

Behavioral Health Crisis and Diversion from the Criminal Justice System: A Model for Effective Community Response

Prepared for Arnold Ventures
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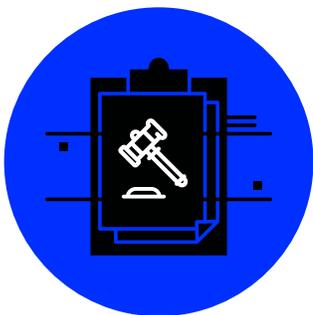
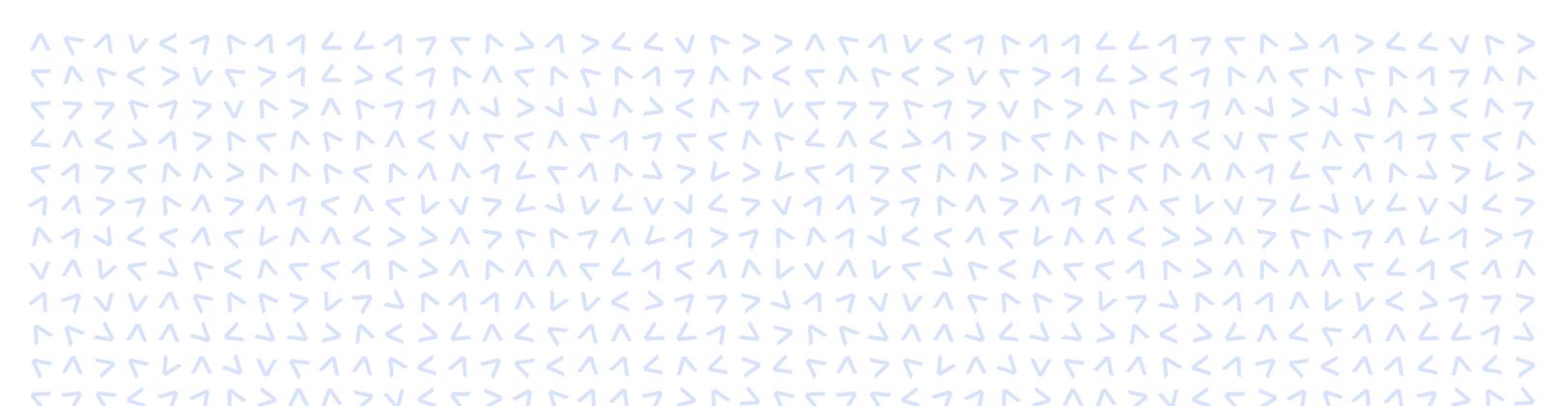


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This is an independent report commissioned by Arnold Ventures. The opinions expressed in this publication are not necessarily those of Health Management Associates or the funders.

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

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

Mental illness and substance use are connected to more avoidable emergency department (ED) visits compared to the general population, and, at the same time, also contribute to repeated involvement with the criminal justice system and 911/emergency response and other safety net systems.^{6,7}

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

A 2017 study found that almost half of inmates were diagnosed with a mental illness (48%), of whom 29% had a serious mental illness.¹⁰ In addition to high rates of mental health conditions, as many as two-thirds of people in correctional settings have a diagnosable substance use disorder.¹¹ And, increasingly homelessness and other social determinants of health are recognized as contributing to criminal justice system and ED encounters.¹² People in jails with mental health and/or substance use conditions are most likely to be there due to low-level offenses like jaywalking, disorderly conduct, or trespassing.¹³

Involvement in the criminal justice system compounds the challenges faced by people with behavioral health issues, interrupting their access to benefits, treatment relationships and routines and other sources of support and stability, and making them vulnerable to trauma.¹⁴ At the same time, EDs, which provide screening and triage for acute medical conditions, are not the best treatment option for individuals whose crisis state is driven by mental illness and or substance use that could be more effectively addressed in a specialized setting. Concerns about these trends, and mounting pressures on jail capacity, have led to efforts to generate solutions that are cost effective, person centered, and conducive to effective treatment.

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

A 2014 study found that almost half of inmates were diagnosed with a mental illness (48%), of whom 29% had a serious mental illness and 26% had a history of a substance use disorder.²

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

The criminal justice system has made strides in developing alternatives to booking and incarceration for people whose primary reason for law enforcement encounters is their mental illness or addiction. Programs such as specialized law enforcement training, screening in the field by officers who can divert to treatment, and specialty courts that connect individuals to treatment are growing in number across the country and demonstrating positive results. Communities have fostered these alternatives to address concerns about jail capacity and to better serve citizens who are in the criminal justice system because of their circumstances rather than criminogenic traits.

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

A Promising Model: The Crisis Diversion Facility

The crisis diversion facility model is based on the premise that co-locating and coordinating services that effectively respond to mental illness and/or addiction can stop the revolving door at emergency departments and jails. The **crisis diversion facility** is among emerging community-based strategies to engage and better serve this population. The crisis diversion facility model shows success in reducing these patterns by coordinating health and service sectors with law enforcement and first responders in a central facility. Comprehensive care and coordinated systemic response from the crisis diversion facility can better support and stabilize vulnerable community members to reduce their reliance on the public safety net and emergency and acute care.

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

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

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

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



What is a Model Crisis Diversion Facility?

The model crisis diversion facility ...

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

This report offers a model for BH crisis diversion facilities based on a literature review of strategies for BH crisis and criminal justice diversion in the United States and case studies of four established crisis diversion facilities with promising results.

Criteria for the model include:

- Development driven by collaboration and stakeholder input;
- A structure for community governance that includes systematic data sharing and analysis;
- A business case for initial capital expenses and sustainability; and
- A collaborative integrated service delivery system leveraging partnerships and evidence-based practices.

A Promising Model for Crisis Diversion Facilities: Selected Case Studies

The crisis diversion facility is based on the premise that co-locating and integrating services that effectively respond to mental illness and/or addiction can stop the revolving door at EDs and jails. Facilities highlighted in this report were developed by community stakeholders who recognized that the absence of coordination led to fragmentation and gaps despite best efforts of providers and responders and investment of safety net dollars. These facilities coordinate health and service sectors with law enforcement to effectively address system gaps that can contribute to potentially avoidable ED use and criminal justice system recidivism and have shown success in reducing these patterns. The collaborative partnerships, comprehensive person-centered care, and coordinated systemic response core to the crisis diversion facility model better support and stabilize vulnerable community members and reduce their reliance on the public safety net and emergency and acute care.

Components seen in effective facilities were compiled to vet and select four representative sites for case studies. The following locations are included in this report: 1) Knoxville, Knox County, Tennessee; 2) Rapid City, Pennington County, South Dakota; 3) San Antonio, Bexar County, Texas; and 4) Tucson, Pima County, Arizona. See **Appendix A** for criteria for case study inclusion.

Case Studies Of Crisis Diversion Facilities

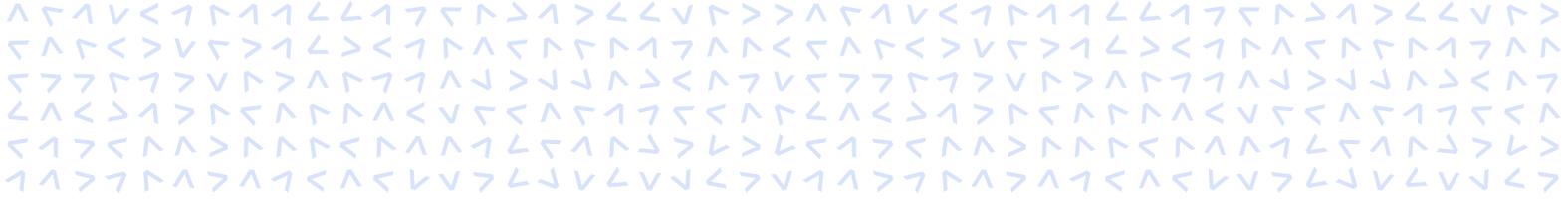
The Crisis Response Center: Tucson, Pima County, Arizona

The Crisis Response 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 is physically connected to the hospital through a short secure passage, 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 the centerpiece of a robust crisis continuum and an example of cross-system collaboration. The facility is owned by Pima County, licensed to Banner-University Medical Center, and managed by Connections Health Solutions, a private behavioral health provider. Law enforcement accesses the CRC through a dedicated entrance with a "no wrong door" policy and benefits from rapid disposition of individuals experiencing behavioral health crisis.

Leadership – Champions and Collaborations

The CRC has its origins in leadership and advocacy efforts led by 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's Department, 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. Building upon existing relationships, the champions and stakeholders confirmed a common commitment to transforming the dominant discourse about mental health to one that recognizes that people with mental health challenges are not "other" but are "our families and our coworkers." This effort sought to reduce the stigma attached to mental illness and substance use disorders and endorse an approach to measure and transform the impact of mental health and addiction services across all systems in Pima County. This effort is based on a culture of transparency and accountability among participants to each other and to the community. Relationships are cultivated and valued and communication about goals and priorities with each other and the community is a priority.

Additionally, Crisis Intervention Team (CIT) training has been in place in Pima County for decades, which has contributed significantly to the efforts to cultivate a compassionate and proactive approach to addressing the needs



of people with behavioral health challenges. System transformation efforts are driven in a quality improvement environment that includes sharing data to drive outcomes and highlight opportunities for improvement; a commitment to empowering officers and staff through training and leadership communication and being solution-oriented; and intentional integration of the multiple systems involved. A quality improvement approach synthesizes the efforts across systems, cultivating empowerment, willingness to take risks to innovate, and focus on outcomes. The culture supports the journey of residents to reach and maintain recovery and empowers law enforcement officers and providers who interact with them, along with the staff and administrators charged with making decisions about planning, delivering, and funding services.

Community Context and Culture

Pima County is one of the largest and oldest continuously inhabited counties in the country covering 9,200 square miles. The county’s total population is 1.1 million and metro Tucson accounts for half that at about 500,000 with the remainder of the county consisting of small towns and large swaths of rural areas. Demographically, Pima County is 52% White, 37% Hispanic or Latino, 4% Black or African American and 4% American Indian. The implications of the county’s geography for sheriff’s deputies in Pima County is that they might drive two to three hours to bring someone with apparent behavioral health concerns to the Crisis Receiving Center for screening. According to the County Administrator, deputies put 1 million miles per year on their cars. This translates to an imperative of operating under a “no wrong door” policy for law enforcement that ensures no officer is turned away and is always back on the street within minutes. The two primary law enforcement entities are the Tucson Police Department with approximately 950 officers and the Pima County Sheriff’s Department with about 500 deputies. There are fifteen other small police departments for various municipalities throughout Pima County, some with three or less officers. In 2017, Arizona had a per capita suicide rate of 19 per 100,000. While Native American people in Arizona represent 5% of the population contrasted with the 55% percent of White people, the suicide rate for Native American people was 15.4 per 100,000 compared to a rate of 20 per 100,000 for White people.

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Pima County has been faced with rising numbers of incarcerated individuals in the county jail, creating pressure to consider investment in new jail facilities. Five years ago the average jail daily census was 2,200 per day, significantly challenging the existing infrastructure. The Sheriff conducted a study to understand the composition of the jail population. This revealed that up to 65% of detained individuals had a diagnosis of mental illness, substance use disorder, or both. This study sparked conversations among the Sheriff and Tucson Police Department regarding the need to identify options for better addressing the needs of individuals with behavioral health issues. These conversations, that grew to include city and county leaders and other stakeholders, led to the multiple initiatives to create treatment alternatives to incarceration underway in Pima County. The current average daily jail census is 1,800.

Five years ago the average jail daily census was 2,200 per day, significantly challenging the existing infrastructure. The current average daily jail census is 1,800.

Each community that has developed a crisis diversion facility has unique cultural context and considerations that inspire and inform the community's efforts. In 2011, Jared Lee Loughner opened fire in a Tucson grocery store parking lot where a crowd was assembled for U.S. Representative Gabrielle Giffords' community forum, killing six people including Chief U.S. District Court Judge John Roll and nine-year-old bystander Christina-Taylor Green. Rep. Giffords was critically injured and 13 other people were shot and gravely wounded. In the aftermath of the incident, acquaintances reported that Loughner's behavior had changed dramatically in years prior to the shooting and that he was abusing alcohol and drugs. After his arrest for the shooting medical evaluations diagnosed him with paranoid schizophrenia.

