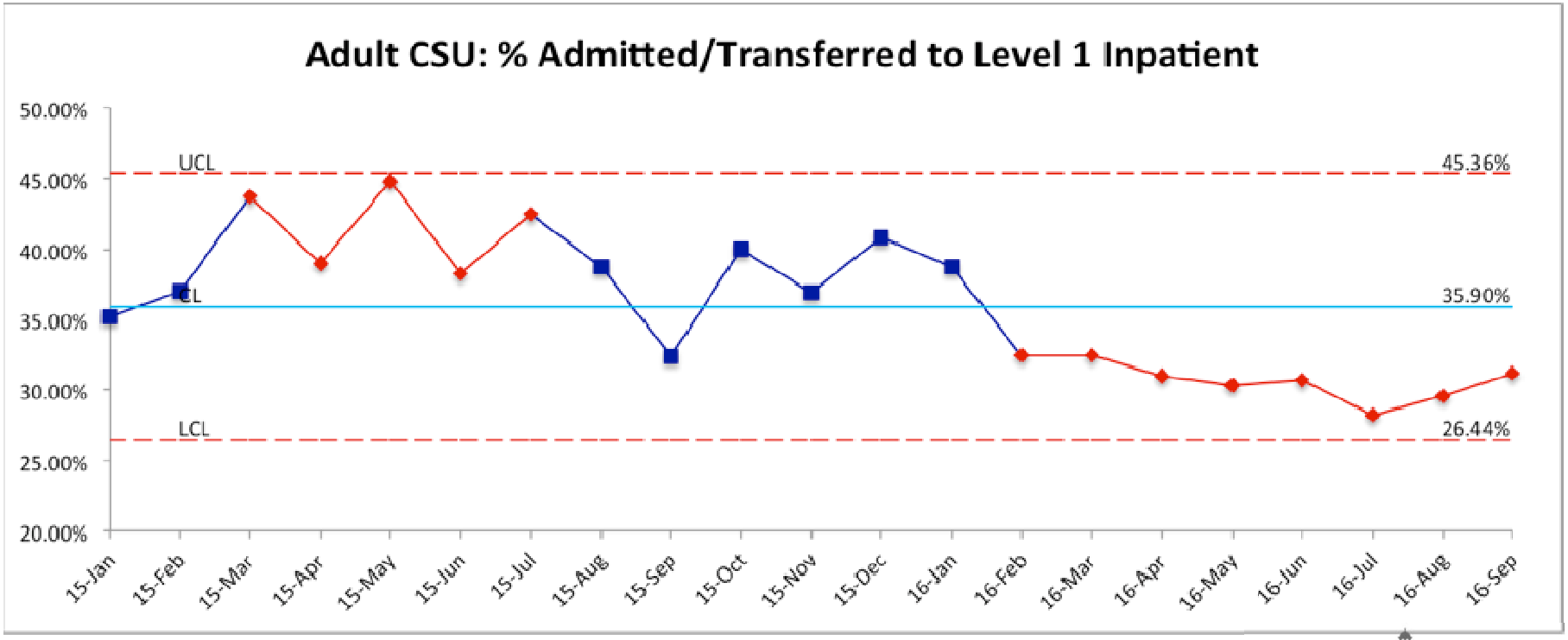
Outcomes: Community Dispositions

Only a fraction of the observation patients are admitted to an inpatient unit. Instead, they can be discharged (diverted) to less-restrictive community-based care. In an ED, many more would board waiting for beds.



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Using data to improve care

Internal Quality Metrics

- We developed a set of quality measures for our organization
  - Endorsed by American Association for Emergency Psychiatry
- Joint Commission project in 2017 will develop core measures for crisis services.

