From Crisis Co-responding to Re-entry:

*Strategies for Criminal Justice Collaboration*

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Experience – Improving Quality in the Face of Healthcare Reform

“Working to help organizations deliver the highest quality care possible, while improving the quality of life for those delivering the care!”

- MTM Services has delivered consultation to over 1,000 providers (MH/SA/DD/Residential) in 49 states, Washington, DC, and 2 foreign countries since 1995.

- **MTM Services’ Access Redesign Experience (Excluding individual clients):**
  - 5 National Council Funded Access Redesign grants with 200 organizations across 25 states
  - 12 Statewide efforts with over 300 organizations
  - Over 30,000 individualized flow charts created
  - Leading CCBHC Set up and/or TA efforts in 5 states
Objectives

1. Developing a common language and understanding to facilitate communication among stakeholders
2. Using Sequential Intercept Mapping (SIM) and GAP Analysis to connect with partners and identify resources, service gaps and barriers to collaboration
3. Identifying best practices that support integrated workflows between community-based services and the Criminal Justice System (CJS)
4. Building a Team Based Model for Crisis Intervention and System transitions that decrease incarceration, recidivism, and increases access to care.
5. Creating a Data Collection Process for evaluation and continuous quality improvement
Behavioral Health and the CJS

- General Population (2017) - 20.6% of American Adults have a MH and 7.7% have a SU challenge
- State Prison – 48% had a MH Condition, 26% had a Substance Use Disorder (SUD) and 24% had co-occurring illness
- General Population (2019) – 3.8% had co-occurring SMI (Schizophrenia or Bipolar) and SUD
- County Jail (Sentenced Individuals only) – 44% had an SMI 63% had an SUD and 45% had co-occurring illness

- **Sentenced individuals in County Jails were 11.8 times more likely than the general population to have co-occurring illness**

A Report by the National Council for Mental Wellbeing for the National Center for State Courts’ National Judicial Task Force to Examine State Courts’ Response to Mental Illness
What Should a Model System Achieve?

• Looking at the big picture – what do we want the System to accomplish?
  • Engagement of Support Services to address Social Determinants of Health … establish hope, resilience and self respect … an ounce of prevention is worth a pound of “cure”
  • Rapid access to Behavioral Health Services in the community … not through incarceration
  • Rapid Response of the right people in a crisis … diverting individuals to treatment, not incarceration
  • Service integration during incarceration and coordinated re-entry to stop the revolving door

• How do we put the pieces together?
What Does a Model System Need to Thrive?

- Community Task Forces Committed to Implementing Change
- Effective Communication
  - Focus on the Facts … data is the common denominator
  - Keep the Discussion Solution Focused
  - Create processes and agreements to share information
  - Implement cross training – CIT, CJS Risk Assessment Tools, Mental Health First Aid
- Integrated, Team Based Approaches
  - Boundary Spanning Team Members
  - Service In reaching … that can work both ways
- Protocols, Care Pathways and Workflows that align
- Patience, Respect and Open-mindedness
What Are the Pieces in Your Puzzle?

Mobile Response Team – Co-Responder or Independent

Pre and Post Booking Diversion

In Jail Assessments and Services

Problem Solving Courts

Coordinated Re-entry

Community Initiatives and Stakeholder Committees
How Do We Start the Conversation or Keep It Going?

What are our shared goals – well being and safety for individuals and the community
   Fighting Crime and Promoting Public Safety
   Fighting Disease and Promoting Public Health
   Fighting Poverty and Promoting Self Sufficiency and Mutual Support

How are we already connected – involuntary commitments, existing pathways

What lenses are we using?
   Criminogenic Risk – Static and Dynamic Factors
   Symptom Profiles/Diagnoses and Functional Impairments
   Impact of SDOH

What does our community data tell us we need – SDOH, Access to Services, Involuntary MH/SUD Holds, Overdose Rescues and Deaths, Diversions, Incarcerated Individuals with MH/SUD Conditions, Recidivism
Sequential Intercept Mapping (SIM) and GAP Analysis

Bringing stakeholders together through Community Taskforces - Public Safety and Mental Health and Substance Use