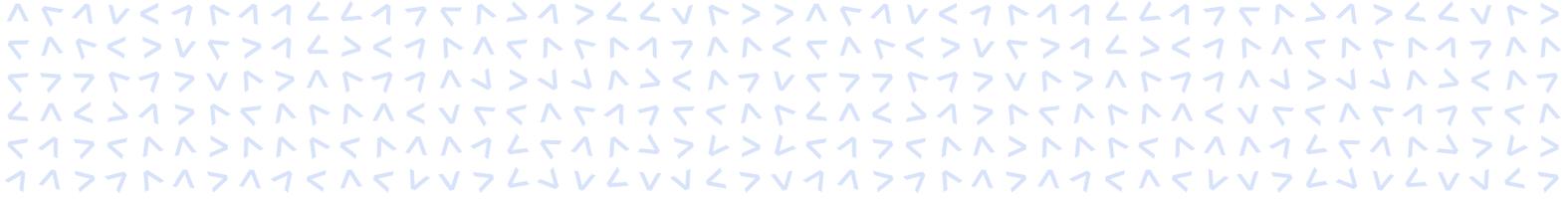
Also of significance to the cultural context for development of the Crisis Response Center is Pima County's CIT training program which was initiated in 2001. One of the oldest and largest in the country, Tucson's CIT program hosts and trains law enforcement personnel from throughout Arizona. All Tucson Police Department personnel receive Mental Health First Aid training, after which 70% voluntarily choose to become CIT trained. This includes 911 dispatchers and records personnel, recognizing their "front line" role with the public. In addition, specialized teams such as the Mental Health Support Team, hostage negotiators, and SWAT receive quarterly Advanced CIT refresher training. The culture developed within law enforcement from CIT created a context for the leadership and officers of the police and sheriff to understand and embrace the rationale for deflection away from jail and to treatment programs like the CRC. In July 2017, Tucson Police Department implemented a deflection program for possession of pocket (small amount of) drugs in two of its service districts. The TPD invested grant funds in a comprehensive training program in Motivational Interviewing and Trauma Informed Care in recognition that meaningful engagement and training of staff is critical to cultivate a culture that would support the initiative. The strategy is to empower officers to support apprehended persons in making recovery-oriented decisions and to play a role in that process. This approach, along with other diversion and deflection initiatives implemented in Pima County, reflects the recognition by leaders that the overwhelming numbers of people with BH issues in the jail is a problem they "can't arrest their way out of." Pima County has also participated in the John D. and Catherine T. MacArthur Foundation Safety and Justice Challenge since 2014 which is using data to reflect the characteristics and drivers of the jail population and develop related community alternative strategies.

Coordination of Services and Community Continuum of Care

The CRC, managed by Connections, is positioned within a care continuum that includes a crisis line, mobile crisis teams, access to inpatient psychiatric care and detox, specialized law enforcement programs designed to connect individuals to treatment rather than jail, and outpatient providers for mental health and SUD treatment and care coordination. The CRC has established processes for continuous communication and improvement with community stakeholders to address the interactions between acute mental health, SUD/addiction, chronic homelessness, and high system utilizers. It operates under a premise of "finding ways to say yes" to support maximum access to and effectiveness with engagement and care. Law enforcement officers experience a "no wrong door" policy at the CRC, under which every person brought to the CRC by an officer is received regardless of behavioral acuity. Law enforcement leadership reports the majority of people brought to the CRC by law enforcement do so voluntarily. The CRC has a dedicated entrance for law enforcement available 24/7 and a 10-minute officer drop-off time. Officers can bring their guns into this entrance and can access the restroom, computer, and refreshments without having to disarm. An example of this spirit of accommodation, or "finding ways to say yes" is the CRC's acceptance, when other options are not available, of the pets of persons in crisis as well as their work with the Humane Society to drop off food or with Animal Control to temporarily house the pet with no fee or charge because of the circumstances.

The CRC's accommodations are designed to provide maximum access and support to the person in crisis and are based on positive relationships between all agencies involved.

A full continuum of SUD services are provided by various community agencies. Several programs are open 24/7 and accessible via both walk-in and law enforcement. The CRC and Community Bridges provide 24/7 access to detoxification, while 24/7 access to medication assisted treatment (e.g. Buprenorphine induction) is available at the CRC and CODAC @



380 – an outpatient clinic offering MAT and integrated mental health and primary care. Many providers offer residential and outpatient SUD programs. Individuals presenting at the 24/7 programs receive assistance with accessing the appropriate level of care, including care coordination, transportation, and a warm handoff.

The Banner-University Medical Center South Campus Emergency Department, physically connected to the CRC via a covered breezeway, is a Level 2 Trauma Center, and the hospital can provide needed medical specialty and inpatient psychiatric care for civil commitments. The 24/7 crisis call center and mental health court are also located on the same campus as the CRC. Call center clinicians are also placed at the 911 call center. Calls that can be handled via a clinical intervention are diverted to call center staff at the County's 911 call center, reducing the number of calls requiring police involvement.

Law enforcement Mental Health Support Teams (MHSTs), initiated four years ago, are dedicated BH teams consisting of patrol officers and deputies, detectives, and deflection specialists. The MHSTs now include peer navigators and clinician co-responders funded by the Regional Behavioral Health Authority (RBHA) who assist with screening and disposition determinations. Prior to addition of the co-responder, the MHSTs had a 51% hospitalization rate when investigating a mental health case, but with the additional input and access to clinical information of the co-responders, the hospitalization rate is now at 15%. The MHSTs process civil MH commitments, facilitate court-ordered treatment, and respond to calls for service from 911 when a MH nexus for the call is determined. 911 operators are CIT-trained and linked with the MH Crisis Line. The MHSTs have increased the percentage of MH civil commitment orders successfully served prior to their 14-day expiration from about 35% to 85% because of these units' centralized function and specialized knowledge of the community. The role of the MHSTs has been expanded to respond to opioid overdose in addition to BH crisis response. All patrol officers have a mechanism in their reporting system where they can trigger a request to the MHSTs to provide a proactive response to a situation they identify on the street.

Funding

Capital Development • The County hospital (formerly Kino Community Hospital, now Banner-University Medical Center South Campus) was built in 1977, and Arizona implemented Medicaid managed care, Arizona Health Care Cost Containment System (AHCCCS), in 1980. With this change, public utilization of the county hospital declined significantly and it continued to struggle financially due to low levels of use. However, the hospital provided the only psychiatric inpatient services in the county and concerns about maintaining those services should the hospital be closed generated stakeholder attention to the community's capacity for response to emergency services. At the same time there was growing recognition among county officials and service delivery leaders, and the public, of the need for reducing the growing jail population, especially for individuals incarcerated with mental health and substance history; that the county jail was the de facto county mental health provider. 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 Response Center. The CRC would meet the needs of the public and law enforcement as a viable alternative to emergency rooms or jail – and for law enforcement officers an alternative from up to six hours off the street for booking - to engage and stabilize individuals in

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Making the Case • In developing crisis response solutions, Pima County leaders and stakeholders benefit from formally aligned, intersystem and interdepartmental functions, processes, and accountability at the local and state levels. The RBHA braids multiple funding streams, including Medicaid, SAMHSA block grants, state, and county funds together to serve as a centralized point of accountability for the behavioral health system. Goals, budgets, and financial incentives are aligned to impact established outcomes and monitor and impact avoidable costs based on a shared vision and recognition that various departments and levels of local and state government and health care systems are serving the same citizens. This includes a recognition of the role of social determinants of health (SDOH) on total cost of community health and funding, and the implementation of proactive measures to address SDOH. Policy and related funding decisions are informed by analysis of the total cost of Community Health, Law Enforcement, EMT and Fire, Legal and Justice, Medical and Behavioral Health, Jails and Detention, and the interconnections between these systems.

Medicaid/State Funding • Arizona is a Medicaid expansion state with robust community-based behavioral health and diversion services. Arizona was the last state to implement Medicaid, but the first state to adopt a state-wide 1115 waiver. Thus, Arizona has had a managed Medicaid system from its inception, which is called the Arizona Health Care Cost Containment System (AHCCCS). AHCCCS contracts via a competitive bid process with managed care organizations throughout the state, including a RBHA in each geographical service area. In southern Arizona, the RBHA is Arizona Complete Health (formerly Cenpatco Integrated Care, part of Centene). The RBHA braids multiple funding streams, including Medicaid, SAMHSA block grants, state and county funds to serve as a centralized point of accountability for the behavioral health system. Pima County has a full continuum of crisis diversion and BH services, including for SUD; and services for both juveniles and adults through a larger provider network. In addition to funding the CRC's services, the RBHA contracts with multiple providers to operate the crisis call center, a dozen mobile crisis teams that are dispatched from the call center, residential and step-down facilities, and various other crisis services not on the CRC campus.

Housing • To support stability in the community for those served at the CRC, Pima County has invested \$3 million in a Housing First Permanent Supportive Housing (PSH) Program through a Housing and Urban Development (HUD) Department of Justice (DOJ) Pay for Success Permanent Supportive Housing Demonstration program which may fund up to 150 people. The evaluation for this program will include a cost benefit analysis for housing individuals with PSH to attract investment partners for sustainability. The population targeted for the program are individuals who have been jailed a minimum of two times in one year who have a behavioral health diagnosis and are homeless.

Opioid Expansion Funding • In 2018 a collaborative effort of Pima County, the Pima County Sheriff's Department, Tucson Police Department (TPD), CODAC Health Recovery and Wellness, a private BH provider, the University of Arizona Southwest Institute for Research on Women, Arizona Superior Court Pretrial Services, and Arizona Complete Health received U.S. Department of Health and Human Services funds through the State of Arizona to address the opioid crisis in Pima County. This 3-year, \$1.475 million grant to address OUD is referred to as the U-MATTER (Unified Medication Assisted Treatment Targeted Engagement Response) project, focused on identifying, engaging, and retaining individuals with opioid use disorder in comprehensive medication assisted treatment and recovery support services and facilitating long-term recovery.

TPD's deflection program, which started in July 2018, gives individuals addicted to opioids the ability to be placed into treatment with no risk of jail. It involves self-referral by drug users and outreach by officers and caseworkers to connect with people who recently overdosed or who have disengaged from drug treatment. The U-MATTER project will augment the deflection program by pairing CODAC peer navigators with TPD's Mental Health Support Team, or MHST, to respond to overdoses and mental-health calls and follow up with people post-overdose or post-deflection to make sure they're keeping up with their treatment. Residents of Pima County can access methadone, suboxone, and naltrexone treatment 24/7 – the only county in the country with this option.

A SAMHSA MAT PDOA (Medication Assisted Treatment Prescription Drug and Opioid Addiction) grant is funding the two peer navigators in the first year; two more will be added in the second and third year of the grant. The project will be formally evaluated to determine the impact of peer counseling support on pre-trial supervision in the community versus jail and other outcomes. The project will also build up infrastructure and capacity for coordination of efforts to address Pima County OUD longer term.



Data Analytics, Data Sharing and Evaluation

The CRC operates within a robust and well-established data sharing and analytics framework and quality improvement culture. An automated feed is sent daily from the CRC to the RBHA, Arizona Complete Health (ACH), which is analyzed for discussion at monthly meetings with CRC and AzCH staff in order to identify trends and opportunities for improvement. In addition, 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, readmissions within 72 hours (from the observation unit) and 30 days (from the inpatient unit) are reviewed. Summaries are given to involved CRC staff, AzCH, and the relevant outpatient clinic for appropriate clinical review and follow up.

The quality improvement approach extends to a focus on high utilizers, defined as an individual with four or more visits in the preceding four months, determined in an initial analysis to be about 17% of the overall population served at CRC. The guiding intent of the focused high utilizer process is to evaluate if persons served at the CRC are getting what they need in terms of services and response from the system and making adjustments to the system as needed. The CRC sends a monthly rolling frequent utilizer report to AzCH for review and follow up. Multi-agency team meetings with CRC, AzCH, and clinic staff to discuss the patient's needs and develop improved crisis and service plans are conducted regularly. Of the original cohort of 64 individuals, only seven remained high utilizers after one year, and there were only a total of 37 individuals who met high-utilizer definition. 72-hour and 30-day readmissions were also significantly decreased.

Prior to 2018, when AHCCCS restructured and re-procured its Medicaid contract, there was one payor (AzCH). These processes continue with AzCH, and CRC leadership is scaling them with the two additional Medicaid payors now operating in Pima County.

Overall, the CRC operates in accordance with the following principles and goals: real time data sharing and analysis; rapid cycle quality improvement approach; using both data and communication with clinics and others serving and interacting with the patient; use of quality improvement and clinical staffing teams that include leaders who can make decisions and front line staff who can provide context based on real world experience; and a collaborative culture based on “figuring out how to say yes instead of looking for reasons to say no.” In addition, system measure dashboards are used to catalyze collaborative solutions to system problems.

