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

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

San Antonio, Bexar County, Texas

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

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

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

Table 2. Public Funding Sources for Crisis Services in Texas

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

Tucson, Pima County, Arizona

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

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

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

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

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

Salt Lake City, Salt Lake County, Utah

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

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

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

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

New York City, New York

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

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

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

Rhode Island

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

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

Funding

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

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

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

Collaborative Funding for Behavioral Health Crisis Intervention

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

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

Federal Funding

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

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

Federal Grants

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

State Funding

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

Augmentation of Medicaid

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

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

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

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

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

State Medicaid Managed Care Contracts

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

Florida

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

Rhode Island

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

Table 4. BH Link Triage Center Medicaid Rate Composition

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

Health Homes

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

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

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

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

Coordinated Care Organizations

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

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

Collaborative Public Funding

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

Bexar County, Texas

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

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

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

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

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

State-Level Grants

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

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

Community Supported Initiatives: Bonds and Sales Tax Initiatives

County Bond: Pima County, Arizona

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

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

Sales and Use Tax: Larimer County, Colorado

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

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

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

The Promise of Recovery

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

Figures

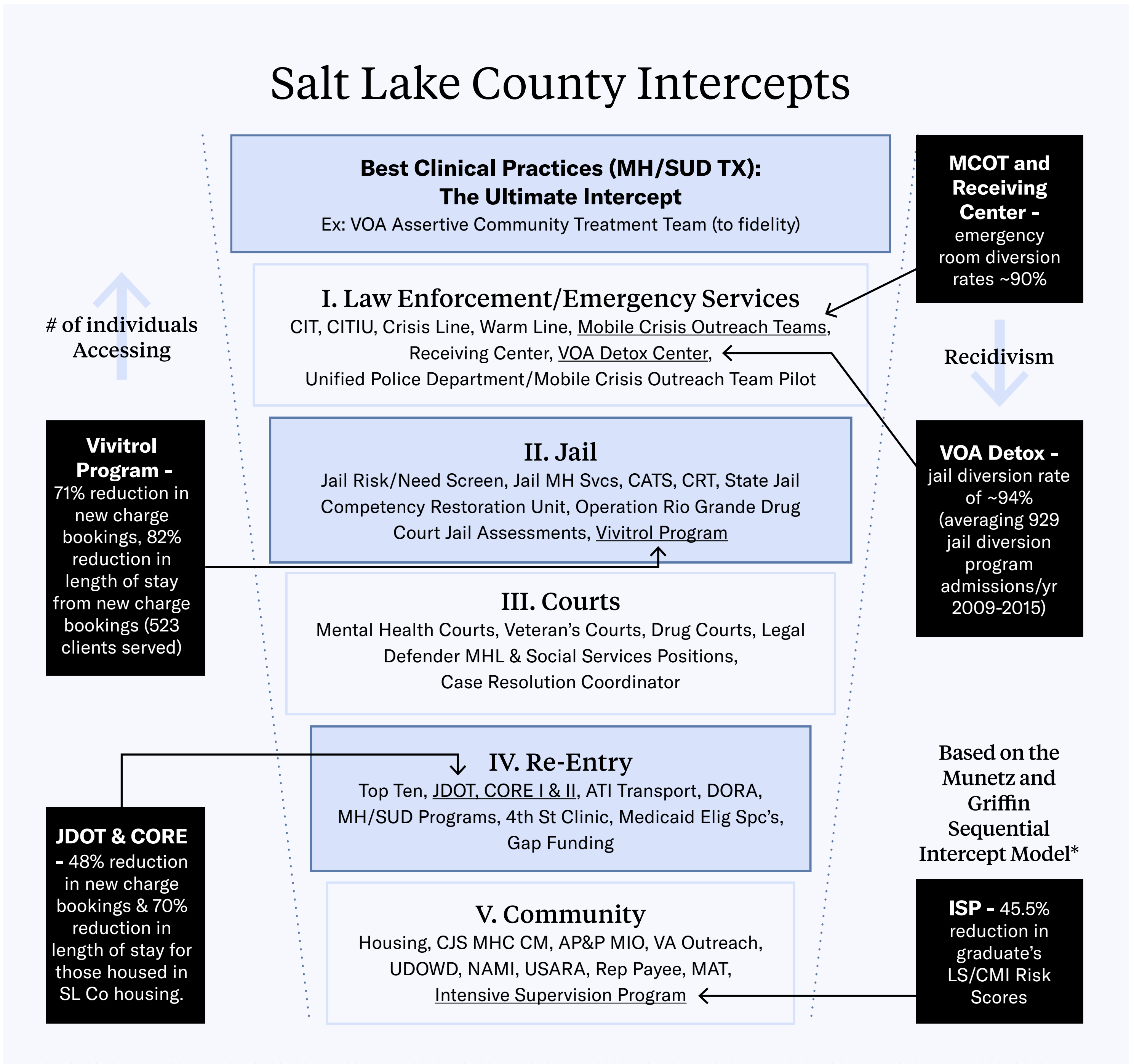
Figure 1. Programs by Sequential Intercept Point - Knoxville, Tennessee

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

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

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

Figure 2. Salt Lake County Diversion System



Abbreviation Key

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

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

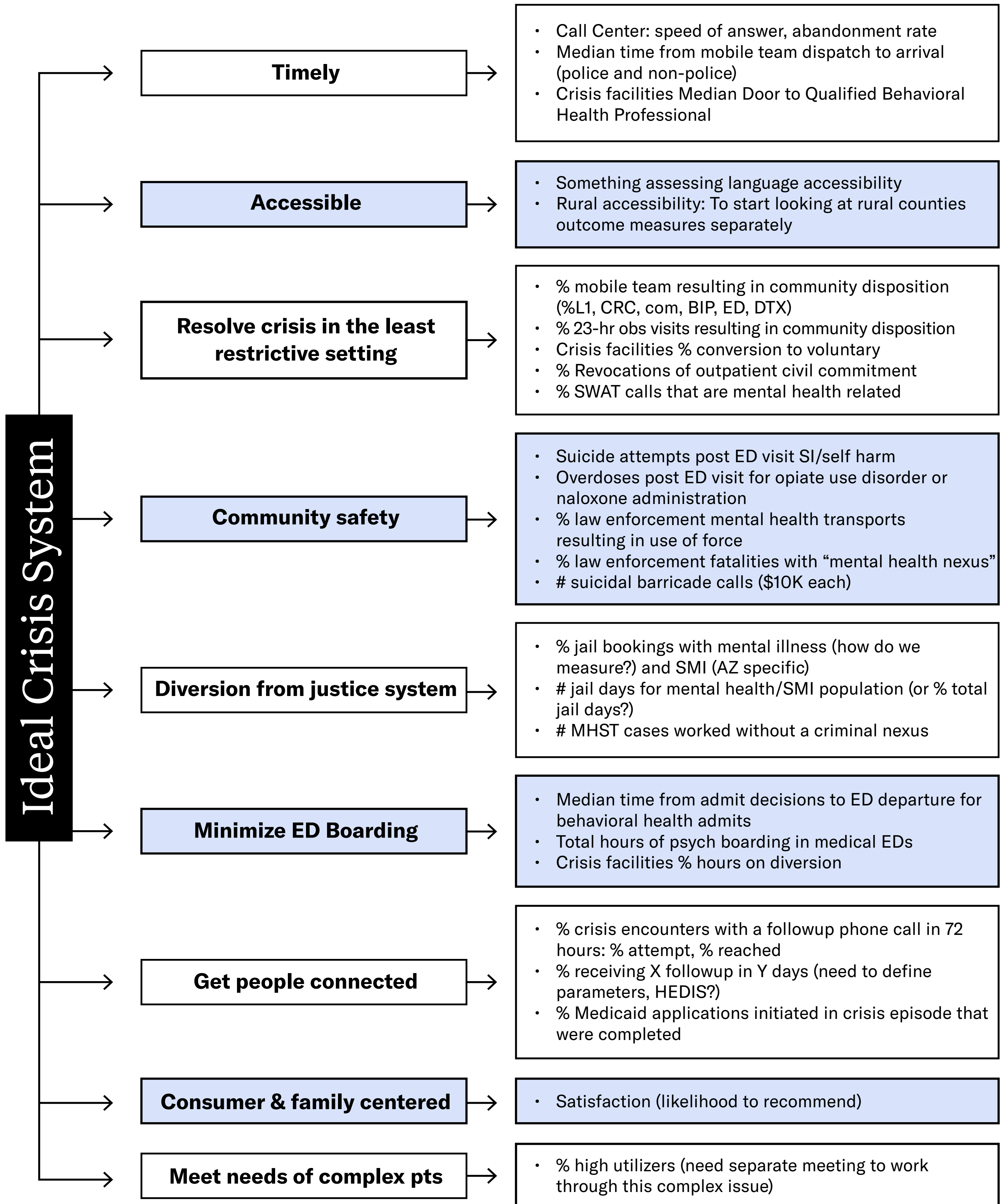
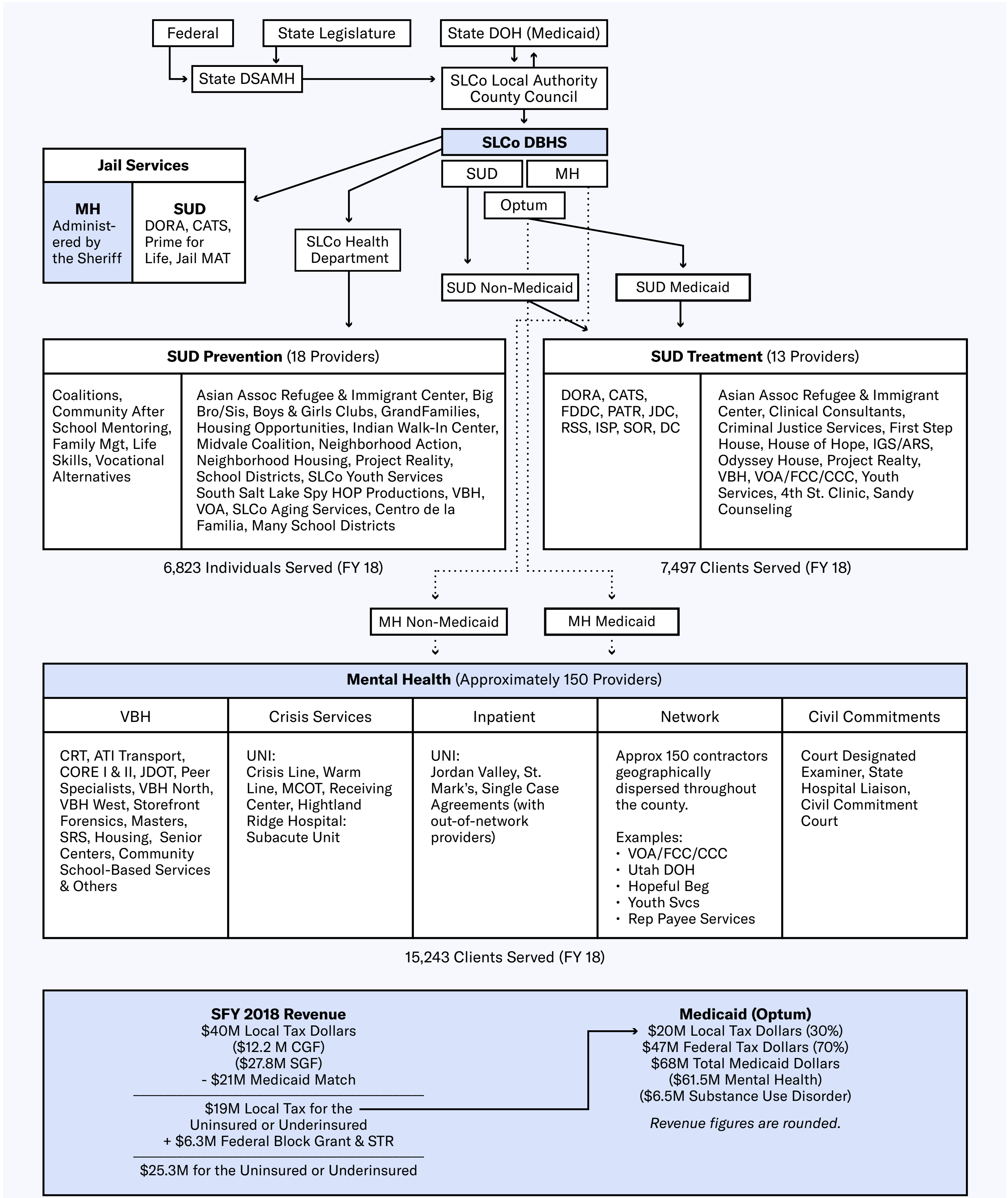


Figure 4. Salt Lake County Department of Behavioral Health Services and Funding



Appendices

Appendix A. Detailed Model Framework

Model for BH Crisis and Jail Diversion Facilities

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

Community Context and Governance

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

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

II. Formal Governance Framework or Structured Informal Collaborative

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

Formal:

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

III. Data Sharing and Analysis Framework

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

IV. Funding

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

Service Delivery System

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

Law Enforcement (LE) and Community Response

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

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

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

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

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

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

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

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

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

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

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

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

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

Crisis Care Center

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

Mobile Crisis Outreach Team

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

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

**Excludes Nix data*

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

Integrated Care Program

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

Crisis Stabilization Unit

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

Crisis Stabilization Unit

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

Sources: STRAC Emergency Department Diversion MOU. August 17, 2018.
STCC. Cost Study High Utilizer Homeless HC Public Report March 2018.
H4H Fact Sheet March 31, 2017.
LE Navigation Data Summary for STCC 3/1/2018.

End Notes

1. Moore, B.J., Stocks, C., Owens P,L. (2017). *Trends in Emergency Department Visits, 2006–2014*. Statistical Brief #227 Healthcare Cost and Utilization Project Agency for Healthcare Research and Quality. https://www.hcup-us.ahrq.gov/reports/statbriefs/sb227-Emergency-Department-Visit-Trends.pdf. Accessed January 15, 2019.
2. McCarthy, M. (2014). *US jails hold 10 times more mentally ill people than state hospitals, report finds.* BMJ. 2014; 348. doi: https://doi.org/10.1136/bmj.g2705. Accessed January 15, 2019.
3. Krawcyk, N., Picher, C.E., Feder, K.A., Saloner, B. (2017). *Only One in Twenty Justice-Referred Adults in Specialty Treatment for Opioid Use Receive Methadone or Buprenorphine.* Health Affairs. 2017; Vol. 36, No. 12: Behavioral Health, Provider Payment & More. https://doi.org/10.1377/hlthaff.2017.0890. Accessed January 15, 2019.
4. NAMI. *Mental Health by the Numbers.* http://www.nami.org/Learn-More/Mental-Health-By-the-Numbers. Accessed January 15, 2019.
5. SAMHSA. *About Us.* https://www.samhsa.gov/about-us. Accessed January 15, 2019.
6. Moore, B.J., Stocks, C., Owens, P.L. (2017). *Trends in Emergency Department Visits, 2006–2014*. Statistical Brief #227 Healthcare Cost and Utilization Project Agency for Healthcare Research and Quality. https://www.hcup-us.ahrq.gov/reports/statbriefs/sb227-Emergency-Department-Visit-Trends.pdf. Accessed January 15, 2019.
7. Nguyen, T., Davis, K. (2016). *The state of Mental Health in America 2017.* Mental Health America.https://www.mentalhealthamerica.net/sites/default/files/2017%20MH%20in%20America%20Compressed.pdf. Accessed January 15, 2019.
8. Torrey E.F., Entsminger K., Geller J., et al. (2008). *The Shortage of Public Hospital Beds for Mentally Ill Persons.* The Shortage of Public Hospital Beds for Mentally Ill Persons. https://www.treatmentadvocacycenter.org/storage/documents/the_shortage_of_publichospital_beds.pdf. Accessed January 2018.
9. American College of Emergency Physicians. (2016). *Waits for Care and Hospital Beds Growing Dramatically for Psychiatric Emergency Patients* [Press release]. Las Vegas, NV.
10. Zeller S.L. *Treatment of psychiatric patients in emergency settings.* Prim Psychiatry. 2010;17:35-41.
11. Krawcyk, N., Picher, C.E., Feder, K.A., Saloner, B. (2017). *Only One in Twenty Justice-Referred Adults in Specialty Treatment for Opioid Use Receive Methadone or Buprenorphine.* Health Affairs. 2017; Vol. 36, No. 12: Behavioral Health, Provider Payment & More. https://doi.org/10.1377/hlthaff.2017.0890. Accessed January 15, 2019.
12. National Institute of Mental Health. www.nimh.nih.gov. Accessed January 15, 2019.

13. Nguyen, T., Davis, K. (2016). *The state of Mental Health in America 2017. Mental Health America*. https://www.mentalhealthamerica.net/sites/default/files/2017%20MH%20in%20America%20Compressed.pdf. Accessed January 15, 2019.

14. Mental Health America. Access to Mental Health Care and Incarceration. http://www.mentalhealthamerica.net/issues/access-mental-health-care-and-incarceration. Accessed January 15, 2019.

15. Moore, B.J., Stocks, C., Owens, P.L. (2017). *Trends in Emergency Department Visits, 2006–2014*. Statistical Brief #227 Healthcare Cost and Utilization Project Agency for Healthcare Research and Quality. https://www.hcup-us.ahrq.gov/reports/statbriefs/sb227-Emergency-Department-Visit-Trends.pdf. Accessed January 15, 2019.

16. Policy Research Associates. *Sequential Intercepts for Developing CJ-BH Partnerships*. SAMHSA's Gains Center for Behavioral Health and Justice Transformation. https://www.prainc.com/wp-content/uploads/2016/04/SIMBrochure.pdf. Accessed January 15, 2019.

17. Policy Research Associates. *Sequential Intercepts for Developing CJ-BH Partnerships*. SAMHSA's Gains Center for Behavioral Health and Justice Transformation.https://www.prainc.com/wp-content/uploads/2016/04/SIMBrochure.pdf. Accessed January 15, 2019.

18. National Association of Counties (NACo). (2016). *The Data-Driven Justice Playbook: How to Develop a System of Diversion*. https://www.naco.org/resources/data-driven-justice-playbook. Accessed January 15, 2019.

19. National Association of Counties (NACo). (2016). *The Data-Driven Justice Playbook: How to Develop a System of Diversion*. https://www.naco.org/resources/data-driven-justice-playbook. Accessed January 15, 2019.

20. US Department of Health & Human Services (HHS). (2016). *May a covered entity collect, use, and disclose criminal justice data under HIPAA?* https://www.hhs.gov/hipaa/for-professionals/faq/2073/may-covered-entity-collect-use-disclose-criminal-data-under-hipaa.html. Accessed January 15, 2019.

21. Truven Health Analytics, Inc. *Crisis Services: Effectiveness, Cost-Effectiveness, and Funding Strategies*. SAMHSA. https://store.samhsa.gov/product/Crisis-Services-Effectiveness-Cost-Effectiveness-and-Funding-Strategies/sma14-4848. January 29, 2019.

22. Truven Health Analytics, Inc. *Crisis Services: Effectiveness, Cost-Effectiveness, and Funding Strategies*. SAMHSA. https://store.samhsa.gov/product/Crisis-Services-Effectiveness-Cost-Effectiveness-and-Funding-Strategies/sma14-4848. January 29, 2019.

23. Truven Health Analytics, Inc. *Crisis Services: Effectiveness, Cost-Effectiveness, and Funding Strategies*. SAMHSA. https://store.samhsa.gov/product/Crisis-Services-Effectiveness-Cost-Effectiveness-and-Funding-Strategies/sma14-4848. January 29, 2019.

24. *Kaiser Family Foundation. State Health Facts. Medicaid Managed Care Tracker.* https://www.kff.org/data-collection/medicaid-managed-care-market-tracker/. January 29, 2019.

25. Katch, H. (2016). *States are Using Flexibility to Create Successful, Innovative Medicaid Programs. Center on Budget and Policy Priorities.* https://www.cbpp.org/research/health/states-are-using-flexibility-to-create-successful-innovative-medicaid-programs. Accessed January 2019.

26. McConnell, K.J., Chang, A.M., Cohen, D.J., Wallace, N. Chernew, M.E., Kautz, G., et al. (2014). *Oregon's Medicaid Transformation: An Innovative Approach To Holding A Health System Accountable For Spending Growth*. Healthcare (Amsterdam, Netherlands), 2(3), 163-167. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4273859/. Accessed February 6, 2019.

27. 76th Oregon Legislative Assembly—2011 Regular Session.(2011). *Enrolled House Bill 3650.* https://olis.leg.state.or.us/liz/2011R1/Downloads/MeasureDocument/HB3650/Enrolled. Accessed February 6, 2019.

28. Oregon Center for Public Policy. (2012). *Updated ABCs of CCOs The Basics of How Oregon Aims to Transform Health Care.* https://www.ocpp.org/media/uploads/pdf/2012/04/fs20120430CCOBasicsUpdatedfnl.pdf. Accessed February 6, 2019.

29. Managed Healthcare Executive. (2011). *Oregon Medicaid shifts to global payments, coordinated care.* https://www.managedhealthcareexecutive.com/news-analysis/oregon-medicaid-shifts-global-payments-coordinated-care. Accessed February 6, 2019.

30. McConnell, K.J., Renfro, S., Chan, B.K., Meath, T.H., Mendelson, A., Cohen, D., et al. (2017). *Early Performance in Medicaid Accountable Care Organizations: A Comparison of Oregon and Colorado.* JAMA Intern Med. 177(4):538-545. doi: 10.1001/jamainternmed.2016.9098. https://www.ncbi.nlm.nih.gov/pubmed/28192568. Accessed February 6, 2019.

31. Oregon Health Authority. (2011). *Oregon's health system transformation legislation*. http://www.theoma.org/system/files/documents/HB_3650_Bill_Summary.pdf. Accessed February 6, 2019.

32. McConnel, K.J., Renfro, S., Lindrooth, R.C., Cohen, D.J., Wallace, N.T., Chernew, M.E. (2017). *Oregon's Medicaid Reform And Transition To Global Budgets Were Associated With Reductions In Expenditures*. Health Affairs (Millwood). 1;36(3):451-459. doi: 10.1377/hlthaff.2016.1298. https://www.ncbi.nlm.nih.gov/pubmed/28264946. Accessed February 6, 2019.

33. McConnell, K.J., Renfro, S., Chan, B.K., Meath, T.H. Mendelson, A., Cohen, D., et al. (2017). *Early Performance in Medicaid Accountable Care Organizations: A Comparison of Oregon and Colorado.* JAMA Intern Med. 177(4):538-545. doi: 10.1001/jamainternmed.2016.9098. https://www.ncbi.nlm.nih.gov/pubmed/28192568. Accessed February 6, 2019.

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Behavioral Health Crisis Stabilization Centers: A New Normal

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ABSTRACT

Shifting resources and funding from institutionalized care for those with mental illness to community-based care has shown promise for behavioral health parity in health crisis circumstances and yet, it has been underfunded. One of the unfortunate trends of deinstitutionalization of behavioral health services in general has been a persistent gap in emergency crisis services. This gap in services leaves those in a behavioral health crisis to receive treatment in the Hospital Emergency Departments culminating in an astounding increase in overall healthcare expenditures. Providing behavioral health crisis assessment and treatment in busy emergency departments that produce long waits for care can be a challenging environment for those in need of immediate treatment for psychological needs. Crisis Stabilization Centers are effective at providing suicide prevention services, addressing behavioral health treatment, diverting individuals from entering a higher level of care and addressing the distress experienced by individuals in a behavioral health crisis. Studies also show that the cost of Crisis Stabilization Centers is significantly less than psychiatric inpatient units and satisfaction among clients is greater. Expanding the options for Behavioral Health Crisis Care from community-based behavioral health out-patient care and inpatient care to various community alternatives, benefits individuals in crisis as well as the community. This article provides an overview of community alternatives to psychiatric hospitalization, financial barriers to care and future research.

