NAMI Ask the Expert: Help, Not Handcuffs
Part 3: Community Models
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Featuring Panelists:

- **Sue Ann O'Brien,** President and CEO, Behavioral Health Link (BHL)
- **Eric Eason,** Community Services Director, Behavioral Health Link (BHL)
- **Margie Balfour,** M.D., Ph.D., Chief of Quality and Clinical Innovation, Connections Health Solutions

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Dan Gillison (00:00:00):

Thank you, Teri, and good midday and good afternoon to all that have joined us, we appreciate you doing that. On behalf of our board and our board president, Shirley Holloway, all of our field leaders and the NAMI staff welcome. We're happy to have you with us and welcome to part three in our ask the expert on community models. I will hand it off to our chief medical officer, Dr. Ken Duckworth, who will take us into the agenda and the introductions, Ken.

Ken Duckworth (00:00:34):

Thank you Dan, and thank you all for joining. So as Dan mentioned, this is the third in our series of Help Not Handcuffs and the goal in this is to provide you with the best models, practices and leaders in jail diversion strategies, so that you can think about how to make that happen in your own community. As we all know most services are very local in the United States and so we're very fortunate to have two of the leading organizations in the country to follow up our conversation with Ebony Morgan of Kahoots from Eugene Oregon, with our 988 policy leaders at NAMI last month. This month we're going to be discussing with behavioral health of Georgia.

Suzanne O'Brien is the president and CEO, and has become a national leader in applying and thinking about crisis response at the same level as a medical response. She's also worked on some national guidelines and her colleague, Eric Eason is the community service director for that same organization in Georgia behavioral health link and he has done many different roles, but Georgia has kind of one-stop shopping for access and crisis in most places in Georgia, Eric will correct me if I'm wrong, mobile crisis to follow. This is remarkable in that we haven't seen too many examples of this, but we have another remarkable speaker from Arizona who will join us after we learn from our fellow Georgians. So Sue Ann and Eric, I want to thank you for joining us. Thank you for sharing your knowledge and leadership, and I'll have you take it away.

Sue Ann O'Brien (00:02:22):

Sure. Thanks so much, Dr. Duckworth for that introduction, as you said, I'm Sue Ann O'Brien, I'm the president and CEO of behavioral health link. We are based in Atlanta, Georgia, and currently we operate the Georgia crisis and access line, which is the single point of entry into all crisis services for the State of Georgia. We also provide mobile crisis services to two thirds of the State and we have a software platform that makes, what I like to say is keep all the trains running on that track. So I hope that we will be able to share with you a little bit about what we do today in Georgia, and it'll help inform your practice in your respective state.

See if I can go to the next slide. Jordan, I'm not sure I have control of the PowerPoint, can you forward for me? Thank you. So just by way of introduction here, you have all been hearing you had a prior presentation on the CAHOOTS model, mobile crisis has been all over the news, it's a really hot topic right now and for really good reason. There is no better time than right now for all of us to start re-envisioning how we can provide a safe cost-effective mobile outreach crisis care to folks in the community, in their own homes, wherever they are in crisis, that results in a lot better clinical outcomes than some of the alternatives to that. So I would just share with you to start with this article was published just last month in CNN, the title alone is compelling, there's a new approach to police response to mental health emergencies, and it's by taking the police completely out of it.

We know that 20 to 50% of fatal law enforcement encounters, actually involved a person with some type of mental illness, conversely 70% of situations in which mobile crisis is dispatched to the person's home or community locations those get resolved onsite without the need to engage law enforcement or to step up to a higher level of care. A couple more articles I would just make note of, if you subscribe to crisis talk, this is an article that comes out fairly frequently that the mental health care shouldn't come in the back of a police car, it was one of the most read articles of 2020 and then just a couple of weeks ago we had an article from Preston Looper on how the time is now to start standardizing mobile crisis services across the country. We know that law enforcement, even with the best of intentions when law enforcement engages in helping a person in crisis that can often be very traumatic to that person.

When you call 911, we know that there's two outcomes from that phone call, you're either going to get a law enforcement dispatch, or you're going to get an EMS ambulance dispatch. When you get a law enforcement dispatch, majority of the time that person is going to end up in jail or incarcerated and we know that people with mental health issues are incarcerated sometimes up to three to four times greater than what we find in the general population. So diverting away from jail or from hospital ERs is really the goal with what we're going to be sharing with you today. So if you don't register and you don't follow crisis talk, I'd encourage you to do so, there's a lot of really great information there. Just backing up, many of you on the call have probably heard of the Crisis Now guidelines.

Sue Ann O'Brien (00:06:52):

If you haven't, the website is a crisisnow.com, the guidelines were put forth by the national association of state mental health and program directors in partnership with SAMHSA, these came out in July of last year and they really start setting forth a national framework for crisis care that's a lot less fragmented. We all know that if you've seen one county or one state in crisis care, you've seen just that one and we have no federal standard for crisis response. Now conversely, if we look at a response for physical health issues, we have a very robust system on that side, we have 911 doesn't matter what state you're in, you could be traveling, you could be on vacation somewhere in a place you've never been to before and you know what to do to access help in the physical health emergency and you know what's going to happen from that phone call.

You're going to get an ambulance that arrives within a certain amount of time and you're going to get care that matches whatever situation that you're facing. This framework attempt to put forth some guidelines that will help us get on the same page with mental health parody when people are in a mental health crisis. The idea here is that a mental health crisis can be just as life-threatening as a physical health crisis and we want to have the same level type of response that we have on the physical health side. Mobile crisis services are a really key component to that. So a little bit about that structure coming out of these national guidelines, as I said, I'll use Georgia as an example because we have three of these four components here in Georgia, the crisis call center hub, as I said, the BHL operates the Georgia crisis and access line, which is the single point of entry into the state of Georgia's crisis system. So this is one hotline number that all the calls are coming into this call center. Many of you might have a statewide crisis hotline, maybe your state is looking to moving towards that, you might still be in a county based system or every provider in your area might have their own after hours or a crisis hotline, this all contributes to a very fragmented system of care. As states start moving towards one, two or three central entry points, you're going to have all these calls coming into one call center hub and somewhere between 80 and 90% of calls can be resolved over the phone.

Ideally for those remaining 10 to 20%, you have to have other levels of care, I guess, is what I would say, to be able to place those folks with a level of care that matches their need and not have a one size fits all. That second core component in this three legged model is the crisis mobile teams. Now in the Georgia model is really a 24/7, 365 response team, these are two person teams, Eric's going to dive more into a little bit of the operational details around this, but this is a clinician usually accompanied by a peer or a behavioral health technician level, a person as well, responding to folks wherever they are at in their home or in their community.

Then the third piece of this puzzle is really for those that can't be resolved. So earlier I said, usually around 70% depending on which state status you look at, around 70% of those mobile crisis responses are resolved in the person's home without going on to a higher level of care without going on to jail. That's a really significant cost diversion and it's just overall better care for the person and their family that was in crisis. The third component for that 10 or 20% that cannot be resolved in the community or in their home you need a crisis receiving center. Again, inpatient psychiatric hospitalization is not a one-stop shop, not a one size fits all for folks in crisis, but getting to a more short-term crisis receiving center is really another option for those folks, Margie's going to talk a lot more about that later this afternoon as well.