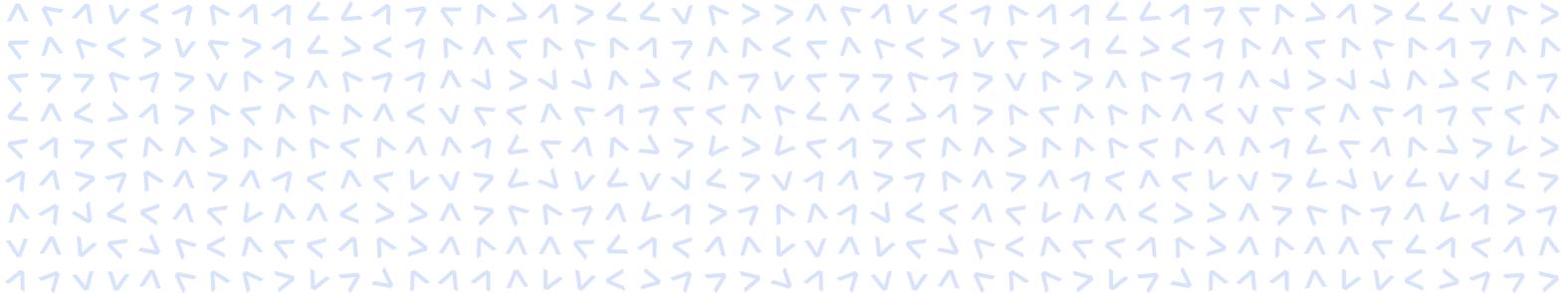
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Table 1a. Services Located at the Crisis Response Center Campus

Program/Service	Description	Responsible Agency/Partner
Law Enforcement Receiving Center	<ul style="list-style-type: none"> • Dedicated entry for law enforcement. • 10-minute drop-off time. • Policy of never turning away law enforcement. 	Crisis Response Center: Pima County-owned facility; licensed to Banner-University Medical Center; managed by Connections Health Solutions, a private provider agency.
Acute Crisis Stabilization	<ul style="list-style-type: none"> • Behavioral health services provided to adults and children/adolescents 24 hours a day/7 days per week/365 days per year. • For Adults, walk-in urgent-care clinic, 23-hour observation (34 chairs), and brief inpatient care (15 beds). • For children/adolescents (ages 0 - 17), 24/7 walk-in clinic, and 10 observation chairs with full clinical staffing. • 24/7 clinical staffing including MDs/mid-levels providers, Nurses, Techs, Peers, Social Work. • No behavioral health exclusion criteria: patients can be voluntary or involuntary, and law enforcement is never turned away. • Provides community with alternatives to arrest, emergency department utilization, and inpatient psychiatric care. Disposition planning includes financial eligibility screening, crisis follow up, and transitional case management services that connect individuals with treatment and other services to prevent reemerging crisis. 	Crisis Response Center: Pima County-owned facility; licensed to Banner-University Medical Center; managed by Connections Health Solutions, a private provider agency.
24-hour Crisis Call Center	<ul style="list-style-type: none"> • Receives calls from the public, law enforcement, and 911. • Provides telephonic crisis counseling with masters-level clinical staff and a warm line staffed with peers and tribal liaisons. • Dispatches mobile crisis teams and monitors location via GPS tracking tool. • Crisis line clinicians stationed at 911 call center to divert calls to clinical interventions instead of police response. 	AZ Crisis Line
Civil Commitment Services	<ul style="list-style-type: none"> • Behavioral Health Pavilion: 66-bed inpatient unit where most civil commitment evaluations are performed. • Mental Health Court: Courtroom on-site for civil commitment hearings. 	Banner-University Medical Center Pima County
Peer After Care Team (PACT)	<ul style="list-style-type: none"> • Peer run program co-located at the Crisis Response Center. • Provides 45 days of post-crisis wraparound services, including peer support, transportation for appointments and picking up medications, help getting ID/completing application for benefits. 	HOPE Inc., a private peer-run provider.

Table 1b. Additional Crisis Services in Tucson/Pima County

Program/Service	Description	Responsible Agency/Partner
<p>Crisis Mobile Teams</p>	<ul style="list-style-type: none"> Community-based crisis screening, assessment, disposition, and, if necessary, transport to facility-based crisis services. 24/7 coverage with 12 mobile teams. Policy requires 90-minute response; typically in Pima County response time is 60 minutes and 30 minutes for law enforcement. Veterans' Assistance: All Crisis Mobile Teams trained as veteran navigators. 	<p>Community Bridges Inc. Community Health Associates. Centralized dispatch via the AZ Crisis Line.</p>
<p>Law Enforcement Co-Responders</p>	<ul style="list-style-type: none"> Mobile Team Clinicians and Peer Responders help police respond to cases with mental health and substance use disorder nexus and navigate mental health and civil commitment systems. Officer helps clinicians respond to higher acuity calls. 	<p>Community Bridges, Inc. CODAC Health, Recovery, and Wellness, Inc.</p>
<p>Brief Intervention Programs</p>	<ul style="list-style-type: none"> Brief (7-14 day) crisis-focused residential care. Referrals via mobile teams and behavioral health homes to prevent higher levels of care. Can be step-down after CRC or inpatient stay to prevent readmission. 	<p>Community Partners Incorporated, COPE, Community Bridges Incorporated, CODAC, La Frontera</p>
<p>Substance Use Focused Crisis Stabilization</p>	<ul style="list-style-type: none"> Behavioral health services provided to adults 24 hours a day/7 days per week/365 days per year. For adults 24/7 walk in clinic with access to up to 40 observation chairs, 16 co-ed inpatient detox beds, 16 subacute psychiatric beds. Referrals accepted from but not limited to Crisis Mobile Teams, Emergency Departments, Law Enforcement, Walk-in, and outpatient assignment. Functions as outpatient office and holds group services on site. Can provide community pickups for admission and service provision via crisis transportation. 	<p>Community Bridges, Inc.</p>



Program/Service	Description	Responsible Agency/Partner
<p>24/7 Medication Assisted Treatment for Opiate Use Disorders</p>	<ul style="list-style-type: none"> Residential SUD beds provided for outpatient referral for long term stays accessible during business hours. Residential Crisis SUD beds accessible 24/7 by crisis mobile teams, Observation Units, and outpatient providers. These are approved under the Brief Intervention Program for 5-10 day stays with the ability to transfer to residential services. CODAC at 380, for 24/7 access to MAT services in an outpatient clinic setting. Outpatient SUD treatment provided by all Southern Arizona providers including but not limited to groups, therapy, and care management. 	<p>Residential: Community Partners Incorporated, COPE, Community Bridges Incorporated, CODAC, La Frontera</p> <p>MAT services: CODAC, Connections, CMS</p> <p>Outpatient: Community Partners Incorporated, COPE, Community Bridges Incorporated, CODAC, La Frontera, Community Health Associates</p>
<p>Residential and Outpatient Substance Use Disorder Treatment</p>	<ul style="list-style-type: none"> 24/7 access to Medication Assisted Treatment (e.g. buprenorphine induction) accessible via walk-in or law enforcement drop-off. CODAC at 380, for 24/7 access to MAT services in an outpatient clinic setting. Crisis Response Center, 24/7 MAT access for people with high acuity co-occurring mental health needs. 	<p>CODAC Health, Recovery, and Wellness, Inc. Connections Health Solutions (CRC)</p>
<p>Post crisis follow up</p>	<p>Second Responder Teams:</p> <ul style="list-style-type: none"> Community outreach and engagement and case coordination with individuals challenged by chronic homelessness, mental illness, and/or substance use. 45 days post crisis peer services: peer support, transportation to appointments, picking up meds, getting benefits, etc. Assistance with housing, children’s services, etc. Follow up phone calls and welfare checks. 	<p>Devereux, HOPE Incorporated, Old Pueblo Services, CFSS</p>

Table 1c. Law Enforcement Programs

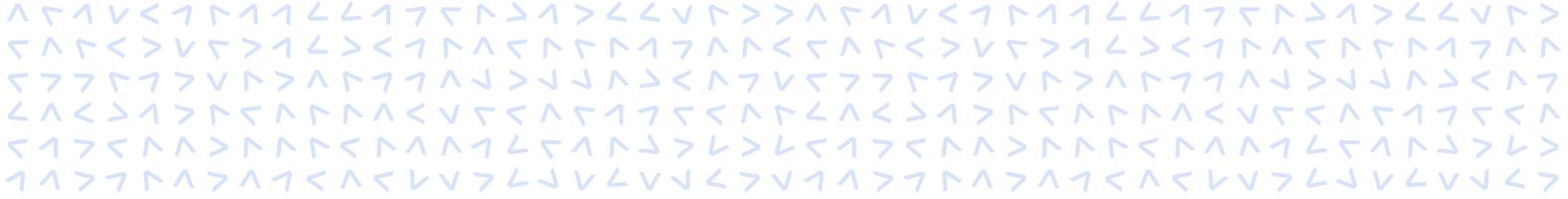
Program/Service	Description	Responsible Agency/Partner
Law Enforcement Mental Health Support Team	<ul style="list-style-type: none"> • A specialized team with select group of 12 officers/deputies and detectives dedicated solely to mental health (distinct from CIT trained patrol officers, who respond to other calls in addition to MH). • Focus on high risk individuals with the goal of preventing crisis and threats to public safety. • Some MHST members are paired with clinician or peer co-responders. 	Tucson Police Department Pima County Sheriff’s Department
Deflection Programs	<ul style="list-style-type: none"> • People in need of SUD or MH treatment can ask LE for help and be connected, even if they are in possession of illegal drugs at the time. • Uses 24/7 MAT drop-off locations. • Peer Responders follow up to help make sure the person is connected to care. 	Tucson Police Department CODAC Health, Recovery, and Wellness, Inc.
Mental Health First Aid and CIT Training	<ul style="list-style-type: none"> • 100% officers and deputies are required to receive Mental Health First Aid training. • 70-80% voluntarily receive Crisis Intervention Training. • Advanced CIT is required for specialized teams (SWAT, Hostage, MHST). • Additional trainings for MHST include Motivational Interviewing and Trauma Informed Care. • TPD and PCSD host trainings for smaller agencies throughout southern Arizona. 	Tucson Police Department Pima County Sheriff’s Department

The Care Campus: Rapid City, Pennington County, South Dakota

Rapid City in Pennington County South Dakota is the site of The Care Campus, a facility that opened in September 2018 offering a single point of entry to the community for, and law enforcement disposition of, behavioral health crisis with co-located programs in one location. The Care Campus is a partnership of the Pennington County Sheriff’s Office; Pennington County Health and Human Services; the City of Rapid City; and the Crisis Care Center operated by Behavior Management Systems, a private provider, under the oversight of the Pennington County Sheriff’s Office. The Care Campus includes a full continuum of co-located services addressing the crisis stage of mental health and substance use disorders and support services to assist Care Campus clients with attaining recovery and maintaining stability in the community.

Leadership – Champions and Collaborations

According to Care Campus leadership Rapid City has been able to build the Care Campus and other innovative strategies because “all the right people are in the right place” and aligned in a common mission. Systematic assessment and information gathering to make a case based on data have been key, along with consistently promoting a message that Rapid City can meet the challenge of better responding to the needs of its residents. This appeal, combined with data, has built a base of support among elected officials responsible for making funding decisions, and with community members who elect them and whose support of such initiatives is critical to its success. Though personnel has changed over the past few years, the people in the roles of Sheriff and Chief of Police have remained collaboratively aligned, including operating in a shared facility, for decades. These and other current key leaders continue this tradition and have built on it to champion the Care Campus.



Community Context and Culture

The location of the Care Campus, Rapid City, in Pennington County, is the economic and service hub for western South Dakota. The population of South Dakota is 869,666, with the population of Pennington County being 110,141, and Rapid City's population numbering 74,421. South Dakota has not implemented Medicaid Expansion. Demographically, the state of South Dakota is comprised of 82.2% White, not Hispanic or Latino, and 9% American Indian/Alaska Native, with Pennington County comprised of 80.4% White, not Hispanic or Latino, and 10.1% American Indian/Alaska Native. In 2017, South Dakota had the nation's highest per capita suicide rate with a rate of 16.7 per 100,000. The rate of suicide for Native American people in South Dakota is almost double that at 26.8 per 100,000.

Native American people are also disproportionately represented among those in the criminal justice system in Pennington County; this disparity is the subject of an improvement initiative underway through a John D. and Catherine T. MacArthur Foundation Safety and Justice Challenge grant.

This grant is one of several initiatives Pennington County has underway in the community that support and extend the mission of the Care Campus and further represent the commitment of key leaders and stakeholders to create a comprehensive full-continuum service delivery system that effectively meets the needs of all residents, focusing on the county's most vulnerable residents.

The \$1.75 million Safety and Justice Challenge grant is intended to implement strategies that address the main drivers of the local jail population, including practices that take a particularly heavy toll on people of color, low-income communities, and people with mental health and substance use issues. The county plans to implement four new strategies aimed at addressing racial and ethnic disparities, reducing system inefficiencies, and expanding non-jail options for lower-risk offenders. This will include conducting tribal outreach on reservations to implement several initiatives with the goal of reducing the overrepresentation of Native American people in the Pennington County jail system. The Care Campus is further developing its substance abuse services to address generational alcohol abuse among Native American people coming into contact with the criminal justice and crisis systems, and planning for implementation of medication assisted treatment to address opioid use disorder.

Coordination of Services and Community Continuum of Care

The Pennington County Sheriff's Office has operated detox beds for over 30 years. The new Care Campus facility incorporates that operation, while also creating a new safe sobering area. The intake, sobering, and detox staff at Care Campus are under the jurisdiction of the Sheriff. The Crisis Care Center, now housed within the Care Campus, is operated by Behavior Management Services (BMS), a private not for profit behavioral health provider. Pennington County Health and Human Services (HHS) oversees case management for persons served at the Care Campus to support continuity of care and other supportive

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services such as assistance with benefits and medical transportation. HHS case managers use three cars formerly owned by the Sheriff department for this purpose and they have accessed a local grant to provide public transportation vouchers for additional transportation support. Since 2006 HHS has operated a community re-integration program for individuals not under court order – Rebuild – that is staffed by 2.5 HHS caseworkers with staff based in the jail and in the community. The new HHS offices are also placed within the Care Campus footprint.