Introduction

The Community Mental Health Act (1963), signed by President John F. Kennedy was the first federal policy that shifted funding and services from institutionalized settings to community-based behavioral health services. In the 55 years since President Kennedy's initiative to deinstitutionalize Psychiatric Hospitals, we have seen a growth in community-based behavioral health services in the United States[1] (Action Alliance, 2016). This growth has incentivized community behavioral health centers, channelized funding to individuals with mental illness through Medicaid while addressing client's rights and experiences with the deinstitutionalization of Psychiatric Hospitals and creation of community-based services. More improvement in Community-based Care is needed in order to provide adequate services to individuals experiencing a behavioral health crisis[2] (Angar-Jacomb & Read, 2009). Historically, states have been unable to provide sufficient resources and alternatives to psychiatric hospitalization for individuals experiencing a behavioral health crisis.

According to the[3] Agency for Healthcare Research and Quality

(2017), 1% of all adult Emergency Department (ED) visits involved suicidal ideation, which is a serious behavioral health concern. For those who experience a behavioral health crisis, upon arrival at a hospital emergency department (ED) there is usually a long wait in a busy environment with other individuals experiencing treatment for severe medical complications. The person experiencing a behavioral health crisis will eventually receive a behavioral health assessment, an expensive bill and a referral to a Psychiatric Hospital or community service[4,5] (Saxon, 2015; Mukherjee & Saxon, 2017). These systems of care environments trigger symptoms and stress for those experiencing a behavioral health crisis[1] (Action Alliance, 2016). In 2017, often the services received were not sufficient, comprehensive or intense enough to meet the needs of individuals who were at risk of entering or exiting psychiatric care.

In order to improve care and reduce the frequency, cost, and length of stay (LOS) of ED visits for those in a behavioral health crisis, communities are creating Crisis Stabilization Centers[4] (Saxon, 2015). The National Action Alliance for Suicide Prevention (2016) considers Crisis Stabilization Centers to be a core element of Crisis Care. The Substance Abuse and Mental Health Services Administration (2014) defines Crisis Stabilization Services as:

A direct service that assists with deescalating the severity of a person's level of distress and/or need for urgent care associated with a substance use or mental health disorder. Crisis stabilization Services are designed to prevent or ameliorate a behavioral health crisis and/or reduce acute symptoms of mental illness by providing continuous 24-hour observation and supervision for persons who do not require inpatient services. Short-term crisis residential stabilization services include a range of community-based resources that can meet the needs of an individual with an acute psychiatric crisis and provide a safe environment for care and recovery (page 9).

Crisis Stabilization Services include telephone services, walk-in services, mobile crisis, short-term residential treatment, 23-hour Crisis Stabilization Units, the Living Room Model, Crisis Stabilization Units and psychiatric hospitalization. Crisis Stabilization Services provide safety and security for individuals in a psychiatric crisis and they can range from stand-alone sub-acute community-based units with length of stays from 1-10 days to hospital-based systems with recliner chairs and 24-hour length of stays[6] (James & Gilliland, 2001). These programs provide a range of services as an alternative to long term hospital stays and often allow the client to remain in their community to receive treatment services. Services provided can include assessment, case management, counseling, referrals, and linkage[2] (Agar-Jacomb & Read, 2009).

This article summarizes community-based behavioral health Crisis Stabilization Services, multidisciplinary teams, and financial barriers to providing quality services.

Crisis Stabilization Center Models

23-Hour Crisis Stabilization

23-hour crisis stabilization units offer an alternative to emergency department and psychiatric hospitalization admission by providing 23-hour crisis respite and observation in the community[7] (SAMHSA 2014). The setting of this model resembles a home environment and offers assessment, rapid stabilization, reduction in crisis symptoms and observation in a community-based setting[8] (Thin et al, 2015). The model seeks to provide a safe environment, relieve crisis symptoms immediately, provide observation, determine level of care and to deflect from unnecessary higher levels of care[7,8] (SAMHSA, 2014; Thin et al, 2015). Evaluating the impact of the 23-hour crisis stabilization units showed effectiveness in deflecting individuals from psychiatric hospitalization, reduction in health care cost and improved treatment[9,10,8] (Gillig et al., 1989; Francis et al., 2000; Thinn et al., 2015).

The Living Room Model

The Living Room Model is a walk-in respite centers for individuals in crisis. These home-like environments offer a courteous and calming surrounding for immediate relief of crisis symptoms and to avert psychiatric hospitalization[11] (Heyland, Emery, & Shattell, 2013). The goal of treatment in the Living Room Model is to provide a safe and secure environment where multidisciplinary professionals and peers with similar experiences provide treatment services. The Living Room Model highlights peers working or collaborating directly with clients to assist with symptom relief[1] (Action Alliance, 2016). The Living Room Model is distinctly different from the 23-hour crisis stabilization units. The Living Room Model provides crisis resolution and treatment for those who need more than 24 hours to resolve the issues that brought them into crisis, are short term and provide intensive treatment.

Crisis Stabilization Centers

Crisis Stabilization Centers (also known as short-term crisis residential stabilization services, community-based behavioral health stabilization, crisis stabilization, and crisis stabilization facilities) are home-like environments that address behavioral health crisis in a community-based behavioral health or hospital setting. They are bedded units that range from 6-16 beds and staffed by licensed and unlicensed peer support as well as clinical and non-clinical professionals who hold masters and bachelor degrees[7,5] (SAMHSA, 2014; Mukherjee & Saxon, 2017). Services may consist of assessment,

diagnosis, abbreviated treatment planning, observation, case management, individual and group counseling, skills training, prescribing and monitoring of psychotropic medication, referral, and linkage. Service delivery is offered on a 24-hour basis to address the client's immediate safety needs, develop resilience and create a plan to address the cyclical nature of behavioral health challenges and future behavioral health crisis for adults and children. The National Alliance for Suicide Prevention (2016) considers Crisis Stabilization Centers to be a "core element" of behavioral health crisis systems. Different from the Living Room Model and the 23-Hour Crisis Stabilization Unit, Crisis Stabilization Centers offer services to individuals whose needs cannot be met in the community. The environment is safe and secure and less restrictive than a hospital setting.

In a recent study by Mukherjee and Saxon (2017), the authors reported on the creation of a model of care at a Crisis Stabilization Center in rural Illinois that implemented one of three models for deflecting individuals from increased levels of behavioral health care. In this model, clients entering the ED would receive a clinical assessment and on the basis of the assessment could be transferred to a community-based crisis center for treatment. The study showed the LOS in the ED decreased from 7.3 hours to 4.12 hours after the introduction of the behavioral health crisis stabilization center intervention. The study also conducted a cost-analysis that showed this intervention saved an approximate $4.1 million in Medicaid cost.

In a separate study by Wilder Research (2013), a crisis stabilization unit in a metropolitan Minnesota area examined the impact of the unit on the ED, outpatient services and inpatient psychiatric service utilization. The study found the overall cost of providing services in a community-based crisis center was less than providing services in an inpatient unit.

Multi-Disciplinary Team Approaches

Mukherjee and Saxon (2017) found that one of the keys to developing Crisis Stabilization Centers is to work in multi-disciplinary teams. Crisis Intervention is provided by multiple entities which can include police, hospitals, nurses, ambulatory services, behavioral health and many other professionals[6,5] (James & Gilliland, 2001; Mukherjee & Saxon, 2017). When we combine the cumulative knowledge, skills, and ability of partners that serve individuals in psychiatric crisis we achieve a panoply of interdisciplinary skillsets that address the needs of a comprehensive integrated behavioral healthcare system. When identifying key stakeholders the following agencies can be engaged: behavioral health, health care, substance abuse, children and family services, older adult services, ambulatory services, state, home health, employment services, women's centers, family planning, Medicaid, Social Security, Health and Human Services, legal services, advocacy groups, education and federal leaders, public and private agencies[11,1,5] (National Action Alliance for Suicide Prevention, 2011; National Action Alliance for Suicide Prevention, 2016; Mukherjee & Saxon, 2017). Building a team that can collaborate and address the systematic and personal challenges of those experiencing a behavioral health crisis creates a more effective system that increases service delivery while reducing the overall health care cost for those in crisis[6] (James & Gilliland, 2001). When collaboration among agencies and individuals is performed it reaches into political, local, state wide, federal, bureaucratic systems to create an environment where the voice of those who are suffering from psychiatric crisis can be[6] heard (James & Gilliland, 2001).

While multi-disciplinary teams improve the outcomes for individuals in crisis they also face challenges. Challenges to forming and sustaining multidisciplinary teams include selecting the most appropriate community providers to be a part of the team, the loss of funding that effect service delivery, agency turnover, inconsistent meeting dates and times, lack of communication, and the ability to provide adequate oversight of the client[8,13] (Thinn, et al., 2015; Colombo, Bendelow, Fulford & Williams, 2003). It is important to carefully consider the challenges to multidisciplinary teams as they are being formed and as the client progresses in treatment.

Financial Barriers

Crisis Stabilization Centers are a core part of the continuum of care for clients who experience a behavioral health crisis[7] (SAMHSA, 2014). When behavioral health crisis services exclusively rely on transitional funding such as grants, or they are tied to insurance requirements for care that narrowly define the prospective clients; this negatively impacts how crisis services are delivered, particularly in rural communities with smaller populations[7] (SAMHSA, 2014). Private insurance companies have inflexible requirements for crisis services, resulting in states utilizing funding for indigent clients instead of funding through insurance. These pose challenging barriers to sustainable behavioral health crisis stabilization models of any sort. To be successful at providing individuals in crisis with supplemental services that will enhance treatment, there is a need to blend multiple categorical and single-service funding sources and resources to address the diverse needs of this population[14] (Collins et al., 2010).

Future Research

Heyland & Johnson (2017) [15]report that the need for variation in community-based treatment options for those in a behavioral health crisis still exist. The need for more treatment options coupled with funding cuts increases the number of individuals in crisis. This reduction in resources

leaves emergency departments as the primary resource for psychiatric crisis services. Community alternatives for crisis care are a viable option for individuals in crisis. After reviewing 27 studies on the effectiveness of Crisis Stabilization Centers, the Action Alliance (2014) found that Crisis Stabilization Centers provide cost savings and are effective at treating individuals experiencing a behavioral health crisis. The authors encourage more research in this area including the connecting of funding opportunities that would address multiple streams of combined funding. Although preliminary outcomes on Crisis Stabilization Centers are positive, more research is needed to create outcomes and understand environmental challenges, continuous quality improvements, models of service, evidence-based approaches, outreach programs and multicultural issues.

Conclusions

Crisis Stabilization Centers are a viable alternative to Emergency Department behavioral health treatment. Research has shown that models such as 23-hour stabilization, the Living Room Model and Crisis Stabilization Centers have been shown to be effective at treating individuals in crisis and are cost effective. While communities create effective partnerships with federal, state and local administrative bodies they lack resources and funding to provide consistent treatment and improve on service delivery. At a time when the need for behavioral health service is in the national spotlight, behavioral health agencies and hospital systems are seeing the importance of new community-based crisis service delivery models and are addressing individuals in crisis.

Conflicts of Interest

The authors listed below declare that they do not have a conflict of interest:

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References

1. National Action Alliance for Suicide Prevention: Crisis Services Task Force. Crisis Now: Transforming Services is Within Our Reach. Washington, DC: Education Development Center, Inc. 2016.
2. Agar-Jacomb K, Read J. Mental health crisis services: What do service users need when in crisis? Journal of Mental Health. 2009); 18(2): 99-110.
3. Agency for Healthcare Research and Quality. Emergency department visits related to suicidal ideation. 2017; 2006-2013. Retrieved from https://www.hcup-us.ahrq.gov/reports/statbriefs/sb220-Suicidal-Ideation-ED-Visits.pdf. Accessed March4, 2018
4. Saxon V. Psychiatric Boarding: Evolving models for Community Crisis. 2015.
5. Mukherjee, D. & Saxon, V. "Psychiatric Boarding" and challenges to community-based behavioral health crisis stabilization. Community Mental Health Journal Retrieved. 2018. from: https://link.springer.com/epdf/10.1007/s10597-018-0237-9?author_access_token=b0oASxFNOpBmCZEpn8Y5QPe4RwlQNchNByi7wbcMAY4y5AaIvaFbzbItoLET5amUgsp86rColZwr_NSDp0bXmeWkmMiMJ4FNSNDvis0xTM0xia9Qq9R5946XIY_MplIvdaKzYyogMLtE1ITJu2uz1w%3D%3D
6. James RK, Gilliland BE. Crisis Intervention Strategies: Fourth Edition. Belmont, CA: Wadsworth/Thomson Learning. 2001.
7. Substance Abuse and Mental Health Services Administration Crisis services: Effectiveness, cost-effectiveness, and funding strategies (HHS Publication No. (SMA)-14-4848). Rockville, MD: Author. 2014.
8. Thinn DS, Kuswanto CN, Sum MY, et al. The 23-hour observation unit admissions within the emergency service at a national tertiary psychiatric hospital: Clarifying clinical profiles, outcomes, and predictors of subsequent hospitalization. The Primary Care Companion for CNS Disorders. 2015; 17. Doi: 10.4088/PCC.15m01789
9. Gilli, PM, Hilard JR, Bell J, et al. The psychiatric emergency service holding area: Effect on utilization of inpatient resources. American Journal of Psychiatry. 1989; 146: 369-372.
10. Francis E, Marchand W, Hart M, et al. Utilization and outcome in an overnight psychiatric observation program at a Veterans Affairs Medical Center. Psychiatric Services. 2000; 51(1): 92-95.
11. Heyland M, Emery C, Shattell M. The living room, a community crisis respite program: Offering people in crisis an alternative to emergency departments. Global Journal of Community psychology Practice. 2013; 4(3): 1-8.
12. National Action Alliance for Suicide Prevention: Clinical Care and Intervention Task Force. Suicide care in systems framework. Washington, DC: Education Development Center, Inc. Retrieved. 2011. from http://actionallianceforsuicideprevention.org/sites/actionallianceforsuicideprevention.org/files/taskforce/ClinicalCareInterventionReport.pdf
13. Colombo A, Bendelow G, Fulford B, et al. Evaluating the influence of implicit models of mental disorder on processes of shared decision making within community-based multi-disciplinary teams. Social Science & Medicine. 2003; 56(7): 1557-1570.
14. Collins C, Hewson DL, Munger R, et al. Evolving models of behavioral health integration in primary care. Milbank Memorial Fund. New York, NY. Milbank Memorial Fund. 2010. Retrieved from: https://www.milbank.org/publications/evolving-models-of-behavioral-health-integration-in-primary-care/
15. Heyland M, Johnson M. Evaluating an alternative to the emergency department for adults in mental health crisis. Issues in Mental Health Nursing. 2017; 38(7): 557-561.
16. Centers. Open Minds Management Newsletter. Retrieved from: https://www.openminds.com/market-intelligence/editorials/psychiatric-boarding-evolving-models-community-crisis-centers.htm/

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Assessment #4

Addressing Substance Use in Behavioral Health Crisis Care: A Companion Resource to the SAMHSA Crisis Toolkit

August 2020

Alexandria, Virginia

Fourth in a Series of Ten Briefs Addressing—Beyond Beds: Crisis Services

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Addressing Substance Use in Behavioral Health Crisis Care:

A Companion Resource to the SAMHSA Crisis Toolkit

August 2020

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Addressing Substance Use in Behavioral Health Crisis Care: A Companion Resource to the SAMHSA Crisis Toolkit

Introduction

A comprehensive crisis response system has an opportunity to direct the turning point of a behavioral health crisis for the better. In a webinar hosted by the National Association of State Mental Health and Program Directors (NASMHPD) on the recently published Substance Abuse and Mental Health Services Administration (SAMHSA) "National Guidelines for Behavioral Health Crisis Care – A Best Practice Toolkit,"[1] the United States Assistant Secretary for Mental Health and Substance Use, Dr. Elinore McCance Katz, stated that "crisis services and systems play an integral role in the delivery of care … provide acutely needed care and they also serve as a very important entry point for so many people in to the mental healthcare delivery system … [and] serve as a means of immediate mental health intervention by trained professionals." In essence, for individuals experiencing a behavioral health crisis, first impressions are important. As an illustrative point of reference, the American Psychological Association, Dictionary of Psychology includes in its definition of the word crisis: "a turning point for better or worse in the course of an illness."[2]Especially for individuals with substance use disorders (SUD), crisis response may be the first and only chance to get it right, and impact not only the outcome of the crisis itself, but the entire recovery process.

The publication of SAMHSA's Toolkit for Behavioral Health Crisis Care (hereafter referred to as the SAMHSA Crisis Toolkit) serves to coalesce a national effort to draw attention to the importance of crisis response for behavioral health. In 2005, the Technical Assistance Collaborative published "A Community-Based Comprehensive Psychiatric Response Service",[3] an informational and instructional monograph that laid the foundation for identification of essential service components in the crisis care

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[1] Substance Abuse and Mental Health Services Administration (2020). National guidelines for behavioral health crisis care – a best practice toolkit*.* Rockville, MD: Substance Abuse and Mental Health Services Administration.
[2] VandenBos, G. R. (2015). APA dictionary of psychology (2007 ed.). Washington, DC: American Psychological Association.
[3] Technical Assistance Collaborative, Inc. (2005). A community-based comprehensive psychiatric crisis response service*.* Boston, MA: Technical Assistance Collaborative. http://www.tacinc.org/knowledge-resources/publications/manuals-guides/crisis-manual/

continuum. In 2016, the National Action Alliance published the "Crisis Now"[4] policy paper which identified exceptional practices desired in crisis services. NASMHPD has consistently voiced the need to prioritize crisis response for adequate funding, emphasizing community solutions to better address psychiatric needs outside of institutional based care in its 2017 paper "Beyond Beds."[5] And now the SAMHSA Crisis Toolkit serves to give the national voice of leadership in a call to action.

It is essential that the "Anyone" from "Anyone, Anywhere, Anytime" cited in SAMHSA Crisis Toolkit include substance use disorders meaningfully. Substance use disorders cannot be an afterthought in our approach to crisis care. Full integration of mental health and substance use disorders in treatment needs to be embraced across the continuum, which includes the crisis system. We know that 7.7 million adults have co-occurring mental and substance use disorders. Of the 20.3 million adults living with a substance use disorder, 37.9% also had a mental illness. Of 42.1 million adults living with a mental illness, 18.2% also had a substance use disorder. Only 9.1% of those with co-occurring conditions received both mental health care and substance use treatment.[6] And the percentage of people that receive the simultaneous *recommended* care for both is even lower.[7] An assessment of factors that prevent systems from embracing full integration of SUD must include screening for the presence of negative perceptions or attitudes related to SUD. Such perceptions can manifest in prejudicial attitudes about and discriminatory practices against people with substance use disorders. These and other forms of stigma at the organizational and individual levels pose major challenges to the integration of SUD into crisis response systems.

Of great significance in the SAMHSA Crisis Toolkit is the clear inclusion of substance use crisis within the behavioral health definition. It could be interpreted that previous descriptions of crisis care focused solely on mental illness, excluding substance use diagnoses. There is no doubt now that funding, policies, planning and operationalization of a community-based crisis system needs to incorporate the specific needs of individuals with co-occurring mental health (MH) and SUD as well as individuals with substance use only diagnoses and crisis needs related to substance use itself. This report highlights states and programs that are demonstrating success integrating substance use disorders in the three core services described in the SAMHSA Crisis Toolkit – crisis call centers, mobile crisis response services, and crisis stabilization services. This report also identifies the essential principles that are crucial for effective integration, as well as practices that are more specific to the SUD population not identified within the SAMHSA Crisis Toolkit but may be useful for consideration of implementation.

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[4] National Action Alliance for Suicide Prevention: Crisis Services Task Force (2016). Crisis now: Transforming services is within our reach. Washington, DC: Education Development Center, Inc. https://www.sprc.org/resources-programs/crisis-now-transforming-services-within-our-reach

[5] Pinals, D. & Fuller, D. (2017). Beyond beds: The vital role of a full continuum of psychiatric care. Arlington, VA: Treatment Advocacy Center *and* Alexandria, VA: National Association of State Mental Health Program Directors. https://www.nasmhpd.org/sites/default/files/TAC.Paper_.1Beyond_Beds.pdf)

[6] Han, B., Compton, W. M., Blanco, C., & Colpe, L. J. (2017). Prevalence, treatment, and unmet treatment needs of US adults with mental health and substance use disorders. *Health Affairs, 36*(10), 1739-1747. doi:10.1377/hlthaff.2017.0584

[7] Substance Abuse and Mental Health Services Administration (2017). Key substance use and mental health indicators in the United States: Results from the 2016 National Survey on Drug Use and Health. (HHS Publication No. SMA 17-5044, NSDUH Series H-52). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration.

Person-Centered Care: Integrating Mental and Substance Use Disorders within the Crisis System

Crisis care cannot be diagnosis dependent, and the "no wrong door" approach is therefore critical, especially when there remains such a fragmentation of SUD and MH treatment delivery systems. Historically, the entire continuum of care for behavioral health from prevention to recovery, including crisis intervention, has segregated care for mental and substance use disorders. The SAMHSA Crisis Toolkit "Interview 6 with Nick Margiotta" illuminates this fragmentation.[8] The interview provides his account of a frustrating effort to access help for an individual in crisis who was turned away from psychiatric care because they were actively using substances, only to be subsequently turned away from substance use disorder care because they were suicidal. This cycle of denying care due to active symptomology of co-occurring disorders is a clear demonstration of a poorly integrated system of care. As noted by NASMHPD in its 2019 Technical Paper "Integrated Systems and Services for People with Co-Occurring Mental Health and Substance Use Conditions: What's Known, What's New, and What's Now?", much work had been done beginning in the late 1980's through early 2000s to support an organized implementation process for integrated services for mental illness and substance use disorders. Then as attention focused on costs and negative outcomes associated with comorbid physical and behavioral health conditions (specifically mental and substance use disorders), momentum shifted to integration within the physical health realm, as if mental health and substance use integration were completed.[9] It was not.

Low perceived need and barriers to care access for both disorders likely contribute to low treatment rates of co-occurring disorders.[10] Individuals with substance use disorder often do not perceive the need for help, as the illness is often accompanied by a denial of its existence.[11] A moment of crisis may open the window of opportunity to break through and engage individuals to see the consequences of continued substance use more clearly and plant the seed of hope for recovery. Intervention at the time of crisis using evidence-based practices such as motivational interviewing combined with seamless connection to treatment and effective follow up may increase the rates of treatment initiation for a population typically hard to engage. Understanding the stages of change model prepares crisis responders to identify interventions that will have the greatest impact. This report offers specific examples of programs and States that have implemented person-centered approaches for individuals with substance use disorder through a crisis response system.

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[8] Substance Abuse and Mental Health Services Administration (2020). National guidelines for behavioral health crisis care – a best practice toolkit, pp. 73-55. Rockville, MD: Substance Abuse and Mental Health Services Administration.

[9] Minkoff, K. & Covell, N. (2019). Integrated systems and services for people with co-occurring mental health and substance use conditions: What's known, what's new, and what's now? pp. 4-5. Alexandria, VA: National Association of State Mental Health Program Directors.

[10] Han, B., Compton, W. M., Blanco, C., & Colpe, L. J. (2017). Prevalence, treatment, and unmet treatment needs of US adults with mental health and substance use disorders. *Health Affairs*, 36(10), 1739-1747. doi:10.1377/hlthaff.2017.0584

[11] American Society of Addiction Medicine (2011). Public policy statement on relapse in healthcare and other licensed professionals. Chevy Chase, MD: American Society of Addiction Medicine. https://www.asam.org/docs/default-source/public-policy-statements/111pip_relapse_4-11.pdf?sfvrsn=b274212a_0

As described further in this report, universal incorporation of Screening, Brief Intervention and Referral to Treatment (SBIRT) throughout the continuum of care can improve our identification of substance misuse and use disorders. It is critical that our crisis response system be fully prepared to address substance use disorders from triage to connection to care. Screening and assessment tools need to be inclusive of substance use and connections to care need to include referrals made to appropriate levels of care within the SUD treatment continuum, including medication-assisted treatment (MAT). As concluded by the National Academies of Science, Engineering, and Medicine, MAT prevents death, stabilizes patients, and should be available to all people – including people interacting with the crisis system.[12]

Core Services and Best Practices

The SAMHSA Crisis Toolkit identifies three essential elements of an effective behavioral health crisis response system incorporating a no wrong-door, integrated approach: crisis call centers; crisis mobile teams; and crisis stabilization facilities and services. This section identifies examples of states and/or programs that have effectively and meaningfully integrated substance use or co-occurring disorders into these core components of a crisis response system. It is important to note that SUD integration is most effective when integrated throughout the entire service delivery system. Some states, such as Georgia, have achieved integration across the three domains. Other states are evolving to become more inclusive of Co-occurring Disorders (COD) and SUD. For example, Delaware is in the process of re-procuring its crisis response system to comprehensively include SUD in all response services. Washington requires its central crisis administrator, the Behavioral Health Services Organization, to manage both SUD and MH crisis and has invested in cross-training its mobile crisis responders to develop and improve the competencies for addressing the needs of individuals with SUD experiencing crisis.