Sue Ann O'Brien (00:11:36):

So all of this comes together to form a really comprehensive, less fragmented, highly integrated approach. The technology platform that is part of what we offer at Behavioral Health Link, it's a software technology we call Care Traffic Control that really brings it all together. That's what allows our call agents at the Georgia Crisis and Access Line to be able to connect people to the appropriate level of care at the appropriate time. When Georgia first went live with this model, really back in 2006, they saw a $1.7 million savings to the behavioral health system, just in terms of cost avoidance alone, from diverting away from jail and very costly ER services and resolving the majority of issues either on the phone or in-person at the person's home. Taking a deeper dive into what those best practice standards really outline as the gold standard for mobile crisis community-based response.

This is, as I said, a two person team that is usually a licensed individual, perhaps joined with a bachelor's level clinician or even a peer level staff, they outreach and dispatch to the location of the person in crisis, so we meet you where you are at, wherever you are at. The two person teams allow for safety and optimal engagement, we do a warm handoff wherever needed and like I said, Eric's going to talk a lot more about how we do that in Georgia and some of the specifics that hopefully you'll be able to use in your own area today. We also employ real-time GPS technology. This allows us to see which of our mobile crisis teams are not only available, but who's available and the closest to the person in need and be able to dispatch that team directly from the call center with just a one-click sending all that information directly to our mobile crisis team. So they know exactly what the caller's issue is and what they can expect.

We always attempt to make face-to-face contact without engaging law enforcement or EMS, unless it's absolutely required. We do have a risk assessment system that we use to guide our clinical decision-making around that. Also on the Crisis Now website, you'll see a five level scoring tool. This can be helpful, anybody can use this, when you go to the website you can download this, you can use the tool to assess your own system, whether it be at a provider level, a county level, a region, or a statewide, but you can use this as a checklist of where does your particular region fall in terms of getting to what we would consider the gold standard for crisis services, so just to helpful a resource there. Some of the outcomes from mobile crisis, and I took this with permission from Matt Boldman, Dr. Boldman, many of you might've heard him speak just a few weeks ago on some of the benefits of diverting away from jail and ER, but mobile crisis has a lot of very significant outcomes for the person.

There's an increase in community-based mental health services and engagement, reduced post-crisis hospitalization, reduced emergency department use and as I've mentioned a couple of times, very significant cost savings due to the diversion from inpatient admission. Really again, as I said, when I kicked off the time is now you all have heard that 988 is on the horizon as of July 16th of next year, 2022. All calls coming into the national suicide prevention lifeline when 988 will be alive three digit number. When folks call 988 they're going to route through the NSP online, much like they do today and get sent out to whatever the MSPL call center is in your state. This single event is going to be one of the biggest transformations of our behavioral health system as we know it nationally.

Sue Ann O'Brien (00:16:20):

So as we think ahead to having more accessibility for people in a crisis, having an easy three digit number, a way for people to access care when they most need it, where they most need it, and being able to have a more comprehensive approach to crisis care, that includes a call center, 24 seven mobile crisis and having some place for folks to go to that is not jail and not ER, is really what we're all striving for. So with that, I will hand it over to **Eric Eason**. Eric works at BHL, he's our director of community services and guru of all things mobile crisis and happy to have him share with you all the great work that we do in Georgia.

Eric Eason (00:17:06):

Thank you, Sue Ann. Here in Georgia, we actually, Dr. Duckworth, have mobile in all 159 counties, but VHL provides that service in 104 of the 159. If you look on the map, we cover regions two, three, five, and six, that's the center four regions. That accounts for nearly 50,000 square miles and as of 2010, the last census numbers that I was able to locate a little over a population of about 7 million. We've of course grown in the last 10 years and we'll know soon how many people we're covering then. Georgia to give you a sense of scope, it takes about six to drive all the way from the Northern to the Southern tip of Georgia and about four to drive from east to west, I think of travel in those terms, if that's helpful to you all. Of course, when we're covering such a large area, it becomes really important that we staff strategically.

We hire staff who live and work in their own communities, without doing that it would be impossible for us to cover such a large area and get any kind of reasonable response time. We aim to have response averages under an hour, in our urban areas it's relatively easy to do that, in our more rural areas that of course is a challenge that we are sometimes able to do that where sometimes not. But as I said, having staff who live and work in their own communities is really critical to making that happen. Our teams are composed as Sue Ann mentioned of licensed professional clinicians. We also have paraprofessionals, we have board certified behavior analysts and we also have a large number of peers. Those peers are really critical to the work that we do and I'm going to emphasize in a few minutes about the importance that peers hold on our teams.

As Sue Ann mentioned, we have, I'll say the luxury of having a centralized phone operations system in Georgia, G-Cal or the Georgia Crisis Access Line is the single point of entry for mobile crisis. When they receive phone calls, they of course do all that they can to deescalate and refer people to appropriate services but as we know, not everyone is able to be deescalated and therefore, sometimes mobile becomes the most appropriate linkage for those folks. So in those cases, G-Cal has the ability to use the electronics processes to generate a dispatch that then populates on our electronic board. We have mobile dispatchers who monitor that board 24/7 and then are able to use the tools at their disposal to make an appropriate assignment of staff. Now I recognize that this is probably so small that you can't really read it, but I just wanted you to have a sense of what our live dispatch board looks like.

Eric Eason (00:20:02):

This is a copy of the live dispatch board that we operate off of and so we're able to see, of course some of the information is redacted for privacy, but we're able to see at a glance, the names of individuals, the type of location, many of these are residences, there's a handful of jails, you'll often see in their street, you'll often see other types of agencies there. You have a designation for which team is responding as well as some basic address information to help us know that. So we have all this at our fingertips, we also have the ability with these buttons at the top to download that printed triage that G-Cal has created for us. So we have in front of us, a written document, it's generated as a PDF that provides us with all the information that G-Cal was able to obtain.

In pretty quick order, we're able to gather the primary reason for our consultation, a lot of the safety factors that have been screened at that point, as well as other critical information about why we're responding and what it is that we have to be able to do for folks. Sue Ann mentioned our leveling system, we do have a five level dispatch process, when G-Cal takes information, they have certain screening questions and they use certain metrics to determine based on safety factors, which level to assign that call. This level is then communicated to mobile who uses this as a guide to determine the safest and most appropriate way to respond to the dispatch location. We know that one of the biggest points of this whole series and I think we can all agree that by taking law enforcement out of this process, that's really one of our big goals to improve outcomes for folks. This system helps us do that to a large degree.

I won't read for you, but level one and level two calls indicate a need for police because of safety concerns, level one police leads level two mobile leads, but they're there with police. Levels three, four, and five don't necessarily involve police, it's possible they may escalate it's always a possibility, but by and large any call that is dispatched below a level two does not involve police at all. I pulled our numbers since July of last year, we've been dispatched to a total of about 10,000 dispatches and of that number only 2% were dispatched as a level one and only about 13% were dispatched as a level two. So more than 85% of our dispatches are not by default intended to be a response with law enforcement. Even when we do have to bring law enforcement along with us for safety concerns, we are usually able to help navigate that situation through the collaboration between law enforcement as well as our team, and many more times than not we are able to support a positive outcome that does not result in- ... able to support a positive outcome that does not result in arrest or incarceration. We do a tremendous amount of work with our law enforcement teams, so that they know who we are and they understand what we're doing, so that we can have successes like that.

We also have one of our latest and greatest things that we use is our GPS software. This is the dashboard that our dispatchers look at. You'll notice this yellow pin ... Keep in mind, this is test data. This is not reflective of the people we actually have working. We have a lot more. But if you look at the yellow pin, that's the location of the dispatch, the crisis location, where we're going to be responding. And we can see, based on this dropdown, the list of names of people. What is not reflected here, just because of the size of the screenshot I had to take, is each of these names also has a mileage designation, to tell you, "This person is 24 miles from the location, 37 miles from the location." We're able to, at a glance, be able to say, "I need a clinician. Here's the closest clinician. I need a parapro to support that person. Here's the closest parapro to support that person." So our dispatchers are able to use these tools to assign the two closest people to the call, to support the most rapid response possible.