The Care Campus partners are able to access 23 supportive housing units for clients: 11 are reserved for Rebound clients; 12 are for individuals with Serious and Persistent Mental Illness served by BMS to support effective transitions and stability in the community. Rents for these efficiency units at a local apartment facility are offset 30% by a private foundation. This supportive housing model, which mirrors Shelter+Plus Care, provides housing for individuals who typically would not have access to housing due to factors like poor rental history or criminal justice system involvement. 99% of tenants were homeless before moving in to the units.

Funding

Capital Development • The Care Campus was developed primarily with capital funding from the County in the amount of \$13.1 million, with the City contributing \$900,000, and \$1.5 million coming from a private philanthropist. Ongoing operations are supported by County and City budget allocations, and State reimbursement for detox services provided at the Campus. The Care Campus concept has been part of the County Master Plan review and development discussions, a formal process of the County Building Committee to determine priorities for capital investment, for over a decade. The plan for the actual Campus has been actively vetted and developed as part of this process for three to four years and the building was purchased in October 2015, renovated, and opened in September 2019.

Making the Case • The case made to the County by the Sheriff and other champions for investment in development of the Care Campus was based on evaluation of and recommendations for improving efficiencies in county facilities. Facilities and related functions were scattered at various sites, and many of those sites were space-limited and in need of renovation and updating to be conducive to a treatment environment. The project champions also developed the case for getting buy-in from elected officials and other stakeholders with a discourse based on providing an alternative to incarceration, i.e. would they rather pay for another jail facility or fund treatment and diversion options? The Sheriff, elected eight years ago, developed a business case that showed that proposed centralization and upgrades of the county-owned facilities would address inefficiencies by consolidating space and functions (e.g. food service, cleaning, etc.) to reduce costs while also creating the context for effective treatment and services as an alternative to criminal justice system involvement.

Recognizing the potential positive impact of the Care Campus on area hospitals, the sheriff made a funding request to Regional Hospital for assistance with three years' operating costs to join the Care Campus partnership. The case to the hospital was based on the premise that the sobering, detox, and crisis services provided there would reduce costs by diversion of individuals with substance use disorders from inappropriate utilization of the Emergency Department (ED) and avoidable inpatient admissions. Costs associated with ED encounters by individuals with SUD are incurred from medical testing and other standard procedures required for ED episodes. Since South Dakota is a non-Medicaid expansion state, a significant percentage of these individuals do not have insurance coverage, resulting in a cost burden for the hospital. In addition to generating avoidable costs, these encounters are also reported to be challenging to the hospital dealing with patient behaviors related to substance use and withdrawal. The Care Campus' diversion option gives the hospital a means of mitigating both issues by offering an alternative to inpatient psychiatric care with improved access to crisis intervention services and coordination and integration of service providers at a lower level of care to better meet the needs of residents. From 2011 to 2017, over 9,000 individuals accessed the Crisis Care Center with 1,896 referrals from the ED to the Crisis Care Center. Without the Crisis Care Center ED diversion option these individuals would likely have been placed on an Emergency Hold at Regional Behavioral Health.

Table 2 reflects cost avoidance calculations provided by the Pennington County Sheriff to Regional Hospital, based on diversion to the Crisis Care Center for individuals who would have otherwise been on a 24-hour hold at the hospital's behavioral health unit.

Table 2. Cost of Emergency Room Referrals (1,896 Emergency Room Referrals Total)

Service	Cost
Psychiatric Bed Per Day	\$1,843.00
Psychiatric Doctor	\$215.00
Total (Combined Services)	\$2,058.00
Total (# of Referrals x Total Combined Services)	\$3,901,968.00

Additional cost calculations were provided for referrals from law enforcement to the Crisis Care Center as an alternative to ED encounters from 2011 to 2017. 1,847 individuals were diverted from the ED to the CCC, with basic costs calculated as noted below for a 24 hour hold at the hospital’s behavioral health unit, as reflected in Table 3.

Table 3. Law Enforcement Referrals (1,847 Law Enforcement Referrals Total)

Service	Cost
Psychiatric Bed Per Day	\$1,843.00
Emergency Room Costs	\$676.00
Psychiatric Doctor	\$215.00
Total (Combined Services)	\$2,734.00
Total (# of Referrals x Total Combined Services)	\$5,049,698.00

The resulting estimated cost savings to the hospital by Emergency Department doctors and law enforcement referring individuals to the Crisis Care Center based on these figures was almost \$9 million dollars. These estimates do not include the additional ancillary charges the hospital incurs which include items such as labs, medications, x-rays, and behavioral health interventions.

Operating Costs and Sustainability • The City and County have designated \$750,000 in their respective budgets to support ongoing operations. Revenue reimbursement from detox services provided at the Care Campus also support the operating budget and a percentage of operating costs is covered by federal grants.

Behavior Management Services (BMS), a private not for profit behavioral health provider, has its own funding streams from the State Department of BH and other sources. Partnering at the Care Campus allowed them, and the other site partners, including Pennington County Health and Human Services and Sheriff’s Office, to evaluate opportunities to combine staffing and otherwise gain efficiencies that ultimately enhanced BMS’ operating budget with increased efficiencies that support their sustainability.

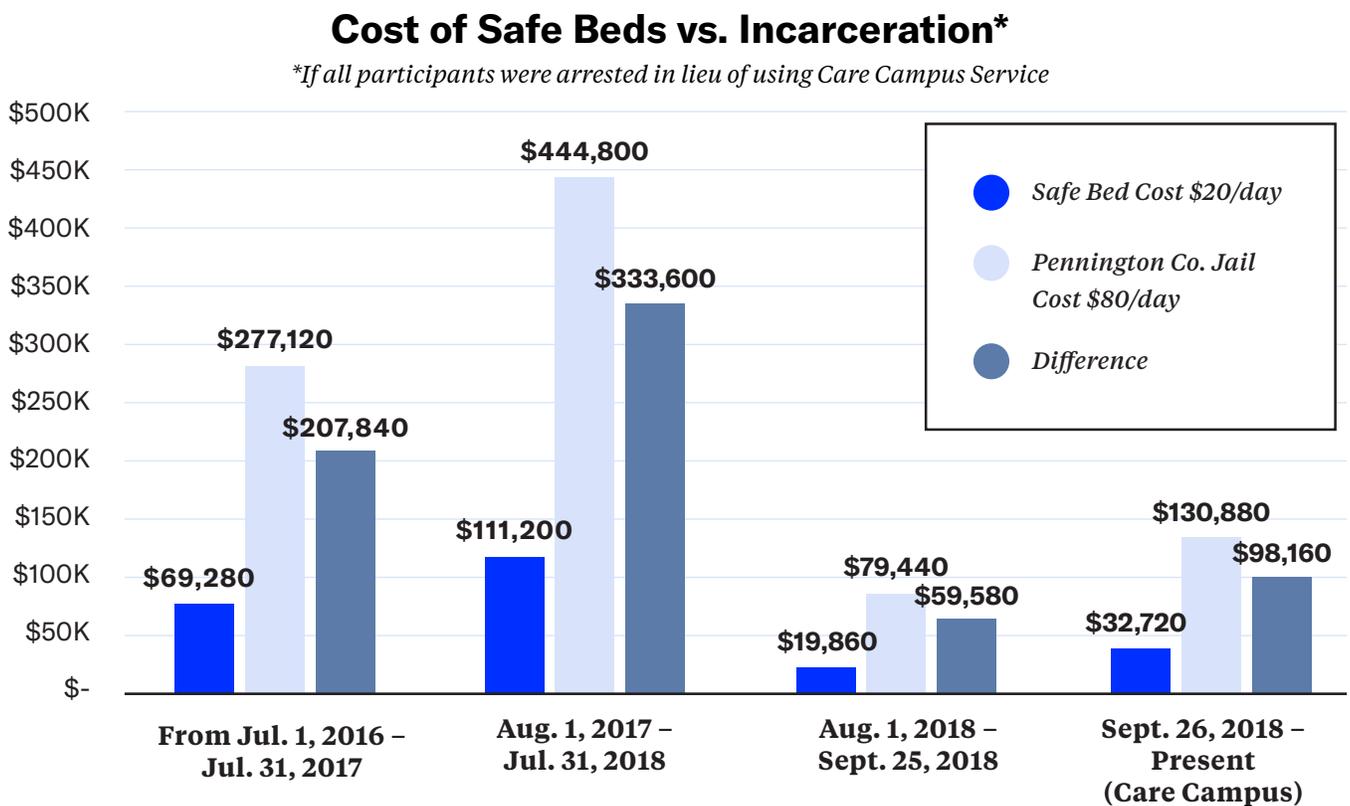
The Care Campus leadership has recognized from its inception the importance of having a proof of concept model to be able to demonstrate the program’s potential to save lives and reduce costs for the safety net.

The cost avoidance and individual outcomes data will be augmented by individual success stories. Leadership also believes that downtown business owners and other community stakeholders will experience firsthand the positive impact of the Care Campus’ contributions to addressing addiction and mental health issues that can lead to homelessness and public behaviors that community members find concerning, and will support continued investment of public dollars in the Campus.

Data Analytics, Data Sharing and Evaluation

Services at the Care Campus are documented in the same electronic record that is used for the Rapid City Police Department, Pennington County Sheriff Office, Pennington County Jail and Juvenile Detention Center, and the neighboring county’s criminal justice system. This creates a coordinated view of individuals served in the Care Campus with their history in the criminal justice system, while also supporting the ability to analyze and report on a shift in costs from jail to services provided at the Care Campus, as illustrated in Figure 1.

Figure 1. Cost of Beds at Safe Solutions (Care Campus) vs. Incarceration



In 2017 Pennington County received a five-year John D. and Catherine T. MacArthur Foundation Safety and Justice Challenge grant to support the goal of reducing the jail population by 20% within two years while also impacting the disproportionate representation of Native American people in the county’s justice system. The County is in the process of building performance measures for four strategies: (1) Tribal Outreach, (2) Case Processing, (3) Community Supervision, and (4) Pretrial Alternatives. Safe Solutions at the Care Campus is a key component of the Pretrial Alternatives strategy as an alternative to being booked into jail. The number of admissions to Safe Solutions at the Care Campus will be tracked by referral entity: Self, Law Enforcement (LE) Officer, or hospital. Specific to tracking progress with jail diversion, when a LE officer provides the referral to Safe Solutions they will provide information about what the individual would have been charged with if the person had been booked into jail. In January 2019 the County began collecting data monthly to monitor the impact of defined strategies on the jail population reduction goal. The Tribal Outreach strategy, primarily focusing on community outreach and engagement, drives the goal of reducing the disproportional representation of Native American people in the Pennington County jail population.

Table 4. Care Campus Services

Program/Service	Description	Responsible Agency/Partner
Safe Solutions	Sobering center with 46 mats for males and females under the influence of substances, primarily alcohol. Includes Safe Solutions case management services - case management to engage identified frequent utilizers in alternative options. Safe solutions is also an integral part of the County’s jail diversion program offering a pre-trial treatment alternative.	Pennington County Sheriff’s Office
Detoxification Services	35 detoxification beds for males and females (social detox; not licensed for medical detox).	Pennington County Sheriff’s Office; Pennington County HHS provides case management services
Residential Substance Use Disorder Treatment	Up to 64 treatment beds, <i>opening Spring of 2019</i> .	Pennington County Sheriff’s Office
Crisis Care Center	9 beds staffed 24/7 with Qualified Mental Health Professional on site; provides community with alternatives to inpatient psychiatric care and crisis follow up and transitional case management services that connect individuals with treatment and other services to reduce reemerging crisis.	Pennington County Sheriff’s Office; Contracted Operator is Behavior Management Systems, a private provider agency; Pennington County HHS provides transitional case management services
Quality of Life Unit	Specialized Unit conducting community outreach and engagement and case coordination with individuals challenged by chronic homelessness, mental illness and/or substance use.	Rapid City Police Department
Veterans Service Office	Links eligible individuals with VA benefits.	Pennington County HHS; VA
Economic Assistance	Rent, utility, transportation assistance.	Pennington County HHS
Medical and Medication Assistance	Indigent burials, medication voucher assistance, medical bill assistance.	Pennington County HHS
Individual Grant Assistance	Use of active grant funds for rent and deposit assistance, tools and clothing for employment, identifications, birth certificates.	Pennington County HHS
Rebound Reentry Program	Intensive case management services for individuals involved in the criminal justice system.	Pennington County HHS
Transitional Housing	Transitional housing option for individuals with a mental health diagnosis, substance abuse disorders, criminal histories and homeless.	Pennington County Health and Human Services, Behavior Management Systems, Private Developer and Local Foundation Funding for rental assistance

Behavioral Health Urgent Care Center: Knoxville, Knox County, Tennessee

The Behavioral Health Urgent Care Center (BHUCC), located in Knoxville, is the result of a long term-collaborative effort of leaders from county and city government, the District Attorney, Knoxville Police Department, Knox County Sheriff’s Office, and the Helen Ross McNabb Center, a private not for profit behavioral health agency. The BHUCC, established in March 2018, provides a full continuum of crisis services and drop off disposition for law enforcement. Nine misdemeanor charges have been established in the county for which law enforcement can automatically divert individuals who appear to have behavioral health issues to the BHUCC unless deemed violent, or for other exclusions based on risk, where they are assessed and offered voluntary admission with charges being dropped after successful completion of the program. The BHUCC offers access to a full continuum of substance use disorder services including sobering and withdrawal management, detoxification, and medication assisted treatment (MAT). Funding from the state of Tennessee provides the majority of the startup and operating costs for the BHUCC, while also funding six other sites in Tennessee, which are developing community-specific models for diversion of individuals with behavioral health conditions from the criminal justice system.