Regional Crisis Call Centers

People contact crisis lines for different reasons. Individuals who are feeling overwhelmed and unable to cope reach out in desperation seeking help and hope. Family members, teachers, friends, faith-based leaders, loved ones, and co-workers also call crisis lines seeking help for someone else and guidance on how to support the individual. A crisis call responder must provide a compassionate presence and quickly assess the needs of the caller as well as safety risks and concerns. Substance use is a risk factor for both fatal and nonfatal overdoses, suicide attempts, and death by suicide, accident, medical complications, and other causes. Compared with the general population, individuals with alcohol dependence and persons who use drugs have a 10–14 times greater risk of death by suicide, respectively, and approximately 22% of deaths by suicide have involved alcohol intoxication. Among the reported substances, alcohol and opioids are associated with the greatest risks of suicidal behavior.[13] Additional risks associated with substance use disorders include non-suicidal accident, injury, victimization (including intimate partner violence) and trauma sometimes related to increased risk-taking behavior. Crisis lines must be equipped to take all calls; therefore, to adequately address needs of individuals using substances, with or without a co-occurring mental illness, training for call responders must include substance specific information. Crisis responders need to assess for risks specific to

[12] National Academies of Sciences, Engineering, and Medicine (2019). Medications for opioid use disorder save lives. Washington, DC: National Academies Press. https://doi.org/10.17226/25310.

[13] Esang, M. & Ahmed, S. (2018). A closer look at substance abuse and suicide. *American Journal of Psychiatry, 13*(6): 6-8.

substance use, such as acute intoxication, withdrawal requiring medical monitoring or management, or overdose in order to adequately triage and determine appropriate response and referral options.

The SAMHSA Crisis Toolkit establishes minimum expectations for a regional crisis call services which include: 24/7 operation; a workforce of clinicians and trained team members overseeing triage; ability to answer all calls; ability to assess suicide and other danger risks; and ability to connect individuals to mobile crisis teams as well as facility based care. Examples of crisis call centers that meet these expectations as well as combining real-time service availability and scheduling capacity include New Mexico's NMCAL, Colorado's Crisis Services and Support Line, Georgia's GCAL, Behavioral Health Response in St. Louis, and the New York City NYC Well program.

For states and municipalities with crisis call services geared for mental health conditions, one option is to integrate SUD-specific capacities and competencies into the existing system. For example, Delaware has developed a comprehensive hotline workflow chart to incorporate SUD as well as social needs or emotional support. Retraining its crisis staff, Delaware is working to ensure individuals with SUD are connected to the right level of care using their real-time open beds platform, the Delaware Treatment Referral Network.

In addition, many states provide substance use-specific hotlines. A crisis for individuals with primary substance use may present differently than individuals with primary mental health or co-occurring disorders. Crisis response for these individuals often involves connections to a specialty addiction treatment system that may be hard to understand or navigate. The caller may present with a defined desire to discontinue their use of alcohol or other drugs. For this reason, substance use specific crisis lines have been developed in many states. For example, the Indiana Addiction Hotline is available 24/7 for individuals seeking addiction treatment services in Indiana. Referral to state-approved agencies is provided by master's degree counselors with bilingual capabilities. Hotline counselors can directly transfer calls to a treatment provider when available. While Tennessee has made significant investment in building a community-based behavioral healthcare system that is co-occurring capable, it also provides a SUD specific hotline. The Tennessee "red line" offers not only a warm handoff to treatment services; it also makes a real-time connection to "lifeliners" – individuals in recovery, employed by local behavioral healthcare providers.

Mobile Crisis Team Services

Community-based mobile crisis services provide face to face interventions for individuals in crisis with trained clinical professionals and peers. These teams meet the person where they are, at the time of need, reaching the individual in the community in order to achieve the best outcome for that person. Historically, mobile crisis teams have been components of community mental health centers (CMHCs), serving a population with primary mental health diagnoses. Across the country, CMHCs have varying capabilities – and deficiencies – related to addressing co-occurring disorders and substance use primary diagnoses. However, there are several strong examples of states and programs that developed mobile crisis team services to meet the needs of individuals with SUD experiencing crisis.

For example, the Georgia crisis response system incorporates all three of the essential services described by the SAMHSA Crisis Toolkit and integrates substance use disorders throughout its services.

The Georgia Department of Behavioral Health & Developmental Disabilities (DBHDD) established a clear guide outlining the appropriate use of mobile crisis teams (MCT) in the community.[14] MCTs are dispatched to response to SUD crisis after determining this as the appropriate response as outlined below The Georgia DBHDD acknowledges SUD as a core component of the mobile crisis system by articulating the intent of mobile crisis:

- De-escalate crisis situations;
- Relieve the immediate distress of individuals experiencing a crisis situation;
- Reduce the risk of individuals in a crisis situation doing harm to themselves or others; and
- Promote timely access to appropriate services for those who require ongoing mental health or co-occurring mental health and substance abuse services.

Prior to dispatch of an MCT, the call center makes an effort to engage the individual in crisis in order to create an alliance, involve the individual in care decisions, and assess safety concerns. Individuals are screened related to substance use which includes type of substance(s) used, amount, and presence of withdrawal symptoms. Based on acuity, a decision is made as to whether an MCT is appropriate or if an individual needs a more intensive response involving emergency medical services and/or law enforcement. For example, the MCT will be dispatched as long as the individual is not in active withdrawal from alcohol, benzodiazepines or barbiturates as the associated risks require medical intervention. Alternatively, opioid withdrawal may be appropriately responded to by MCTs that can provide the connection to the appropriate level of care with the ability to provide MAT induction.

In addition to determining clinical appropriateness for an MCT response, there are other community collaborators to facilitate MCT responses. For example, when MCT is the appropriate response, established guidelines help determine when to request varied levels of support from law enforcement, and when it is safe for MCTs to respond alone. This support ranges from asking law enforcement to accompany, follow behind, or be on standby for the team. MCTs are uniquely positioned to address SUD crises in the community when team members have received specific training in SUD risk assessment.

While not aligning with the best practices detailed in the SAMHSA Crisis Toolkit, **co-responder models** in which behavioral health specialists respond to crisis calls in collaboration with law enforcement exist in many states. There are generally two approaches to the co-responder model: an officer and behavioral health specialist ride together in the same vehicle for an entire shift; or the behavioral health specialist is called to the scene and the call is handled together. Aside from reducing costs, diversions of this sort are extraordinarily important for minimizing the criminalization of mental illness and substance use disorders and ensuring people are treated in the least restrictive environment possible. Also, identifying high volume time periods can help maximize this approach given the funding required to support the co-responders. In this way, co-responder models represent a promising tool to help achieve the goals of

[14] Georgia Department of Behavioral Health and Developmental Disabilities (undated). Guide: Using mobile crisis services in lieu of an order to apprehend. https://dbhdd.georgia.gov/sites/dbhdd.georgia.gov/files/related_files/site_page/Guide%20to%20Mobile%20Crisis%20Services.pdf

the American with Disabilities Act as reflected in the *Olmstead* decision for individuals with mental health and substance use disorders.[15]

In response to the opioid crisis, many co-responder programs have been established in states, with a concerted focus on outreaching to the SUD population post-overdose. In Rhode Island, the Hope Initiative is a statewide collaboration between law enforcement and substance use professionals to help guide those in need toward recovery. These teams respond to individuals who have recently survived an overdose as well as responding to community referrals for outreach from friends and family members. If engaged individuals are interested in treatment, the team will provide transportation if needed. Treatment referrals and transportation include access to MAT. The outreach teams continue follow up with individuals who may not be interested in services at point of first contact to offer support and recovery resources. Teams will also provide support to family members impacted by the addiction. West Virginia has taken steps to expand the statewide capacity of similar co-responder models called Quick Response Teams. Quick Response Teams are composed of emergency response personnel, law enforcement officers and a substance use treatment or recovery provider who contact individuals within 24-72 hours of their overdose to offer and assist those individuals with recovery support including referrals to treatment options.[16] And the Massachusetts Post Overdose Support Teams program involves teams of first responders, public health advocates and harm reduction specialists returning to the site of a non-fatal overdose to provide follow-up services to overdose victims and their families.

[15] Martone, K., Arienti, F., & Lerch, S. (2019). *Olmstead* at 20: Using the vision of *Olmstead* to decriminalize mental illness. *Access: The TAC Blog*, September 2019. Boston, MA: Technical Assistance Collaborative. Retrieved from: http://www.tacinc.org/blog/september-2019/september-2019-olmstead-at-20-using-the-vision-of-olmstead-to-decriminalize-mental-illness/

[16] https://dhhr.wv.gov/News/2018/Pages/DHHR-Awards-Funding-for-Quick-Response-Teams.aspx

Crisis Receiving and Stabilization Services

Behavioral health crisis centers serve as an alternative to emergency departments for an individual experiencing a mental health or SUD crisis. These centers are staffed 24/7 with a multidisciplinary team of behavioral health specialists, typically including access to peers, nurses and prescribers and they receive referrals, walk-ins and first responder drop-offs. Crisis centers are designed to address the behavioral health crisis, reducing acute symptoms in a safe, warm and supportive environment while observing for safety and assessing the needs of the individual. Over the last two decades, crisis centers have been expanding across the country, evolving to become more comprehensive, recovery-oriented, and welcoming to individuals receiving care as well as first responders and other referral sources.

Crisis stabilization centers vary in their approach to individuals presenting with co-occurring or primary substance use disorders. On one hand, some have established criteria that exclude individuals who may need withdrawal management services (detoxification), representing a clear opportunity for improving this pillar of the crisis response system to better meet the needs of individuals with SUD experiencing crisis. However, many crisis stabilization providers are connected to detoxification programs and can coordinate rapid admissions for crisis center patients who require that service. In areas where methamphetamine use is prevalent, such as California, Hawaii, and Georgia, crisis providers have become skilled in addressing methamphetamine induced psychosis, recognizing the need to treat the psychosis first and then connect individuals to the right level of care.

For example, to improve the clinical capacity to address both MH and SUD, the Department of Public Health in Los Angeles County instituted incentives to promote workforce enhancements by providing increased rates for agencies with increased levels of licensed clinicians on staff. LA County inpatient detoxification programs can address mild symptoms of psychosis that are often a part of the treatment for methamphetamine. An adequately trained workforce is a key element in effectively addressing SUD in a crisis setting. Crisis centers often employ peers with lived experience with substance use disorders as well as peers with lived experience with mental illness. Training the crisis response workforce in evidence-based practice for SUD can improve outcomes. In early stages of interaction with a SUD population, incorporating the transtheoretical model of behavior change to assess stage of change and guide the use of evidence based practice such as motivational interviewing has demonstrated improvement of treatment engagement and retention rates. In Pima County, Arizona, leaders recognize that the number of individuals with behavioral health conditions in the correctional system represents a problem that cannot be addressed solely through legal means. The Tucson Police Department invested grant funding for comprehensive training in Motivational Interviewing and Trauma Informed Care. This training empowers officers to play a role in encouraging individuals to make recovery oriented decisions. In the provision of SUD crisis response, meeting the individual where they are is both a literal and figurative imperative.[17]

The "Rediscover Assessment and Triage Center" (ATC) is a regional crisis center located in Kansas City, Missouri that addresses both mental health and substance use disorder related crises. Originally established through collaboration with the criminal justice and hospital healthcare systems, the center has expanded to include walk-ins and referrals from community based providers. Case management and

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[17] Carroll, K., Ball, S., & Nich, C., Martino, S., Frankforter, T., Farentinos, C., Kunkel, L., et al. (2006). Motivational interviewing to improve treatment engagement and outcome in individuals seeking treatment for substance abuse: A multisite effectiveness study. *Drug and Alcohol Dependence, 81*(3). 301-312.

connection to peers are areas of significant focus at the triage center. As a regional service, peers come in from across all of the mental health agencies. The ATC dedicates equal attention and resources to both disorders. At the ATC, individuals with opioid use disorders (OUD) are offered induction on buprenorphine or methadone and connected to opioid treatment programs (opioid treatment programs are the sites legally allowed to offer methadone for OUD) in the community. Rapid access to MAT offered through onsite inductions can drastically increase the rates of follow-up and continuity of care and save lives. As ATC is a Certified Community Behavioral Health Center (CCBHC) and operates an opioid treatment program (OTP), their ability to provide continuity of service in the community is enhanced. The success of this program has led to plans for expansion in the state.

The Crisis Response Center (CRC) in Tucson, Arizona provides another example of a comprehensive crisis receiving and stabilization Center. Established in 2011, CRC has a longstanding history of providing services in coordination with community stakeholders through implementation of a no wrong door policy and has access to a comprehensive treatment system for SUD available 24/7. The CRC and Community Bridges provide 24/7 access to detoxification and 24/7 access to medication assisted treatment (e.g. Methadone and Buprenorphine induction) in outpatient settings through community partners. CRC provides access to MAT 24/7 for individuals with high acuity co-occurring mental health need. Individuals presenting at CRC receive assistance with accessing the appropriate level of care, including care coordination, transportation, and a warm handoff.

The SAMHSA Crisis Toolkit identifies short-term residential facilities as an additional element in the system of care. While not necessarily meeting the definition of a "crisis" facility required to take all referrals, these programs are often referred to as crisis stabilization units (CSU) and involve longer stays, usually between 4-7 days. In general, these programs serve individuals who need a longer period of time to return to the community but do not require a hospital-based level of care. Like receiving and stabilization centers, CSUs vary in their ability to address co-occurring or SUD primary patients. In West Virginia, CSUs are facilities with less than 17 beds that accept individuals with MH, SUD and co-occurring disorders. The CSUs provide psychiatric stabilization services, withdrawal management, and induction on buprenorphine for OUD. Individuals who are more appropriate for, or prefer methadone, are transported to the nearby OTP for methadone induction and then daily for continued dosing. While early in implementation, the state is already seeing positive outcomes related to MAT induction, including reductions in readmissions.[18]

Core Principles and Essential Partnerships

Beyond the three components constituting a comprehensive crisis response system as described in the SAMHSA Crisis Toolkit, there are core principles and essential partnerships necessary for effectively addressing co-occurring and SUDs before, during, and after crisis. These principles may be incorporated into services described above; however, for the SUD population, there are key nuances for consideration.

The SAMHSA Crisis Toolkit identifies six core principles that, when fully implemented, represent excellent crisis care systems that incorporate best practices:

- Addressing Recovery Needs;

[18] Interview with West Virginia Bureau for Medical Services official. May 2020.

- Significant Role for Peers;
- Trauma-Informed Care;
- Zero Suicide/Suicide Safer Care;
- Safety/Security for Staff and People in Crisis; and
- Crisis Response Partnerships with Law Enforcement, Dispatch and Emergency Medical Services.

The identified principles of **Trauma Informed Care, Zero Suicide/Suicide Safer Care, and Safety/Security for Staff and People in Crisis** directly apply to individuals with SUD in crisis and are thoroughly addressed in the SAMHSA Crisis Toolkit. The remaining principles require additional exploration with respect to how they relate to SUD specifically.

Applying Core Principles to SUD: Addressing Recovery Needs

The principle of **Addressing Recovery Needs** deserves expanded consideration for a SUD population. *Recovery is possible*. This statement has such significance in the world of substance use disorders. It is easy to give up hope and hard to have compassion for one whose disorder is understood as a moral failing as opposed to a health care condition. For many years, and unfortunately to a significant extent to this day, society has viewed SUDs in this light. This belief is reflected in the oft-heard statement that a person with SUD does not want to change. This is an unfortunate variant of the "Stages of Change" construct in substance use treatment, which typically recognizes the enormous importance of motivational techniques to help people move from one stage of readiness for change to another.

A large percentage of those admitted to SUD treatment cite legal pressure as an important reason for seeking treatment. And some expert sources suggest that outcomes for those who have choices where participation might eliminate some legal consequence to enter treatment are as good as or better than those who were not. In addition to legal consequences, outside influences are also relevant- such as views of families, employers, significant others, desire to not compromise parenting, etc. Individuals with such outside influences, such as those who face some legal consequences if they are in the criminal justice system tend to have higher attendance rates and in remain in treatment for longer periods, which can have a positive impact on treatment outcomes.[19] Implementation guidance suggesting pursuing a "no-force-first" approach is important in SUD crisis, but must not negate the important role that the criminal justice system has had for those facing criminal legal consequences on connecting individuals to care. This is especially the case when such legal "pressure" can itself be seen as a motivational force rather than an unwanted mandate. Indeed how the legal pressure is formulated as part of the treatment can be a crucial difference if presented as a motivational opportunity rather than something being imposed on one who is "not ready." These types of conversations to aim toward engagement can be nuanced, and it is useful to have training in techniques like motivational interviewing, even to help individuals make decisions where there can be criminal justice consequences to a particular decision about treatment engagement.

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[19] National Institute on Drug Abuse (last updated April 2014). Principles of drug abuse treatment for criminal justice populations — a research-based guide. Retrieved on 3/27/20 from https://www.drugabuse.gov/publications/principles-drug-abuse-treatment-criminal-justice-populations-research-based-guide

Applying Core Principles to SUD: Significant Role for Peers

The **Significant Role of Peers** in crisis response for individuals with SUD can differ from roles of peers in the traditional MH system. Despite the prevalence of co-occurring disorders previously noted, there continues to be some division amongst peers defined as having MH or SUD lived experience.

The nascent yet growing recovery movement has been game-changing for individuals affected by substance use disorder, and the power of peers with lived SUD experience sharing their experiences, hope, and resilience has had significant impact not only on affected individuals but also on the system of care as a whole. Despite a foundation of addict helping addict through traditional 12 step programs, the SUD delivery system was slow to engage the power of peers throughout the continuum. With the launch of the SAMHSA Access to Recovery (ATR) discretionary grant program in 2004, peers with SUD experience were increasingly considered to be essential members of the overall system of care. The Connecticut Community for Addiction Recovery (CCAR) led the nation in the development of training, standards, and the activation of peer experience to influence care.[20] In addition, Georgia has a rich history of peer involvement in the continuum of care for mental health. However, even there, the number of peers working throughout the continuum with SUD lived experience is significantly less than those with MH lived experience. As is the case with virtually every state, Georgia seeks to increase the number of SUD peers in their crisis system, as they do not yet have enough who are trained and certified to meet the need.

The opioid crisis has prompted states to consider new ways to leverage and employ the SUD recovery community to share hope and resilience with individuals who are hard to engage and at risk.

Pre-crisis programs like AnchorMore in Rhode Island deploy Peer Recovery Specialist to overdose hotspots to engage high-risk individuals.[21] Weekly team calls identify areas where overdoses have been most prevalent and may convene more often if there is a marked increase in an area not previously identified. Teams of peers are sent to these areas and dispense Narcan kits as well as fentanyl test strips. During these interactions, peers are establishing connections with active users and will provide referral to treatment and recovery services when individuals are interested. This program has demonstrated a high rate of engagement for services with an at-risk population.

Peers have also been deployed to respond to crises, including overdoses, in EDs. While preferable to address crisis in community-based settings, the nature of SUDs may necessitate the use of ED in crisis, and it is important to have SUD-focused supports across settings in the crisis continuum to effectuate the “no wrong door” approach. Individuals who have overdosed or those whose substance use has resulted in serious injury must receive appropriate medical care first. In the wake of the opioid crisis, EDs have become an important component of the crisis system in addressing SUD. Many states have incorporated peer response to overdose survivors and other individuals with SUD presenting in EDs and have seen this crisis point as a successful point of intervention and engagement for care. For example, Kentucky implemented the Bridge Program which not only provides peer support post overdose, but also involves hospitals providing induction on MAT. Pennsylvania integrates peers in community based

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[20] Connecticut Community for Addiction Recovery (2010). CCAR history (2000-2010). Retrieved on 5/27/20 from: http://ccar.us/about-ccar/history/ccar-2000-2010/

[21] Waye, K. M., Goyer, J., Dettor, D., Mahoney, L., Samuels, E. A., Yedinak, J. L., & Marshall, B. D. (2019). Implementing peer recovery services for overdose prevention in Rhode Island: An examination of two outreach-based approaches. *Addictive Behavior 89,* 85-91. doi:10.1016/j.addbeh.2018.09.027

care management teams that reach out to clients in EDs post overdose, but also extends outreach to correctional facilities, primary care settings and other community- based settings. The aim of the outreach is to engage individuals in their successful Center of Excellence program, expanding access to MAT, providing case management to address other social determinants of health, and encouraging continued involvement with health and mental health treatment.

Crisis receiving stabilization centers, such The Restoration Center in San Antonio, Texas employ peers, identified as recovery support specialists to provide follow up care for individuals discharged from the crisis centers. These peers provide services to individuals up to 45 days post crisis which include assistance in obtaining housing, accessing medications, transportation to appointments, peer support, follow up phone calls and welfare checks.