- Law Enforcement, Court System, Probation
- County Government
- Service Providers
- School Systems
- Advocates and consumers
- SDOH Support Systems

Engage in Brainstorming

Catalog what you have ... is it working the way you want it to?
Identify the missing pieces ... what will it take to build the system?
The SIM Model

• Intercept 0 – Community Services – **Getting Our House in Order**
  • Non-Four Walls Crisis Systems and Rapid Access to Community Based Care
  • Mobile Crisis – Behavioral Health only
  • Emergency Departments
  • Social Services Engagement

• Intercept 1 – Law Enforcement Engagement
  • Dispatch/Call Center and Law Enforcement Officers as First Responders
  • CIT Trained Officers and Co-Responder Mobile Response
  • Drop off Crisis Services and Withdrawal Management Services – an alternative to incarceration
  • Specialized Responses – Pre-Booking Diversion (Filing a Capias) and Collaboration with CBHOs

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The SIM Model

- Intercept 2 – Initial Incarceration and First Appearance
  - Screening for Mental Health and SUD
  - Post Booking/Pre-trial Diversion to reduce episodes of incarceration
  - Service Linkage – MH, SUD, SDOH

- Intercept 3 – Jails/Courts
  - Specialty Treatment Courts for high risk/high need individuals
  - Jail-based programming – jail staff vs. boundary spanning by Community Based Services
  - Collaboration with Veterans Justice Outreach and Health Administration
  - Multisystem approach with care coordination and service linkage
The SIM Model

• Intercept 4 – Reentry - APIC Model
  • Assess individual’s needs
  • Plan for services and treatment while in custody and at time of release
  • Identify community and correctional processes and staff responsible for post release planning
  • Coordinate transition plans to avoid gaps in services
    • In-reaching by Service Providers for assessments and transition planning with care coordination and warm hand-offs
    • Continuity of Medication including Medication Management of Addictions (OAT, Naltrexone and Narcan) with fillable prescriptions to bridge to appointments

• Intercept 5 – Community Corrections
  • Specialty BH Community Supervision collaborating with Service Provider
  • Required Treatment Compliance for Mental Health and SUD
  • Comprehensive Service Linkage to address SDOH
  • Graduated Response - dealing with multiple “relapsing” conditions

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GAP Analysis

What are our Expectations – CJS, CBHO, Public Health, Community
  Response Times and Timelines to service delivery
  Rapid access to data and critical information
  Sharing data and CQI

Are we meeting them - ask staff on the frontline

What are the barriers and how do we overcome them?
  Identification of individuals with BH needs – are we asking the questions?
  Communicating information in real time
  Changing and Aligning Workflows and Processes
GAP Analysis – a CJS Example

- Multiple LEO Agencies with different Processes and Protocols
- Call Centers not screening for Behavioral Health Concerns
- MRT requiring all information before setting out to assess
- Limited Access to information – No HIE System between agencies
- Inadequate space to support appropriate client engagement
- Focus on intercept needs 0 and 3-5 rather than the initial interface between the CJS and individuals with Behavioral Health Concerns
- Involuntary Hold Processes and Transportation
GAP Analysis – a CJS Example

• Identify as an Integrated, County Wide System and collaborate to standardize processes and protocols
• **Develop, train and implement screening process for call centers**
• Identify **essential** information needed for MRT with rapid deployment utilizing effective co-responder processes – setting a response time of 60 minutes
• Use technology to link EHR Systems and create data bases for high utilizers - **create a multidisciplinary “treatment plan” using combined expertise**
• Redesign space utilization and access processes so treatment providers can easily see individuals regardless of their location – **prioritize engagement with BH Services**
• Create standardized Involuntary Hold Processes including Transportation Plans and rapid release of officers after drop off

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Defining the Problem and Creating a Roadmap

Individuals with Mental Health and Substance Use Disorders are ending up in the CJS rather than engaging in Treatment in Community Based Services

Multidisciplinary Task Force – Developing a Common Agenda
  Identifies Root Causes – everyone needs to own problems within their system
  Collect Baseline Data
  Solution Focused Discussions
  Create and Commit to SMART Goals with agreed upon Action Plans (Including Ongoing Data Collection) and Realistic Timelines
  Commit to CQI and Maintenance once outcomes are achieved

Who are the target populations?