Eric Eason (00:24:21):

From the clinician or the team member's perspective, these are some screenshots of our app. There's the login screen. Here's the basic address. This is test data, so no worries about that. But this is an address that they're going to be responding to. You see they have to press an accept button. When they do that, that pops up the map to show them how to get there. And then they're able to return to that screen to indicate when they've arrived. So they use this app to be able to update their status in real-time. Apart from the GPS tracking, we're also able to get live information about where they are in the process.

So for instance, if you're seeing that a team is remaining on scene, it typically takes a team about an hour to complete an encounter and begin the linkage process. So if you see that a team is starting to be there for 75 minutes, 90 minutes, that's a clue that we might want to check in with that team and be sure that they're safe on site and nothing has happened. So it supports safety for not only the individual, but also the team. There's, of course, a list of assigned jobs that we're able to track. You see the statuses here, that the team was able to update in real-time as they go.

One of the components, of course, of any encounter with mobile is an assessment tool. I wanted to just let everyone know the basics of our assessment tool. It is very heavily focused on a risk assessment. Typically the reason we're sent is we often respond to people who are in a suicidal crisis. So that is the heart of much of what we do. Our risk assessment is based on the Columbia scale for suicide risk assessment. It also incorporates elements of Dr. Thomas Joiner's interpersonal theory of suicide. If you're not familiar with that, it measures suicide across lethality, capability, and looks at risk factors and protective factors as a means of assessing risk.

The assessment, of course, also includes current and historical information about symptoms, any diagnoses that this individual already has established, what types of treatments, medications, whether there've been particular outpatient treatments, inpatient treatments that have been helpful, or have not been helpful. We use all of that information as well as an evaluation of that person's natural support, natural existing people and resources that they have at their disposal that can help support them through this crisis event, to hold a discussion with that individual and to help that individual guide the conversation around, what do you think is going to be your best bet? Our clinician is there to ensure that we're not doing anything that's clinically inappropriate, inadvisable, or that violates our primary desire to keep the individual safe during this crisis. But we understand that having that person drive their own encounter is so critical, not only to having them invest in the process, but also, we find that it supports better outcomes.

When we were making this process, the linkage and the safety planning portion of our encounter is really a critical piece, because what we want to do is we want to focus on that person's own desire for treatment, their own decision-making processes. We use a safety plan intervention, which many of you are probably familiar with, developed by Dr. Stanley and Brown. That safety planning intervention helps us through this process. It helps them focus on natural supports. It kind of gives them an escalating series of steps for how to obtain assistance if their crisis were to recur in the future.

Eric Eason (00:28:06):

So with all of this together, we use all of these tools to help make that final decision and then we're able to link people. Usually we're able to keep people in their homes, in their communities and help them link with some sort of community-based service, perhaps an outpatient appointment, perhaps some sort of more intensive community service than that. And of course, when we need to, we are able to refer for inpatient stabilization at a crisis unit or other location. Our clinicians do have the ability to initiate an involuntary referral, but that is a very small number of folks. Even the folks who we do wind up hospitalizing, we typically do that voluntarily. It's around about 6 or 7% of people that we wind up 1013-ing, of the total volume that we see. So it's a pretty small number of the total people that we're encountering.

Of course, follow-up is a critical piece as well. We find that the ability to follow up with someone, and we've had an encounter with, kind of helped cement that linkage. It gives us an opportunity to go back over that safety plan intervention that we developed with the individual. We get to ask them, "Have you had to use your safety plan? Do you understand it? Is there any piece of this plan that you feel like is not going to be helpful, that we might want to revisit?" So we can actually review it. Of course, our follow-up team has access to a copy of the document itself, and they can review that over the phone with the individual. That way they can also help coach them through improving that safety plan, or making a change if needed.

It also gives us an opportunity to confirm that they understand any types of referrals or resources we've provided them. So for instance, I may have given a person directions that they were supposed to walk into a facility between certain hours and here are the documents they need to have with them. But in a moment of crisis, sometimes even when you have a paper in front of you that tells you that, it's hard to process that information. So being able to talk to that person the next day and say, "Hey, I know we went over a lot of stuff last night, let's just go back over this and be sure you understand it." We typically will continue our follow-up until one of two things happens, either the individual finally makes it to that next step in treatment. So they finally make it to their appointment, at which point we hand off care. Or until the person for whatever reason says, "I appreciate your help, but I've got it from here." So we respect that preference and we do let them manage it for themselves.

Those follow-up conversations become really important for people who might be facing barriers to linkage. A lot of times we have folks, I'm sure this is a common problem, but we have a lot of people who have transportation limitations. They don't have transportation themselves. They don't have access to any kind of transportation that they're aware of. So sometimes we're able to help them think through, "Do you have a family member? Do you have a friend who might be able to support you? Is there access to public transit where you live? Is there any way for you to get a voucher for a cab or some sort of lift like that?" Or, in some cases, there are community providers that provide those resources to people who are potential or current consumers for their organizations. So we're able to help them navigate those resources and potentially find something that can help them out.

Eric Eason (00:31:34):

When I think about the primary components of what helps us be really successful in mobile, collaboration, collaboration, collaboration. I've talked to you today about all the people we collaborate with, law enforcement, sometimes with EMS. We collaborate with community providers. We collaborate with a lot of these other resources, transportation resources. Sometimes we'll refer to homeless housing resources, food resources, financial resources. We can't do that if we don't know each other. So we actually have people in all of our regions whose sole job is to develop these relationships and to nurture those relationships. In each of the counties in Georgia, there are multiple law enforcement agencies. So we've got a lot of law enforcement agencies we have to talk to. We do that constantly. We round back with people. We ask how things are going. We try to get feedback. What's working well, what's not working well. How can we be a better partner to you? That is really, really critical for any kind of mobile program to succeed, because we can't do it all on our own.

Not only does that collaboration extend outside the company, but it extends within our own team. The integration of CPS, as I talked to you about, has been a really, kind of an experiential change for us. That's something we had. CPSs, a number of years ago, we introduced those to the team. But we use them in somewhat of a limited capacity, only with our follow-up process. But beginning a few years ago, we started to integrate them into actual live response and we send them out on live response. It has been a fantastic decision, because the use of peers in that way, their skillset allows them to connect with people in a way that I can't do. It's the ability to talk to someone who understands your own experience from their personal experience. And that really has made a huge impact. They do continue to support our follow-up process as well, but it's really getting them out in the field that has, I think, been one of the smartest things we've done with how we're utilizing our peer skillset.

Of course, the emphasis on consumer-driven linkage is something I do want to highlight, because I do think that is really critical. If you tell someone what they're going to do, they're less likely to be invested or believe that that's going to be helpful. And we know that that tends to have a less positive outcome. So I think that's really a crucial piece. And then of course that collaboration among the team. No one ever does this work by themselves. There is always someone on the team with them. There is always a supervisor available, checking in, available to staff if there's a need. We do this as a team. Crisis work is very difficult, and isolating yourself and trying to be one person gets really exhausting really quickly. So being able to approach this as a team really helps support, not only those that we're serving, but even those of us on the team who are doing this great work.

I'm going to turn this over to our colleague, Dr. Balfour, who has a lot more to tell you about her program.