Applying Core Principles to SUD: Crisis Response Partnerships

Effective response to SUD throughout the crisis care continuum entails developing **Crisis Response Partnerships** with partners and in settings above and beyond those described in the SAMHSA Crisis Toolkit. As noted previously, EDs can provide a place of engagement for individuals with SUD. Intervention efforts can extend beyond connecting individuals with SUDs to peers. Forty percent of ED visits are due to trauma, and of these, between 40% and 50% are alcohol related. Implementation of Screening, Brief Intervention, and Referral to Treatment (SBIRT) in ED settings allows an opportunity for identification, engagement and intervention. Massachusetts' Project Assert uses health promotion advocates (HPAs) to perform SBIRT as part of routine emergency department care. These encounters with HPAs provide patients with the opportunity to explore change through non-judgmental conversations combined with access to health and treatment services. EDs can also be an effective site for treatment initiation.[22] A study published in 2015 demonstrated the impact of MAT induction within an ED setting for individuals presenting with Opioid Use Disorder (OUD). This study concluded that ED-initiated buprenorphine, "compared with brief intervention and referral, significantly increased engagement in formal addiction treatment, reduced self-reported illicit opioid use, and decreased use of inpatient addiction treatment services."[23] In California, the Bridge Program supports hospitals to provide buprenorphine and embeds Recovery Support Navigator staff in EDs with the goal of meeting individuals with SUD where they are and improving connections to care following an SUD-related ED visit.[24] The Bridge Program shows comparatively high rates of completed follow-up visits to community-based providers among patients who received buprenorphine and Recovery Support Navigator services in the ED.[25]

Forming partnerships with first responders also have the potential to achieve significant impact on assisting individuals experiencing SUD crisis in areas of crisis prevention, response and post crisis outreach. For example, the Safe Stations program initiated in Manchester, New Hampshire has now been replicated in cities across the country. The Safe Station program provides fire stations as open doors for individuals seeking help for substance use disorders, 24/7. Fire Department personnel

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[22] Massachusetts ED SBIRT Initiative: https://www.bu.edu/bniart/sbirt-experience/sbirt-programs/sbirt-hospital-emergency-department/

[23] D'Onofrio, G., O'Connor, P. G., Pantalon, M. V., Chawarski, M. C., Busch, S. H., Owens, P. H., Bernstein, S. L., & Fiellin, D. A. (2015). Emergency department-initiated buprenorphine/naloxone treatment for opioid dependence: A randomized clinical trial. *JAMA*, *313*(16), 1636–1644. https://doi.org/10.1001/jama.2015.3474

[24] http://www.californiamat.org/matproject/california-bridge-program/

[25] California Bridge Program. *Barriers, Gaps, and Opportunities*. Treatment Starts Here convening. January 2020.

conduct a brief medical assessment before connecting these individuals to treatment and recovery resources. Similarly, partnerships with law enforcement also represent a promising opportunity for responding to the needs of individuals with SUD experiencing crisis. The Police Assisted Addiction & Recovery Institute is a national network of police departments spanning 32 states that offer simple, stigma-free, non-arrest pathways to treatment and recovery based on the Angel Program established by the Gloucester Police Department in Massachusetts in 2015.[26]

Financing Strategies

There are several federal funding authorities that states can leverage to finance crisis care systems, including those that deliver services for individuals with co-occurring and SUD-only diagnoses experiencing crisis. States can use traditional federal funding sources available for mental health-oriented crisis response services to achieve progress towards a more fully integrated crisis care system. Given the patchwork nature of mental health and SUD crisis service funding highlighted in the SAMHSA Crisis Toolkit, states can develop a braided funding approach to finance system improvements and pay for service provision.[27] In a braided funding approach, policymakers coordinate the use of multiple, discrete funding authorities to support a single strategy while retaining the identity and expenditure data specific to each authority.[28] SAMHSA has identified strong examples of states that braid funding sources to develop crisis service systems and provide crisis care, including with state general funds, federal grants, and various Medicaid authorities.[29]

Discretionary SAMHSA grant funding opportunities can be used to pay for certain costs of crisis care systems not covered by payments from health care plans, such as infrastructure and "startup" costs associated with developing crisis care system capacities, crisis response care for uninsured individuals, and components of crisis response care that are not included in individual plan coverage. States can use the annual Community Mental Health Services Block Grant and Substance Abuse Prevention and Treatment Block Grant programs to develop and enhance crisis response systems with SUD-specific capacities.[30] In addition, states (and often providers) can apply for other SAMHSA grant funding opportunities to implement crisis response efforts with SUD-specific capacities. States are leveraging the State Opioid Response (SOR) grant funding opportunity to implement some of the best practices described in this report. For example, California and West Virginia are allocating SOR funding to scale up the Bridge Program and Quick Response Team SUD crisis interventions described above to meet

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[26] The Police-Assisted Addiction and Recovery Initiative: https://paariusa.org/about-us/

[27] Page 36

[28] AGA Work Group on Blended and Braided Funding, operating under the auspices of AGA's Intergovernmental Partnership (2014). Blended and braided funding: A guide for policy makers and practitioners. Alexandria, VA: Association of Government Accountants. https://www.agacgfm.org/AGA/Intergovernmental/documents/BlendedandBraidedFunding.pdf

[29] Substance Abuse and Mental Health Services Administration (2014). Crisis services: Effectiveness, cost effectiveness, and funding strategies. HHS Publication No. (SMA)-14-4848. Rockville, MD: Substance Abuse and Mental Health Services Administration. https://store.samhsa.gov/product/Crisis-Services-Effectiveness-Cost-Effectiveness-and-Funding-Strategies/sma14-4848

[30] FFY 2020-2020 Block Grant Application (Community Mental Health Services Block Grant Plan & Report *and* Substance Abuse Prevention & Treatment Block Grant): https://www.samhsa.gov/sites/default/files/grants/fy2020-2021_blockgrantapplicationandplan_091718_508.pdf

individuals with SUD literally where they are and improve connections to care following an SUD-related crisis event.[31]

States can also design their Medicaid program to maximize federal matching funds and secure a sustainable source of funding for crisis response services in ways that account for local circumstances. There are longstanding federal policy and regulatory options at states' disposal to cover crisis response services for Medicaid beneficiaries with SUD, including the core components described in the SAMHSA Crisis Toolkit. For example, components of crisis call center, mobile crisis response, and crisis stabilization services can be covered under Medicaid:

- in the state plan through the rehabilitation, other licensed practitioner, and clinic services at Section 1905(a);
- in the state plan through the home and community-based services option at Section 1915(i);
- in the home and community-based services waiver programs at Section 1915(c); and
- as administrative costs, especially for crisis call centers.[32]

In addition, states have additional flexibilities to receive federal Medicaid funding for crisis stabilization services provided in facilities that meet the definition of an institution of mental disease (IMD) and would otherwise be excluded for federal Medicaid reimbursement. Specifically, in states delivering crisis services through risk-based managed care, federal Medicaid funds are available for capitation payments to managed care plans whose enrollees receive psychiatric and SUD crisis residential services provided in IMDs as an "in lieu of" service so long as the length of stay is less than 15 days.[33] In addition, states can apply for the Section 1115 demonstration opportunity announced in 2018 that offers federal Medicaid funding flexibilities for mental health services provided in IMDs, including crisis stabilization services.[34] Notably, the 2018 guidance identifies improved availability of crisis response services, including crisis call centers, mobile crisis response, and crisis stabilization services, as a milestone that states must meet over the course of the demonstration.

Impact and Lessons Learned from COVID-19

The COVID-19 pandemic has created a new set of challenges for policy makers and providers serving individuals with SUD, including those who may experience a crisis episode. Yet amid these challenges are key opportunities to leverage for developing comprehensive crisis response systems designed to meet the needs of individuals with SUD experiencing a crisis, and mitigate disparities in public health and crisis care that are being brought to the forefront during this pandemic.

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[31] California MAT Extension Project: California Bridge Program (updated April 2019). Retrieved on 5/28/20 from: http://www.californiamat.org/matproject/california-bridge-program/

[32] U.S. Department of Health and Human Services Center for Medicare and Medicaid Services (2018). State Medicaid Director 18-011: https://www.medicaid.gov/sites/default/files/federal-policy-guidance/downloads/smd18011.pdf

[33] 42 CFR 438.6(e)

[34] U.S. Department of Health and Human Services Center for Medicare and Medicaid Services (2018). State Medicaid Director 18-011: https://www.medicaid.gov/sites/default/files/federal-policy-guidance/downloads/smd18011.pdf

For one, individuals receiving MAT are at increased risk for morbidity and mortality caused by interruptions in their pharmacotherapy as discontinuing MAT often leads to relapse and overdose.[35] Despite federal agencies such as SAMHSA and DEA issuing guidance offering states and providers considerable flexibility for maintaining access to medications, access to certain SUD treatment services has nevertheless been jeopardized during COVID-19. Intensive levels of care provided in congregate care settings such as inpatient and residential treatment programs have been especially impacted by COVID. For example, a survey of behavioral health providers reveals that 91 percent have reduced operations, with two-thirds closing at least one of their programs.[36] It is essential that the crisis response system be aware of these capacity limitations and develop strategies to maintain engagement with individuals if they must wait for admission.

Another important consideration for the crisis response system is the increase of substance use in general. A survey of patients, families, and individuals in recovery revealed that 20 percent of respondents have increased their substance use since the start of the pandemic, and 14 percent were unable to access needed services due to COVID-19.[37] Individuals in recovery may be challenged by increased stressors resulting from COVID-19, such as loss of a job and income, lack of child care, and increased isolation. Some data indicates increase in alcohol sales up to 32% compared to a same point in time one year prior, and several states show an increase in per capita alcohol sales in April 2020 compared to the prior 3-year April average.[38] Excessive alcohol use can increase not only susceptibility to COVID-19 but also severity. Alcohol use is also indicated in increased Intimate Partner Violence. The United Nations Secretary General called for measures to address the "horrifying surge" in domestic violence associated with government lockdowns and stay at home orders.[39] Increased use of alcohol and other substances during COVID-19 heightens the need for crisis responders to be fully aware of assessing and addressing SUD during intervention.

The associations between certain SUDs and COVID-19 risks are not fully known. However, there are several areas worth noting as data is still emerging. For instance, individuals who smoke or vape as a route of administration may be more susceptible to infection and face poorer prognoses due to respiratory health issues, which might include higher case-fatality rates. Conversely, COVID-19 positive individuals who develop compromised lung function could be at heightened risk of hypoxia associated with opioid and/or methamphetamine use given the potential for pulmonary damage associated with

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[35] National Academies of Sciences, Engineering, and Medicine 2019. *Medications for Opioid Use Disorder Save Lives*. Washington, DC: The National Academies Press. https://doi.org/10.17226/25310.

[36] National Council for Behavioral Health. (April 6, 2020). "COVID-19 Economic Impact on Behavioral Health Organizations". National Council for Behavioral Health. Retrieved from https://www.thenationalcouncil.org/wp-content/uploads/2020/04/NCBH_COVID19_Survey_Findings_04152020.pdf?daf=375ateTbd56.

[37] Hulsey, J., Mellis, A., & B. K. (June 8, 2020). "COVID-19 Pandemic Impact on Patients, Families & Individuals in Recovery from a SUD." Addiction Policy Forum. Retrieved from https://www.addictionpolicy.org/post/covid-19-pandemic-impact-on-patients-families-individuals-in-recovery-fromsubstance-use-disorder; Meadows Mental Health Policy Institute. (April 28, 2020).

[38] Macmillan, Carrie (June 4, 2020). "Drinking More Than Usual During the COVID-19 Pandemic?" Yale Medicine. Retrieved from https://www.yalemedicine.org/stories/alcohol-covid/.; National Institute on Alcohol Abuse and Alcoholism. "Alcohol Sales During the COVID-19 Pandemic". Retrieved from https://pubs.niaaa.nih.gov/publications/surveillance-covid-19/COVSALES.htm.

[39] United Nations (April 6, 2020). "UN chief calls for domestic violence 'ceasefire' amid 'horrifying global surge'". UN News. Retrieved from https://news.un.org/en/story/2020/04/1061052.

each of these conditions under various circumstances.[40] Harm reduction strategies such as "never use alone" and ensuring naloxone is available may not be effective or possible when individuals are socially distancing and sheltering-in-place consistent with public health guidelines.

As data is starting to come to light, some of the worst fears about the connection of the pandemic to the SUD population may be coming true. Suspected overdoses have increased by 191% in January-April 2020 compared to January-April 2019, according to the Overdose Detection Mapping Application Program, an initiative developed by a federal Office of National Drug Control Policy grantee.[41] The COVID-19 pandemic is reinforcing the value of crisis response strategies especially tailored for individuals with SUD. During the pandemic, it will be critical to ensure overdose response teams as described earlier in this paper have sufficient personal protective equipment and funding to perform these vital engagement, follow-up and referral services to overdose survivors and their families.

Crisis Services for Substance Use Disorders Examined with a Racial Equity Lens

The COVID-19 pandemic is also reinforcing the need to address disparities inherent in the public health emergency and in the systems designed to address crises and SUDs. Research shows that racial and ethnic minority groups are disproportionately affected by the coronavirus and the resulting economic crisis.[42] In addition, data that parses out the impact of various substances and access to services among racial and ethnic minority groups is shedding light on disparities in outcomes. Disparities in health care may actually have attenuated the impact of the "first wave" of the opioid epidemic associated with prescription opioids in the Black/African American community, as Black/African American patients are 29 percent less likely to be prescribed opioids for pain than white patients.[43] However, as part of the "third wave" of the opioid epidemic associated with skyrocketing rates of overdose deaths involving fentanyl, between 2011 and 2016 the Black/African American population experienced the highest increase in fatal overdose rates of deaths involving fentanyl.[44] Between 2015 and 2016, the rate of increase in overdose deaths was highest for the Black/African American population among all racial and ethnic groups. In addition, Black/African American individuals with OUD experience disparities in access

[40] Volkow, Nora (July 2020). "Collision of the COVID-19 and Addiction Epidemic." *Annals of Internal Medicine, Vol.* 173(1).

[41] Alter, A., Yeager, C (May 13, 2020). "The Consequences of COVID-19 on the Overdose Epidemic: Overdoses are Increasing." Overdose Detection Mapping Application Program. Retrieved from http://www.odmap.org/Content/docs/news/2020/ODMAP-Report-May-2020.pdf.

[42] Centers for Disease Control and Prevention. COVID-19 in racial and ethnic minority groups. Retrieved on July 16, 2020 from https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/racial-ethnic-minorities.html; Brown, S. (2020). The COVID-19 crisis continues to have uneven economic impact by race and ethnicity. *Urban Wire,* blog of the Urban Institute. Retrieved on July 16, 2020 from https://www.urban.org/urban-wire/covid-19-crisis-continues-have-uneven-economic-impact-race-and-ethnicity;

[43] Centers for Disease Control and Prevention. "Understanding the Epidemic". Retrieved from https://www.cdc.gov/drugoverdose/epidemic/index.html; Pletcher MJ, Kertesz SG, Kohn MA, Gonzales R. Trends in opioid prescribing by race/ethnicity for patients seeking care in US emergency departments. JAMA [Internet]. 2008 Jan 2 [cited 2019 Dec12];299(1):70-8.

[44] Substance Abuse and Mental Health Services Administration: The Opioid Crisis and the Black/African American Population: An Urgent Issue. Publication No. PEP20-05-02-001. Office of Behavioral Health Equity. Substance Abuse and Mental Health Services Administration, 2020.; Centers for Disease Control and Prevention. "Understanding the Epidemic". Retrieved from https://www.cdc.gov/drugoverdose/epidemic/index.html.

to evidence-based treatment for OUD, with studies showing that buprenorphine-based treatment is less accessible and delivered less frequently to Black/African American patients than white patients.[45]

American Indians and Alaska Natives (AI/AN) also experience disparities in both the COVID-19 pandemic and opioid epidemic. The AI/AN population is hospitalized for COVID-19 at five times the rate as the white population.[46] In addition, Tribal governments and communities are facing relatively greater economic devastation than many states during this severe fiscal environment. Because Tribes do not have tax bases similar to local and state governments, casino and other enterprise represent Tribes' main revenue stream. As these industries have been put on hold as a public health measure, Tribes are grappling with even greater budget shortfalls than states; COVID-19 threatens to "completely reverse" the progress that Tribes have made in community economic development.[47] With respect to SUD, relevant data for American Indian and Alaska Native populations are often compromised by racial misclassifications in surveillance and vital statistics systems. The racial misclassifications – whereby AI/AN individuals are reported as belonging to racial/ethnic groups other than AI/AN – result in undercounting the true prevalence of health conditions among AI/AN communities. For example, a recent study matched drug and opioid-involved overdose-related death records from the Washington State Center for Health Statistics with the Northwest Tribal Registry, a database of AI/AN patients seen in Indian Health Service, tribal, and Urban Indian health clinics in Washington state. The Washington death records were corrected for AI/AN classification using the Northwest Tribal Registry data, and the corrected death records were then compared with federal CDC data. The comparison suggests that CDC data underestimate drug overdose mortality counts and rates among AI/AN by approximately 40%.[48] Underestimation notwithstanding, AI/AN individuals still experience above-average rates of drug overdose deaths.[49]

Disparities in public health and overdose deaths represent an opportunity for states to develop innovative, community-specific outreach and engagement strategies, especially for individuals with SUD experiencing a crisis. For example, Black/African American individuals were found to be three times more likely to die during a police encounter than white individuals, even though they were more likely to be unarmed.[50] Given the recognition of police violence as a public health risk by organizations such as the American Medical Association and American Public Health Association, states are more poised than ever to reallocate resources and responsibilities for crisis care services away from law enforcement and

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[45] Ibid.

[46] Centers for Disease Control and Prevention. COVID-19 in racial and ethnic minority groups. Retrieved from https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/racial-ethnic-minorities.html.

[47] Akee, R (April 10, 2020). "Re: allocation of COVID-19 Response Funds to American Indian Nations." Harvard Kennedy School ASH Center for Democratic Governance and Innovation. Retrieved from: https://ash.harvard.edu/files/ash/files/hpaied_covid_letter_to_treasury_04-10-20_vsignedvfinv02.pdf.

[48] Seven Directions: A Center for Indigenous Public Health (September 2019). "An Environmental Scan of Tribal Opioid Overdose Prevention Responses: Community-Based Strategies and Public Health Data Infrastructure". University of Washington. Retrieved from https://www.nihb.org/docs/04092020/Environmental%20Scan%20of%20Tribal%20Opioid%20Response%20Booklet.pdf.

[49] Centers for Disease Control and Prevention. "Injury Prevention in American Indian and Alaska Native Communities." Retrieved from https://www.cdc.gov/injury/fundedprograms/tribal.html.

[50] DeGue, S. "Deaths Due to Lethal Force by Law Enforcement." *Am J Prev Med.* 2016 Nov; 51(5 Suppl 3): S173–S187.

towards appropriate crisis response systems such as those described in the SAMHSA Crisis Toolkit and this brief.[51]

SUD crisis care during COVID-19 is revealing a confluence of disparities. Yet from crisis comes opportunity: this moment in time presents an excellent opportunity for policy makers to catalyze on public sentiment and political will to ensure crisis response systems are adequately funded and positioned to respond to behavioral health crises. The momentum provided by a heightened national and state interest in transferring public and social service functions from law enforcement entities to human service agencies also offers states a platform to continue evolving their crisis systems to adequately address the needs of individuals with SUD experiencing a crisis event.

Conclusions

Behavioral health parity requires some insurers that provide coverage for mental health and substance use conditions to ensure those benefits are subject to limitations that are not more stringent than similar benefits physical health conditions.[52] The healthcare system can no longer tolerate services that are disparate for individuals with substance use disorders. SAMHSA's specific inclusion of SUDs in its Crisis Toolkit should serve as notice that service parity needs to exist in all behavioral health crisis response systems. The "Anyone" in the "Anyone, Anywhere, Anytime" from the SAMHSA Crisis Toolkit must include individuals with co-occurring SUDs or sole SUD diagnoses. The degree to which states' crisis response systems encompass SUD varies and states are continuously evolving these systems to meet needs.

A comprehensive system of crisis response can positively impact the entire continuum of care for individuals with SUD from prevention through recovery. Incorporating SUD meaningfully into a crisis response system requires training of staff at levels, implementation of evidence-based screening and assessment tools, employment of peers with lived SUD experience, access to services that can support withdrawal management and medications to treat conditions such as OUD, and monitoring fidelity to evidence based practices as well as outcomes. Crisis providers should be able to demonstrate success of interventions with SUD and implement processes for continuous quality improvement with this population. Providers should also routinely assess staff for presence of negative perceptions or attitudes related to SUD, as stigma poses a challenge to strategic planning and implementation efforts to better meet the needs of individuals with SUD.

Effective partnerships are crucial for positive outcomes in crisis response. Partnerships ensure appropriate resources for preventing crisis, responding to crisis, and providing effective warm handoffs for care and continued recovery support. Including SUD in a behavioral health crisis response may require the system to expand these partnerships to include community based organizations and providers outside the historical networks. Law enforcement, EMS, health care providers, hospital

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[51] Strazewski, L (June 8, 2020). "Why police brutality is a matter of public health." American Medical Association. Retrieved from https://www.ama-assn.org/delivering-care/health-equity/why-police-brutality-matter-public-health; American Public Health Association (November 13, 2018). "Addressing Law Enforcement as a Public Health Issue." Policy Number 201811. Retrieved from https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2019/01/29/law-enforcement-violence.

[52] Centers for Medicare and Medicaid Services, Center for Consumer Information and Insurance Oversight. The Mental Health Parity and Addiction Equity Act. Retrieved on 5/28/20 from: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet

systems, peer-based recovery organization and substance use specific treatment providers all have a critical role in SUD throughout the continuum. This call to action also requires SUD providers to come out from the shadows to be front and center as partners is responding to the emerging needs of individuals in crisis with SUD. It is no longer sufficient for the SUD treatment world to stand back and wait for individuals to show up at the door. The absence of SUD specific providers as active partners in the crisis system only perpetuates the potential for discrimination toward individuals with SUDs.

There is clear opportunity for all states to use and incorporate the SAMHSA Crisis Toolkit to improve, enhance and expand their crisis response systems to be more inclusive of individuals with SUDs. The potential for positive impact throughout the behavioral healthcare system, and most importantly for the individuals in need of care, their families, and their communities cannot be overstated.

This working paper was supported by the Center for Mental Health Services/Substance Abuse and Mental Health Services Administration of the Department of Health and Human Services.

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INSTITUTE FOR YOUTH, EDUCATION, AND FAMILIES

Triage Centers as Alternatives to Jail for People in Behavioral Health Crises

POLICY BRIEF

POLICY BRIEF

Triage Centers as Alternatives to Jail for People in Behavioral Health Crises

Cities, together with county or regional partners, increasingly use triage centers as alternatives to jails, emergency rooms, and other expensive, ineffective responses to substance abuse and mental health crises. City leaders can assist in the establishment of triage centers through championing the effort, enlisting city agencies, exploring funding and data sharing models, and convening county or nonprofit partners. City agencies save both time and money through the use of triage centers.

For example, the per day cost of a Safe Solutions bed in the triage center in Rapid City, South Dakota is one quarter of the local jail's per day cost.

Triage centers serve as a single location where first responders, including police and emergency medical services, can bring an individual experiencing a behavioral health crisis. Trained clinicians assess and provide immediate treatment and referrals to ongoing treatment while first responders, such as police, can return to patrol after completing a short intake process. Juvenile assessment and service centers (JASC) serve as similar one-stop structures that cities implement to provide services to diversion-eligible youth.

Triage centers are better equipped to respond to the 64 percent of people in jail who struggle with mental health and the 68 percent who struggle with substance use. The conditions these individuals face in jails, such as solitary confinement and abuse, often exacerbate health problems. People with unresolved behavioral health issues can be homeless and often end up in jails, emergency rooms, and other crisis services repeatedly, even as often as multiple times a month. Repeated, ineffective crisis responses for these individuals, referred to as high utilizers, become huge avoidable costs for cities.

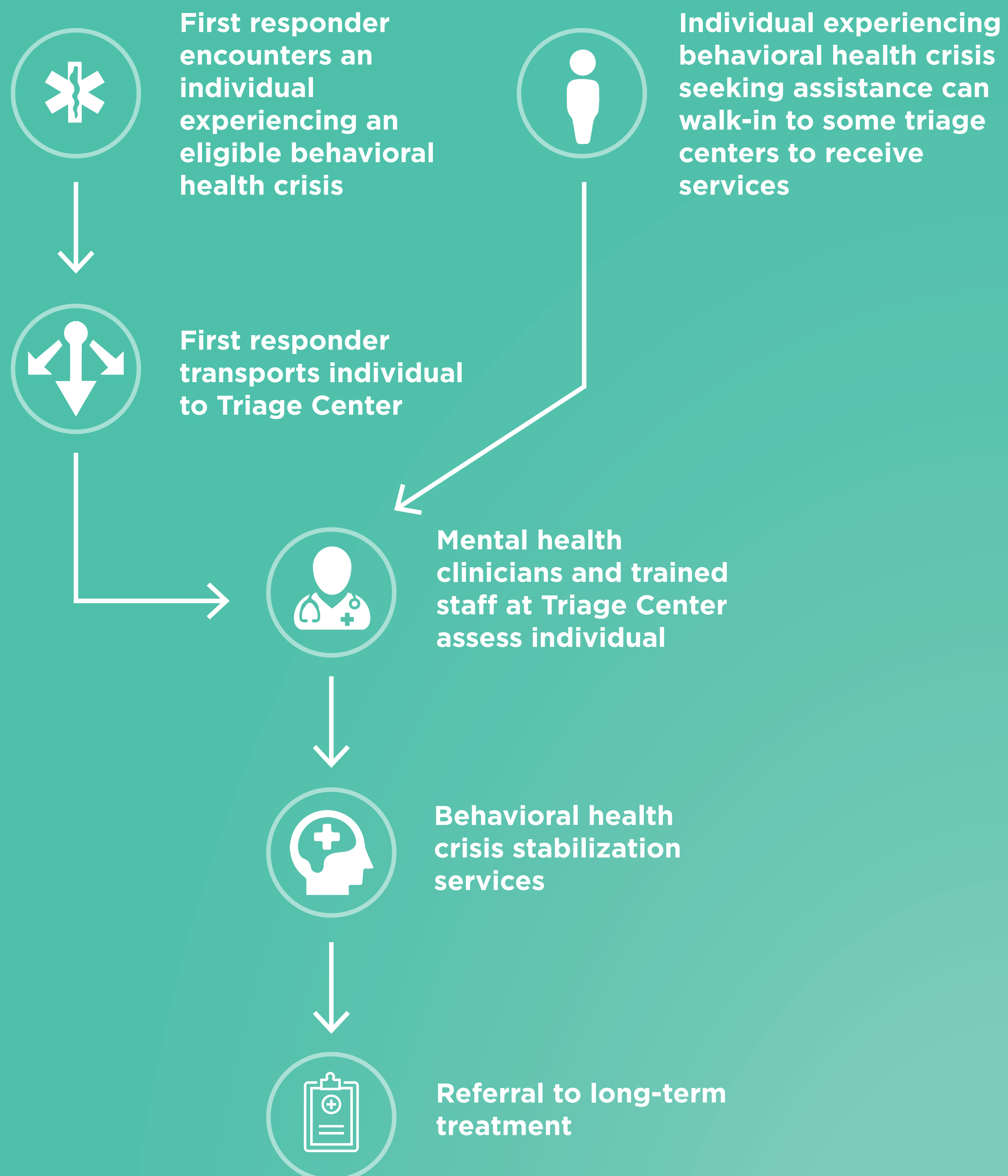
The per day cost of a Safe Solutions bed in the triage center in Rapid City, South Dakota is one quarter of the local jail's per day cost.