Community Ment Health J (2016) 52:1–9
DOI 10.1007/s10597-015-9954-5

CrossMark

ORIGINAL PAPER

Crisis Reliability Indicators Supporting Emergency Services (CRISES): A Framework for Developing Performance Measures for Behavioral Health Crisis and Psychiatric Emergency Programs

Margaret E. Balfour[1,2,4] · Kathleen Tanner[3] · Paul J. Jurica[3] · Richard Rhoads[2,3] · Chris A. Carson[1]

http://link.springer.com/article/10.1007/s10597-015-9954-5

System Performance Data

- Crisis utilization is a "canary in the coal mine" performance indicator of the overall behavioral health system
- We developed daily data feeds for the Regional Behavioral Health Authority (our primary payer)
  - Real time analysis of network performance
  - Identification of high utilizers

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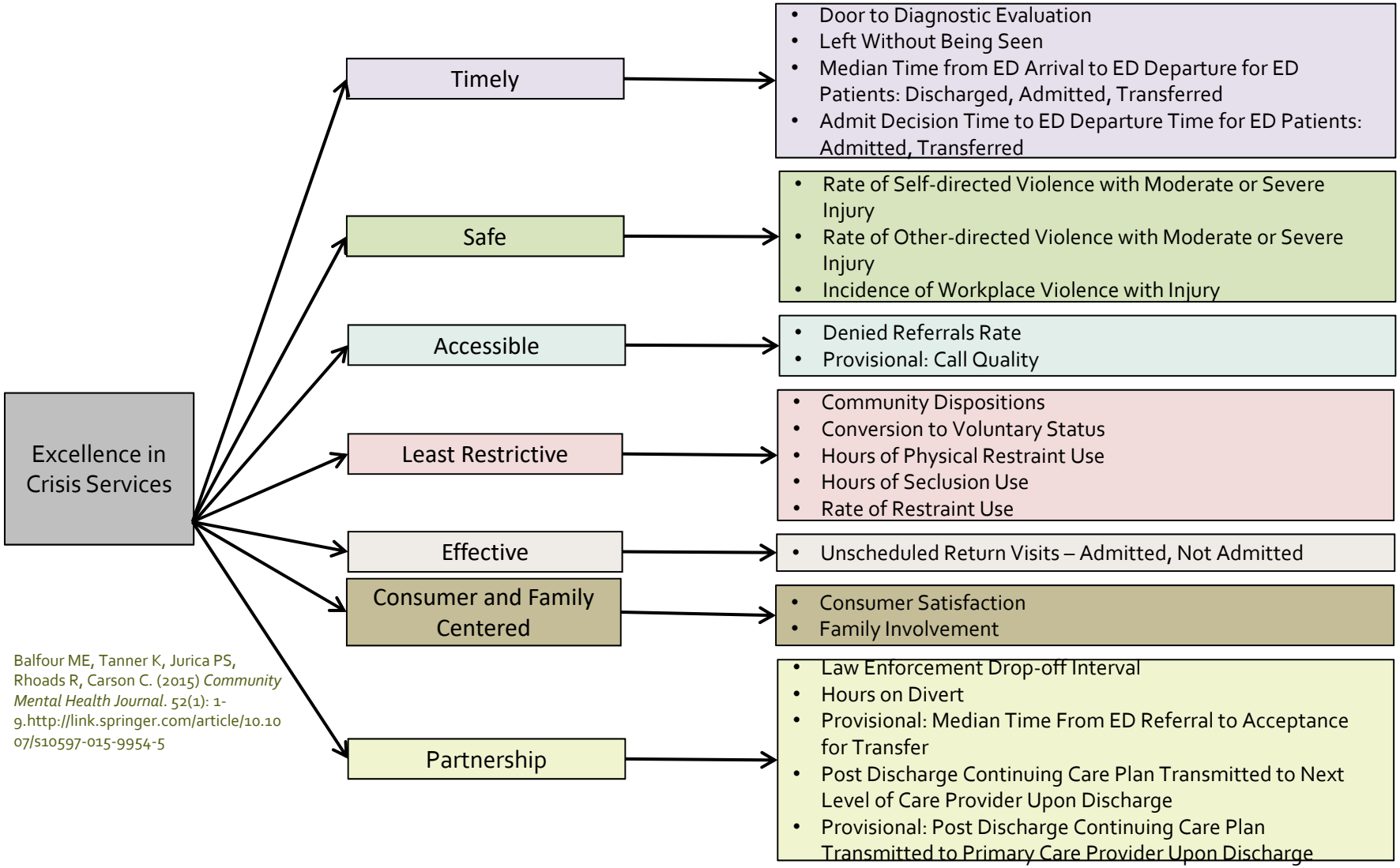
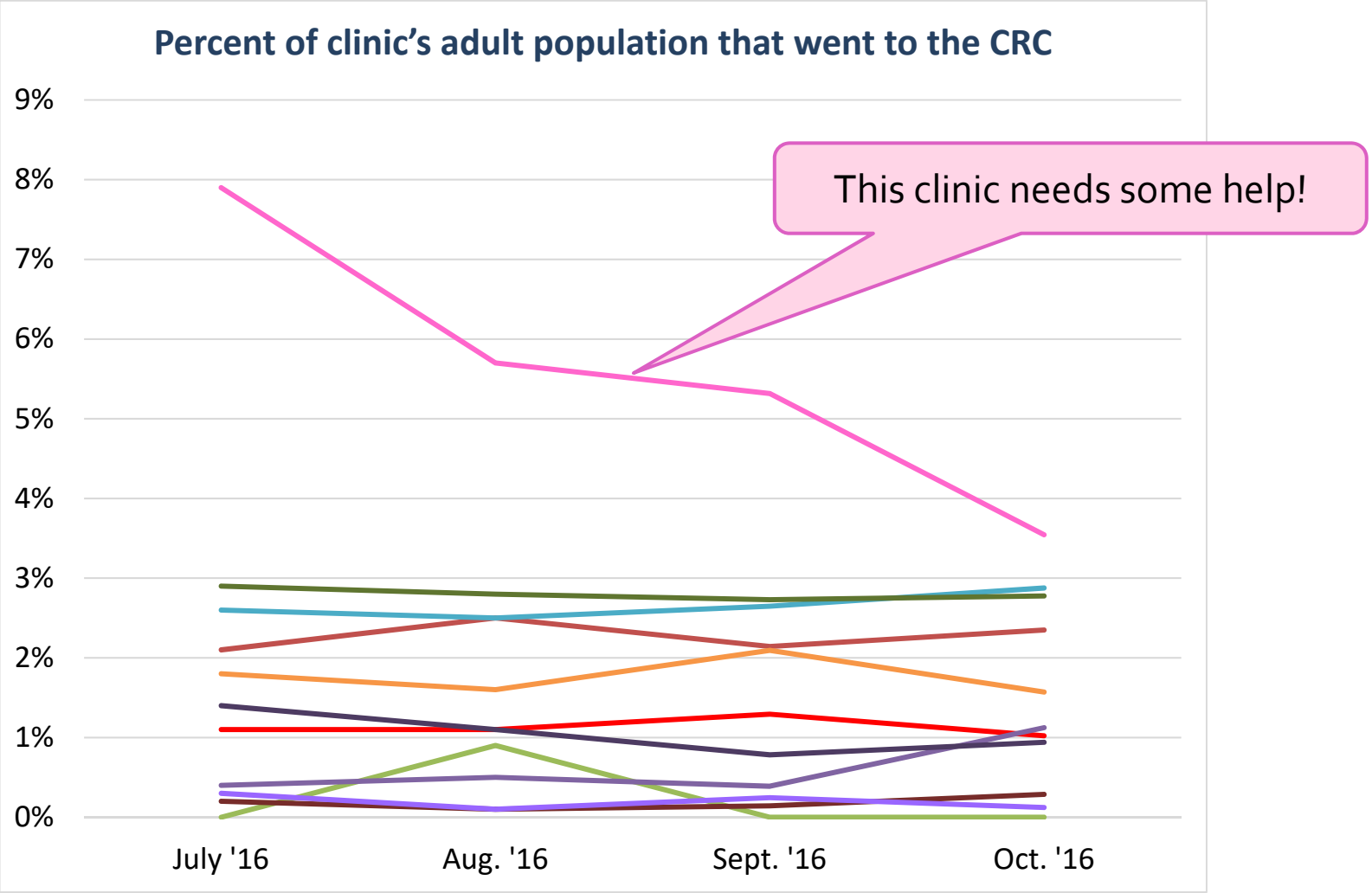
Values-Based Outcome Metrics