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# Intervention Decisions: Where should you focus your attention?

**Behavioral Health – Low**
- Situational Crisis
- Well managed MH Conditions
- Intoxication and SUD Induced Symptoms

**Behavioral Health – High**
- SMI
- Severe SUD with risk of significant withdrawal and cravings
- Co-occurring Conditions

**CJ – Low**
- Low Level Misdemeanor
- Public Nuisance

**CJ – High**
- High Misdemeanor
- Felony

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Data Collection – Everyone’s Responsibility

Shared and Jointly Managed - Courts and CJS, Service Providers, Social Service Agencies, Health Departments

Individual specific and aggregate de-identified
- Treatment Planning
- Program Development
- Alignment, Maintenance and CQI
- Grant Opportunities and ongoing initiatives

SAMHSA Download: Data Collection Across the Sequential Intercept Model (SIM): Essential Measures (2019)
• In addition to GAP Analysis, it is important to look at the expected savings to your organization and your local criminal justice partners compared to your current system.

• This is a sample calculator from one team. We build a custom calculator for every team based upon their local realities.

• Teams can save a significant amounts of money by de-escalating the situation versus having their traditional institutionalized responses as their only option.
What Does Success Look Like

View Point Health Behavioral Health Units (BHU) – Georgia
- Licensed Clinician – View Point Health
- Dedicated Officer – Law Enforcement

Emergency Response time for behavioral health crisis – 2-4 Hours
- BHU response time – 15-30 minutes
- Significant reduction in incarcerations and recidivism
- Governments and municipalities can redirect funding to other needs
- Current LE savings is estimated at $80,000 per BHU
View Point Health
Results

98% Diversion Rate!

- Incarceration rate dropped by 97% - from 75% to 2% of all encounters
- Number of admissions to needed acute care services increased 440% from 5% to 27% of all encounters
- 71% stabilized in the community with follow up services as needed

Linked to Services
Resolved
Hospital - Voluntary
Hospital - Involuntary
Arrested

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What Does Success Look Like

• Aspire Health Partners – 20+ Years of System Development … and Maintenance
• Tragedy Galvanized a Communities’ Response and Identified Boundary Spanners
• System Development
  • MHSATF, CIT Training and AOT
  • Development of Drug Court and Community Based Services for this population and others over time
  • Pre and Post Booking Diversion and Outpatient Commitment
  • In Reaching Psychiatric Care and access to Community Based Crisis Stabilization Services for appropriate individuals
• Creation of Mental Health and Veterans Courts
• Competency Restoration and State Hospital Diversion

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What Does Success Look Like

The Single Point of Access Solution (SPA) – Creating a contract to address Gaps in Coordination

• Sharing Client Specific Information
• Jail Assessment and Referral Processes
  • Referrals to services post incarceration
  • Review and Admission Dates to coincide with release dates
• Regularly Scheduled Treatment Team Meetings
  • Jail Staff and Relevant Aspire Personnel
  • Standing Agenda and case reviews including individuals at the Forensic State Hospital and diverted but at risk for incarceration
  • Coordinate Reentry plan including transportation and medication resources

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What Does Success Look Like

Mental Health and Substance Abuse Task Force (MHSATF) – 22+ Years and going strong!

- Needed a group of committed stakeholders with buy-in and commitment to support grant applications and develop systems
- Developing and maintaining connections even as team members change within organizations.
- Ongoing system assessment with periodic SIM Assessments/Gap Evaluations and redesign as EBP emerge
- Monitoring grant opportunities in all sectors to support growth and development of the system
Best Practice Take Aways

- Establish Stakeholder Connections and create a multidimensional Task Force to design and lead change committing stakeholders to a shared vision and implementation plan.
- Identify existing connections and areas of collaboration and develop a strategic plan to enhance these while creating pilot projects to expand and develop system integration.
- Share and use data to drive decision making and monitor outcomes.
- Create realistic timelines and keep momentum going by being solution focused and outcome driven.

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What's Your Path Forward

Questions
Comments
Ideas
Thank You

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