QUICK FACTS

Each triage center is unique, responding to the needs and assets of the community, but certain commonalities exist across many examples:

- Often open to referrals 24 hours a day, 7 days a week, 365 days a year.
- Keep clients under their care up to 23 hours, while others have capacity to provide care for several days.
- Centrally located in downtown areas or on hospital campuses.
- Funding and oversight can be governed by Memorandum of Understanding among city, county and service provider partners.
- Staff structures often combine case managers, registered nurses, social workers and psychiatrists.
- Often provide immediate placements – including detox units, sobering beds, medication management, intensive treatment for mental illness – and referral to ongoing, long term services, such as case management, counseling, medication management, addiction services, housing, employment.
- Operating agency varies by location; examples include a non-profit organization, the state mental health department, or the county behavioral health agency.
- Measures of success include number of clients served per year and reduced use of first responder services and time.

First Responder Interactions and Access to Services Flowchart



STARTUP STRATEGIES OF SUCCESSFUL TRIAGE CENTERS

Cities can learn from four strategies several cities and their partners employed to build and open triage centers.

1 Form a stakeholder group that incorporates first responders and clinicians, led by a champion

Multi-disciplinary stakeholder groups for triage centers include elected and appointed officials from all participating jurisdictions, first responders, local court leaders, the local jail administrator, hospitals, probation or pretrial community supervision authority, community-based mental health providers and substance addiction providers. Local individuals with relevant lived experience, advocates and faith leaders should share the table with government officials and providers. A local criminal justice coordinating council (CJCC) may already engage all of these partners and, therefore, serve as a strong pre-existing stakeholder group.

The convening power of elected officials or judges, as well as their awareness of broad community needs and assets, make them particularly strong champions. In Kansas City, Missouri a well-known judge learned about triage centers and stepped in as the local champion. He brought together a stakeholder group, including the city's Mayor Pro Tem, Deputy Police Chief and Fire Chief, to identify an appropriate response to high utilizers with behavioral health needs. The stakeholder group met every month for two years to analyze local data, research best practices, tour facilities across the country and apply that learning to a new triage center, the Kansas City Assessment and Triage Center.

2 Make the case: assess the community's behavioral health needs and assets

City leaders should collect data demonstrating trends of substance abuse and mental health crises in the community from first responders, local jails, and hospitals to first determine the need for a triage center and, on an ongoing basis, to assess the triage center's effectiveness. As one of its first tasks, the stakeholder group should also identify existing services in the community, including their capacity to serve clients with and without insurance in all areas of the city, and gaps in service.

Charleston, South Carolina's local CJCC conducted focus groups with high utilizers and with law enforcement to determine needs in the community and identified a triage center as a crucial way to meet those needs. The Tri-County Crisis Stabilization Center operates as a component of the Charleston Dorchester Mental Health Center. Within a recent six-month period, the Tri-County Crisis Stabilization Center received a total of 408 diversions from jail, emergency departments, and hospitals. In addition, 59 percent of individuals referred had co-occurring mental health and substance abuse disorders.

3 Plan for sustained funding

City leaders will want to plan for sustainable funding so as to remain open after exhausting initial startup or capital funds. Cities can contribute capital funds from municipal bonds and Community Development Block Grants or provide in-kind support through use of city-owned property. Beyond that, city leaders need partners to sustain operational funds. Common mechanisms to support sustained collaboration and funding are Memorandums

of Understanding among multiple governments or agencies to govern shared authority and funding of a triage center. City leaders with local authority to do so may also consider targeted tax initiatives to increase access to mental health and addiction services. City leaders should also explore whether Medicaid expansion coverage will be available to bolster private health insurance for service costs.

Local stakeholders worked with a non-profit organization to cover costs for the initial funding of the Community Triage Center in Las Vegas, Nevada. To sustain services, multiple counties and cities, the state of Nevada, and local hospitals each pay one-third of operational costs. Local municipalities divide their one-third across the cities and counties involved based upon referrals from each zip code. A memorandum of understanding instituted in 2005 governed shared authority and funding for the past 13 years.

4 Train and communicate to ensure first responders and the community accurately understand the triage center's use and benefits

Triage centers rely on referrals from first responders and self-referrals from the community. Therefore, city leaders should ensure active, ongoing training and communication to all relevant groups about the appropriate use of a triage center. First responders must understand who the center accepts, the referral proces, and the benefits to them of utilizing the triage center. For example, triage centers never accept people in medical crisis, so first responders still need to take an individual experiencing an overdose to the emergency room.

A NOTE ABOUT ONGOING EVALUATION AND OVERSIGHT

City leaders should ensure the stakeholder group continues to routinely evaluate and use its authority to revise the operations of the triage center. As triage centers operate, communities often see savings and can redirect those savings to expanded services still needed in the community. As triage centers continue to emerge, there is still much to learn and document about the benefits and impacts on the community.

LOCAL EXAMPLES

Tucson, Arizona – Crisis Response Center

Community acknowledgement of the behavioral health crisis in Tucson helped spur the passage of two bond measures with the proceeds going to build a Crisis Response Center in a downtown location. Today, ConnectionsAZ operates the Center at a volume of approximately 12,000 adults and 2,200 children in crisis served annually. To sustain the services, this center contracts with major health plans, bills Medicaid when applicable, and receives funding from the county and state for indigent and crisis care.

Rapid City, South Dakota – Crisis Care Center

The CEO of a local South Dakota foundation served as the champion and initial funder for the Rapid City Crisis Care Center. The mayor, chief of police, county sheriff and other community members participated in the stakeholder group. Minimizing capital costs, a local hospital provided the space from within an established inpatient behavioral health center. Following startup assistance from the local foundation, the triage center now

receives operating funding from the city, the county and local hospitals, in addition to in-kind service donations from the community.

Over the course 26 months, beginning in the summer of 2016, the Crisis Care Center had a total of 10,009 intakes from 1,027 individual clients – 37 percent of referrals derived from emergency services and 63 percent from self-referrals. During the same time-period, the utilization of a Safe Solutions bed within the Crisis Care Center cost the facility $20 a day in comparison to $80 a day at Pennington County Jail saving approximately $645,000 over the 26-month period.

Chicago, Illinois – Community Triage Center

The Community Triage Center in Chicago learned crucial lessons about educating first responders and the community to achieve success. Initially, the center did not experience the expected high volume of clients. Through evaluation, staff learned that patrol officers needed further in-depth training to fully understand uses and benefits of the triage center. Law enforcement referrals increased after patrol officers received additional training. Success led to the creation of a second triage center in an additional high need neighborhood on the Southside of Chicago.

This brief was created with support from the **John D. and Catherine T. MacArthur Foundation** as part of its Safety and Justice Challenge initiative, which seeks to address over-incarceration by changing the way America thinks about and uses jails. More information available at www.SafetyandJusticeChallenge.org

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Works-Wright, Jamie

From: Works-Wright, Jamie
Sent: Thursday, December 2, 2021 10:45 AM
To: Works-Wright, Jamie
Subject: FW: SAMHSA: National Guidelines Behavioral Health Crisis Stabilization Best Practices

Hello Commissioner,

Please see the information below

Thank you for your time.

Jamie Works-Wright
Consumer Liaison & Mental Health Commission Secretary
City of Berkeley
2640 MLK Jr. Way
Berkeley, CA 94704
Jworks-wright@cityofberkeley.info
Office: 510-981-7721 ext. 7721
Cell #: 510-423-8365

From: Margaret Fine <margaretcarolfine@gmail.com>
Sent: Thursday, December 2, 2021 7:09 AM
To: Works-Wright, Jamie <JWorks-Wright@cityofberkeley.info>
Subject: SAMHSA: National Guidelines Behavioral Health Crisis Stabilization Best Practices

WARNING: This is not a City of Berkeley email. Do not click links or attachments unless you trust the sender and know the content is safe.

Hi Jamie,

I hope you're well.

In 2020, the Substance Abuse and Mental Health Administration (SAMHSA) published its National Guidelines for Behavioral Health Crisis Care - A Best Practices Toolkit. They include a definition for "crisis stabilization" and an outline of minimum expectations and best practices for operating these crisis services.

There are screenshots below of this material, which should inform our discussion on this topic for upcoming program. Would you please kindly send this material to the Mental Health Commissioners? Thank you so much!

Here is the information:

The National Guidelines refer to SAMHSA's definition of crisis stabilization in its 2014 report as stated below:

23 of 80

In the 2014 *Cr*
SAMHSA define

A direct
distress
disorder.

The National Guidelines further outline minimum expectations for operating these services and best practices (scroll further down):

Minimum Expectations to (

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   to more medically
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   a. Psychiatrist

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planning w

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planning w

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3. Incorporat
the service
need addit
4. Include he

Works-Wright, Jamie

From: Works-Wright, Jamie
Sent: Thursday, December 2, 2021 10:41 AM
To: Works-Wright, Jamie
Subject: FW: 1,500 unhoused LA residents died on streets during pandemic - Report

Hello Commissioners,

Please see information below

Thank you for your time.

Jamie Works-Wright
Consumer Liaison & Mental Health Commission Secretary
City of Berkeley
2640 MLK Jr. Way
Berkeley, CA 94704
Jworks-wright@cityofberkeley.info
Office: 510-981-7721 ext. 7721
Cell #: 510-423-8365

From: Margaret Fine <margaretcarolfine@gmail.com>
Sent: Wednesday, December 1, 2021 11:17 PM
To: Works-Wright, Jamie <JWorks-Wright@cityofberkeley.info>
Subject: 1,500 unhoused LA residents died on streets during pandemic - Report

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Hi Jamie,

Would you kindly share this article with the Mental Health Commissioners? Thank you so much.

Hello All,

The Guardian newspaper covered a new report by researchers from the University of California, Los Angeles (UCLA), and a coalition of unhoused residents. The report analyzed the LA county coroner's records to identify 1,493 cases of people who died between March 2020 and July 2021 on the streets and were probably unhoused.

The **common cause of death was accidental overdose:**

- Nearly 40% of the accidental deaths were attributed to drug and alcohol overdoses, mirroring the sharp increase in overdoses in the broader population.
- The information is important for our consideration of unhoused people living with mental illness and/or substance use disorders and their having equitable access to crisis response and stabilization services.

Overall it is important to meet the needs of demographic populations of people through providing access to these services, particularly given high numbers of people with co-occurring mental illness and substance use disorders. These services are also important for family members and friends seeking resources and services for individuals.

https://www.theguardian.com/us-news/2021/dec/01/1500-unhoused-la-residents-died-on-the-streets-during-pandemic-report-reveals?CMP=Share_iOSApp_Other

Works-Wright, Jamie

From: Works-Wright, Jamie
Sent: Wednesday, December 1, 2021 2:13 PM
To: Works-Wright, Jamie
Subject: FW: The Bend, Oregon, Crisis Stabilization program as a potential model for Berkeley

Please see information below

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Consumer Liaison
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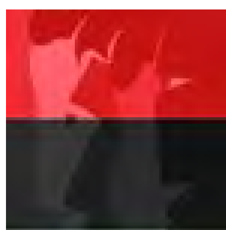
510-423-8365 cl
510-981-7721 office



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From: Edward Opton <eopton1@gmail.com>
Sent: Tuesday, November 23, 2021 2:43 PM
To: Works-Wright, Jamie <JWorks-Wright@cityofberkeley.info>
Subject: The Bend, Oregon, Crisis Stabilization program as a potential model for Berkeley

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11.23.21

I'd appreciate it if you would circulate the attached memo to members of the Mental Health Commission, to members of the Homeless Commission, to members of the Task Force for Reimagining Public Safety, and to others on the distribution lists for documents related to these groups.

Edward Opton

November 23, 2021

To: Berkeley Mental Health Commission
Berkeley Homeless Commission
Task Force for Reimagining Public Safety

The Bend, Oregon, crisis stabilization model, as described in the Berkeley Homeless Commission's resolution of October 13, 2021, has a number of features that look promising. The Bend model could be a welcome replacement for part or all of Berkeley's current reliance on Santa Rita Jail and the John George Psychiatric "Hospital" in "5150" situations. (I have placed "Hospital" within quotation marks because it appears that John George, from the perspective of its 5150 services, may be a hospital in name only.)

Much remains to be learned before Berkeley can make a well-reasoned decision to adopt one model or another. Important issues include:

1. Is Oakland's Amber House available to Berkeley residents, housed and/or unhoused?

2. Does the Berkeley Police Department ever take people to Amber House? If so, how frequently? If not, why not?

2. If so, under what financial arrangements?

3. If Amber House is closed to Berkeley residents because of its limited capacity, could it be expanded?

4. How do Amber House's services, funding, and rules differ from those of the Bend facility?

5. In what ways do Amber House and the Bend facility differ from other similar and somewhat similar programs, as, for example, the facility in Louisville, Kentucky?

6. Do City of Berkeley staff have the time and resources to research issues such as those listed above?

7. Are City of Berkeley staff interested in collaborating with members of the Mental Health and/or Homeless Commissions or members of the Task Force for Reimagining Public Safety on these and related issues?

Edward Opton, Ph.D., JD
Member, Mental Health Commission and Task Force for Reimagining Public Safety

Works-Wright, Jamie

From: Klatt, Karen
Sent: Monday, November 29, 2021 1:55 PM
To: Berkeley/Albany Mental Health Commission
Subject: Free Mental Health Apps for the Berkeley Community
Attachments: Berkeley Mental Health App Campaign Toolkit.final.pdf

Greetings Mental Health Commissioners!

The Mental Health Division, City of Berkeley is excited to make available mental health apps to the community. We are hoping you will partner with us on getting the word out about this exciting opportunity. Anyone 13 and over who works, lives or attends school in Berkeley can access these free mental health resources. We are attaching a toolkit to this email that you can use to promote the apps, and you can email MHApps@CityofBerkeley.info if you have any questions. Below is the community message we are promoting, that explains the apps and the opportunity. Please consider spreading the word and utilizing the toolkit to promote this opportunity.

Anyone at least 13-years-old who lives, works or attends school in Berkeley can now use one of two apps for free to help navigate issues ranging from depression and substance abuse to a more general support around mindfulness and meditation.
These two widely-used apps can help develop daily practices and habits that have the potential to provide a space of solace, address a long-standing struggle or simply lower stress.
No one tool can address all of a person's individual needs. But the goal is that these two differing apps – myStrength and HeadSpace – can provide stepping stones on a path toward greater emotional well-being.
The state provides almost all of the funding for Berkeley Mental Health with a mandate to help those with the most serious needs in our community. The division – one of only two operating at the City level in California – joined this state-funded, multi-county initiative to help address mental health issues that are even more pronounced during the pandemic. This initiative allows for providing support to a much larger population than the Mental Health Division usually serves.
Sign up for one or both apps. And spread the word – we never know who may be struggling and could use some support.

myStrength app: Access proven mental health interventions

The MyStrength app provides personalized and interactive activities that address depression, anxiety, stress, substance use, chronic pain and sleep challenges. The individually tailored program is designed to empower users and also supports the physical and spiritual aspects of whole-person health.
The myStrength experience is based on clinical models like cognitive behavioral therapy, acceptance and commitment therapy, positive psychology, mindfulness, and motivational interviewing – proven interventions that have helped millions improve and sustain health and wellbeing.

Headspace app: Access meditation, sleep and movement exercises

The Headspace app is a popular online meditation and mindfulness resource. The app's library of exercises can help manage anxiety, encourage stress relief, increase focus, enhance sleep and improve mood.
Additional features include meditation reminders, tracking your practice statistics, and inviting a buddy to join and meditate together. Meditations for children are also available, though only those at least 13-years-old can sign up.

Sign up for one or both apps

For either app, you must be at least 13-years-old. Start by visiting the Help@Hand website

1. For myStrength subscription (active until Oct. 31, 2022)
    a. Scroll down and select the myStrength button

b. Complete the myStrength sign-up process, use access code: cityofberkeley and set up your profile.

2. For Headspace subscription (active until Sept. 30, 2023)
    a. Scroll down and select Headspace button
    b. Complete the Headspace sign-up process, enter "Berkeley" and your zip code where you work, live or go to school, and set up your profile.

Improving mental health in Berkeley

Help@Hand, a multi-County collaborative, originated the project. The total cost for this state-funded project is $462,916, which covers the development, coordination, licenses for the apps, and evaluation of the project.
Having our own Mental Health Division gives the City of Berkeley the freedom to tailor services closer to our community's needs. Berkeley's mental health has a significant focus on increasing access to mental health services, offering walk-in hours, operating a daytime mental health crisis line, and, for several decades, having a mobile crisis team to help people suffering from mental health crises. Many of the programs are primarily aimed at individuals with serious mental illness and major impairments and who have Medi-Cal or no insurance.
The COVID-19 epidemic has increased isolation and limited access to mental health services for many Berkeley residents. The partnership with myStrength and Headspace is an exciting expansion of benefits available to the community. This platform, open to all Berkeley community members, builds upon our existing effort to provide access to mental health information and resources.
Improving your mental health will make you, the people you care about, and our community stronger. Sign up and spread the word about these free online mental health resources.
"Downloading the apps are just the start," said Grolnic-McClurg, the Berkeley's Mental Health division manager. "We hope people will use these apps to develop sustainable habits and practices to nurture and protect their emotional health."

Links

- myStrength and Headspace sign-up page
- City of Berkeley Mental Health Division

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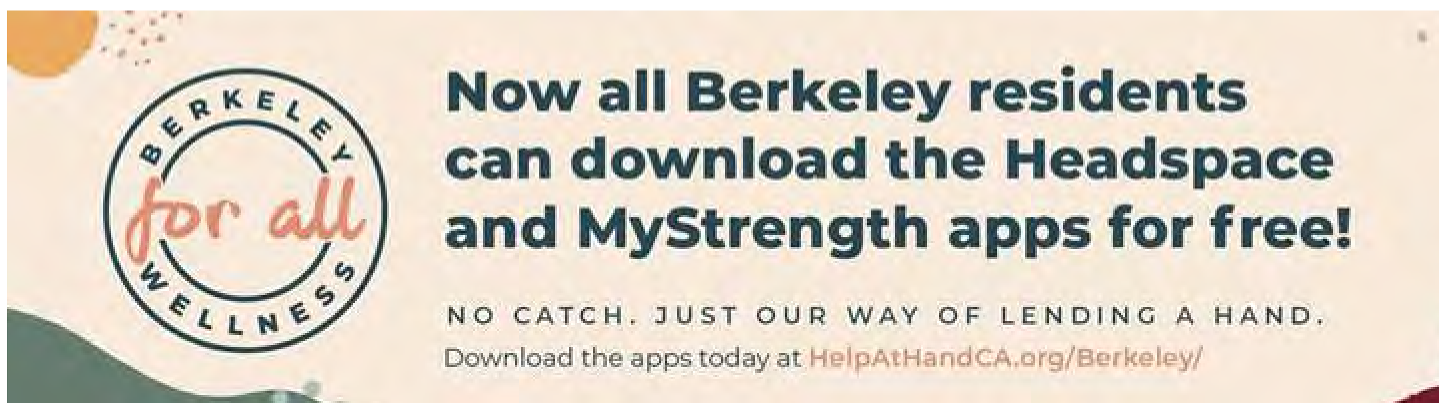
KKlatt@cityofberkeley.info



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CITY OF BERKELEY MENTAL HEALTH DIVISION
BERKELEY
WELLNESS
for all
2021 - 2022 PARTNER TOOLKIT
NOVEMBER 2021
UptownStudios

BERKELEY

WELLNESS *for all*

PARTNER TOOLKIT

Welcome to the Wellness For All Partner Toolkit presented by the City of Berkeley's Mental Health Division. This toolkit has been created to help community leaders and organizations encourage Berkeley residents to take advantage of the City's newest program, designed just for those who live, work, or go to school in Berkeley. The City of Berkeley has partnered with two well-known self-care apps, Headspace and myStrength. Headspace is a guided meditation, sleep aid, fitness, and focus-assistance app, whereas myStrength is an app focusing on providing emotional support for life's challenges. Each resident, worker, and student (over age 13) has been gifted Headspace access through September 2024 and myStrength access through October 2023. With your help in spreading the word, each and every person in Berkeley can kick-start their self-care journey as soon as they download the apps!

As trusted neighborhood leaders and community connectors, your help is our next step in bringing the gift of free self-care to Berkeley. With your help, everyone in Berkeley can begin to create their own lasting wellness habits to take them through the pandemic and beyond.

Within this Partner Toolkit, you will find the following resources to educate and encourage community members to download the apps and take the first step towards a much-needed reset:

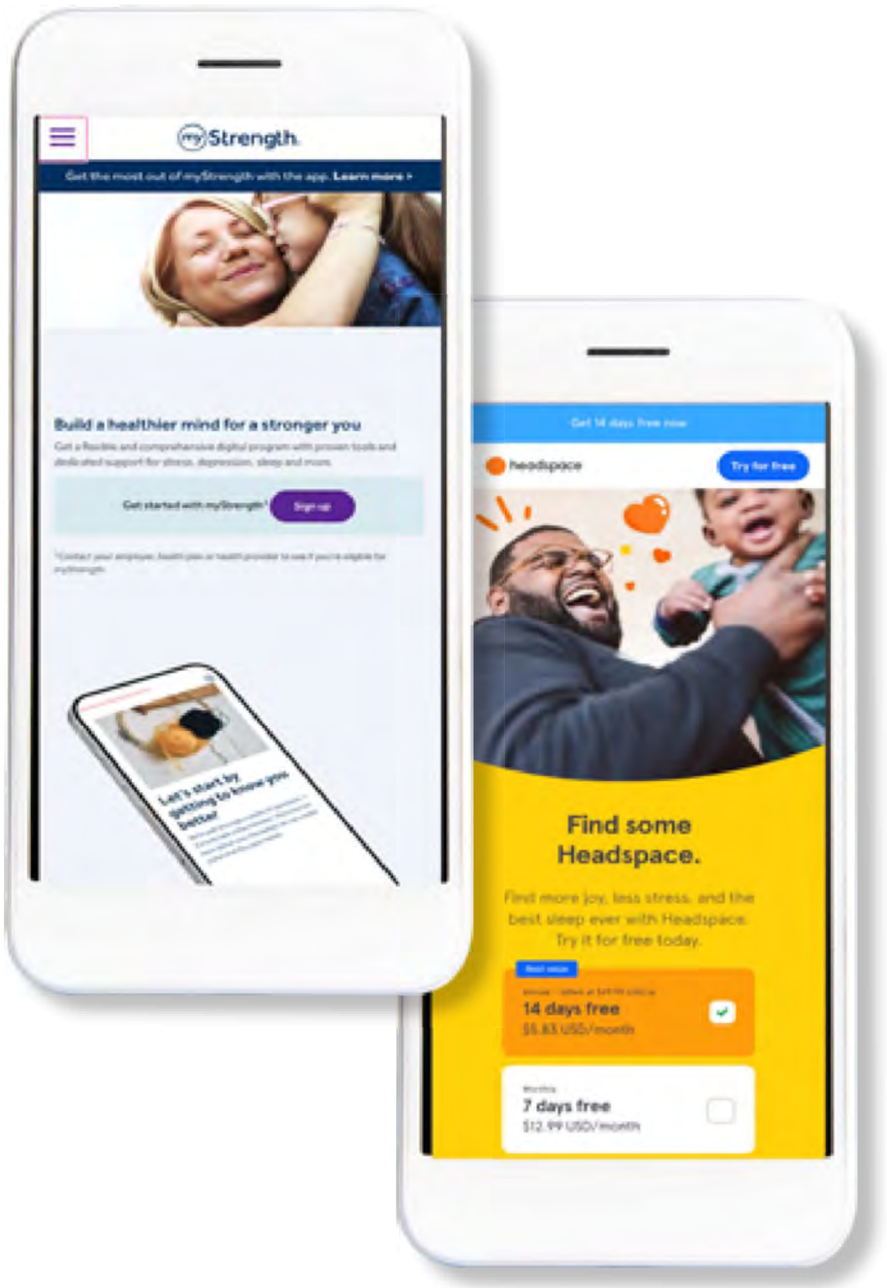
+ The who, what, where, when, and why of the Wellness For All campaign
+ 8.5 x 11 printable flyer
+ Social media posts and graphics
+ Eblast content for emails and e-newsletters

WHAT IS THE WELLNESS FOR ALL PROGRAM?