Sequential Intercept Model

Knoxville has developed its service delivery system in alignment with the Sequential Intercept Model. The table below highlights current services and programs operating at each Sequential Intercept point. These programs are the context for the BHUCC, with the criminal justice (CJ) system and behavioral health services coordinating community response to identify and divert, where possible, individuals from the CJ system and from hospital emergency rooms.

Table 5. Knoxville Programs by Sequential Intercept Point

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.

Leadership – Champions and Collaborations

The key leaders of the BHUCC initiative --- County and City officials; District Attorney; Knoxville Police Department and Knox County Sheriff’s Office; and Helen Ross McNabb Center --- have forged relationships with each other and with community stakeholders for many years, with some of the leaders working in the community for decades, building relationships with each other and the community to create a collaborative foundation that supported development of the BHUCC. All involved leadership partners speak to the critical nature of relationships based on trust and mutual respect to build and sustain a community’s crisis diversion facility. The Helen Ross McNabb Center has been operating in Knoxville for 70 years with a legacy of service to the community and ongoing relationships with leaders of public agencies and elected officials. As elected officials change, the core leadership group engages new incumbents and cultivates their understanding and support of the efforts underway in Knox County to provide alternatives to jail and effective response to individuals in behavioral health crisis. The BHUCC opened in 2018, but is the culmination of ten years of dialogue, relationship building, commitment, and advocacy for a centralized facility solution. The leadership of the Helen Ross McNabb Center is committed to quality improvement and this culture extends to their city and county partners, with stakeholders working together to identify and develop solutions and foster an environment for taking risks to support innovation.

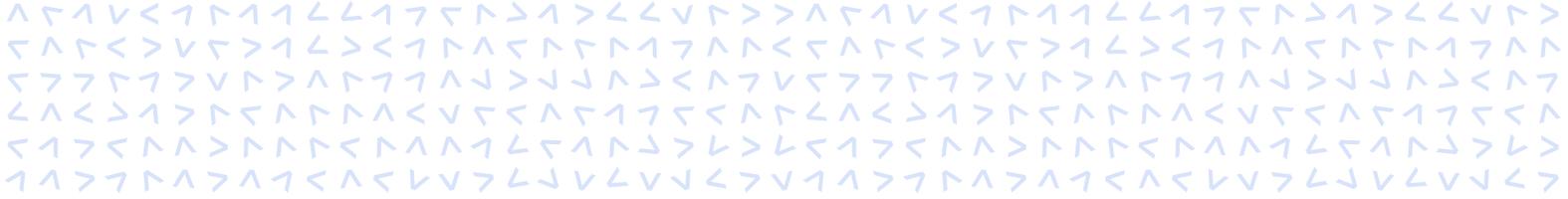
Community Context and Culture

The population of Tennessee is 6,715,984, with the population of Knox County being 461,860, and Knoxville’s population numbering 187,347. Demographically, the state of Tennessee is comprised of 73.9% White, not Hispanic or Latino, 17.1% Black or African American and 5.5% Hispanic or Latino with Knoxville comprised of 72.1% White, not Hispanic or Latino, 17.9% Black or African American and 4.9% Hispanic or Latino. In 2017 Tennessee had a per capita suicide rate with a rate of 16.1 per 100,000.

Over the past several years the Knox County Jail faced a growing problem with insufficient capacity at the jail while it also became increasingly difficult to hire adequate correctional officer staff. At the same time there was a growing population of individuals with mental illness in the jail requiring additional resources to manage. These trends became a topic of focus for the Sheriff and District Attorney in office at the time who began a dialogue between themselves, the former CEO of the Helen Ross McNabb Center, the Mayor, and other community leaders, about possible solutions. The District Attorney observed simultaneously at the court system that many people appearing in court had mental illness and related issues leading to their involvement in the criminal justice system. The leaders determined that the best outcome to drive the system toward was “individuals with mental illness never seeing the inside of a jail.” They had a growing clarity that the criminal justice system is designed for and effective with dealing with people with criminogenic traits and behaviors, but the people who were appearing because of mental illness, homelessness, and other social determinants, were amassing in the system and severely challenging its capacity and resources.

Current leadership refers to this as the “stars aligning” in terms of all the key leaders with potential to foment change coming together with a shared vision and commitment to develop a different way of addressing the needs of individuals in behavioral health crisis in Knox County. These leaders embarked on a community communications campaign, meeting with community groups to share their message and vision for developing a centralized facility to provide a behavioral health diversion alternative for law enforcement officers. They encountered a significant amount of concern from citizens about the location of such a center: the “Not in My Backyard” (NIMBY) phenomenon. Their response was to continue to share the information about the reality of the situation in the jail and criminal justice system, i.e. that community members who needed and

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could benefit from treatment were not getting what they needed and ending up in jail and that the facility they proposed could offer a better outcome. Speaking with passion and compassion, drawing on their authority and credibility of the leadership positions they held, and sharing data and information to tell the story, they cultivated the support of the community. Since the BHUCC opened in 2018 there have been no adverse incidents in the community emanating from its operation.

The former District Attorney now serves as Special Counsel to the current Sheriff and a key part of his role is supporting and continuing the momentum to proactively respond to behavioral health and related challenges in Knox County. Emerging issues in Knox County that are the subject of new initiatives include the large number of people with alcohol dependence being brought to the BHUCC by law enforcement not previously known by or served by the McNabb Center as part of its BH crisis services. Opioid use disorder is another focus, with the County addressing the comorbidity of Hepatitis C with street-based testing outreach and other measures to address this substance use disorder issue. The current District Attorney continues to be a champion of these efforts, continuing and building on the efforts established by her predecessor. The Knoxville police department leadership speaks to the evolution of the role of law enforcement to add the role of engagement and linkage to treatment to the historical role of public safety. Law enforcement officers tend to see the same people with the same issues that are the subject of 911 calls and are well-positioned to intervene at that point to link people to appropriate services and supports to break the cycle. This frees up resources for law enforcement and the safety net system. The current police chief also noted that if, through their intervention, officers can “disrupt that cycle with linking a person to the BHUCC for three days, it’s a win for the system.”

Communication and messaging has been key to developing support for the BHUCC, across the community and among law enforcement. For the past twenty years the Knoxville Police Department has established and expanded CIT and otherwise has developed a culture that supports the role of law enforcement in a community response to BH crisis.

Knoxville Police Department leadership has played a strong role in linking officers and BH providers, helping each understand and support the role of the other in addressing the needs of community residents.

Leadership underscores the problem-solving nature of the BHUCC and related efforts, building officer buy-in by sharing positive results, e.g. a person they have responded to numerous calls on is no longer showing up in the system because he has been successfully engaged at the BHUCC.

Initially, law enforcement officers who suspected they were dealing with an individual with BH issues who could be a candidate for the BHUCC called and spoke to a screener at the BHUCC. Leadership changed this to universal BH screening of every person on misdemeanor charges with a face to face screening at the BHUCC; officers bring the individual to the BHUCC for screening. This has resulted in a significant increase in the census at the BHUCC; 65-70% of those screened are kept for services. While the BHUCC does not have a 100% no wrong door policy, management requires staff to call the clinical leader if they are refusing a law enforcement drop off to staff the refusal and get approval for refusing. Officers report that the BHUCC is a more convenient option than the ER which requires medical clearance.

Coordination of Services and Community Continuum of Care

The BHUCC has a strong nursing component with coordination of care being a central focus for the clinical team. Individuals served at the BHUCC are linked to needed primary care at Cherokee Health or to the public health department. Data since the opening of the BHUCC shows that 60% coming through BHUCC are homeless. A community policing station is located on the periphery of the BHUCC, co-locating law enforcement and treatment. A primary focus of the BHUCC is jail diversion; most people served there would be in jail if the BHUCC did not exist.



The McNabb Center crisis services are located in the same building as the BHUCC and include crisis stabilization services, started in 2009, which are voluntary and referred with a warm hand off from law enforcement or referring clinical entities. The McNabb Center provides a full continuum of drug and alcohol treatment. This includes residential and detox services at a facility it operates next door to the BHUCC, with medication assisted treatment (MAT) with buprenorphine for 8-10 weeks. The focus for MAT and other SUD treatment is stabilization with a goal to transition to abstinence or to community-based MAT providers. While the detox/withdrawal management center typically has access, capacity for long-term rehab for individuals without insurance is limited and a challenge for continuity of care. When the BHUCC opened, McNabb and other BHUCC leaders saw a trend of people with alcohol use disorder being diverted who had been going to jail. These were not individuals previously known to the McNabb Center as part of their BH crisis services system. Vivitrol is initiated for those with alcohol use disorder in the jail and continued on an outpatient basis.

Funding

Capital Development • The capital cost for the BHUCC's 10,000 square foot facility was approximately two million dollars. Knox County and the City of Knoxville secured six hundred thousand as match to the state funds. These funds represented a split of 75% / 25% (state/local) of the total award. County leadership recognized the BHUCC plan was viable only with significant state investment so worked to garner a state appropriation of \$1 million for a five-year capital plan for renovation and repurposing of the BHUCC facility. The state of Tennessee funds the majority of the BHUCC through the state Department of Mental Health with matches from Knox County and the City of Knoxville. The State allocated funds in 2018 for seven crisis diversion initiatives dispersed throughout the state with the impetus being a reduction in jail overcrowding through pre-arrest diversion. Knoxville and each of the other six sites has unique funding match and program structures based on the funding available and prioritized needs in that community. While these funds were made available by the state in 2018, leaders in Knoxville have been meeting and working on developing a crisis facility solution for the past ten years.

Medicaid • The BHUCC in Knoxville is positioned within a crisis and SUD continuum of care operated by the state of Tennessee with general funds and a Medicaid managed care system, TennCare. The state has seven crisis stabilization units with walk-in centers (one for each of its planning regions), three crisis respite units, and five medically-monitored detoxification units. The crisis stabilization units are 15-bed facilities serving adults where walk-in triage is available and mobile crisis teams based in these units are available statewide. Law enforcement CIT teams are also an integral part of this crisis service delivery system.

Making the Case • McNabb Center received a SAMHSA early diversion grant five years ago which the Center used to generate cost avoidance data to support the case for a BH crisis diversion center. Community leaders used this data to make their case with the governor, whom they knew from his previous leadership tenure in Knoxville. The BHUCC opened with a focus on diversion for law enforcement; at this time the BHUCC is available for law enforcement diversion disposition only. A next step for BHUCC leadership is developing a case for hospitals to support ED diversion which is currently the primary option used by the community for BH crisis response. Like most communities and states across the country, Knoxville and Tennessee are challenged by insufficient jail capacity. Knox County is initiating a comprehensive assessment of its current jail infrastructure and capacity to analyze the possible need for more jail space, while continuing to seek and develop appropriate alternatives to jail, including the BHUCC which promises to have a significant positive impact on the community's diversion efforts.

Operations and Sustainability • The majority of initial funding for the BHUCC came from the state of Tennessee through the state Department of Mental Health. The operational plan for the BHUCC includes a County investment of \$600,000 and \$400,000 from the City committed annually for three years. 75% of the operating budget is state funds. BHUCC partners are gathering data to make the case for the state's continued investment in the BHUCC to sustain its operations.

Transforming a Life: A Story from the BHUCC

“Susan,” a middle-aged woman, had been incarcerated for several months after being arrested for a criminal misdemeanor charge and was refusing all medical care. She had a long history of complicated serious physical and mental health issues and the complexity of her health issues was compounded by her delusional belief that she was being poisoned. This ongoing refusal of care was contributing to a severe decline in her health, putting her at risk for death. Recognizing the urgency of the situation, leadership across systems (DA, Sheriff, and BHUCC Medical and Clinical Directors) came together quickly to determine a strategy, and Susan was furloughed from the jail to the BHUCC. Upon admission, BHUCC staff worked with her to develop an immediate rapport in the hope that she would agree to medical care. Susan agreed to treatment and spent time in a medical hospital to stabilize her medical condition before returning to BHUCC.*

At the BHUCC, the treatment team began working with her to help stabilize her psychiatric condition. Her fixed delusions that she owned a home and business made it difficult for staff to help her develop a discharge plan. But staff persevered in engaging her, and simultaneously worked on re-establishing her benefits, completing a housing match assessment for a priority housing placement, and coordinated with outpatient partners to make sure all components of her medical and psychiatric care were in place. Staff was also able to make contact with her family out of state who had been estranged from Susan for almost a year because they did not know her whereabouts. Once engaged by staff, her family has been supportive and helpful in the process of finding her an appropriate and safe home.

With the help of many partner agencies, her family, and the staff at BHUCC Susan now resides in a long-term supportive living environment that assists in helping her get to her medical appointments and provides her psychiatric care and monitoring on-site, and is enjoying greatly improved health, stability, and quality of life.