Margie Balfour (00:34:56):

Hi, thanks for having me. My name's Dr. Margie Balfour. I am a psychiatrist out here in Arizona. I work-

Ken Duckworth (00:35:05):

Dr. Balfour, I think I was supposed to introduce you.

Margie Balfour (00:35:09):

Okay.

Ken Duckworth (00:35:10):

I want to thank our colleagues from Georgia for their exceptional and quite comprehensive approach. I haven't really seen anything that is statewide and as comprehensive as that. Forgive me for missing my cue. Dr. Margie Balfour is an MD and PhD in her spare time, who is an associate professor of psychiatry at the University of Arizona, and is the director of quality and innovation at Connections, covering Tucson and Phoenix. Her work and team covers the vast majority of the state. I'll check back in for questions. Thank you.

Margie Balfour (00:35:49):

I am going to skip some of my beginning because Sue did such a great job of talking about that before. I want to just step off and reiterate this point that Sue did a great job of making, which is that a behavioral health crisis is ... it's a potentially fatal health emergency. We have this system where it's often easier to get into heaven than access psychiatric care. You hear that people say that sometimes. That's because our system is difficult to access. We should expect the same kind of systemic response, with the same quality and consistency, as we would expect for a heart attack or a stroke or other healthcare emergencies. I know NAMI is a great avid advocate for mental health parity. It's just something to think about is, why do we settle for this haphazard, piecemeal system that is in most states? When, if you were calling 911 for a heart attack, you would expect a completely different level of care.

I want to make the point about a crisis system versus just the services, because I think that's a part of the conversation that gets lost a little bit. There's so much momentum now for improving crisis care, as was mentioned before. It's like every day now there's a new story on CNN or the news about some cool new program, like CAHOOTS out in Oregon, or one another community that has a really cool mobile team, or one that has a really cool crisis line. All those programs are necessary and wonderful, but we really need them to work together as a whole crisis system.

Just like your region has a whole system for when people get into trauma. There's level one trauma centers and level two trauma centers, and there's EMS, we need a similar system for crisis. Where we have all these different services, many of which you've heard about in this webinar and the ones before, and they're kind of illustrated in this slide where you've got ... there's no one size fits all. There's mobile teams, and there's phones, and there's post-crisis, and there's crisis residential, and crisis respite, and facilities and all kinds of things. But they need to work together in a coordinated way towards common goals. That way, instead of individual programs here or there that are expected to solve a large problem, you've got all these different services working together so that they're more than the sum of its parts.

Three things that you need for a system to work is accountability. So if you're saying we want the system to be working towards common goals, well, who determines what those goals are? And how do we hold the different parts of the system, the different programs and different organizations and agencies involved, how do we hold them accountable to working together towards those goals? Oftentimes, that's tied to the governance and the financing structure, which I'll give an example of in a bit. The other thing we need is collaboration. Eric just talked a whole lot about collaboration. In crisis care, in particular, compared to other parts of healthcare, there's so many ... such a broad group of stakeholders. So it's Behavioral Health, but it's also emergency care, and 911, and schools, and justice, and jails and police. So you really need a culture where people get together, communicate, and problem solve.

Margie Balfour (00:39:45):

And then data. I'm a nerd. I like data. We really need ... If we are saying that we're working towards common goals and we're trying to achieve these common outcomes, how do we know if we're doing it? How do we know if there's something that we need to focus on and improve? It's always good to make decisions based on data versus anecdote. The Arizona system, I'm going to talk about as an example of where these things come together.

Another reason I want to talk about it is because in Arizona, the whole crisis system is funded and managed through the Medicaid department. There's a lot of discussion with all of this momentum around improving crisis care about where the funding's going to come from and should we move funding around from public safety and police budgets, or government budgets, and this and that, to fund this kind of stuff. This is health care. This is going to get kind of soapboxy, but what other type of medical emergency would we say, "Well, where's the money supposed to come from?" Other than the ones with a psychiatric diagnosis, we don't go, "Well, where's this money going to come from to send ambulances to respond to heart attacks?" That's just expected, that health insurance should cover that.

In Arizona, this is all done via the Medicaid system. So here's our state. We don't have a hundred and something counties like Georgia, we have 15 very giant counties. Very spread out. The state's divided into three regions, the north, the south, and the central, which is Maricopa, which is Phoenix. I'm going to be talking about Tucson, which is where the star is in the southern region. In Arizona, our Medicaid department is called AHCCCS, which stands for Arizona Health Care Cost Containment System. Which, I thought it stood for access to care, but it stands for that. Actually, though, it explains one of the reasons why Arizona has invested so heavily in crisis care.

Arizona was the last state to even have Medicaid. It wasn't until the '80s, in response to a lawsuit around mental health. Part of the settlement for that lawsuit was that people were entitled to a continuum of mental health care, including crisis care. So in order to meet the terms, the state had to buy into Medicaid for the first time in the legislature. Because it's kind of fiscal conservatives out here, they wanted cost containment in the name of the department. So we were the first state then to get a statewide managed care waiver. Where instead of just people popping up and putting on a shingle and sending bills to the state because you want to open a clinic, the state actually has a waiver where they can contract with managed care organizations to take all the money from various sources and administer it. The advantage to that is from the very beginning, some ... I don't know how policy wonky folks want to get, but from the very beginning, people have had to think about the system as a system, versus just clinics that pop up and send bills to some department in the state.

The way that it currently works is the state's divided into these regions. And then AHCCCS, our Medicaid department, they contract, they put out a competitive bid process for people to apply to be the regional Behavioral Health Authority. We call them RBHA, for short. And then the one that we have for the south is Arizona Complete Health. It's part of Centene, which is one of the big insurance companies. So they have a contract with the state that says they're supposed to provide crisis care. And then they contract with all of us crisis providers. So we're one of the crisis providers. There's a couple of different agencies that do the mobile teams. A different agency that has the phones. But all of us contract with that one single authority. They're kind of like our benevolent overlords.

Margie Balfour (00:43:51):

And then the money, they braid different funding together. There's the Medicaid funds, which is most of it. SAMHSA has funds that are given to each of the states that can be used for crisis care. So that's included. There's state funds, and then there's some local county funds. They take all of that together and they keep track of what can be applied to what. But from our perspective, we have a contract with the Behavioral Health Authority to provide crisis care. So you can see that that structure kind of has this idea of accountability and oversight, it's kind of baked into how we're structured. What that means for the crisis system is that there's a central place where someone is planning it out as a system, and that there's a central place where someone is responsible to make sure that everyone else is being accountable to doing what they're supposed to do in the system. Kind of like the conductor over here, where all of us providers are like the orchestra. We're all supposed to be working together, but if one of us is out of line, then they can say, "Hey, you need to get with the program. This is what we're doing."

And then the other advantage of this is ... this again is why there's been such an investment in crisis services, is crisis is a great example of where the clinical goals and the financial goals are actually pretty well aligned. Which is important when you're advocating for services like this, especially if you're out in red state land, like me. So what I want as a psychiatrist is I want my patients to not be languishing in emergency rooms, to not be locked up in jail when they have a mental health issue that they need treated, and to not be locked up in the hospital if they could potentially be able to be well in the community. If you're paying for stuff, you want those things too. Because it's a much better use of taxpayer funds to have people well in the community rather than in those-... to have people well in the community rather than in jail, emergency rooms, and hospitals, which costs a lot.