Headspace for Berkeley comes with a free subscription through September 2023. The app is centered around easy guided meditations, but also provides ways to get your body moving each day, help to focus when things get hectic, and a myriad of options to help you fall and stay asleep. myStrength for Berkeley offers a free subscription through October 2022. myStrength offers programs for life's evolving challenges through emotional health support designed for you, providing access to a licensed therapist seven days a week without ever visiting an office.

Better self-care isn't a want, it's a need. Everyone needs self-care, especially during a pandemic. This program encourages all residents, workers, and students to create better self-care habits. Whether you are a self-care beginner, a meditation master, or just don't know where to start, the Wellness For All program seeks to offer a hand to any and all in Berkeley. There's no dress code, no paying for parking, and no copayments. No minimum. No maximum. Just free self-care apps that can help calm, maintain, move, sleep, focus, and tackle whatever life throws your way. Click on the button below to download the apps today!

Download Apps Here



WHY GET INVOLVED?

Everyone could use a little wellness.

WE'VE ALL BEEN THERE.

Whether it was a rough week or just an off day, it happens to all of us. Sharing the free tools that Wellness For All provides might be exactly what someone needs to turn their week around. You could be giving an incredible gift, just by letting someone know that Wellness For All exists.

GIVE YOURSELF A BREAK.

A recent study showed that only ten days of Headspace increased self-compassion. Add that to the 96% of myStrength users who enjoy using the app and you've got a perfect vacation from life's twists and turns.

WELLNESS FOR ALL IS AS UNIQUE AS YOU ARE.

If you are looking to explore self-care at your own pace, Wellness For All is for you; it's both private and customizable. Try Headspace's sleepcasts for better sleep or check out myStrength for suggested coping skills if you want advice on ways to manage an issue.

CAMPAIGN SOCIAL MEDIA LINKS

Please use the following information when posting about the campaign on social media to help us keep a consistent message and look. Make sure to tag your posts with our hashtag!

CAMPAIGN HASHTAGS
#WellnessForAllBerkeley

CAMPAIGN URL
HelpAtHandCA.org/Berkeley

CAMPAIGN FACEBOOK
/BerkeleyWellnessForAll

CAMPAIGN INSTAGRAM
@WellBerkeley

CAMPAIGN TWITTER
@WellBerkeley

PRINTABLE CAMPAIGN FLYER

Download and use the printable flyer to educate the Berkley community on the importance of their mental health, and how to download these free applications provided by the City of Berkeley.

Download Flyer Here

BERKELEY

WELLNESS *for all*

The Pandemic has taken a toll on all of us. Let's reset together.

The City of Berkeley is giving every person living, working, or going to school in Berkeley a free subscription to Headspace until September 2024 and myStrength through October 2023.

SELF-CARE ISN'T A WANT, IT'S SOMETHING WE ALL NEED.

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Download the apps today at HelpAtHandCA.org/Berkeley/

SOCIAL MEDIA CONTENT

Encourage others to spread the message about the importance of mental health and self care. Share the following posts on your social media channels to promote the City of Berkley's Wellness For All Campaign.

Download Posts Here

Facebook | LinkedIn | Twitter

Instagram

The Pandemic has taken a toll on all of us. Let's reset together with Wellness For All. Free self-care apps for every person working, living, or going to school in Berkeley. Download the apps today and your subscription for Headspace is on us until September 2024 and myStrength until October 2023 **#WellnessForAll**

Download the Apps Today!
HelpAtHandCA.org/berkeley/

Take back your day with Wellness For All. Free self-care apps for every person working, living, or going to school in Berkeley. Visit **HelpAtHandCA.org/berkeley/** to activate your subscriptions and download Headspace and myStrength!

#WellnessForAll

SOCIAL MEDIA CONTENT

Encourage others to spread the message about the importance of mental health and self care. Share the following posts on your social media channels to promote the City of Berkley's Wellness For All Campaign.

Download Posts Here

Facebook | LinkedIn | Twitter

Instagram

Bad days don't discriminate. Start your wellness journey today for free with Wellness For All. Sign up to get Headspace on us until September 2024 and myStrength until October 2023!

HelpAtHandCA.org/berkeley/ **#WellnessForAll**

EMAIL BLAST CONTENT

Download and use the eblast content and graphic to educate Berkley community on the importance of their mental health, and how to download these free applications provided by the City of Berkeley.

Email Content

Wellness For All program delivers free self-care for every person living, working, or going to school in Berkeley.

The Pandemic has taken a toll on all of us. It's created unique boundaries and an entirely new way of living our lives, at times making it difficult to foster the connections and maintain routines that we came to know and love. The City of Berkeley saw this change happening and reached out to some incredible partners to help each person in Berkeley prioritize some much-needed wellness.

Wellness For All is a free program that brings every Berkeley resident, worker, and student a free Headspace subscription through September 2023 and a free myStrength subscriptions through October 2022. If you're looking to meditate, get your body moving, focus when life gets hectic, or just want to fall asleep and stay asleep, Headspace can lend a hand. If some specific, guided help through life's challenges or some coping strategies seem more in order, myStrength is happy to assist.

Let's reset together. **Click here to download the apps today!**

Download Graphic Here

CONTACT INFORMATION

For more information regaurding the Wellness For All Berkeley 2021-2022 mental health awareness campaign for the City of Berkley use these contacts below.

Website

HelpAtHandCA.org/berkeley/

Questions?

CITY OF BERKELEY
Mental Health Division
MHApps@CityofBerkeley.info

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for all
2021 - 2022 PARTNER TOOLKIT
NOVEMBER 2021
UptownStudios

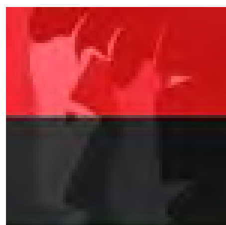
Works-Wright, Jamie

From:	Works-Wright, Jamie
Sent:	Monday, November 22, 2021 8:37 AM
To:	Works-Wright, Jamie
Cc:	Grolnic-McClurg, Steven; Warhuus, Lisa
Subject:	FW: 60 Minutes Segment Tonight - Reimagining Policing & Non-Police Crisis Response

Hello All,

Please see the email below from Margaret Fine, MHC chair

Jamie Works-Wright
Consumer Liaison
Jworks-wright@cityofberkeley.info
510-423-8365 cl
510-981-7721 office



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From: Margaret Fine <margaretcarolfine@gmail.com>
Sent: Sunday, November 21, 2021 9:52 PM
To: Works-Wright, Jamie <JWorks-Wright@cityofberkeley.info>
Subject: 60 Minutes Segment Tonight - Reimagining Policing & Non-Police Crisis Response

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Hi Jamie,

This evening the television news magazine show, 60 Minutes, focused on reimagining policing and non-police crisis response (e.g. SCU) in its first segment. 60 Minutes' journalist, Scott Pelley, covered the episode, entitled "Reimagining Police Department's with Safety and Justice in Mind."

I watched this segment with keen interest and want to pass it along to you, the Mental Health Commissioners, and the Mental Health Division Manager and additional staff that may have an interest. Would you kindly forward this message? It is much appreciated. Thank you so much.

Below I also wrote a summary and provided a link to an article with the segment video and transcript.

Hi All,

I hope you're well.

This evening the first segment of the television news magazine show, 60 Minutes, focused on reimagining policing and non-police crisis response (e.g. SCU).

60 Minutes' journalist, Scott Pelley, covered the episode, entitled "Reimagining Police Department's with Safety and Justice in Mind."

This segment covered the following:

First near the beginning the reporting covered the Center for Policing Equity and its Berkeley study showing the largest policing disparities in low-level traffic stops among different demographic groups here, and stated the City stopped enforcing them. The reporting showed a picture of the Berkeley Police Department building on the corner of Milvia Street, and no police or police cars.

Journalist Scott Pelley discussed these above points and additional policing reforms through his interview with Professor Philip Atiba Goff, Carl I. Hovland Professor of African American Studies and Psychology, at Yale University and Co-Founder and CEO of the Center for Policing Equity. Further they discussed defunding, and there was also additional reporting on state legislation in Texas that prohibits reducing city police budgets.

The segment then turned to the City of Austin, Texas as an example for policing reforms. The segment reported on how the City Manager shut the police academy down in order to revise the curriculum, including now emphasizing de-escalation for violent situations and a course on race and policing. They also discussed addressing diversity among their police officers. In addition, there was mention the police chief plans to send civilian employees to fender benders, vandalism, or to take reports on auto thefts and burglaries—only 1 percent of calls involve violent crime

The segment reported on the City of Austin as leading the nation in non-police crisis response. Austin answers 911 calls for service with 4 options—police, fire, EMS, or mental health services, which is referred to as the "next evolution in 911." The segment reported that Austin dispatches mental health clinicians when interventions are needed and there is no apparent threat of violence. The segment reported that Austin diverted 3,564 calls away from police in 2021 (so far).

Here is the article with the video segment and transcript:

Reimagining Police Department's with Safety and Justice in Mind

https://www.cbsnews.com/news/police-reform-austin-texas-60-minutes-2021-11-21/

Hope you have a lovely Thanksgiving holiday.

Best wishes,
Margaret

Margaret Fine
Cell: 510-919-4309

Works-Wright, Jamie

From: Kim Nemirow <nemirowkimmy@aol.com>
Sent: Friday, November 19, 2021 1:41 PM
To: Works-Wright@aol.com <Works-Wright@aol.com>; Jamie <JWorks-Wright@cityofberkeley.info>" <Jamie <JWorks-Wright@cityofberkeley.info>
Cc: boonache@aol.com; tescarcega53gmail.com@aol.com
Subject: Fwd: Equal Protection of the Law- Mentally Ill Citizens

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Jamie

Please include this in the upcoming MH Commission Packett
Margaret is planning to allow a five minute presentation on the issue
so the submission is for an agenda item

To: Chief Louis
cc: Officer Cummings Internal Affairs
Fr: Kim Nemirow
Re: Complaint and Commentary Alleging Unequal Enforcement
of Law- and ADA non Compliance

I spoke with Officer Cummings of BPD today regarding my complaint detailing the refusal of BPD Officer Phelps (#153) to assist an intoxicated or drug altered mentally ill individual out of the middle of the sidewalk on San Pablo Avenue at Harrision Street. In instances to innumerable to recount combined with anecdotal accounts reported to me by others- BPD officers increasingly in the last decade and with a sharp spike after the Chauvin trial and verdict- are refusing to render aide, provide 51.50 evaluations in compliance with the actual mandates and case law of that legislation, and refusing to protect- many homeless and mentally ill citizens in Berkeley.
In discussion with Officer Cummings, I was treated, as I always am by BPD with cordiality, respect and clarity in communication, but beyond how I was treated, I am left horrified, gutted at the core of my moral conscience and soul- to hear Officer's Cummings primary response to my complaint.
It was explained to me that there is "no legal duty" of police in this country to PROTECT citizens And after reading several legal commentaries and factual renditions of the infamous Supreme Court case which Scalia's majority decided that police officers are under no duty to protect any citizen against harm- and the string of cases proceeding from that ungodly ruling- I am still aware of three points of leverage to REQUIRE BPD (and of course other police departments) to protect its citizens and particularly its most vulnerable citizens.
And lest this commuication be taken as an academic exposition on the duty to protect and serve I want the readers to know that facing this issue is the functional equivalent to me of watching European citizens and SS Guards sympathetic to mass suffering do nothing- to ensure that evil prevails.

Those points are as follows:

1) Disparate or Unequal Application or Enforcment of Law

* While police are under no duty to enforce the law to protect citizens they MAY NOT UNEQUALLY ENFORCE THE LAW. So that if a mother or grandmother or child of a wealthy person in the hills or the like- is intoxicated or mentally impaired and is lying in the road or crossing against traffic or refuses to get up as she is strew across a sidewalk consistently refusing or unable to appreciate the need to get up to avert oncoming bikes or motorized bikes or skateboards- and the police place her on a hold or assist her in moving and then refuse as is now typically the case to touch or handle or suceed in counselling a likewise impaired homeless person with symptoms of mental illness- that is not only UnConstiutional, but a potential

source of liablity if the person not afforded appropriate assistance or a welfare check is then injured.

2) ADA- Adherence to the Mandates of the ADA in Police Encounters

* While the rendering of assistance or aide may be refused- though not selectively on the basis of status- IF officers make contact with a person whom they have reason to believe or know has a mental illness or is experiencing symptoms of mental illness or drug or alcohol induced psychosis or delirium or functional impairment serious enough to render them unable to appreciate the threat that their behavior actually or likely poses to themselves- then the requirements of the ADA mandate that officers who make reasonable efforts to communicate the risk or threat a mentally or substance abuse impaired person presents to themselves- those officers must take into account in a real and appreciable way- that the capacity of the person to understand their circumstances is so impaired- that they must, to accomodate that individual- either act to reduce or annihilate the threat- or act to place that person under a 51.50 LPS hold.

The ADA argument is fairly simple: if another individual not mentally or emotionally or chemically or neurologically impaired- were by accident or another form of impediment placed in a position of peril the police would offer assistance communicated and understood in terms appreciated by a reasonable person standard. But if a person who is similiarly at risk by virtue of not appreciating the risk involved then either the form of communication must accomodate the mentally , emotionally , neurologically or chemically impaired individual or the accomodation that must take place must stand in the place of that person's judgement and decision making to compensate for their failure to fully appreciate their circumstances.

I can think of almost no circumstance where the mental status of a person relative to 51.50 is not called into question if they "refuse assistance" or "medical help" by placing themselves or continuing to place themselves in harms way- to the extent that the risk of injury or gbi or death is unreasonable. The out liers involve those strangely grey areas of assuming risk or injury for a reason or basis not directly linked to mental illness- such as in a protest or by a person terminally ill but not diagnosed or evidencing mental illness.

I personally endure half a year of watching a neighbor in the process of dying in his bed from two chronic untreated medical conditions- who was on meth and otherwise mentally ill- as a virtual parade of APS workers, IHSS staff, Sergeants, Fire, and Medical Transport paraded by his window as he screamed in pain- in a urine filled matress not dressed- with his eyes and face swollen from conjestive heart failure- being brought groceries through the window- until Francesa Tannenbaum of MHAAC finally wrote a compelling letter persuading BPD and inter-departmental decision makers that indeed my neighbor was gravely disabled within the meaning of LPS. My neighbor was repeatedly brought back to his unit apparently unable to survive or care for himself until one day he forgot a pot on the stove and nearly died in in an inferno.

It is beneath the dignity and intelligence of BPD officers to pretend to themselve or the public that my neighbor understood or meaningfully appreciated his circumstances and was in a position to make decisions to care for himself. It is utter insanity to suggest that his untreated diabetes, conjestive heart failure, de facto blindness, schizo affective disorder, meth intoxication and presenting symptoms placed him a postion to "CHOOSE to refuse aide or choose to die in his bed or choose to set the building on fire.
A child standing in front of his window would not be moved by his ability to tell them how many coins are in a dollar or who the President is- to believe my neighbor understood and appreciated his condition and the threat of gbi or death his condition presented increasingly to himself. And I hope I am never stupid enough to continue listening to a dispatcher or supervisor condescend to me to explain to me that a man I know to be psychotic in a street or on a sidewalk in harms way is simply "choosing" to be there.

Common sense has left Berkeley as long time ago and is now overtaking first responders.

I recall distinctly when the last medical transport finally arrived prior to the fire to save him from his own bed ridden decline the paramedic saying "someone has to take a stand for what's right"

If BPD continues to head in the diretion of moral nihilism- and that brand of nihilism that is consistent with Nazi ideology- survival and domination of the strongest- by pretending that those clearly unable to help themselves are similiarly situated to everyone one else and simply '"don't want our help" or more aptly DON'T DESERVE POLICE ASSISTANCE, then I will break rank with my longstanding support and alliance with this division.

I have personally witnessed over one hundred police encounters easily in the last thirty years in Berkeley which were humane, kind, honorable, accomodating, protective and professionally applying and enforcing the law, but I have seen and heard of FAR too many instances of neglect, deliberate indifference, total disregard for the ADA- and the principles driving it- and unequal protection and application of law

It cannot be that BPD has become so afraid of public opinion or so saturated in self interest that it walks away

from situations that IT KNOWS requires intervention, assistance or holds, and leaves people on the streets to get hit by cars or bikes or left to die unable to care for themselves. It is the essence of cowardice to lack a moral will and conscience- and if Justice Scalia is so lacking- that does not give others the pass to gain the public trust and confidence to ask for public funding - while refusing to to protect and serve ALL members of that public.

Finally there is one more "exception" to the "no duty to protect" ruling:

3) Altering Someone's Position Actually or Potentially

* Any indication by BPD or action or inaction that changes a persons' chance of survival or indicates to them something that is not done which if done would have kept them out of harms way makes BPD liable for any harm that occurs. The famous example in tort law is that of a man drowning who cries out for help and stops trying to reach the shore because someone begins to rescue him and then aborts the attempt. He drowns when he might have made it to shore if he didn't rely on the offer of rescue.

I will be asking the Mental Health and Homeless Commissions to engage the "reimagining policing" initiative by including subcommittee dedicated the onerous task of collecting and analzing data- to compare welfare checks and mental health calls and outcomes of housed and unhoused individuals Just as racial bias in policing - stops and arrests- were discerned by analysis- so can indifference and animus to the "mentally ill" homeless be discerned in disparate treatment.

I will be documenting any and all refusals to render aide or assitance or provide a meaningful welfare evaluation and outcome consistent with the legislative meaning and purpose of LPS to those citizens seemingly or ostensibly incapacitated by mental or emotional illness or chemical dependency.

I will also be asking DREDF what sort of evidence needs to be documented for a class action of homeless persons with known mental health or dependency impairments to bring suit for a refusal to provide them with equal protection and ADA accomodations when they were attacked by others on the streets and the police refused to protect them or when they were hit by automobiles and the police refused to intervene or hosptialize them. I have seen far too many people I knew before they were in wheelchairs struck by cars and wheelchair bound to believe none of those instances were called into BPD and triaged on the bottom of list to respond to.

I am decidely not againt the notion of law enforcement and do not believe in eradicting the police or even any form of excessive defunding, but if law enforcement in Berkeley now means that only the white and wealthy and educated and housed receive intervention and assistance relatie to the their ACTUAL condition or circumstance, then I will be all for defunding.

If it is the discretion of individual officers and vacillation in public policy who lives and who dies and who stands a chance of access to quality of life and who doesn't, then it ought to be the discretion of the public to ask for the removal or replacement of those officers from public duty.

-----Original Message-----
From: Kim Nemirow <nemirowkimmy@aol.com>
To: RCummings@cityofberkeley.info <RCummings@cityofberkeley.info>
Sent: Mon, Nov 15, 2021 12:13 pm
Subject: Fwd: Please Include in MH Packett as Communication from Public

Officer Cummings

Please see below- letter to Chief

-----Original Message-----
From: Kim Nemirow <nemirowkimmy@aol.com>
To: boonache@aol.com <boonache@aol.com>
Sent: Sun, Nov 14, 2021 7:01 pm
Subject: Re: Please Include in MH Packett as Communication from Public

boona

please fwd to include in mh commission packett

-----Original Message-----
From: Kim Nemirow <nemirowkimmy@aol.com>
To: Works-Wright@aol.com <Works-Wright@aol.com>; Jamie <JWorks-Wright@cityofberkeley.info>" <Jamie <JWorks-Wright@cityofberkeley.info>>
Sent: Sun, Nov 14, 2021 6:56 pm
Subject: Fwd: Please Include in MH Packett as Communication from Public

-----Original Message-----
From: Kim Nemirow <nemirowkimmy@aol.com>
To: JLouis@cityofberkeley.org <JLouis@cityofberkeley.org>
Cc: AMcDougall@cityofberkeley.org <AMcDougall@cityofberkeley.org>; VID3577@gmail.com <VID3577@gmail.com>; boonache@aol.com <boonache@aol.com>; berkeleycopwatch@yahoo.com <berkeleycopwatch@yahoo.com>; BPhelps@cityofberkeley.info <BPhelps@cityofberkeley.info>; margaretcarolfine@gmail.com <margaretcarolfine@gmail.com>; eopton1@gmail.com <eopton1@gmail.com>; daphnesflight@yahoo.com <daphnesflight@yahoo.com>; LWarhuus@cityofberkeley.info <LWarhuus@cityofberkeley.info>; s@aol.com <s@aol.com>
Sent: Sun, Nov 14, 2021 6:52 pm
Subject: Re: Intervention Refused for Mentally Imparied Homeless Man

-----Original Message-----
From: Kim Nemirow <nemirowkimmy@aol.com>
To: JLouis@cityofberkeley.org <JLouis@cityofberkeley.org>
Cc: AMcDougall@cityofberkeley.org <AMcDougall@cityofberkeley.org>; VID3577@gmail.com <VID3577@gmail.com>; boonache@aol.com <boonache@aol.com>; berkeleycopwatch@yahoo.com <berkeleycopwatch@yahoo.com>; r@aol.com <r@aol.com>; margaretcarolfine@gmail.com <margaretcarolfine@gmail.com>; eopton1@gmail.com <eopton1@gmail.com>; daphnesflight@yahoo.com <daphnesflight@yahoo.com>; LWarhuus@cityofberkeley.info <LWarhuus@cityofberkeley.info>; daphnesflight@yahoo.com <daphnesflight@yahoo.com>; s@aol.com <s@aol.com>
Sent: Sun, Nov 14, 2021 6:30 pm
Subject: Intervention Refused for Mentally Imparied Homeless Man

To: Office of the Chief- BPD
cc: Officer Andrew McDougall- area coordinator
Fr: Kim Nemirow
Re: Complaint- Refusal to Render Aide to Mentally Ill Homeless Man

On or about 5pm I observed a man in a blanket completely blocking the side walk adjacent to the entrance at McDonalds on San Pablo in Berkeley. The man was positioned almost horizontally across the side walk at a slight angle where it was possible for pedestrians in single file to walk past him but impossible for a motorized bike, or scooter or non motorized bike to pass him without hitting him.
That area of San Pablo sees a great deal of foot traffic day and night . The way the man was positioned it was not possible to see his head from the Northerly direction and he his body could easily be confused with the blanket he was using- To say- anyone approaching could easily involuntarily drive right over him. And many, intoxicated or indifferent might drive over him whether or not they suspected that a person was under the blanket.
In fact, I had to stop one bike that indeed was approaching him rapidly and he dismounted.
When I contacted BPD, there was a long wait. I finally called back and was told that officer Badge 153 refused to assist in moving the man from this position- which presumably could be done without making physical contact. The reason given- as it was relayed to me by dispatch was that the police already checked on him

and he refused medical help.
However, the call I made was not directed at his medical condition but that he was a current risk to himself in the manner in which he collapsed on the sidewalk. I did not ask for a 51.50 evaluation but simply that police effect a removal of him from the MIDDLE of the SIDEWALK as it placed his safety in jeopardy- apparently.
The supervisor of dispatch in her infinitely superior wisdom attempted to explain to me that " the man " CHOSE" to lie down on the sidewalk and therefore there was nothing anyone could do- as we cannot control what others do" . And I, in my infinite stupidity attempted to explain to her that a man well known for being ostensibly psychotic or otherwise impaired through drug and alcohol into a delirium was not in a position to CHOOSE to lie across a sidewalk at night in a highly trafficked area.
And come to think of it- I cannot imagine anyone who is not a threat to themselves of "sound mind and body" who elects knowingly and voluntarily to place their body across a sidewalk but for in a protest where others are present to safeguard the prone person or persons.
So this is what much of what policing has come to for the gravely impaired in Berkeley. Now instead of being required to relocate to safety or being evaluated for being a danger to himself- we have a live and let die philsophy that some beat officers have adopted
I am hurt and disgusted by the attitude and refusal to render assistance. It is beneath this department to showcase a kind of deliberate indifference that has developed over the last few decades as the situations on the streets have grown more dire- police are withdrawing.
I have encountered MUCH WORSE scenarios where officers simply refuse to intervene.
In one such encounter in West Berkeley, a woman was barely dressed and holding onto an oncoming train at the Amtrack Station as it approached and slowed down to prevent injury.
An officer, with whom I otherwise had a good repore, told me that if she refused assistance there is nothing that BPD can do.
I don't know how to put this politely. So forgive my New York slang- that is utter bullshit.
The police are fully charged to protect those unable to protect themselves even as against themselves and their own will. We all know that- its not a news flash.
Whatever is preventing BPD from intervening and using its discretion to allow a mentally ill person to remain in peril- in any meaningful sense of the that word- has to stop.
This isn't a game or a pick and choose who we will assist exercise of preference or judgment.
The fact that some BPD officers are willing to disregard the safety of some people is a status based offense. BPD officers are required to protect all citizens- and not just those who happen to ask or cooperate with assistance. And again, we all know this.