**Not her real name*

Data Analytics, Data Sharing and Evaluation

The Knox County Sheriff’s office, the administrator for the jail and related criminal justice data, the Knoxville Police Department (KPD), and the McNabb Center have a coordinated approach to reviewing and sharing data with a commitment to comprehensive discharge planning and following up with individuals to support stability in the community. Utilization trends at the BHUCC are monitored for quality improvement purposes. For example, if the number of law enforcement dispositions at the BHUCC trends down, administrators communicate with law enforcement leadership to, together, identify possible root causes for the reduction in use. Review of data combined with ongoing communication and education about the BHUCC are key to assuring it is used by law enforcement. The KPD Chief and her management team conduct a review of each charge of the established nine diversion charges every week to review the details and disposition of each case. This QI process assures that the BHUCC is being used by officers and provides an opportunity for corrective input when law enforcement's utilization of the BHUCC trends down.

Data Collected at the BHUCC:

- Cumulative number of individuals served
- Number of assessments completed
- Average length of stay
- Daily Census and Average Daily Census
- Population Demographics – Sex, Age (18+)
- Housing Status
- Frequency of Charge Types (in each of nine established charges).
- Outcomes: Referrals to Post-Discharge Treatment; Post-Discharge Initial Appointment Status; Repeat encounters at BHUCC: Returned to BHUCC, did not return to BHUCC.

Table 6. Highlighted Data from BHUCC (March 19, 2018 (BHUCC opening) – September 30, 2018)

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

Table 7. Behavioral Health Urgent Care Center (BHUCC) Services

Program/Service	Description	Responsible Agency/Partner
BHUCC	16 beds staffed 24/7 with clinical team (includes: nurse practitioner, registered nurses, master’s level clinicians, bachelor’s level clinicians/ case managers, and peer specialists). As a jail diversion center, the BHUCC provides drop-off disposition for law enforcement and pre-booking diversion for established nine misdemeanor charges. Provides comprehensive behavioral health assessment including medication evaluation, stabilization, treatment, discharge planning and referral and post discharge case management that connect individuals with community based treatment provider.	Helen Ross McNabb Center
Substance Use Disorder Triage and Sobering	Sobering services for four males or females under the influence of substances.	Helen Ross McNabb Center
Detoxification Services	Detoxification beds for four males or females licensed for medical detoxification services.	Helen Ross McNabb Center
Residential Substance Use Disorder Treatment	Referrals made for residential SUD treatment within the Helen Ross McNabb Center’s continuum of services or to outside providers.	Helen Ross McNabb Center or other providers
Medication Assisted Treatment – Induction for Opioid Use Disorder	Referrals made for residential SUD treatment within the Helen Ross McNabb Center’s continuum of services or to outside providers.	Helen Ross McNabb Center or other providers

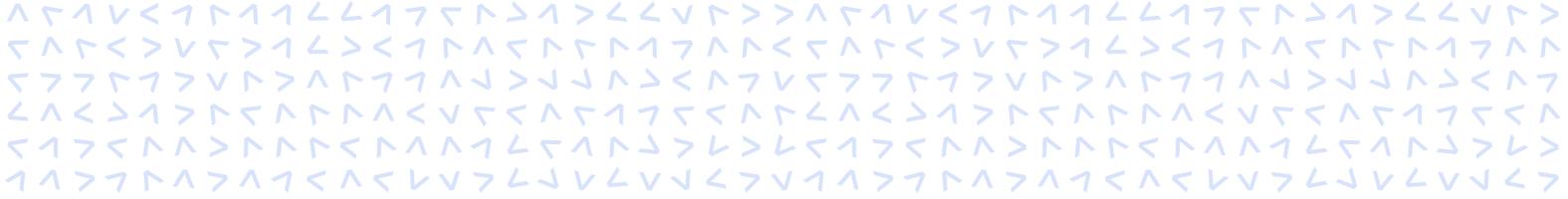
Program/Service	Description	Responsible Agency/Partner
Post crisis follow up	Community outreach and engagement and case coordination with individuals challenged by chronic homelessness, mental illness and/or substance use. Length dependent upon need, peer support, transportation to appointments, picking up meds, getting benefits, etc. Assistance with housing, follow up phone calls and visit if needed.	Linkage/referral to other McNabb Programming as eligible or other community based providers
Economic Assistance	Rent, utility, transportation assistance.	Pennington County HHS
Medical and Medication Assistance	Indigent burials, medication voucher assistance, medical bill assistance.	Linkage/referral to other community based providers
Individual Grant Assistance	Use of active grant funds for rent and deposit assistance, tools and clothing for employment, identifications, birth certificates.	Linkage/referral to other McNabb Programming as eligible or other community based providers
Rebound Reentry Program	Intensive case management services for individuals involved in the criminal justice system.	Referral to McNabb's Criminal Justice continuum of services or to outside providers
Transitional Housing	Transitional housing option for individuals with a mental health diagnosis, substance use disorders, criminal histories and who are experiencing homelessness.	Linkage/referral to other McNabb Programming or other community based providers

The Restoration Center: San Antonio, Bexar County, Texas

The Restoration Center is situated within the larger crisis response and jail diversion system in Bexar County and includes a full continuum of services for BH crisis and law enforcement disposition. The Restoration Center is a comprehensive crisis service center with a crisis walk-in center; 48-hour crisis observation unit; law enforcement drop-off; full continuum of care for mental health and SUD services; and primary care for triage/minor medical clearance. The Restoration Center was built with and has continued investment and involvement from county, city, state, and private entities including community hospitals and a local private hospital foundation. The Restoration Center is positioned within an advanced community initiative to address BH Crisis and criminal justice system diversion across the continuum of the sequential intercept model and acuity level for BH response.

Leadership – Champions and Collaborations

The Restoration Center has its origins in the Bexar County Jail Diversion program, initiated in 2002 by a group of stakeholders referred to as the Jail Diversion Planning and Advisory Committee (PAC). Leadership at the local mental health authority, The Center for Health Care Services (CHCS), brought together 22 community partners to form the PAC to help CHCS expand service capacity and educate the community about the benefits of jail diversion. To establish the PAC, leaders of the Bexar County program cultivated relationships through interpersonal contact, discussed the benefits of providing treatment alternatives to incarceration, and enlisted the support of a champion, a local judge, to build support for the initiative. The PAC met monthly for a year with sessions devoted to analyzing the human and systemic costs of the current system and inventorying the criminal justice, mental health, and human service entities involved in service delivery. Work groups developed recommendations for improvements to the system. From the work of this initial group multiple diversion initiatives were put into place and a stakeholder leadership group was formed to meet



monthly to review the functioning and outcomes of the local BH crisis system and to collaboratively identify opportunities for improvement. This group, known as the Community Medical Directors Roundtable (CMDRT), continues to meet monthly, and includes leadership representation from CHCS, the County, the City, San Antonio Police, Bexar County Sheriff, the local state psychiatric hospital, the county hospital, private hospitals, judges and other court representatives, Haven for Hope, a not for profit homeless services and transformation campus, and local providers and advocacy groups.

The group has several common commitments which have supported its longevity as a collaborative effort to address the community’s challenges in responding effectively to individuals experiencing BH crisis. These include:

- Representatives who attend the meeting are in positions of leadership or are otherwise empowered to speak for the entity they represent;
- Consistent attendance;
- Data-informed decision making;
- Interacting and working together as a system by respecting the roles and agendas of each participating partner and working together to address the challenge of resource gaps, i.e. recognizing that the sum is greater than the parts to move away from “turf battles” to cultivating solutions together.

The systemic response in place through the diversion system provided the foundation to develop a centralized facility with the primary aim of increasing efficiencies for law enforcement officers with disposition of BH crisis and consolidating CHCS’ MH crisis and SUD services. CHCS leadership identified a property downtown to serve as a site for the facility, in a location that would be convenient to law enforcement and central to the community near the downtown County hospital facility, where CHCS’ 24/7 crisis center had been located, the Magistrate Court, and central stations for the SAPD and Bexar County Sheriff. The property is also adjacent to Haven for Hope.

Community Context and Culture

San Antonio is the seventh largest city in the country with a population of 1,469,845, within Bexar County’s population of 1,958,578. Demographically, the state of Texas is comprised of 42% White, not Hispanic or Latino, 39.4% Hispanic or Latino and 12.7% Black or African American. Bexar County has a minority majority population with 60.3% Hispanic or Latino, 27.7% White, not Hispanic or Latino, and 8.5% Black or African American. According to Census reports 40.1% of households in Bexar County speak a language other than English at home.¹⁶ In 2017 Texas had a per capita suicide rate with a rate of 12.9 per 100,000 under the United States average of 13.7. A recent United States Census Bureau report using 2016 data shows the percentage of uninsured Texans at 16.6 percent in 2016: the highest uninsured rate of all 50 states — and almost double the national uninsured rate of 8.8 percent. Texas has the highest uninsured rate of all non-Medicaid expansion states. The uninsured rate in Bexar County was also reported at 16.6%.¹⁷

Bexar County’s diversion model includes components to divert individuals with mental illness and addiction from the criminal justice system, support successful community re-entry of incarcerated individuals, and provide behavioral health crisis disposition for law enforcement and the community. The criminal justice diversion and deflection system

There is currently an average of approximately 1,000 open beds per night at the Bexar County Jail. In June 2010, the jail was over capacity and the County sought to move prisoners to other cities.



includes multiple components contributing to its effectiveness. These include pre-adjudication screening and deflection for individuals with mental health conditions, multiple specialty courts including those focusing on specific populations – mental health, drug, solicitation charges, and veterans; and a county re-entry center with services to support former detainees with resources needed to successfully transition to the community. Law enforcement officers use a field-based screening tool (known as LE4) with four questions to identify and divert to screening those who may have BH issues. Its purpose is to flag persons who are suicidal and or may have a mental health issue. The LE4 tool is the initial step of the intake process at magistration. The Bexar County Sheriff’s Office, the San Antonio Police Department and all other law enforcement agencies in Bexar County have implemented procedures instructing officers to administer and document the LE4 questionnaire prior to submitting the required booking slip. The LE4 questions appear on the back of the booking slip which are then provided to a pretrial assessment officer for review as the detainee proceeds through the booking process. Based on the person’s response, if indicated, further assessments are completed by a licensed mental health professional.

The Restoration Center is connected to Haven for Hope, a private not for profit transformation campus for serving individuals experiencing homelessness. The Haven Campus opened in April 2010 and offers housing and transformational services for adults and families experiencing homelessness in Bexar County. 137 community partners provide over 300 services. There are 61 on-campus partners who provide regular services on Haven’s campus. 28 have offices on campus and 76 referral partners provide services to members at their own sites. CHCS operates an integrated care clinic, offering both psychiatric and medical services, on the Haven campus to approximately 900 patients per year. This clinic was initially funded by a CMS Health Care Innovations grant and focuses on individuals with a history of homelessness, mental illness, and co-morbid medical conditions.

Coordination of Services and Community Continuum of Care

The Restoration Center, operated by CHCS, is the site of Bexar County’s facility offering behavioral health crisis services to the community and drop-off disposition for law enforcement. The Restoration Center includes a comprehensive array of services: sobering beds for public inebriates; medical detox beds; intensive outpatient substance abuse treatment; outpatient substance abuse treatment; methadone administration; minor medical clinic; mental health crisis – screening and assessment; 23-hour crisis observation beds; access to crisis stabilization unit (15 beds) at a local private hospital – funded by appropriations through Senate Bill 292 in Texas’ last biennial legislative session; and mobile crisis outreach teams (MCOT). The Integrated Treatment Program that meets the needs of individuals with co-occurring mental health and addiction needs is supported by braided funding. Clinicians that are employed under separate state contracts for mental health, SUD, and the state’s Co-Occurring Psychiatric and Substance Use Disorder (COPS-D) services work together in an integrated team model. MCOT provides 24/7 coverage to conduct mental health crisis assessments in the community. If the call originates from a controlled environment, i.e. a hospital or other facility, the team responds without law enforcement. A law enforcement officer from the dedicated mental health unit accompanies MCOT for crisis assessment calls at homes or other locations in the community.

CHCS operates crisis respite and residential facilities at other locations. Individuals referred to the 24/7 crisis care center at the Restoration Center may be linked with these services for continuity of care or these beds may be accessed through the agency via other eligibility portals.

Peer support specialists are employed in various roles at the Restoration Center and in other roles in the county’s continuum of care, including jail in-reach through Haven for Hope to support community re-entry. The HUD Projects for Assistance in Transition from Homelessness (PATH) program operated by CHCSC employs a mental health certified peer support specialist to conduct outreach and facilitate linkage to services for PATH clients; another peer support specialist works in Supported Housing; and ten recovery support specialists are employed throughout the care continuum in substance use disorder services who engage clients and support connection to services and supplementary community resources. Peer services are funded under the relevant program contract, typically cost reimbursement, though the State has recently authorized Medicaid codes for billing for recovery support specialist peer activities.

Funding

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.

Making the Case • The Restoration Center opened in 2008 with \$6.1 million in state funding. In its first eight years of operation (2008-2015) approximately \$96,740,478 has been documented as cost avoidance for City and County jails, emergency rooms, and court rooms. The Restoration Center creates cost efficiencies because the San Antonio Police Department can quickly divert inebriates to the Center instead of detention facilities. Officers can also efficiently divert injured prisoners to the Center's on-site minor emergency clinic instead of the hospital ER, thereby saving time they once spent in emergency rooms. CHCS estimates the combined estimated value of getting officers back on the street is approximately \$2 million per year.