Another way of showing how these things are all aligned is, this is data from the Southern Arizona system where it shows the arrow at the bottom is going towards the clinical goal of care in the least restrictive setting, the most community-based setting. And also that fiscal goal of having care in the least costly setting where at the far end is the person out in the community and they can call the crisis line. The Arizona crisis line for Southern Arizona gets about 10,000 calls a month. They resolve about 80% of those on the phone via many of the things that Sue talked about with being able to do counseling, make appointments for people with that care traffic control function.

Then if they can't resolve the crisis on the phone, then they can dispatch the mobile teams. Again, very similar to what Eric was just talking about, where they've got software on their phones with GPS and blinky dots, and they can tell who's where and dispatch them. It's two different agencies that are the mobile teams, but they're centrally dispatched by the crisis line, which is a third agency. But it's having that structure with the behavioral health authority that keeps it all working together.

If they do a face-to-face out in the field, then they can resolve about 70% of those in the field. For those that need a higher level of care, we have our crisis facilities, which I'll talk about it in more detail. But there's ours, which is the largest in the Southern region, but there's also some smaller ones out in the rural areas. Collectively, after an overnight stay, about 60 to 70% can be discharged back to the community after an overnight observation stay. And then there's post-crisis follow-up care from a variety of different programs that keep people stable in the community.

Margie Balfour (00:47:57):

At every point, along here, it's baked in to have easy access for law enforcement. Because if one of the goals of the system is to keep people out of jail then the police are the people that... they have the people that we're trying to keep out of jail. So we need to treat law enforcement and the justice system as a customer, just like we treat our patients and families as customers. So at the crisis line level, we began with protocols to transfer calls back and forth. Now there's actually crisis line staff co-located in the 911 call center with access to their dispatch programs. They are able to intercept calls and then they never make it to the police path of responding because they're intercepted early.

If I'm at my house and I call the crisis line and a mobile team has to come see me, their contract says they have an hour to get to me. But if I'm an officer calling from the field saying, I need a mobile team to come help me, they have a half hour. So there's things like that, that incentivize a preferred response, prioritize response to police. There's some mobile teams that are dedicated to respond with police on. There's also co-responder teams, the whole bunch of different ones, which we'll talk about, but there's all these different things to make that relationship work better. Then there are crisis facilities as you'll see, are really set up, they're designed, to be easier and preferable to the officer to use than jail. As a result of all of this working together, you were all working towards these goals of decreased jail, emergency room and hospital use.

Now to the officer on the street though, it's not all lined up in that nice, pretty schematic with everything, all lined up like that. To the officer on the street or the family member or a person on the street, there's all of these different services and how are they supposed to know which one to access for what? That's where this concept of No Wrong Door comes in. We have all of us providers, we all are different agencies, but we all say, "Well, we're not going to say, 'The officer brought someone to quote the wrong place.' Maybe instead of our center, they should have gone to the detox place across town."

We're not going to tell the officer to put the person back in your car and go on a wild goose chase and drive them to somewhere else. We're going to say, "Thank you, sir. May I have another?" And then we will get the person to where they need to be. We don't put that back on the officer or the person and the family member that's trying to get help. So that whole working together to really focus on getting the person where they need to be is that No Wrong Door. When you hear people talk about No Wrong Door, that's part of it what it means.

At the center of this for Tucson Pima County is the Crisis Response Center. This is the crisis center that my organization, Connections Health Solutions, operates. It was built by the county. They had a bond election and opened in 2011. We have been managing it since 2014. The county owns the building. But again, the services are financed by Medicaid and the RBHA. So it's healthcare dollars that are the operating budget. That's why it's sustainable. The county had a capital investment, which was great, but it's healthcare funds that fund the ongoing care. It was designed to be an alternative to jail, emergency rooms and hospitals. We serve about a thousand adults and 2,400 kids per year, 0 to 17, mostly adolescents. Again, we've been managing it since 2014.

Margie Balfour (00:51:43):

It is the law enforcement receiving center, with its No Wrong Door approach. There's a walk-in function of it where urgent care, where you can do walk-in and say, "I'm new to town and need to be hooked up with services. I'm out of meds." And we see people in the clinic setting and get people on their way within a couple hours. The heart of the operation is the observation unit, which I'll describe in detail. Then we have a short-term subacute unit for people who need to stay another couple of days for adults. It was meant to be a place for the community to come together. So there's space for various co-located community programs that depending on whether or not we're in the middle of a pandemic, may be in the building. Like post-crisis wraparound, things like that.

As part of the school campus where... It's on the county hospital campus, which is run by Banner University of Arizona, we have a breezeway that attaches us to their emergency department. The call center is in our building. The bond also built inpatient psych unit where most of the involuntary admissions go. There's the Mental Health Court there too, also does some criminal stuff.

The clinical model is this concept of... This is our old mission statement... is we address any behavioral health need at any time. That is the mindset that you need to run one of these places. I'm sure many of you have heard of CIT or Crisis Intervention Training, which is the 40 hour training that a lot of police agencies do. And which is becoming the standard of what communities should be doing with their police officers, where they are trained to recognize signs of mental illness, to deescalate people and divert them to treatment. Well, if you ask an officer to divert someone to treatment, their first question is going to be, "Divert to what?"

For that reason, the original CIT framework talks about how CIT is not just that training, even though that's what we typically associate it with. It's a whole community response. That includes a place for officers to bring people because they're busy and they have crimes to fight. If you send them on a wild goose chase and go sit in the emergency room for hours, they're not going to be able to do their jobs. So the original CIT framework actually lays out the criteria for an ideal law enforcement receiving facility. These two in the middle are highlighted because those are the two that are hardest to do well when we go around the country and see systems that maybe having some trouble, which is the "No clinical barriers to care," and, "Minimal law enforcement turnaround time."

What does that mean? That means when we take everybody. A lot of places don't want to take people who were, and this is where psychiatry gets it's bad reputation for being difficult to access. People who were too agitated, too violent, too acute. We like those people. We want those people with us. We don't want to turn them away. Because then they'll go to an emergency room and not get the care they need. And probably be restrained and all kinds of terrible things, or go to jail. We feel that we're a specialized setting. We have the staff, we have the training, we have the space, to be able to help deescalate people and not have to resort to that kind of stuff and get them the treatment that they need. We don't use security. We feel that our staff are highly trained. So why would we defer to someone who has less behavioral health training?

Margie Balfour (00:55:15):

Again, we try to figure out how to say "Yes," rather than look for reasons to say, "No." People can be intoxicated. They can have co-occurring substance use issues, need detox. That can be voluntary, involuntary. We don't require medical clearance prior to arrival, because like our Chief Medical Officer likes to remind us psychiatrists, we did go to medical school. So we could do the medical clearance ourself. We never, ever, ever turn law enforcement away. The research shows that when you have a receiving facility, CIT works better. Officers are more likely to bring people to treatment and you reduce arrest. You reduced people waiting at ERs and unnecessary hospitalization.

This is part of our approach with law enforcement. Police, what they don't like, is they don't like to wait. They don't like to be turned away. They don't like people hassling them about taking their guns off. So they have their own entrance via a gated sally port. They can get in and out quickly. We were told it takes 20 minutes to book somebody into the Pima County Jail. So we get them in and out in 10. They don't have to walk all over the place, trying to get their work done with people telling them take their guns off. They've got everything they need right back in their entrance. They've got an office. They can do their paperwork. Their own bathrooms, refreshments. National donut day, they get donuts. Again, they're just in and out. And they prefer to come to us rather than take someone to jail, because we're actually easier and nicer.