CRISES: Crisis Reliability Indicators Supporting Emergency Services



Balfour ME, Tanner K, Jurica PS, Rhoads R, Carson C. (2015) *Community Mental Health Journal*. 52(1): 1-9.http://link.springer.com/article/10.1007/s10597-015-9954-5

Improving the larger system
Example: Crisis utilization by clinic



A few words about high utilizers

- Only 3.8% ED visits were for principal dx of MH/SA
  - Except in the high utilizer group, where SA accounts for 20% of the visits
- But patients with frequent visits for medical dx had high MH/SA comorbidity
  - 58% with comorbid SA dx
  - 72.3% with comorbid MH dx
  - 48.9% with both
- Most had high outpatient utilization as well.

Billings J, Raven MC. Health Aff. 2013 Dec;32(12):2099-108

By John Billings and Maria C. Raven

Dispelling An Urban Legend: Frequent Emergency Department Users Have Substantial Burden Of Disease

Take home message:

1. Look for co-occurring MH/SA needs
2. These patients don't simply need to be connected to outpatient services – they are ALREADY connected but not getting care that meets their needs
3. This is a great opportunity to to study these patients and design better care in collaboration with other providers (esp for those in large health systems)

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Is the system is sicker than the patient?

Situation	Response
Has PTSD and can't tolerate the shelter environment	Come to the ED for a place to stay that feels safe
Wants to stop using drugs but everyone in their group home or shelter is actively using around them	Come to the ED and try to get admitted to the inpatient until they can get into rehab
It takes 6 weeks to get an outpatient appointment but ED discharges get seen in 7 days	Go to the ED and say I'm suicidal so I can be seen by psych and get a f/u appt
Don't feel listened to at the clinic, I've been telling them my meds aren't't working but I get a different doctor every time.	Go to the ED and say I'm suicidal so can get admitted and have my meds looked at
I'm hungry and have no natural supports and the ED has sandwiches and the people are nice there.	Go to the ED

Could I, as a well-adjusted professional with reasonably good coping skills, really tolerate things that we ask our patients to do in order to seek help "appropriately?"

A different approach

- Be a **detective** not a bouncer.
  - What does this person really need and how can we help them get it in a more constructive way?
  - Both you and the patient will have a better experience ☺
- Learn from their experiences in order to improve care
  - For that individual via case conferences
  - For the system as a whole via aggregate data
  - Who is responsible?

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Summary: Lessons Learned

- The solution is not always more inpatient beds.
- Both patients and law enforcement are our customer.
- Figure out how to say yes instead of no.
- Safety is the Prime Directive
- Start treatment early
- Use data to guide improvements
- It takes a village: multidisciplinary teams + community partners

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Questions?

- **Margie.Balfour@ConnAZ.com**
- www.connectionshs.com
- bit.ly/crisisnowvideo

Now THIS guy could really use some crisis intervention.

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H. Clarke Romans

Executive Director

NAMI Southern Arizona

PIMA COUNTY

DECRIMINALIZING MENTAL ILLNESS

The Law of Holes

If you find yourself in a hole

Stop Digging

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Stigma

The Great Initiator

PIMA COUNTY

Ignorance

The Mother of Stigma

PIMA COUNTY

Education

The Cure for Stigma

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The Long March-I

Start in Schools

PIMA COUNTY

The Long March-II

Public Awareness

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The Long March-III

Criminal Justice

- CIT: Pima County, 2000
- City Mental Health Court: Tucson, 2000
- Superior Court Mental Health Court: Pima County 2002

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FAMILIES

Then, Now, Future

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Next Steps

- Education
- Support
- Advocacy

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Thank you for attending our Conference.

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Pima County Attorney's Office
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