Medicaid • Texas has not expanded Medicaid and crisis services are funded in a variety of ways including state general funds, state Medicaid match, the Medicaid Rehabilitation Option, a Medicaid 1915(b) waiver, a Medicaid 1115 waiver, Federal Emergency Management Agency (FEMA) funds, and local government funding.

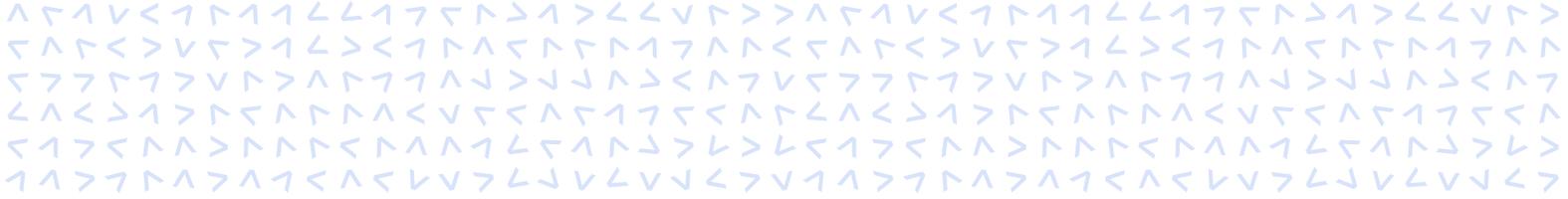
General Funds for Crisis Services • About 40 percent of those served by crisis services programs are covered by Medicaid, with the remaining 60 percent being uninsured and covered by state general and local funds. In Texas, hotlines are funded through state general and local funds and warm lines are typically funded through state general funds and the mental health block grant.¹⁸

Operations and Sustainability • Multiple funding streams are braided to support the array of services and programs housed at the Restoration Center, with a total operating budget of \$36 million. The crisis services – 24/7 screening/assessment, crisis observation, psychiatric medical services and MCOT - are contracted with the Texas Health and Human Services (HHS) Department of State Health Services (DSHS) within a state funding and regulatory system structured for the local mental health authorities (LMHA) to provide crisis services in their respective catchment areas. CHCS is the LMHA for Bexar County. DSHS has specific contracts for SUD services lines offered at Restoration Center. The Medication Assisted Treatment (Methadone) services are funded by a cost reimbursement contract with HHS and billing of third-party payors. Historically the payor mix has been approximately 60% funded and 40% unfunded (billed to HHS under cost reimbursement) but this trend has shifted recently with the advent of new MAT clinics opening in Bexar County and is now closer to 40% funded and 60% unfunded. The county/safety net hospital, University Health System (UHS), also contracts with CHCS for cost reimbursement for a number of unfunded individuals. Texas HHS funds suboxone treatment for 600 individuals. SUD outpatient treatment is funded through a combination of billing third party payors; Texas HHS cost reimbursement contracts; contracts with Bexar County through the court/diversion system; and through UHS's CareLink, the County's health insurance program. The Restoration Center is licensed for and contracted with HHSC for 28 medical detox beds, with cost reimbursement and UHS-CareLink combining as funding sources.

A specialty program for pregnant and parenting opioid-addicted women (the "Mommies" program) was initiated under a SAMHSA grant and has been continued through braided funding when the grant expired. UHS contracts with CHCS to serve individuals in this program, and Texas HHS 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.

Texas HHS contracts with CHCS for several specialty programs, including the Co-Occurring Psychiatric and Substance Use Disorders Program (COPS-D) program; and three recovery support programs: the neonatal abstinence syndrome; DSHS Recovery Support – a pilot to develop a model for recovery support; and Recovery Support team which supports an integrated treatment program located at a Haven for Hope dorm.

The Sobering and Injured Prisoner operation, which includes the sobering and minor medical triage operations, has dedicated access for all law enforcement in the city of San Antonio, municipalities in greater San Antonio, Bexar County, and Life Safety Officers (security personnel) at Haven for Hope. The City of San Antonio (COSA) funds \$1.25 million of the \$1.5 million operating budget for this portion of the operation at the Restoration Center.



Data Analytics, Data Sharing and Evaluation

The Restoration Center is the subject of well-established and comprehensive data sharing and analytics that include: the CMDRT, the community collaborative forum of stakeholders that reviews and responds to a set of data/metrics on a monthly basis; MEDCOM system, a community initiative that includes real time communications between law enforcement and hospitals for disposition of BH crisis/emergency detentions; and Signify Health, a population health technology platform to identify and provide high utilizer response coordinated among county hospital, the local mental health authority CHCS, 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 operation 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.

The CMDRT reviews a standard set of data monthly at its standing meetings, using this data to monitor trends through the hub of the Restoration Center in mental health crisis, substance use services utilization, psychiatric emergency and inpatient services utilization to understand the demand for, engagement in, and successful completion of services. Data is pulled from the following operations: Public Safety Unit/Sobering; Minor Medical Clinic/Injured Detainee; Detox Unit; Crisis Care Center; Mobile Crisis Outreach Team; Crisis Stabilization Unit; and the Josephine Recovery Center, a crisis residential facility located at another site.

Data Sharing to Coordinate Mental Health Emergency Detention •

MEDCOM (Regional Medical Communications Center) is the Law Enforcement Navigation system used by all law enforcement entities in Bexar County for disposition of individuals on emergency detention. All behavioral health facilities with inpatient beds report their diversion status electronically in the system, and a 24/7 dispatch center also handling all medical trauma patients in the region routes medically stable psychiatric patients to the appropriate facility. MEDCOM monitors both law enforcement responses to psychiatric related calls and psychiatric facilities’ diversion status in real-time to anticipate and navigate patients to ensure load-balancing of the crisis diversion system. System data is analyzed to monitor and enhance system performance. The Southwest Texas Regional Advisory Committee (STRAC) is designated by the Texas Department of State Health Services (DSHS) to develop, implement, and maintain the regional trauma and emergency healthcare system for Bexar and contiguous 21 counties in the region. A collaborative process among all stakeholder hospitals and the local mental health authority facilitated by

In 2018 the Law Enforcement Navigation Program reduced emergency detentions in EDs by 50% and only 1% of navigation requests resulted in a transport to jail.

STRAC resulted in the formation of an emergency department diversion MOU that includes rules and responsibilities for participating emergency facilities to adjust their diversion status and keep information updated. The MOU also includes the law enforcement/MEDCOM Emergency Detention Medical Stability Protocol and facility selection criteria guide.

The Southwest Texas Crisis Collaborative (STCC), under the sponsorship of the STRAC, is an effort focused on ending ineffective utilization of services by the safety net population at the intersection of chronic illness, mental illness, and homelessness in San Antonio and Bexar County. This collaborative uses an online platform, Signify Health, a cloud-based technology platform designed to address a patient's social determinants of health (SDoH) deployed to organizations within the behavioral health system of care. The involved organizations use an Organized Health Care Agreement (OHCA) (see Appendix B), with STRAC serving as the backbone organization, and are entered into a business agreement when participating in the data sharing platform. Different agreements relative to the type of participating organization are used to communicate to the OHCA. OHCA members currently include most area hospitals and CHCS, with the goal to successively add community based organizations. Area hospitals and a private hospital foundation are funding this initiative.

Data elements collected and reported in a dashboard for individuals subject to emergency detention routinely reviewed by the STCC Steering Committee are:

- # of incidents by type
 - LE Transported to Psych, MEDCOM Navigated
 - Emergency Detained in a hospital
 - LE Transported to Psych, MEDCOM Not Requested
 - LE Transported to Jail
 - LE Transported to General Hospital
 - EMS Transported to General Hospital
 - Incident canceled by LE
- # of type of Emergency Detentions Not Transported to BH Facilities
- MEDCOM Program Adoption % and Program Growth
- MEDCOM Navigation by Destination Facility and Response Area and Demographics

Highlights of System for Complex Crisis Patient Data Sharing

- Participating entities of police departments, fire department, hospitals, and LMHA contribute to a common complex crisis patient list. Facilities submit “candidates” electronically that are queued until consent is received. Once the “candidate” presents, the goal is to get their consent and have them become a member of the target served population.
- HL7 feeds from hospitals while admits/discharges are also received in the database. Basic demographic information and a diagnosis are included.
- Once consent is obtained, an SDoH survey (16 questions) is conducted with the goal of making a referral to the appropriate community-based organization.
- The feed from MEDCOM alerts providers once the patient is in the Complex Crisis Patient List in the data sharing platform.

Analyzing Super Utilizers in Bexar County • In March of 2018, a local private hospital foundation released a report detailing an analysis of high utilizers of healthcare in Bexar County for a one-year period.¹⁹ Super-Utilizers were defined as safety net patients who had: 3+ inpatient discharges or had both a serious mental illness diagnosis and 2+ inpatient discharges; ED utilization of 9+ visits. For the analysis the county “safety net” population was unfunded and underfunded patients as defined by insurance plans and generally included Medicaid (traditional, managed Medicaid, CHIP) and Self Pay/Charity, CareLink, and other indigent care programs. Encounters across all sites and setting totaled almost \$1.2 million with the safety net patients generating on average 3.5 encounters per patient. Two percent of the overall safety net population had 24 or more encounters in the 12-month period studied. The analysis also showed there was significant patient crossover among the major systems in Bexar County for total safety net patients representing a challenge for any provider to put together a coordinated care plan for any patient. The total costs of providing healthcare for the safety net population as a whole exceeded \$1.1 billion annually.

Table 8. Restoration Center Services

Program/Service	Description	Responsible Agency/Partner
Public Sobering and Minor Medical Triage	Sobering center with 20 beds for males and females (total of 40) over the age of 18 who are under the influence of substances, primarily alcohol. A co-located minor medical clinic is staffed 24/7 to provide San Antonio Police and Bexar County Sheriff’s Deputies with an alternative to emergency departments for medical clearance and stabilization. These services are also available to law enforcement officers as part of the County’s jail diversion program offering a pre-adjudication disposition alternative for sobering of public inebriates and minor medical clearance.	Center for Health Care Services, the Local Mental Health Authority for Bexar County/City of San Antonio
24 Hour Crisis Care Center	Behavioral health services provided to adults 7 days per week/365 days per year with full clinical staffing: MDs, Nurses, Techs, Peers, Social Work. Provides community with alternatives to inpatient psychiatric care and crisis follow up and transitional case management services that connect individuals with treatment and other services to reduce reemerging crisis.	Center for Health Care Services
24-hour Crisis Call Center	Crisis hotline staffed by trained crisis counselors and licensed mental health professions. Law enforcement, EMS, Mobile Crisis Outreach and other first responders can be dispatched immediately in emergency crisis situations.	Center for Health Care Services
Detoxification Services	28 medical detoxification beds for males (20) and females (8)- licensed for medical detox protocols for alcohol, opioids, benzodiazepines and other substances. Post detox linkage to residential and outpatient substance use disorder treatment. Services reserved for individuals with Medicaid benefits or those without insurance benefits.	Center for Health Care Services

Program/Service	Description	Responsible Agency/Partner
Substance Use Disorder (SUD) Treatment	Intensive Outpatient and Outpatient SUD services available onsite; specialty program for pregnant and parenting opioid- addicted women. Access to primary care.	Center for Health Care Services
Medication Assisted Treatment (MAT) with Primary Care	Buprenorphine Induction for Opioid Use Disorder for 600 people; Methadone treatment provided onsite; includes primary care services for MAT clients and their families.	Center for Health Care Services
Crisis Care Center: 48 Hour Observation	16 beds staffed; provides communi-ty with alternatives to inpatient psychiatric care and crisis follow up and transitional case management services that connect individuals with treatment and other services to reduce reemerging crisis.	Center for Health Care Services
Post Crisis Follow Up Services	<p>Community outreach and engagement and case coordination with individuals challenged by chronic homelessness, mental illness and/or substance use.</p> <p>-45 days post crisis peer services: peer support, transportation to appointments, picking up meds, getting benefits, etc.</p> <p>-Assistance with housing, children’s services, etc.</p> <p>-Follow up phone calls and welfare checks.</p>	Center for Health Care Services
Projects for Assistance in Transition from Homelessness (PATH)	Specialized Unit conducting community outreach and engagement and case coordination with individuals challenged by chronic homelessness, mental illness and/or substance use.	Center for Health Care Services/HUD
Special police department unit for response to frequent 911 callers and recidivists	SAPD MH Unit has a pilot program utilizing CHCS MCOT clinicians to do outreach to individuals who frequently call 911 or have been arrested multiple times.	San Antonio Police Department; Center for Health Care Services
Mobile Crisis Outreach Team (MCOT) and Children’s Mobile Outreach Team (CMOT)	<p>Mobile Team Clinicians respond to calls from the community for crisis screening; help police respond to cases with mental health nexus. Officers help clinicians respond to higher acuity calls. Mobile Team Clinicians MCOT and CMOT clinical staff respond to calls from the community and the crisis hot line for crisis screening and assessment; help police MCOT and CMOT staff coordinate with law enforcement to respond to cases with mental health nexus calls that may present dangerous situations or that require a law enforcement intervention such as an emergency detention. Officers helps clinicians respond to higher acuity calls.</p>	Center for Health Care Services; San Antonio Police Department; Bexar County Sheriff’s Office

Program/Service	Description	Responsible Agency/Partner
Specialty intensive case management and care coordination services for individuals involved in the criminal justice system and for individuals experiencing homelessness with a history of BH crisis	CHCS operates several programs that address justice involved individuals with behavioral health issues through various contracts and funding streams. Forensic ACT; TCOOMMI GENESIS program, Forensic Court program, Drug Court program, Community Reintegration Program; Integrated Care Program at Haven for Hope.	Center for Health Care Services; Haven for Hope
Transitional Housing	Transitional housing and supported housing services for individuals experiencing homelessness with a mental health diagnosis, substance abuse disorders, criminal justice involvement. Short term, crisis response, stabilization and referral services.	The Center for Health Care Services

Replicating the Crisis Diversion Facility Model

Multiple leaders, champions, and stakeholders were interviewed, and programs and facilities in five communities observed, to inform this report highlighting promising practices of crisis diversion facilities. Community efforts to develop crisis diversion facilities are proliferating, 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.