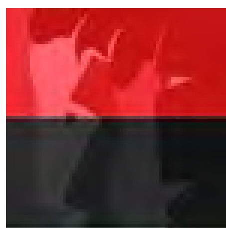
Works-Wright, Jamie

From: Works-Wright, Jamie
Sent: Thursday, November 18, 2021 9:01 AM
To: Works-Wright, Jamie
Subject: FW: MHSA INN Encampment-based Mobile Wellness Center Project

Hello Commissioners,

Please see the email below.

Jamie Works-Wright
Consumer Liaison
Jworks-wright@cityofberkeley.info
510-423-8365 cl
510-981-7721 office



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From: Klatt, Karen
Sent: Thursday, November 18, 2021 8:42 AM
To: Klatt, Karen <KKlatt@cityofberkeley.info>
Subject: MHSA INN Encampment-based Mobile Wellness Center Project

Greetings!

Your input and comments are invited on the **Mental Health Services Act (MHSA) Innovations (INN) Encampment-based Mobile Wellness Center Project** which has been posted on the website for a 30-day Public Review and Comment period. To view the proposed plan, click here.

The 30-day Public Review and Comment period is being held from Thursday, November 18 through Friday, December 17 to provide an opportunity for input on the proposed project. Please share widely with anyone who may be interested in providing input into the proposed project plan. Following the end of the 30-day Public Review period, a Public Hearing will be held at the Mental Health Commission meeting on the evening of Thursday, January 27 at 7:00pm. Information on how to attend the Public Hearing will be distributed in January.

In order to provide input please respond by **5:00pm on Friday, December 17, 2021** by directing your feedback via email, phone or mail to:

Karen Klatt, MEd
MHSA Coordinator

City of Berkeley Mental Health
1521 University Ave.,
Berkeley, CA 94704
(510) 981-7644 - Ph.
(510) 596-9299 - Fax
KKlatt@ci.berkeley.ca.us

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Greetings!

Your input and comments are invited on the **Mental Health Services Act (MHSA) Innovations (INN) Encampment-based Mobile Wellness Center Project Plan.** A 30-day Public Review and Comment period is currently being held from Thursday, November 18th through Thursday, December 17th to provide an opportunity for community input on this proposed new project.

A Public Hearing on this proposed project will also be held at the Mental Health Commission meeting on January 27th at 7:00pm. Information on how to attend the Public Hearing will be distributed in January 2022.

In order to provide input, please respond by **5:00pm on December 17th** by directing your feedback via email, phone or mail to:

Karen Klatt, MEd
MHSA Coordinator
City of Berkeley Mental Health
1521 University Ave.,
Berkeley, CA 94704
(510) 981-7644 - Ph.
KKlatt@ci.berkeley.ca.us

City of Berkeley MHSA Innovation Project Plan

Encampment-based Mobile Wellness Center

City of Berkeley Mental Health Division

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City Name: City of Berkeley

Project Title: Encampment-based mobile wellness center for Berkeley's unhoused community members

Total Amount Requested: $2,802,400

Project Duration: 5 years

Summary Statement: Pilot an encampment-based mobile wellness center that offers a customizable menu of activities and services (i.e. food/hygiene, service navigation, trauma-informed wellness, and community/enrichment) and is staffed by a team of peers that can offer culturally-specific services, including individuals from encampment communities in Berkeley.

Section 1: Innovation Requirement Categories

General Requirement:

An Innovative Project must be defined by one of the following general criteria. The proposed project:

- ☐ Introduces a new practice or approach to the overall mental health system, including, but not limited to, prevention and early intervention
- ☒ Makes a change to an existing practice in the field of mental health, including but not limited to, application to a different population
- ☐ Applies a promising community driven practice or approach that has been successful in a non-mental health context or setting to the mental health system
- ☐ Supports participation in a housing program designed to stabilize a person's living situation while also providing supportive services onsite

Primary Purpose:

An Innovative Project must have a primary purpose that is developed and evaluated in relation to the chosen general requirement. The proposed project:

- ☐ Increases access to mental health services to underserved groups
- ☐ Increases the quality of mental health services, including measured outcomes
- ☒ Promotes interagency and community collaboration related to Mental Health Services or supports or outcomes
- ☐ Increases access to mental health services, including but not limited to, services provided through permanent supportive housing

Section 2: Project Overview

Primary Problem

What primary problem or challenge are you trying to address? Please provide a brief narrative summary of the challenge or problem that you have identified and why it is important to solve for your community. Describe what led to the development of the idea for your INN project and the reasons that you have prioritized this project over alternative challenges identified in your county.

Approximately 1,100 unhoused individuals live in Berkeley, including both sheltered and unsheltered environments.[1] This represents 1% of Berkeley's total population. Not only is homelessness prevalent in Berkeley, most of the time it is also long-term: of the 1,100, 64% reported that their current episode of homelessness has lasted one year or more. Across the three most recent citywide point-in-time counts (2015-2019), unhoused Berkeley residents consistently identify supportive services, such as benefits/income assistance, rental assistance, or mental health services, as interventions that may have prevented homelessness. These findings indicate gaps in service accessibility, availability, and/or awareness when homelessness prevention is still possible. Moreover, as much as supportive services are needed upstream before homelessness occurs, they grow even more vital when an individual or family becomes unhoused. In recent years, including throughout the six-monthlong community input process that resulted in this project proposal, Berkeley residents consistently name homeless services as a top citywide priority.

Though both direct and supportive services for the homeless population are urgently needed and increasingly funded, take-up among unhoused community members in Berkeley remains low for certain services, particularly mental health services. Berkeley Mental Health (BMH) and the City of Berkeley have funded a wide variety of outreach teams to try and connect unhoused individuals to mental health services, and though these efforts have had some success, there remain a large set of individuals who indicate that they are uninterested in services despite appearing to have mental health conditions. Successfully supporting mental health and wellness for individuals who are not connecting to mental health services remains a gap and a challenge in the service landscape. To address this challenge, this project proposes an innovation at the nexus of **service provision** (by focusing on services that unhoused community members define as supportive of mental health, rather than explicitly and/or exclusively clinical services), **service location** (by bringing services onsite to encampments in Berkeley), and **service providers** (by employing individuals with lived or adjacent experience to homelessness, including individuals from encampment communities in Berkeley).

Proposed Project: Encampment-based Mobile Wellness Center

Describe the INN Project you are proposing. Include sufficient details that ensures the identified problem and potential solutions are clear. In this section, you may wish to identify how you plan to implement the project, the relevant participants/roles within the project, what participants will typically experience, and any other key activities associated with development and implementation.

For its Innovation project, BMH is proposing an encampment-based mobile wellness center that would provide a menu of customizable services to Berkeley's unhoused population. The proposed project was developed using input obtained from community members with lived or adjacent experiences of homelessness during the community program planning (CPP) process. Through in-person and online surveys, 1:1 interviews and virtual community meetings, BMH collected robust input during the CPP process.

[1] https://everyonehome.org/wp-content/uploads/2019/09/2019HIRDReport_Berkeley_2019-Final.pdf

The proposed innovation is embedding a mobile wellness center at encampment locations, with peer-led, customizable services that are supported by members of encampment communities in Berkeley. This combination is an innovative delivery model for services that promote health and wellness, while also being designed for those experiencing homelessness in our communities.

The proposed project adapts existing homeless outreach practices by operationalizing community input in the following ways.

- **Service Provision:** Rather than operating on a blanket assumption that clinical and/or psychiatric services should be prioritized, the wellness center project focuses on services identified by unhoused community members as most supportive of mental wellness. These are not traditional clinical mental health services.
- **Service Location:** The wellness center will be a mobile service center stationed at locations where homeless individuals are staying in Berkeley. By hosting services onsite at encampments and other locations where homeless individuals are staying, outreach transforms from outside-in to inside-out, from sporadic to ongoing, and from disconnected to integrated.
- **Service Providers:** Wellness center staff, including the program manager and peer providers, will include individuals with lived or adjacent experience of homelessness and/or recovery. In addition, the wellness center program will use funds to compensate individuals from encampments to connect consumers to services, incentivize participation among existing and potential consumers, and engage in day-to-day program planning and operations.

While many homeless outreach and/or mobile engagement programs employ peers, and others co-locate services with other agency (i.e. educational) or institutional (i.e. correctional) providers, no program adapts homeless outreach services in the above ways.

As the wellness center will **not** explicitly focus on clinical and/or psychiatric services, the project does not aim to directly increase access to traditional mental health services, nor improve the quality of traditional mental health service provision. Rather, it aims to leverage collaboration with unhoused community members to promote mental health outcomes for the target population through non-clinical means, which may include increases in service referrals, service linkages, and improvement of mental health wellness for participants. Figure 1 below summaries key components of the project proposal.

Figure 1. Innovative Components of Wellness Center Project

Wellness Center Service Provision

> *"It's not a psychiatrist they need, it's not a behavioral modification they need; what they need is the basics of life – the ability to eat, wash themselves, read a book, meditate, drink water, take a walk, be around the people who you want to be around, go to the library. If those things were guaranteed, it would support mental health and head off the cases where people develop more deeply entrenched conditions, where they start evidencing behaviors that people assume are intrinsic – not realizing [these behaviors] are from all the times when they don't know where they will be eating, will they have to eat out of a trash can, if when they sleep will someone kick them in the head."*
>
> **- Berkeley community member experiencing homelessness**

The wellness center will deliver onsite services to Berkeley community members who are unhoused. Proposed services are informed directly from community input, with an emphasis on input from community members with lived experiences of homelessness during the CPP process. While some input did call for outreach that included therapeutic services, much of the input called for supportive services more generally. Table 1 lists the wellness center's proposed service areas:

Table 1. Proposed Service Areas & Service Participants

	Food & Hygiene Services	Benefits Enrollment & Service Navigation	Trauma-Informed Wellness Services	Enrichment & Community Services
Proposed Service Areas	- Mobile showers - Hand-washing - Laundry tokens and/or laundry services - Snacks, water - Toiletries & personal hygiene products	- Benefits enrollment (i.e. Medi-Cal, Medicaid, veterans' services, HUD) - ID/document recovery - Appointment reminders - Transit assistance	- Medication counseling - Meditation & mindfulness - Massage therapy - Music therapy - Stress management counseling - Peer-led wellness services	- Day storage - Community enrichment events - Movement & exercise classes - Guided walks and nature-based enrichment - Community library
Service Estimates	*BMH estimates that up to **250 individuals** will receive food/hygiene services each year, with **5-10%** connecting to outside mental health services via this service area.*	*BMH estimates that up to **150 individuals** will receive benefits/ navigation services each year, with **5-10%** connecting to outside mental health services via this service area.*	*BMH estimates that up to **150 individuals** will receive wellness services each year, with **5-10%** connecting to outside mental health services via this service area.*	*BMH estimates that up to **150 individuals** will receive enrichment services each year, with **5-10%** connecting to outside mental health services via this service area.*

Many of the above food, hygiene, and navigation services are comparable to those commonly provided by homeless outreach treatment teams and/or mobile engagement teams. However, in the mobile wellness center environment, service provision will be directed by the changing needs of the community,

with week-to-week service provision being planned via ongoing conversations with members of encampment communities. For example, while psychiatric and/or therapeutic services are not listed above due both to low take-up of these services among members of the unhoused population in Berkeley historically and a minority of community input requesting these services, community needs may shift, and wellness center staff will adapt service provision as needed. The customizable nature of service provision will be made possible through the provider itself, which will be a local organization with deep expertise across proposed service areas.

Coordination with local partners involved in current homeless outreach efforts will be central to service provision, in order to both build on existing efforts and to mitigate duplicative service delivery. For example, the wellness center program might partner with a local food pantry to coordinate meal delivery efforts to the encampment population. Input from members of the encampment community, those with lived experience of homelessness, and the service provider will also inform service provision in a fluid and iterative way, based on identified needs. This was a central theme of the input received from community members and individuals with lived experience during the CPP process – that services should support wellness in creative ways, without assuming that psychiatric or clinical intervention is appropriate for everyone. Community members shared that service delivery should be adaptive and offer a diverse menu of services.

Target Population. BMH estimates that the wellness center will serve up to 250 unique individuals each year, or roughly 25% of Berkeley's current unhoused population. This estimate is based on annual service data from organizations providing outreach services to the unhoused population in Berkeley. The service estimates vary among service areas, as food/supplies represent a majority of services currently provided, compared to case management or other services. For this reason, the above estimates use the best available data, but still may be an overcount of food/hygiene services and an undercount of other service areas.

BMH expects that individuals served by the wellness center will in large part reflect the demographics of the unhoused population in Berkeley. As described by the most recent point-in-time count conducted in 2019, the target population is predominantly male (66%), non-Hispanic/Latinx (88%), Black/African American (57%), single (vs. families), and does not identify as LGBTQ+ (86%). Around half (48%) of the target population is local and has lived in the community for 10 years or more.

The target population also has significant medical needs: 41% reported a disabling health condition, with 28% reporting chronic health problems. Just under one-half (42%) reported a psychiatric or emotional condition, 32% reported a substance use disorder, and 31% reported PTSD. The proposed design of the wellness center is responsive to these needs in regards to both the *types* of services provided as well as *how* those services are delivered.

Wellness Center Service Location

When the plan was initially developed, the City was planning to have a sanctioned encampment, and has since determined it could not find a place for one, so the mobile wellness center will go to multiple encampment sites, or other locations where unhoused individuals are staying. This means that it can provide onsite services where needed, can move where and if the community it is serving changes locations, but will have a consistent, visible presence wherever homeless individuals are staying. The plan is for the locations of service to remain flexible, as the location of encampments and other locations where homeless individuals are staying is fluid and changes on a regular basis.

The location of the proposed wellness center is one way in which it is intended to feel a part of the community it is serving. The other way this project aims to deliver services from the inside-out rather than

the outside-in is by bringing peers and individuals with lived experience, including individuals residing in the encampment, onboard the wellness center team.

Wellness Center Service Team

A key innovation of this project is that it will recruit and hire peers, or individuals with lived or adjacent experiences of homelessness, to staff the wellness center. In addition, the wellness center will compensate individuals who reside in encampment communities in Berkeley to support wellness center services in a separate capacity.

Since a community-based organization (CBO) will be implementing this project (not BMH), the CBO will hire the positions that will staff the mobile wellness center and will recruit and provide stipends to the individuals from encampment communities in Berkeley who are brought on to support wellness center activities.

While position titles will be adapted and finalized by the CBO during program launch planning, broadly, the wellness center team will consist of a **program director, program manager, peer providers,** and **members of the encampment community**. For the purposes of this project plan, individuals from Berkeley encampment communities who are brought on to work with the wellness center team are referred to as **partners from encampment communities**. This role, modeled on the Community Health Worker role as defined by the California Healthcare Foundation, will have the following core competencies and key duties:[2]

- **Cultural Competency.** Acting as a liaison between the encampment community and the wellness center, partners from encampment communities should represent and be able to communicate the needs of the encampment community. Their input and feedback should inform ongoing processes and programming as part of the wellness center project.
- **Information & Resource-Sharing.** Care for and support consumers by doing things such as sharing information regarding resources, documenting wellness center and service-specific utilization, and supporting the care and education provided by wellness center staff.
- **Social Supports.** Provide social support by being available to listen and talk through problems that consumers are experiencing, and referring them to the appropriate wellness center staff member(s). Onsite referrals from encampment community partners are meant to facilitate introductions and trust-building with wellness center staff.
- **Self-Care Coaching.** Educate consumers about self-care and help them learn self-care skills.

Partners from encampment communities will help encourage participation at the wellness center, help define service needs, and support service provision at the site. It will be up to the CBO implementing this project to define the criteria for this role. This proposal is therefore purposefully not prescriptive in defining eligibility. BMH would like to give CBO bidders an opportunity to leverage their insight and expertise in their proposals to define criteria for recruitment, as well as the training plan for this role.

BMH will defer to bidders to define the number and duration of cohorts of encampment community partners. However, proposals must include a plan for providing stipends and guaranteeing compensation for their work at the center.

[2] California Healthcare Foundation. "Building peer support programs to manage chronic disease: seven models for success." Published Dec 2006. https://www.chcf.org/wp-content/uploads/2017/12/PDF-BuildingPeerSupportPrograms.pdf

Full-time, onsite **peer providers** will coordinate and deliver wellness center services. This is a separate role from the partners from encampment communities. The latter are members of an encampment community who will be stipended, while peer providers will be FTE staff hired by the CBO. Peer providers will be trained in trauma-informed best practices for service delivery. Peer providers will have the following key duties, modeled on best practices set by the National Health Care for the Homeless Council, or NHCHC (these key duties are drawn from community input and cross-walked to NHCHC practices):[3]

- **Outreach/Enrollment.** Assist with enrollment into housing, nutrition, and health insurance programs and entitlements; provide culturally competent enrollment, health education, and outreach services; conduct motivational interviewing and rapport building with potential clients using empowering language and taking the lead from the client; offer friendly and helpful advice based on problems and concerns identified by the client; offer day-to-day survival tips and kits such as first aid, clothing, water, hand sanitizer, etc.
- **Navigation.** Help clients fill out and file paperwork for Medicaid, Medicare, Veterans Services, HUD, local housing authority, prescription coverage, and any other services; follow-up and track individuals experiencing homelessness and/or recently housed; schedule and remind clients of appointments and provide transportation if necessary; facilitate client empowerment to fully engage with all members of their health care team; accompany consumers on medical visits as a source of support; help consumers access needed supports for transitions such as attaining housing.
- **Advocacy/Education.** Develop and utilize connections with community service representatives to help clients get what they need; work with partners from the encampment community to update provider teams about what issues consumers are facing; collaborate with partners from the encampment community in program planning for the wellness center.

BMH expects proposals to include a robust training plan for wellness center staff, including a component for supervision and continuous performance evaluation. Depending on the proposal and the capacity of the service provider, this may involve subcontracting with organizations to provide training services. Stakeholder input emphasized the need for training and oversight, particularly to provide clear pathways for peer-to-peer team-building and conflict resolution. BMH would like to give bidders an opportunity to leverage their expertise to propose training components and performance evaluation modalities, rather than be prescriptive in this proposal as to what that will or should look like.

Finally, a **community of practice** comprised of program staff, consumers, community advocates, and city leaders will meet quarterly to create a learning space to exchange insights and tackle challenges related to the wellness center project. This community of practice may take the form of a formal advisory group or an informal relationship-building space. Following project approval and during the initial project development phase, the provider will work with stakeholders and community members, including unhoused Berkeley residents and homeless outreach staff, to collect input on how they would feel best supported by the community of practice.

Research on Proposed Innovation Project

Describe the efforts made to investigate existing models or approaches close to what you're proposing. Have you identified gaps in the literature or existing practice that your project would seek to address? Please provide citations and links to where you have gathered this information.

[3] Community Health Workers in Health Care for the Homeless: A Guide for Administrators. National Health Care for the Homeless Council, June 2011. https://nhchc.org/

Wellness Centers. Many homeless-serving agencies and community-based organizations in local jurisdictions have implemented wellness centers to deliver a multitude of services. Some localities, such as Victorville in San Bernardino County, are developing large wellness center campuses that will offer medical, recreational, and supportive services to individuals experiencing homelessness.[4] Wellness center campuses are innovative, complex projects with high start-up and operational costs, with service delivery occurring in a brick-and-mortar location. Other cities, such as Los Angeles, provide multiple smaller wellness centers as service access points for the unhoused population.[5]

These examples of brick-and-mortar wellness centers largely operate during weekday business hours, and none of them are located within an encampment itself (although Los Angeles does have centers adjacent to Skid Row). BMH seeks to further innovate on the existing brick-and-mortar wellness center model by proposing a smaller-scale, mobile model that is able to go to multiple encampments.

Mobile Approaches in Healthcare for the Homeless. Generally, mobile models used in healthcare for the homeless (HCH) programs are limited to mobile health clinics, and BMH did not identify current or ongoing examples of mobile wellness centers that are co-located with existing encampments. Mobile health clinics embedded within a local or regional HCH service landscape, on the other hand, are increasingly common and well-researched, with thousands of active mobile health clinics nationwide.[6] One such example is WeHOPE in East Palo Alto, which has a fleet of vehicles delivering mobile homeless services, including onsite hygiene services.[7] The learning goals described in the following section are adapted in part from outcomes often seen in mobile health clinics. In this way, BMH looks to build on emergent learnings from the mobile HCH service landscape.

Peer-led Service Delivery. Integrating peer-led service delivery into mental health, substance use disorder, or homeless outreach programs is an emergent best practice across the HCH service landscape. Peer providers may already be credentialed, or the hiring organization may provide training as part of onboarding or ongoing professional development. In other cases, peers may not receive extensive formal training, or they may be volunteers. Regardless of the specifics of the position or training, a growing body of evidence suggests that the non-hierarchical, reciprocal relationship created between a peer provider and a consumer leads to better health outcomes.[8]

Wellness centers may be staffed by peers, such as the RAMS Inc. Peer Wellness Center in San Francisco.[9] These wellness centers provide many of the same services that BMH is proposing to include in its wellness center. However, though many peer-staffed wellness centers do provide targeted services for people experiencing homelessness, BMH could not find examples of peer teams that formally include individuals from encampment communities on the team.

[4] https://www.victorvilleca.gov/services/homeless-outreach/homeless-land-page/city-iniatives/wellness-recuperative-care-center
[5] https://www.thepeopleconcern.org/homeless-services/
[6] Yu, Stephanie W Y et al. "The scope and impact of mobile health clinics in the United States: a literature review." International journal for equity in health vol. 16,1 178. Published Oct 2017. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5629787/
[7] https://www.wehope.org/mobile
[8] California Healthcare Foundation. "Building peer support programs to manage chronic disease: seven models for success." Published Dec 2006. https://www.chcf.org/wp-content/uploads/2017/12/PDF-BuildingPeerSupportPrograms.pdf
[9] https://ramsinc.org/peer-based/

Learning Goals

What is it that you want to learn or better understand over the course of the INN Project? How do your learning goals relate to the key elements/approaches that are new, changed or adapted in your project?

This project proposes innovations related to the method (peer- and community member-led) and location (encampment-based) of HCH service delivery. The following learning goals reflect what the project seeks to better understand in terms of the potential impacts of these innovations on consumer outcomes: Does providing wellness services onsite, in an encampment environment, make a difference in terms of consumers' self-reported overall health and mental health, and their take-up of other health and mental health services? Does it matter that individuals from the encampment community are brought on-board and compensated to help deliver these services?

These questions are captured in the learning goals in Table 2 below. Target outcomes are listed for each learning goal, as well as the data that will be collected to measure progress toward these outcomes. While the specific data collection modalities may change, particularly as service providers transition from virtual back to in-person services, the survey and other tools listed are exemplars intended to reflect the key outcomes supporting each learning goal.