This is the observation unit. This is where people stay overnight. The one on the left is the youth unit. The one on the right is this the adults. It's an open area. The reason why is a few different reasons. One is if people are potentially a danger to themselves or others, the way you keep them safe is to be able to observe people. So it's open, instead of little rooms like the emergency room, so that staff can keep eyes on people and keep them safe. Also, because if you think about what happens in an emergency room, if you go in there because you say you're suicidal. They put you in a room by yourself, they take all the stuff out of it so you can't hurt yourself. They have a sitter who's supposed to come and sit there and watch you and not talk to you about why you're there. And then you stare at the wall for like 12 hours without much treatment. That is not very therapeutic.

Even in the old psych hospitals where we had meds, back in the 40s and the 50s, there was this idea that having a place for people to be able to interact with each other was in and of itself therapeutic. So people can get up and walk around. Our peers are there, talking with people one-on-one, sitting with people and talking, doing groups. There's interaction that's happening and it's flexible so that we can accommodate if we have big surges in volume.

The heart of the operation is really this interdisciplinary teamwork and interdisciplinary care that we do. We start with a different mindset where we don't immediately go, "Oh, this person is really.... They got a lot going on. We need to work on getting them a hospital bed right away." We assume that we're going to resolve their crisis. We say, "Okay, this person has all this stuff going on. We are going to work to resolve that crisis." So we've got a plan and we're going to spend... We got 23 hours and we were going to do all we can to resolve it. We do that through interdisciplinary teamwork. We have a psychiatrist, nurse practitioners 24/7, our peers, nurses, techs, case managers, social workers. We really want to intervene early. We measure our door to doctor time closely and try to get people seen within a couple hours. To start medication if that's what's needed to be done. We can do detox, start Suboxone. We're doing groups, peer support. All kinds of interventions.

Margie Balfour (00:59:10):

Then really proactive discharge planning. Immediately our social workers are on the phone with families, clinics, trying to figure out what's going on with that person. Because we know that we got to hear from the family to really know everything. And the clinic to see what is it that we can do to get this person stable in the community. Then after that, once they're assessed again, if we haven't been able to meet all their goals, then we pursue going to the hospital. So it's kind of a flip. We assume we're going to be able to send folks home. And about 60 to 70% are able to go to the community the next day. We look at our readmissions and there about 2% come back within a couple of days. And then we have special programs for our people who come a lot, we call our familiar faces.

I won't go into this for the interest of time, but I'm a data nerd. So we have worked out outcome measures where we look at things like, how timely are we? What percent are we sending home versus the hospital? If people come involuntary, how often can we get them engaged and convert to voluntary status? Our law enforcement turnaround, that kind of stuff.

Tucson police, you could talk a whole 'nother hour on them. They have done a lot of really progressive stuff around mental health. They've got dedicated teams, plain clothes teams. They also have detectives that focus on finding people. They started this after the shooting in Tucson where Congresswoman Gabrielle Giffords was shot, where they want to... How can we find people before they thought through the cracks and get them connected to care without having to have either a tragic outcome or use the justice system? And so they've got detectives who help with that. Here's some of the outcome data. This shows our law enforcement drops every month. The circles are our turnaround times. So 10 minutes or less. The light part of the bars is the people that they're bringing voluntarily, which is really a testament to one Tucson police, and they really buy into the mental health model. But two, because if the police have a place to bring people, they will engage people that they normally... there's some people they would take to jail, or some people they would just leave the scene because they didn't have anything to do with those folks. And they will engage them. One of our docs calls it the Uber police. They will say, "Hey, wouldn't you like to get somewhere where we can get you some help?" And they'll bring them voluntarily. You can see over the years, the number of mental health transports has just increased and increased because they've bought into the model and they have a place to bring people to and get them help.

Early on they looked at some of the outcomes around the things that tend to land our folks in jail. If people are trying to get them off the street into jail, because they need some kind of treatment, they call them nuisance calls or lifestyle calls where it's things like these low level things like civil disturbance, vagrancy. This group in Ohio we're working with has aggressive jaywalking. So the calls for those have been decreasing since starting this kind of partnership. Also how they respond to people who were suicidal in the community. When someone's in their house and they're suicidal and there's an order to come and pick them up and bring them in for an evaluation and the person says they're not coming out, sending the SWAT team makes no sense. But that's what was the standard thing that most cities do. That makes no sense. So they now have the co-responder teams do that.

Margie Balfour (01:02:49):

Speaking of co-responder teams, there's a whole, you hear about co-responder teams. There are so many different models of co-responders. There's no one size fits all. We actually went out to LA and saw their model, which is the pioneering one where it's the cop and the clinician riding in the car and they're going from call to call to call. That makes perfect sense for downtown LA. Tried it out here. It didn't make sense because it's so spread out and they had all this wasted time just driving around. Now instead of riding around together, there's dedicated mobile teams that respond when police need them and they arrive separately, but then they arrive together... or they leave separately, arrive together. And they've actually focused on not just decreasing people going to jail, but then if they bring people to treatment, can they get them engaged voluntarily versus having to resort to a civil commitment?

The Deflection Program is focused on substance use. Opiates in particular, but also meth and the other substances that they're around. This is a peer that co-responds with police and focuses on the overdoses. They have the option to not arrest people for having drugs and paraphernalia. So they've been connecting people to treatment rather than to arrest. Then the homeless outreach team, that's a co-responder team with one of the officers and a peer in homeless recovery, who works for one of the housing agencies. They're out in the parks, mostly engaging people.

This was done... It's on the Crisis Now website like Sue was referencing. This was done by our former Medicaid director, showing that if you want to make the financial argument with all this is the money that's spent on crisis. But if you look at what's the return on investment from decreased hospitalizations and emergency room visits, it makes financial sense to do. When you look at where the money comes from and you see here Medicaid and private insurance, they're not contributing anything. Somebody with Blue Cross can come and call the crisis line, get seen by the mobile team and taken to our facility and getting taken care of. And at the end of the day, the funding that covers that care comes from state funds or Medicaid funds or indigent funds because private insurance doesn't pay for it. So if you want to make a parity argument, that's a good one.

Lessons learned is that the solution to... When there's been a health problems, everyone always wants to jump to, "We need to build more beds." And I would say that it's more about having a system where the right people are getting the right levels of care and in the community as much as possible. That way you can save the beds for the people who really need them. Just having a culture of No Wrong Door and figure out how to say, "Yes, rather than look for reasons to say, "No." We have a great system and I'm very blessed to be a part of it. Just want to make the point that it didn't happen overnight. This is the 20 year evolution down in Pima County in Tucson, where it started with the Mental Health Court and CIT training. Over the years it's been exponential increases. For community to come together and start to create a crisis system, you've got to start somewhere.

The last thing I want to point out is just some tools. Sue mentioned the SAMHSA guidelines and the Crisis Now websites that has a whole lot of stuff on it. And then there's a report that I was part of as well, that put by the National Council that talks building on the whole Crisis Now model. But I'm also talking about how do you actually then create a system with the governance and the financing? What are the standards that you need to rate your crisis system? That was recently released just this March.

Margie Balfour (01:07:08):

With that, I'm ready for questions. We are a learning site through the Bureau of Justice Assistance. So there is federal funds to have someone come visit us for the jurisdiction is interested in seeing what we do.

Ken Duckworth (01:07:30):

Yeah. I just want to say, we seem to have attracted the actual best ideas going in this space between Georgia and Arizona. Those were fantastic presentations. One of the most common questions is, "What can I do in my state or community to jumpstart this. And how can I learn or connect with these speakers?"