[A Community Guide for Development of a Crisis Diversion Facility](#), provides additional detail on planning, developing, implementing, and funding crisis diversion facilities.

Appendices

Appendix A. Detailed Model Framework

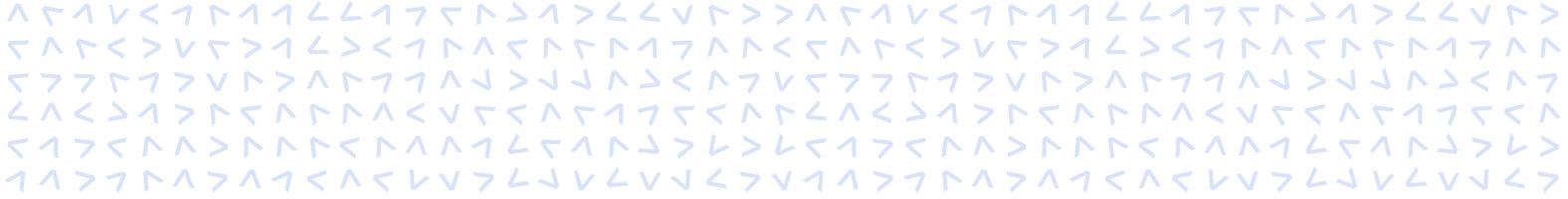
Model for BH Crisis and Jail Diversion Facilities

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.*

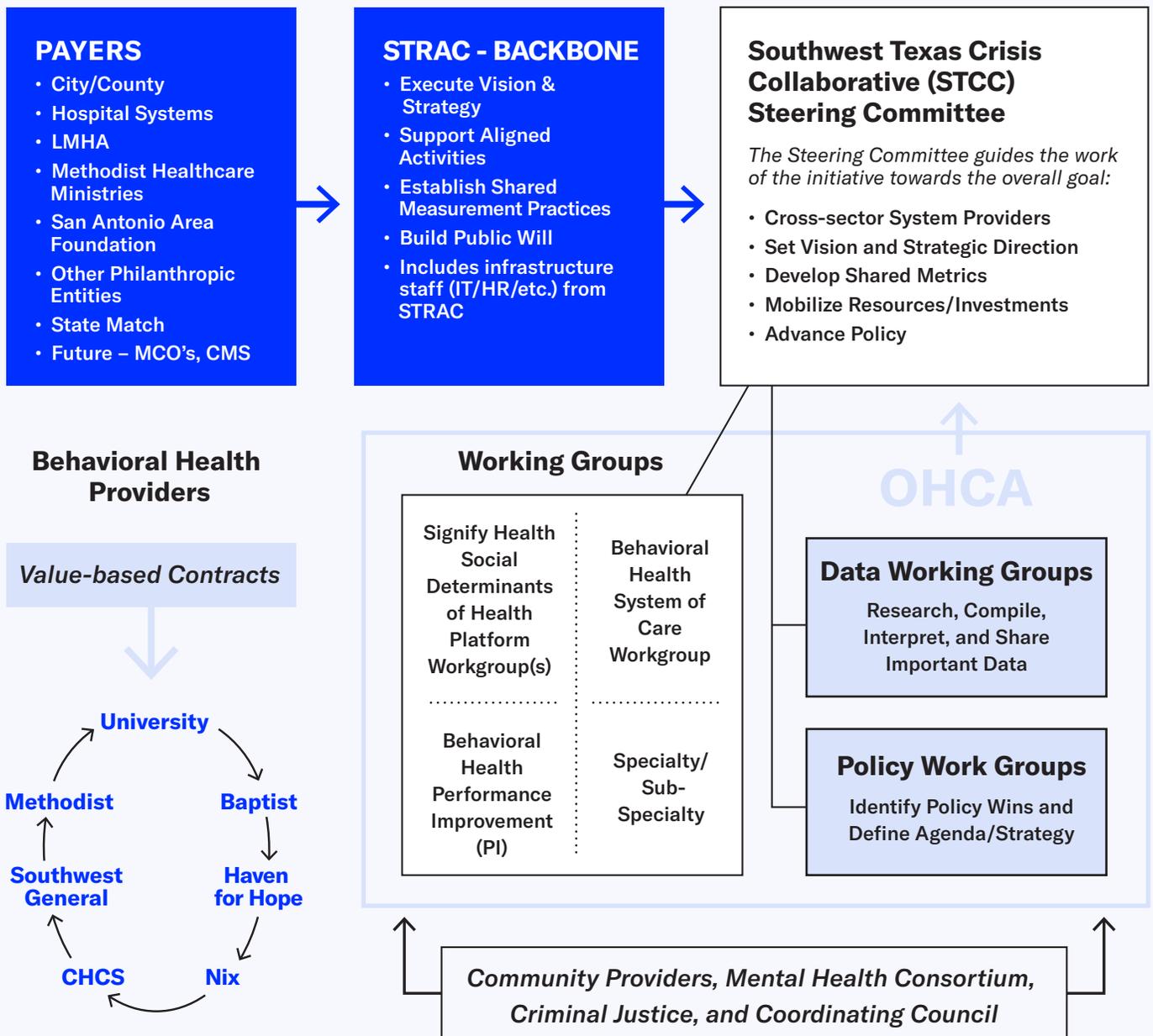
- Crisis Stabilization Unit (24-72 hours)
- Psychiatric Emergency Programs (24-72 hours)
- Sobering Center
- Detoxification Services
- Community Respite (1-2 weeks)
- Peer Respite Programs

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. Integrated System of Care—Southwest Texas Crisis Collaborative

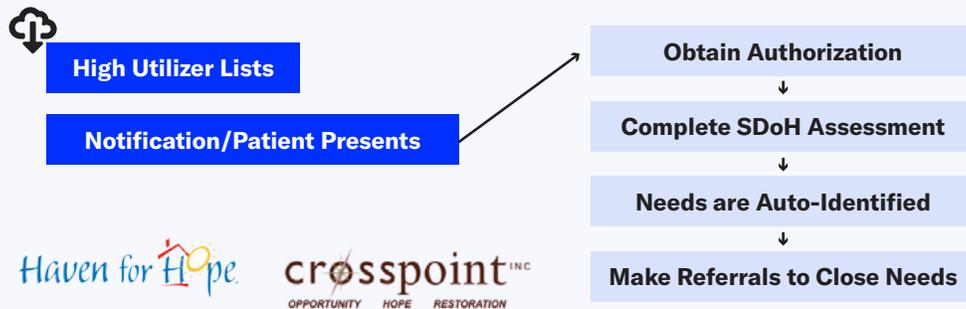
Integrated System of Care



Appendix C. Organized Health Care Agreement (OHCA) with STRAC

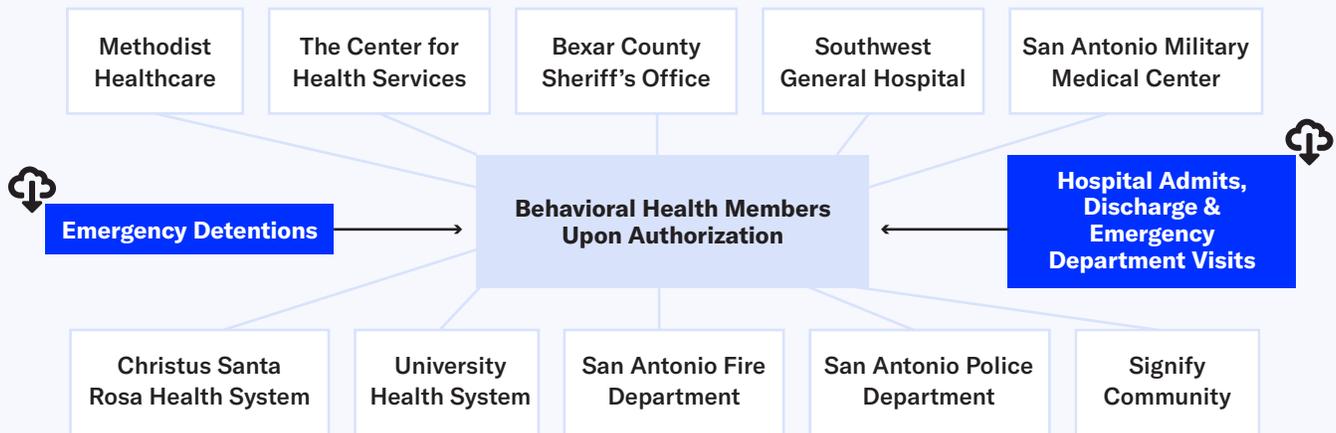
Southwest Texas Crisis Collaborative Referral Network

Network Authorizations



OHCA Agreement

Behavioral Health Candidates Converted

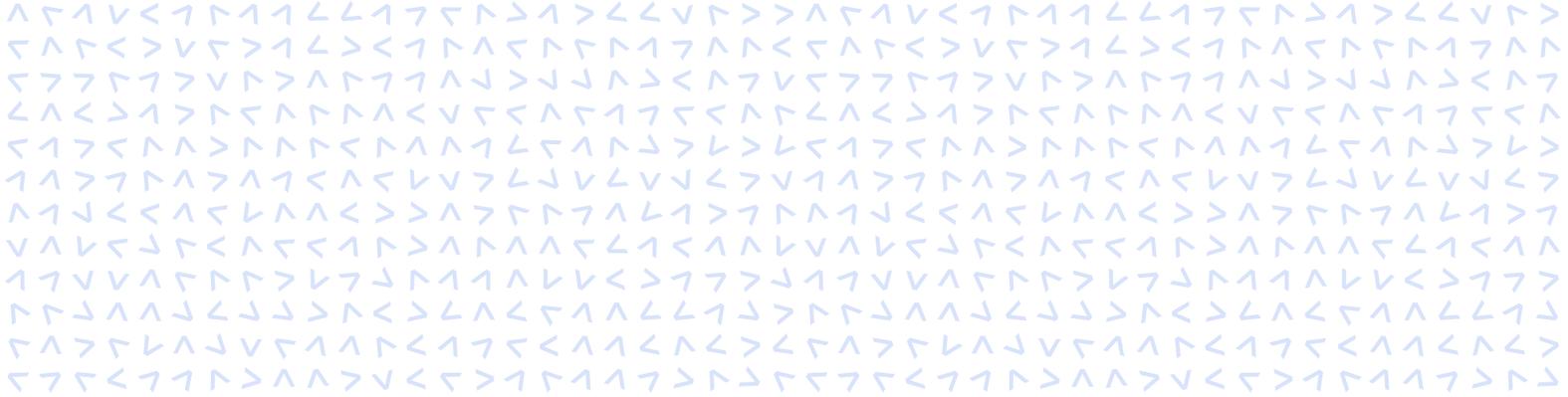


Signify Community™

STRAC
Southwest Texas Regional Advisory Council

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 Krawczyk, 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*. http://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 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.
- ¹¹ Krawczyk, 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://www.ncbi.nlm.nih.gov/pubmed/29200340>. 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 United States Census Bureau. *Quick Facts Bexar County, Texas*. <https://www.census.gov/quickfacts/fact/table/bexarcounytexas/IPE120217>. Accessed January 15, 2019.

¹⁷ Arriaga, A. *Fewer Texans were4 uninsured in 2016, but state still has largest health coverage gap*. (2017). The Texas Tribune. <https://www.texastribune.org/2017/09/12/census-report-finds-45-million-texans-are-still-uninsured/>. Accessed January 15, 2019.

¹⁸ Truven Health Analytics, Inc. *Crisis Services: Effectiveness, Cost-Effectiveness, and Funding Strategies*. SAMHSA. https://www.nasmhpd.org/sites/default/files/SAMSHA%20Publication%20on%20Effectiveness%20&%20Cost-Effectiveness%20of,%20and%20Funding%20Strategies%20for,%20Crisis%20Services%206-5-14_8.pdf. January 29, 2019.

¹⁹ *Bexar County High Utilizer/Homeless Healthcare Analysis*. (March 2018). Southwest Texas Crisis Collaborative: Southwest Texas Regional Advisory Council. Capital Healthcare Planning.