For each of these learning goals, the data collected by the evaluation team at pre-launch or at program launch will comprise the baseline levels for future evaluation reporting. From a program evaluation perspective, because there is not currently reliable data collection and reporting infrastructure to pull historical data from and provide to the evaluation team, the data collected by the evaluation team during its first data collection cycle will comprise the baseline for the learning goals. This will also provide an opportunity for the evaluation team to develop and calibrate mixed methods data collection tools.

Table 2. Proposed Project Learning Goals

	LG 1. Do onsite wellness center services have an impact on consumers' overall and/or mental health?	**LG 2. Do onsite wellness center services increase take-up of mental health services more broadly among consumers?**	**LG 3. How does having individuals from the community help provide services shape delivery, including satisfaction with services?**
What do we want to learn?	#/% self-reported changes in overall health (+/-) #/% self-reported changes in mental health (+/-)	***New referrals:*** # of new service referrals #/% linkages to services #/% service engagement ***Existing referrals:*** Δ in service engagement for wellness center consumers with prior service referrals	% satisfaction with wellness center services #/% new vs. returning consumers #/% of consumers recruited to wellness center services via partners from the encampment community Δ in service take-up between wellness center consumers & baseline service take-up

How will we learn it?	✓ **Pre/post surveys** measuring consumers' self-reported overall health and mental health ✓ **Focus groups** with wellness center consumers ✓ **Onsite observations** at wellness center location(s)	✓ **Interviews** with wellness center consumers ✓ **Interviews** with wellness center staff ✓ **Interviews** with community-based service providers ✓ Program-level **service referral/linkage data**	✓ **Focus groups** with wellness center consumers ✓ **Focus groups** with wellness center staff ✓ **Pre/post satisfaction surveys** for wellness center consumers ✓ **Onsite observations** at wellness center location(s)

These learning goals, along with the proposed key outcomes and data collection modalities, reflect the intention of the project evaluation to include robust and meaningful stakeholder participation.

Section 3: Regulatory Requirements

Contracting

If you expect to contract out the INN project and/or project evaluation, what project resources will be applied to managing the County's relationship to the contractor(s)? How will the County ensure quality as well as regulatory compliance in these contracted relationships?

BMH will follow all City of Berkeley contracting procedures to implement a Request for Proposal (RFP) process and execute a contract with the chosen vendor. MHSA staff will monitor the contractor's performance to ensure quality and regulatory compliance.

Additionally, in terms of ensuring quality in service delivery, as part of the RFP process BMH will require bidders to demonstrate a clear understanding of current homeless outreach efforts that are underway in the community, and furnish an implementation plan that describes how this project will interface with existing efforts and coordinate with other service providers in the community.

Community Program Planning

Please describe the County's Community Program Planning process for the Innovative Project, encompassing inclusion of stakeholders, representatives of unserved or under-served populations, and individuals who reflect the cultural, ethnic and racial diversity of the County's community.

BMH conducted a series of virtual community outreach events during October – February 2020-21 to meet Community Program Planning (CPP) requirements as part of its MHSA Innovation project development process.

With a core objective of identifying a project to support the mental health needs of unhoused community members, BMH implemented a two-tiered CPP process: first, BMH solicited feedback from individuals with lived experience as well as from community members more broadly; then, BMH engaged providers and advocates working in mental health and homelessness to review and further iterate community input.

As part of the initial CPP process, BMH conducted the following community outreach activities:

- **1:1 phone interviews with individuals with lived experiences of homelessness**
- **Paper surveys**, administered by outreach staff, **for individuals with lived experience of homelessness** who were unable to complete an interview
- **Virtual town hall**, open to all Berkeley community members

- **Online community survey**, open to all Berkeley community members

Following this series of community engagement activities, BMH facilitated multiple working sessions with local homeless outreach providers and advocates. The qualitative data from the initial CPP activities, together with the perspectives of local stakeholders with expertise in housing and homelessness, yielded a rich set of prospective project proposals. Additional internal review by BMH staff and city leadership further refined the Innovation project proposal.

Once the initial draft plan was created, it was reviewed by the Berkeley Mental Health Commission, the Berkeley MHSA Advisory Committee, and the California Mental Health Services Oversight and Accountability Commission (MHSOAC). The plan was then modified based on input received.

Figure 2 below shows the CPP process timeline for the Innovation project plan.

Figure 2. Community Program Planning Timeline

Due to the virtual nature of the Innovation CPP meetings, BMH was unable to obtain consistent demographic data for CPP process participants other than for paper survey respondents (paper surveys were administered to individuals experiencing homelessness).

Among paper survey respondents, 33% of respondents identify as Black or African American and 33% identify as White. Other race/ethnicity response categories are suppressed due to n<10. In terms of gender identity, 71% of respondents identify as men. Other gender identity categories are suppressed due to n<10. While all age categories are suppressed due to n<10, ages of survey respondents were equally distributed across age groups with the exception of lower response rates among respondents aged 18-29.

MHSA General Standards

Using specific examples, briefly describe how your INN Project reflects, and is consistent with, all potentially applicable MHSA General Standards listed below. If one or more general standards could not be applied to your INN Project, please explain why.

- **Community Collaboration.** This project was informed by an extensive community collaboration process. The final project idea was generated directly as a result of the two-tiered CPP process described above.

- **Cultural Competency.** The CPP process centered the perspectives of individuals with lived experiences of homelessness. A result of this is the main framing of this project; namely, that is does not purport to offer explicitly clinical interventions at an encampment site. Community members with lived experience shared nuanced perspectives, many of which called for more accessible opportunities for wellness opportunities and social interaction more holistically. This is what the wellness center proposes – to make services immediately accessible, and to make the center a "generalist" health/wellness endeavor, with a customizable menu of service offerings. Moreover, ongoing program planning will be informed via collaboration between the provider team and unhoused community members, ensuring the services remain relevant and culturally competent.
- **Client & Family-Driven.** Both phases of the CPP process included perspectives from individuals with lived or adjacent experiences of homelessness. These perspectives drove the project planning process and defined the wellness center as a viable project option. Moving from project planning to implementation, the wellness center will remain client-driven because consumer input will inform program planning and service delivery.
- **Wellness, Recovery, and Resilience-Focused.** The proposed project is responsive to the tenets of wellness, recovery, and resiliency. In particular, the learning goals reflect a commitment to long-term monitoring and evaluation of consumer outcomes related to mental health and wellness, as well as service engagement rates (including for recovery services and behavioral health services). Moreover, one of the key ways in which the project aims to support consumer outcomes is by operating as a consumer-led initiative.
- **Integrated Service Experience for Clients and Families.** The encampment-based wellness center will effectively function as a possible entry-point to more specialized services, whether through onsite specialty service providers or via service referrals. This framework means that clients will have the opportunity to access a variety of services coordinated by or in tandem with the wellness center.

Project Sustainability

Briefly describe how the County will decide whether it will continue with the INN project in its entirety, or keep particular elements of the INN project without utilizing INN Funds following project completion.

Through the local evaluation process, community of practice meetings, and conversations with stakeholders and city leadership, BMH will regularly evaluate the wellness center project to ensure that the components that are successful, or the entire project, can continue. Funding for continuation could come from a variety of sources: the City of Berkeley General Fund, MHSA funds, and/or existing special taxes in Berkeley that fund homeless services.

Communication & Dissemination Plan

Describe how you plan to communicate results, newly demonstrated successful practices, and lessons learned from your INN Project. Please list up to 5 keywords or phrases for this project that someone interested in your project might use to find it in a search.

To support community-wide dissemination of project information and lessons learned, BMH will engage stakeholders via online public forums as well as virtual and in-person community meetings. These venues have successfully been used with previous MHSA Innovation projects, and feedback from stakeholders during the CPP process supporting this project largely reflected that community members appreciate diverse opportunities for input and discussion.

If a member of the community is interested in learning more about the project, they can use the following keywords in an Internet search:

- **Keywords:** City of Berkeley MHSA, Berkeley mental health projects, Berkeley wellness center, Berkeley encampment wellness center, Berkeley homelessness outreach

Timeline

Specify the expected start date and end date of your INN Project, the total timeframe (duration) of the project, and include a project timeline that specifies key activities, milestones, and deliverables—by quarter.

Program Year (FY 2021-22 thru FY 2025-26)	***2022***				***2023***				***2024***				***2025***				***2026***			
Quarter	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*	*11*	*12*	*13*	*14*	*15*	*16*	*17*	*18*	*19*	*20*
Phase 1. Project Launch																				
1.1 RFP & Contract Execution, Service Provider	■	■																		
1.2 RFP & Contract Execution, Local Evaluator	■	■																		
1.3 Wellness Center Procurement		■	■																	
1.4 Launch Community of Practice		■	■																	
1.5 Community Outreach & Project Marketing		■	■																	
1.6 Recruitment for Partners from Encampment Community			■																	
Phase 2. Wellness Center Implementation																				
2.1 Community of Practice Quarterly Meeting			■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■		
2.2 Onboarding for Peer Providers			■																	
2.3 Onboarding for Partners from Encampment Community			■	■				■				■				■				
2.4 Wellness Center Staff Training				■	■	■	■	■	■	■	■	■	■	■	■	■	■	■		
Phase 3. Local INN Project Evaluation																				
3.1 Evaluation Plan Finalization			■																	
3.2 Data Collection Tool Development				■																
3.3 Baseline (Pre) Data Collection				■	■															
3.4 Interim Data Collection						■	■			■	■			■	■					
3.5 Interim Evaluation Reporting								■				■				■				
3.6 Final (Post) Data Collection																		■	■	
3.7 Evaluation Report Development																			■	
3.8 Evaluation Report Finalization & Dissemination																			■	■
Phase 4. Sustainability Planning																				
4.1 Sustainability Planning Meetings																■	■	■		
4.2 Continuation Funding Planning																		■	■	
4.3 Dissemination of Project Continuation Decisions																			■	■
Phase 5. Project Close																				
5.1 INN Funding Close-out																				■

Section 4: INN Project Budget & Source of Expenditures

Budget Narrative

Provide a budget narrative to explain how the total budget is appropriate for the described INN project.

The total Innovation funding request for 5 years is $2,802,400, which will be allocated as follows:

Service Contract – Personnel plus non-eval direct costs (81%):	Procurement – Non-recurring costs (9%)	Evaluation – Direct costs (6%):	Administration – Indirect costs (4%):
• $259,600 in FY 21/22 • $504,200 in FY 22/23 • $504,200 in FY 23/24 • $504,200 in FY 24/25 • $504,200 in FY 25/26	• $239,000 in FY 21/22	• $15,000 in FY 21/22 • $35,000 in FY 22/23 • $35,000 in FY 23/24 • $35,000 in FY 24/25 • $45,000 in FY 25/26	• $13,750 in FY 21/22 • $26,950 in FY 22/23 • $26,950 in FY 23/24 • $26,950 in FY 24/25 • $27,400 in FY 25/26
Total: $2,276,400	Total: $239,000	Total: $165,000	Total: $122,000

Personnel costs will total $1,777,500 and will include all salaries and benefits of FTE staff. Personnel cost estimates are based on current-year ranges for similar positions in the Bay Area, based on job market data. The following are the FTE positions that are included in this cost proposal (the cost proposal also includes a .10 FTE director role for administrative and supervisory support):

- 1 FTE Program Manager: $120,000 (salary + benefits)
- 3 FTE Peer Providers: $88,500 per year (salary + benefits)
- .10 FTE Program Director: $9,500 per year (salary + benefits)

Direct costs (less evaluation services) will total $498,900 and will include programming expenses such as materials and supplies, technology, utilities, mileage, stipends, client transportation, subcontractors, etc. Personnel and direct costs combined (81% of the total proposed budget, as shown in the table above) will comprise the RFP funded value for the contracted service provider. The estimated total of the evaluation services contract is listed separately above, and in the budget table below, because BMH will use a separate RFP process to contract for evaluation services. This total needs to be clearly designated apart from the service contract with the selected CBO/service provider.

Evaluation services (direct costs) will total $165,000 over the project lifecycle. The evaluation contract will include evaluation plan development, data collection tool development, data analysis, interim evaluation reporting, annual MHSOAC reporting, and a final evaluation report. While evaluation services comprise 6% of the total project budget, less procurement-related non-recurring costs (which are not relevant to the evaluation scope), evaluation services comprise over 7% of the total INN project budget.

Non-recurring costs will total $239,000:

- $220,000 for procurement (i.e. physical wellness center)
  - BMH will coordinate with the contracted service provider/CBO to identify the best way forward for procurement. For example, the mobile unit may be a single RV, it may be a different type of trailer with a hygiene station and/or shower unit, it may be multiple smaller vans/mobile units, or something else.
  - Programming costs, including any materials required for wellness center activities or to “stock” the center, will be funded through “direct services – programming" (line 5). This is separate from non-recurring costs.

- $14,000 for wellness center technology (e.g. staff workstations and/or laptops and laptop docking stations, phone and tablet chargers, mobile cooling fans, etc.)
- $5,000 for a local, community-based marketing campaign

Indirect costs will total $122,000:

- $8,200 for BMH monitoring and management of the evaluation services contract (line 14).
- $113,800 for the contracted CBO/service provider's administration, monitoring, and management of the Innovation project (lines 2 & 5).

In the "Budget Context – Expenditures by Funding Source and Fiscal Year" table below, indirect costs are reflected in the "administration" category, as indirect costs included in this project plan are administrative overhead costs. Row A1 shows total indirect costs.

Federal Financial Participation (FFP): There is no anticipated FFP.

Other Funding: N/A

Budget by Fiscal Year

BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY*							
EXPENDITURES							
PERSONNEL COSTS (salaries, wages, benefits)		**FY 21-22**	**FY 22-23**	**FY 23-24**	**FY 24-25**	**FY 25-26**	**TOTAL**
1.	Salaries (.1 x PD, 1 x PM, 3 x peer providers)	197,500	395,000	395,000	395,000	395,000	1,777,500
2.	Indirect Costs (admin/overhead)	10,400	20,000	20,000	20,000	20,000	90,400
3.	Total Personnel Costs	207,900	415,000	415,000	415,000	415,000	1,867,900
OPERATING COSTS		**FY 21-22**	**FY 22-23**	**FY 23-24**	**FY 24-25**	**FY 25-26**	**TOTAL**
4.	Direct Costs (programming)	62,100	109,200	109,200	109,200	109,200	498,900
5.	Indirect Costs (admin/overhead)	2,600	5,200	5,200	5,200	5,200	23,400
6.	Total Operating Costs	64,700	114,400	114,400	114,400	114,400	522,300
NON-RECURRING COSTS (equipment, technology)		**FY 21-22**	**FY 22-23**	**FY 23-24**	**FY 24-25**	**FY 25-26**	**TOTAL**
7.	Wellness center procurement	220,000	-	-	-	-	220,000
8.	Wellness center technology	14,000	-	-	-	-	14,000
9.	Marketing	5,000	-	-	-	-	5,000
10.	Total Non-recurring costs	239,000	-				239,000
CONSULTANT COSTS / CONTRACTS (Evaluation contract)		**FY 21-22**	**FY 22-23**	**FY 23-24**	**FY 24-25**	**FY 25-26**	**TOTAL**
11.	Direct Costs	15,000	35,000	35,000	35,000	45,000	165,000
12.	Indirect Costs (admin/overhead)	750	1,750	1,750	1,750	2,200	8,200
13.	Total Evaluation Costs	15,750	36,750	36,750	36,750	47,200	173,200
OTHER EXPENDITURES (please explain in budget narrative)		**FY 21-22**	**FY 22-23**	**FY 23-24**	**FY 24-25**	**FY 25-26**	**TOTAL**
14.							
15.							
16.	Total Other Expenditures						
BUDGET TOTALS		**FY 21-22**	**FY 22-23**	**FY 23-24**	**FY 24-25**	**FY 25-26**	
Personnel (line 1)		197,500	395,000	395,000	395,000	395,000	1,777,500
Direct Costs (lines 4 and 11)		77,100	144,200	144,200	144,200	154,200	663,900
Indirect Costs (lines 2, 5 and 12)		13,750	26,950	26,950	26,950	27,400	122,000
Non-recurring costs (line 10)		239,000	-	-	-	-	239,000
Other Expenditures (line 16)		-	-	-	-	-	-
TOTAL INNOVATION BUDGET		**527,350**	**566,150**	**566,150**	**566,150**	**576,600**	**2,802,400**

BUDGET CONTEXT - EXPENDITURES BY FUNDING SOURCE AND FISCAL YEAR (FY)							
ADMINISTRATION:							
A.	**Estimated total mental health expenditures for ADMINISTRATION for the entire duration of this INN Project by FY & the following funding sources:**	**FY 21-22**	**FY 22-23**	**FY 23-24**	**FY 24-25**	**FY 25-26**	**TOTAL**
1.	Innovative MHSA Funds	13,750	26,950	26,950	26,950	27,400	122,000
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding*						
6.	**Total Proposed Administration**	13,750	26,950	26,950	26,950	27,400	122,000
EVALUATION:							
B.	**Estimated total mental health expenditures for EVALUATION for the entire duration of this INN Project by FY & the following funding sources:**	**FY 21-22**	**FY 22-23**	**FY 23-24**	**FY 24-25**	**FY 25-26**	**TOTAL**
1.	Innovative MHSA Funds	15,750	36,750	36,750	36,750	47,200	173,200
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding*						
6.	**Total Proposed Evaluation**	15,750	36,750	36,750	36,750	47,200	173,200
TOTAL:							
C.	**Estimated TOTAL mental health expenditures (this sum to total funding requested) for the entire duration of this INN Project by FY & the following funding sources:**	**FY 21-22**	**FY 22-23**	**FY 23-24**	**FY 24-25**	**FY 25-26**	**TOTAL**
1.	Innovative MHSA Funds	527,350	566,150	566,150	566,150	576,600	2,802,400
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding*						
6.	**Total Proposed Expenditures**	**527,350**	**566,150**	**566,150**	**566,150**	**576,600**	**2,802,400**
*If "Other funding" is included, please explain.							

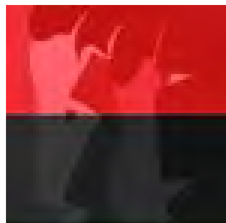
Works-Wright, Jamie

From: Works-Wright, Jamie
Sent: Wednesday, November 17, 2021 1:56 PM
To: Works-Wright, Jamie
Subject: FW: Request for Input to Develop Crisis Stabilization Presentation - Mental Health Commission Meeting, December 16, 2021

Hello Commissioners,

Please see the email below from Margaret Fine

Jamie Works-Wright
Consumer Liaison
Jworks-wright@cityofberkeley.info
510-423-8365 cl
510-981-7721 office



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From: Margaret Fine <margaretcarolfine@gmail.com>
Sent: Wednesday, November 17, 2021 12:57 PM
To: Works-Wright, Jamie <JWorks-Wright@cityofberkeley.info>
Subject: Request for Input to Develop Crisis Stabilization Presentation - Mental Health Commission Meeting, December 16, 2021

WARNING: This is not a City of Berkeley email. Do not click links or attachments unless you trust the sender and know the content is safe.

Hi Jamie,

I hope you're well. Would you please be so kind and send this email to the Mental Health Commissioners? Thank you so much.

Dear Mental Health Commissioners,

I hope you're well.

As you know we will be having a presentation on behavioral health crisis systems, and specifically crisis stabilization programs, in Alameda and Deschutes Counties on Thursday, December 16, 2021 at 7 pm.

I would like to ask for your input for this presentation by the end of November so our presenters can prepare for it. We will also have ample time set aside for questions and discussion.

Please feel free to call me or send your input to Jamie. Thanks so much.

Best wishes,
Margaret

Margaret Fine
Cell: 510-919-4309

Works-Wright, Jamie

From:	Works-Wright, Jamie
Sent:	Monday, November 15, 2021 1:41 PM
To:	Works-Wright, Jamie
Subject:	FW: COB Notice: Opportunity to Comment on Proposed Changes to ESG-CV Expenditures
Attachments:	10-29-21_CM_ESG-CVReallocationMemo_signed.pdf; Nov21_ESG-CVChanges_PublicNotice_ConPlanAmendment3_Translated.pdf

Hello Commissioners,

Please see the information below and attached.

Thank you for your time.

Jamie Works-Wright
Consumer Liaison & Mental Health Commission Secretary
City of Berkeley
2640 MLK Jr. Way
Berkeley, CA 94704
Jworks-wright@cityofberkeley.info
Office: 510-981-7721 ext. 7721
Cell #: 510-423-8365

From: Babka, Rhianna
Sent: Monday, November 15, 2021 1:27 PM
To: Babka, Rhianna <RBabka@cityofberkeley.info>
Subject: COB Notice: Opportunity to Comment on Proposed Changes to ESG-CV Expenditures

Dear Key Stakeholders & Community Partners,

This email contains important information regarding opportunities for public comment on the City's expenditure of Housing and Urban Development (HUD) funds. **Please post and/or distribute the attached flyer to your program participants, commissions, community centers, etc.**

The proposed changes to ESG-CV spending described below are also available for public review on the web at http://www.cityofberkeley.info/ContentDisplay.aspx?id=12160.

CITY OF BERKELEY

REQUEST FOR COMMENTS ON ITS
CONSOLIDATED PLAN (2020-2025) AMENDMENT #3 – CHANGES TO EMERGENCY SOLUTIONS GRANT CARES ACT (ESG-CV) FUNDS

The City has opened a comment period during which the public is invited to review and comment on the City of Berkeley's Consolidated Plan Substantial Amendment #3 for Housing and Community Development that covers the period July 1, 2020 through June 30, 2025 including the City of Berkeley's FY 2021 Annual Action Plan, which covers the period July 1, 2020 through June 30, 2021.The comment period will conclude on November 22, 2021.

The City of Berkeley has received $6,648,603 in Emergency Solutions Grant coronavirus (ESG-CV) funding from the US Department of Housing and Urban Development (HUD) made available through the Coronavirus Aid, Relief, and Economic Security Act (CARES Act). The proposed spending for the ESG-CV funds was adopted by City Council after a Public Hearing on September 15, 2020. In response to the ever-evolving coronavirus response, the City has identified a need to shift the ESG-CV expenditure plan, while staying within budget and providing eligible activities.

The CARES Act funds are available for "eligible activities" to prevent, prepare for, and respond to the coronavirus (COVID-19). Eligible ESG-CV activities include street outreach, emergency shelter, homelessness prevention, rapid re-housing, Homeless Management Information System (HMIS) and administration. Specific activities using ESG funding under the CARES Act do not require a public comment period under the City's Citizen Participation Plan but shall, at minimum, be posted on the City of Berkeley's website.

The City is proposing to decrease funds for rapid rehousing and administration, increase funds for emergency shelter and street outreach activities and make no changes to HMIS ESG-CV funds. The following table details both the initial and revised expenditure plans:

ELIGIBLE EXPENDITURES	INITIAL Expenditure Plan	01/21 REVISED Expenditure Plan	11/21 REVISED Expenditure Plan
Rapid Rehousing	$ 2,597,578	$2,591,095	$ 2,160,000
Emergency Shelter and Street Outreach	$ 3,386,165	$3,380,648	$ 4,013,906
Homeless Management Information Systen	$0	$12,000	$ 12,000
Administration (7.5%)	$664,860	664860	$ 462,697
Total	**$6,648,603**	**$6,648,603**	**$ 6,648,603**

At the time of this notice, charges to the revised activities have not yet been incurred by the City, but eligible expenses may be retroactive and reimbursable to contracted agencies as of the beginning of the fiscal year (July 1, 2020) in alignment with the ESG-CV funding as part of the City's Annual Action Plan.

All written comments must be sent to both rbabka@cityofberkeley.info AND CPD_COVID-19WaiverSFO@hud.gov no later than November 22, 2021, at 5:00 p.m.

For more information only email or call Rhianna Babka at the Health, Housing and Community Services Department. Email: rbabka@cityofberkeley.info Phone: 510-981-5410.

Thank you,

Rhianna Babka
City of Berkeley
Housing and Community Services
2180 Milvia Street, 2nd Floor