Margie Balfour (01:07:55):

Well, my email is there. So feel free to email me and we're, are potentially may expand into other states. So we're happy to talk to people about that. As far as like what to jumpstart in your community is, every community has its own... When I did my training in quality, you want to ask, "Where's the pain?" And in some places, there's a whole momentum from the hospitals because the ERs are full. In other communities there's a bunch of momentum from the County and the Sheriff, because the jails are full. You find who's going to be a good convener to get people together. It could be the County. It could be the Hospital Association. You heard from Judge Leifman in Miami, he was the convener. But just to get stakeholders together, to start talking about what do we have? And then how can we build on what we have? Even without spending any money, just having people together to talk about how all these different components of this-

Margie Balfour (01:09:03):

Just having people together to talk about how all these different components of the system should work better together is a great start.

Ken Duckworth (01:09:09):

Thank you, Margie. How about our colleagues from Georgia? How would you answer that question?

Sue Ann O'Brien (01:09:14):

Sure. So very similarly. Obviously, it all starts in your local community in making those connections with key stakeholders and partners. I don't know if my email was in the PowerPoint, but I did just put it in the chat. Somebody asked about how long does it take to implement the model? What are the first steps of the model? What are some of those... There are some sort of baby steps or low-hanging fruit that either individual providers, counties, or even states can take that are not a heavy investment. So I'm happy to, if anybody wants to reach out to me, I'm happy to talk with folks about how they might get started in their state.

Sue Ann O'Brien (01:10:02):

Many of you put some questions in the chat, I did try to answer some of those while Eric and Margie were talking particularly around some of the 988 questions, but I know that there might, many of you are from states that are already very actively engaged in [inaudible 01:10:20] planning. So I would just encourage you go to your state health website and see how you might get involved or what might already be happening in your state that you might be unaware of. There's so much that's happening every day, every week, it's a really exciting time in crisis, but it's moving very quickly. So it'd be understandable if there's a whole lot happening right in your neighborhood that you weren't aware of that's happening in a lot of places, which is great.

Ken Duckworth (01:10:52):

Thank you, Sue. Eric, do you have a comment on this?

Eric Eason (01:10:56):

Nothing to add.

Ken Duckworth (01:10:58):

Thank you. All right. So one of the questions comes up about capacity for post the crisis. So you both emphasize there's a system, it's not just a crisis team. I think that comes through very clearly and elegantly for both of your state systems. Most people experience, it's hard to get access to a prescribing psychiatrist, nurse practitioner, a DBT therapist, there's a lot of capacity problems where demand is crushing supply. So you've described a comprehensive approach to keeping people out of jail. I think the next question is how about the next step post the immediate crisis? And how are you thinking about that if you haven't figured it out completely?

Margie Balfour (01:11:49):

So we talked a lot about the front door, big wide front door. You also kind of need a nice covered back porch is what we found. So as the crisis center, we are sort of all, anyone who's presenting to us, so you could think about it as a failure of the community, be able to stabilize that person. And so we try to learn from that. So we look at why do people come back? And that is a huge part of it. Is your crisis doesn't flip off at 23 hours, 59 minutes like a light switch and yet we say, go interact with the healthcare system just like you weren't in crisis, and there's all the problems that you just mentioned. So that's where this post-crisis wraparound stuff comes in.

We've started a program that we call transitions where we have an interdisciplinary team that kind of extends that crisis stabilization episode out for 30, 60, 90 days on an outpatient basis, where they're seeing our psychiatrists, our peers are doing a lot around the social determinants of health that are maybe causing barriers to people, getting the transportation and phones and just getting them the resources that they need. And then we really want to get them more stable so that we can then have a really smooth handoff to whatever their next level of care is going to be. And yes, you want a behavioral health system that has capacity, we've also found though that when you look at it this way, that there's people who can then be handed off into primary care that wouldn't otherwise.

Margie Balfour (01:13:25):

So, say if you call a primary cares off doctor's office and say, I've got this patient that we want to transfer for your outpatient care, she was just had a suicide attempt but now we're discharging her. Primary care doctor would be like, "Hell no, that person needs to see a psychiatrist." Versus you call the primary care doc two months later and say we want to transfer care to you, she had a suicide attempt a couple of months ago, but now she's stable on Prozac and she's got a therapist that she sees once a week and need someone to help manage her medication while she's ongoing in her ongoing care, but if you ever have a problem just call us. That primary care will take that and that opens up capacity the know-how system.

Ken Duckworth (01:14:14):

Thank you. How about in Georgia?

Sue Ann O'Brien (01:14:18):

Well, at BHL, we employ a team of peer support specialists that do a lot of that follow-up for us. So at the Georgia crisis and access line two things happen. One, we have identified a group of individuals who are frequent callers that do need a lot of extra support. We know them, we know who they are, the peer warm lines here are not 24/7 so oftentimes that defaults to us. So we do try to be more proactive and engage those folks on a regular basis. The second piece is through the software that I talked about, our own care traffic control, when we schedule somebody for an outpatient appointment, mobile crisis dispatch, or even help them secure a crisis-stabilization bed, we have ways through the system of those providers making a note when the person arrived, whether they arrive for that outpatient appointment tomorrow, whether they made it to the CSU, for example, and our peer support team is doing a followup on those folks as well.

Ken Duckworth (01:15:32):

Thank you. So you described a couple of different models, I believe Georgia was the first state to certify peer specialists which is great-

Sue Ann O'Brien (01:15:40):

They were, and they were the first to have the Medicaid code for peer support.

Ken Duckworth (01:15:47):

Which is quite a feather in your portfolio of excellence in Georgia. Another question is a little, might seem unrelated, but again, if you think about the continuum, a couple of questions, people have family members who got into the correctional system, they weren't able to be prevented. Do you have services for the re-entry connection re-establishment on Medicaid connection to services? And is that part of your universe or is that beyond what you're capable of taking on?

Margie Balfour (01:16:21):

System has created, that's a goal is to help reduce justice involvement. And so just in Arizona, Medicaid, instead of being turned off when you're in jail, it's suspended so it can be turned on quickly. There's requirements of all of the managed-care plans to meet with find their people if they have serious mental illness in jail and have a discharge plan for them before they're released. So that's sort of not in our world because that's more of the outpatient world. But then there's always people that the releases aren't planned, they bond out in the middle of the night, there wasn't time to create that kind of discharge plan. So the jail has what they call courtesy transports. So they can't force anybody to go anywhere because they're released, but they will offer to transport the person to the CRC. And then we then from there work on getting them if they need to stay overnight versus just be connected with services or go into our transitions program. So we serve that function.

Eric Eason (01:17:33):

Re-entry is something that's not really a part of our book of service, so to speak, but Georgia does have re-entry coalitions at both the state and the local levels, that's actually one of the types of organization that we collaborate with a great deal. And in some areas that community is very active and we are often engaged just by virtue of having made connections. So we support it in that capacity, but it's not one of the services that we directly provide.

Ken Duckworth (01:18:02):

Understood. Two other themes of questions come up around mental health courts and the judges piece of this, and also potential changes that are likely to happen in policing and police culture. And how do you think about those two big forces as you look ahead to the future?

Margie Balfour (01:18:24):

Tucson is a great model for where police culture should be going, and it's really bought in from the very, their top leadership. Our chief is the one who's being nominated for the border patrol, so he's very progressive. But from the very top, they are trying to have a culture of the guardian versus the warrior and community policing and mental health is a huge part of that. And when you listened to the chief talk to other chiefs, he talks about having these mental health programs. In addition to being the right thing to do, it's a risk management strategy because that's how you reduce your bad outcomes. They do a lot of police training and there is a sort of a generational effect where the younger, newer officers, they get it, they want to be connecting people to treatment. So I think the time is really ripe for it, but again, it needs to be done in a way where it makes the officer's life easier. It's helping them feel they're actually helping people. But I think there's a lot of positive momentum around that.

Ken Duckworth (01:19:48):

Back to our friends in Georgia. So both kind of a mental health court angle and the police culture opportunity that is happening now?

Eric Eason (01:19:59):

I'll speak to the police culture. I do think that we find ourselves in a moment where this conversation, which is long over due is suddenly a conversation that a lot of people are joining. It's one that we've been trying to have for many, many years, and suddenly we have a lot more people who were interested in joining that conversation. I mentioned in one of my replies in the Q&A that we have a wide variation in our successes with collaborating with law enforcement. I do think as Dr. Balfour said that the folks who are younger tend to be a little more open to that concept. I find also in our circumstance that larger organizations tend to be more open to those conversations for whatever reason, it's the really small town, three and four person departments that tend to be really close to new ideas. And so that just becomes really challenging.

I think there will always be a need for law enforcement, I am not an advocate personally disbanding police and things like that. But I think it is critical that law enforcement agents receive proper training, including sensitivity and cultural awareness training about mental health, mental illnesses, things like that, but also that there are robust support systems such as mobile crisis, such as crisis lines such as community service providers to which those law enforcement agents can turn when they need that support. It's great if they understand there's a problem, but then when they have no tool to utilize or no support to access it, what are they going to do with that? It's a challenge and I think it's one that the conversation is long overdue.

Ken Duckworth (01:21:52):

Our last question is about training in social determinants, discrimination, racism. How do you think about that as you try to provide community? You're serving diverse communities and how does that play out in the training and in the care that you provide?

Margie Balfour (01:22:20):

I mean, that's something that we are like the rest of the country re-evaluating and trying to think more about. I think starting with just looking at our data in a different way, who are we serving? How does that relate to what's the, the demographic mix and the general population? Arizona is interesting, I mean, I grew up in the deep south. Arizona is very different demographically where there's actually a very small African-American population compared to other parts of the country, the 40% Latino, and then a lot of tribal nations. And so either there's been a lot of work with tribal involvement in the Arizona system over the years. There's tribal liaisons with the crisis line who can get on the phone and kind of help bridge that cultural gap.

And so there's some cool stuff in that arena, but I think in terms of looking the question around social determinants and kind of how does that factor in, I think that's a great question and something that we need to focus more on, especially with the stigma around looking for treatment and engaging in treatment. And so it's something that we're exploring, I would just say I don't have a great answer yet because it's that we need to work on.

Ken Duckworth (01:23:54):

Thank you. Georgia is also known for having a pretty active demographic shift that's happening over time. And I wanted to just follow up with this last question about your approach to that in your training and service delivery.

Sue Ann O'Brien (01:24:08):

Sure. On the call center side, we are continuously making adjustments to our training, as Margie said, making sure that our call takers are reflecting the demographic that we serve. Obviously, the demographic of downtown Atlanta is very, very different than in the rest of the state. And we see examples of this all the time, being able to connect with somebody on the phone is going to take somebody that is very skilled and can quickly cross cultures and be able to connect with somebody regardless of differences and in race or political leanings or anything else for that matter.

I did want to note that we do, and I'm going to let Eric catch a little bit more on this as well, but we do active participants in CIT in the state. And while we are not a co-responder model, we do have some of our mobile teams that do dispatch or share space with our law enforcement jurisdictions. So, again, focusing on those relationships. On the mobile side, I would ask Eric to talk about our community outreach positions in the work that they do to really try to connect people, decrease stigma and help our mobile teams get to know the people that are in the community in which they serve.

Eric Eason (01:25:35):

Yeah, sure. So, first of all, though, you may not be able to tell it from Sue Ann and me, we actually do have a very diverse group of staff members. And so I think that is a significant factor as Sue Ann said, and being able to have our workers reflect the people that we serve that is really important. We don't shy away from conversations around race and other types of social determinant factors things like that. We also do a tremendous amount of outreach in our communities, we do a large amount of education. We will support or provide or fund in some cases, assist trainings other types of mental health awareness trainings. We go into our communities and we find out, "You're having a job fair, a resource fair, okay? We'll be happy to participate. You're having a drive at your local school around this." We actively seek out these opportunities on a local level to embed ourselves within our community.

And that's not just the people in our region whose job it is to do that, they manage that, but we're sending our own staff. We're sending the clinicians, the para-pros, the peers who respond to calls to also go into these fairs and connect with people one-on-one. So that's one of the main ways that we build our connection in our communities. Just as we have people who live and work in our communities, those folks also build relationships on a very a micro local level.

Ken Duckworth (01:27:08):

Well, I can talk to the three of you for hours. I mean, you are three of the leading thinkers in America on this essential question, which is actually the third part of NAMI's multi-year strategic plan, which is keeping people out of the criminal justice system and instead connecting them to care. I'm going to turn this, here's some resources you might want to take a look at that you mentioned earlier. The commissioners group for crisis now, the SAMHSA guidelines and the care traffic control technology. I'm going to hand it back to our CEO, Dan Gillison

Dan Gillison (01:27:45):

Thank you very much, Ken. Really appreciate our presenters on today. We often talk about care and how much people don't care, how much you know until they know how much you care. And you guys have demonstrated how much you know and how much you care. So please share with your staffs how much we appreciate them and their work and your leadership. And to Sue O'Brien, Eric Eason, and Dr. Margie Balfour, thank you so very much. This has been so engaging and you can read in the over 130 questions and comments how much people really wanted to engage. And there was even a comment about someone feeling very blessed to join this call today for the difference that it made in her brother's life and connecting him to connections in Phoenix. So thank you very much.

When we first conceived of this series, we've been doing the Ask the Experts and we decided we wanted to be innovative and create a series. And the NAMI team really put a lot of effort into it and today is proof positive of how valuable this is. Thanks to all of you who have joined us on today. And we really welcome you to join us for our future Ask the experts. And as you all know, we are a not-for-profit, if you care to donate, it's donate.nami.org. The donations allow us to do the work that we do like this and share great information. Our convention is coming up, it is in July the 27th and the 28th. And you can register at the site of below. And thank you very much for that slot. As you'll see our theme, bringing people together for mental health the time is now.

And I heard a thread through your presentations about this window of opportunity, the time is absolutely now. So if you'd like to hear more about our body of work and the body of work of all of us that are the mental health space, please register for the convention. And we are looking to have young people involved, so students, NAMI members and non-members and we really would welcome. Want to close by thanking the production team, this does not go on without the production team. And the team of Jordan Miller, Teri Brister, Jessie Walthall and Christina Bott, really did the yeoman's work so that when the curtains were pulled apart and the session began, everything went very smoothly and seamlessly. So to all of them and to all of our leaders in the field, to our board, to our board president, the leaders in the field of very passionate and care so much about this as well. And they're doing a tremendous job and we just wouldn't want to take a moment to acknowledge them as well.

And we'll close by setting that remember you're not alone, it does take all of us. If you care to donate again, the information is there for you. And we just want to say, thank you very much. I know time is your currency and you've invested a lot of time in supporting us in bringing this information to people across the country for us. So we really appreciate it at NAMI. So thank you all. And hope you have a great close to your week and a wonderful weekend to everyone that is listening, that has participated, and most importantly, to our presenters. And thank you so much. We wish everyone the best. Bye now.